**Health of Older People Strategy 2016–2026**

**Consultation submissions**

**109 – 131**

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| **Submission 109** |

**RETIREMENT VILLAGES ASSOCIATION  
COMMENTS ON THE DRAFT HEALTH OF OLDER PEOPLE STRATEGY**

1. **Introduction**

The Retirement Villages Association represents the interests of the owners, developers and managers of retirement villages throughout New Zealand. Our 350 member villages are made up of around 26,400 villas and apartments that are home to some 34,400 older New Zealanders. These figures are growing at a rate of around 40 units and 60 new residents each and every week.

As a result, the RVA’s members are major domestic house builders as well as providing purpose-built, comfortable warm accommodation for older people. As at December 2015, 83 villages had 5,900 units at some stage in the planning, consent, or construction process and a further 65 “new build” villages had been identified, offering a further 10,200 units and apartments. This development pipeline would add almost 50% to the existing village stock, although it would take several years to complete.

The RVA was a member of the Expert Advisory Group involved in the development of the Strategy and we appreciate the opportunity for the input in that process.

This submission will consider the draft Strategy in the order it has been published.

1. **A “homogenous population”**

We agree with the observation on P.1 that the older population is far from homogenous. Aging is partly chronological and partly psychological. Frailty is not necessarily associated with a particular age, but rather a combination of age, physical ability and mental acuity. For that reason we prefer the concept of the three stages of retirement developed by the Commission for Financial Capability:

The Discovery stage

This first or early stage of retirement will, for many, be the 'doing' years. The time to have a go at all the things you've said you'd get around to 'some day'.

[The 'Endeavour' stage](http://www.cffc.org.nz/retirement/the-three-stages-of-retirement/stage-two-75-84/)

The middle years of retirement may be more about consolidation, a time to choose fun things, develop old skills, explore fresh talents and grow new friendships.

[The 'Reflection' stage](http://www.cffc.org.nz/retirement/the-three-stages-of-retirement/stage-three/)

As this third stage is a time when health and finances may limit choice, it's a time to accept help graciously, to make the most of all those memories and to keep up with old friends because you hold each other's history.

We also support the concept of a “person-centred” approach and suggest that it would be helpful if the Strategy reflected a similar approach to ageing.

1. **Healthy ageing**

We note and support the focus on health environments and age-friendly communities. Retirement villages are designed to be leaders in providing age-appropriate housing and an environment that supports people as they age. Many villages incorporate elements of universal design, which contribute to the physical environment factors for healthy ageing.

We support the Strategy’s recognition of the importance of age-friendly housing (p. 16), including rentals (there are approximately 450 rental units in retirement villages across NZ), and social housing.

Around 35% of our residents [[1]](#footnote-1) report that they realised more than $100,000 when they sold their homes and released the equity they had saved for decades. This extra money provides a firm economic base for their retirement and is one of the key drivers for people to move to a village.

1. **Living well with long-term conditions**

We support the use of technology to enable healthy aging (p. 22). However, we note that so far much of the development of the technology has fallen on providers without any recognition of the cost-savings the technology delivers to the health system. We submit that the cost benefits to the funders as well as to the older person should be recognised in the Strategy.

1. **The delivery of home-based support**

We support the shift in philosophy away from doing things *for* people to doing things *with* people to help them regain the ability to manage their lives (p.17). Retirement villages are designed to encourage independence as well as provide a continuum of care should that be needed.

However, one essential element in providing a continuum as well as enabling effective restorative care is the inability of most village operators to contract directly with DHBs to provide home-based support services to their own residents. This issue has been raised on numerous occasions during the Strategy’s consultative process and it is disappointing that there is no direct reference to it. We note that the Strategy’s wording focus on “integration”, especially around “gaps and delays in coordinating care” (p. 18) and the desirability of further trials in achieving the successful transition from hospital to home.

While our preference is for a direct reference to the desirability of contracting competent villages to undertake this work, the Association argues that the wording on p.18, along with other observations in the Strategy such as in the “Health Workforce” on p. 22, “Services closer to Home” on p. 24, and, on p. 25, encouraging DHBs to “achieve best value and high performance” by commissioning services “in a way that provides older people with quality care in the right setting at a sustainable cost” supports our stance.

We note the intention in the Strategy (p. 22) to “invest in this workforce, and develop service and funding models that support a sustainable … approach to the support of older people ...”and expect this intention to be backed with increases in the subsidies paid to aged residential care providers and others who deliver the care to the older person.

Having made that point, we note on p. 24 that “older people value their independence highly”. While this may be true, we would be concerned if this is used as an excuse to prevent an older person receiving appropriate care in an aged residential care facility. There needs to be a balance between respecting independence, delivering suitable home-based support and admission to appropriately-supported and funded care. It would be useful if the Strategy included this point.

The same page notes that older people “want to stay at home”. We would be interested to see if this is supported by research and whether it takes into account circumstances when it’s simply not safe for the older person to remain at home when they would be better off in a retirement village or in care.

1. **Action Plan**

While we support an action plan in sufficient detail to be able to measure performance in achieving the Strategy’s outcomes, we believe that the responsibility for the “lead agency” needs to be more widespread than just the government agencies listed in most of the points .

We understand that for each action point, the Ministry intends to clarify the lead agency, ensure the lead agency can be accountable, and define resources required such as funding, and then list other agencies and organisations that have an implementation role.

We would like to add the RVA as an organisation that has an implementation role in the following areas:

1 – Build social connectedness and wellbeing … subclauses a, b and c

3 – Work across government to prevent harm … subclauses d and e (dealing with social housing and age-friendly communities)

6 – Support effective rehabilitation closer to home … subclause a

9 – Ensure that those working with older people … subclause e

10 – Enhance cross-sector, whole-of-system ways of working … subclause b

13 – Use new technologies to assist older people … subclause b

15 – With service users, their families and whanau, review the quality … subclause c

18 – Better integrate services for people living in aged residential care … subclause d. The RVA is keen to work with members, DHBs and the Ministry to find ways that existing villages and residential care facilities can provide medical services beyond those required for older people to others in their immediate community. For example, rural villages could provide basic health care for all ages as the clinic and staff are (generally) available.

25 – Implement the Strategy … subcause a. The RVA is keen to continue to work with the Ministry and other stakeholders to develop the Strategy Implementation Plan.

26 – Include older people in service design … subclause d and e (RV Resident Association members could be representatives for their cohort in regional forums).

1. **Conclusions**

The RVA appreciates the opportunity to contribute to the Strategy and we look forward to continuing to do so during the Implementation phase.

We are happy to meet with officials to discuss any aspect of this submission.

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| **Submission 110** |

This submission *(tick one box only in this section)*:

x comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

is made on behalf of a group or organisation(s)

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Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

Māori  Regulatory authority

Pacific x Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

x Academic/researcher x Other *(please specify)*:  
Consultant in Health Service development…interest in rural health.

## Key points in response to the draft strategy:

Firstly, well done on putting this draft strategy together. I know a lot of effort has gone into it. However, its only when its compiled that you get a feel for it. I appreciate this opportunity to comment. I would like the feedback to be looked on as constructive. I am also happy to speak to this if you like.

Suggestions that come to mind from a strategic perspective:

1. Change the name of the strategy to ‘the healthy aging strategy’.
2. This strategy should be an adjunct to the NZ Health Strategy, not a stand alone or repetition of it. There should be clarity over where this informs the overarching strategy. This strategy should just relate to the challenges in health care and maintenance that are faced by those who are ‘older’.
3. Take more of an outcomes focus in the strategy instead of a process one. An outcomes focus enables innovation more readily. How do we know that the processes espoused in this document will actually work here in NZ in 2016 and beyond? In fact some have been tried and don’t, that why we need this strategy.
4. Value aging. The increasing experience people gain as they age should be valued as a potential contribution towards building a more sustainable health system. This includes valuing consumer engagement and partnership and also valuing the aging employee.
5. Enable people to age in communities of their choice safely. That includes those living rurally. Not all of us fancy living in a Las Vagas styled communal living environment.
6. Build on the potential of telehealth and associated digital technology for both consumers and also for health providers.
7. Don’t replicate in this strategy goals and actions that are (should be) in the NZ Health Strategy. This relates specifically to the goals around chronic conditions and end of life care. Most with chronic conditions would likely have had them prior to old age. Same with end of life goals. Demonstrate how this strategy can to the impact of older age on these.

Maintain the vision in each of the sections.

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The strategy title should be changed to the ‘**healthy aging strategy’**. There is no definition of an ‘older person/people’ in the document. Many chronic conditions have well set in by 65 years of age if that is when being an older person begins. To enable healthy aging we need healthy living well before 65.  The vision should include ‘**in communities of their choice’** not ‘age friendly communities’. Not all of us want to live in retirement villages. The concept of ‘age friendly communities implies they are artificially generated in specific localities. All communities should enable those who are aging to live in safety (regardless of age!).  You also need to include **valuing the knowledge, skills and wisdom of people with life experience**:   * Support the transition from paid employment. This is a huge adjustment and will enable better mental health among older New Zealanders. * Provide opportunities for them to engage in the health sector to partner providers and consumers (volunteer/coach). * Provide ‘step sideways’ roles in the health sector. We will need all of the workforce we can retain. * Value Kaiawhena over the age of 40 years. They will likely stay significantly longer in their roles and have the appropriate life skills to meet the growing demand in the community particularly. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| **Build connectedness:**  I notice that responsibility in this section is given mainly to social agencies, if so, then the MOH need to be accountable for the outcomes.  ***This strategy needs to be more outcomes focused not process focused***. How do you know for sure that the processes you espouse will actually work and further more it is shameful that many of the processes stated are not in place already 9in fact I know they are but are not working…….why not??.  I have been doing some work lately about access to health services for those in **rural localities** and have also lived rurally. Many older people in these communities feel the need to move into the cities to be closer to specialist services. The aged care facilities in these localities, because of their scarcity are often in a state of neglect. This shift to a new location in your late seventies onwards can be devastating for those who have lived for generations in these localities. In my experience this shift reduces their life expectancy. A city is a complex and confusing place for someone who is used to knowing everyone in their community. Also with their moving out, the local historical knowledge goes too and the institutional memory is gone leaving those behind to make the mistakes of the previous generation.  There is the potential to use **telehealth much more proactively** if the specialists in the base hospital took the time to use this technology. In 1 rural community I know of the bus leaves at 530am for the 2 hr run to the base hospital and returns at 730 in the evening. More effort needs to go into using technology to maintain rural health services. Technology has the potential to enable more creative use of the local workforce and not so much reliance on having doctors live locally. There are many examples now of how telehealth can support local rural clinicians, nurse and others.  The **surgical bus** has made an outstanding contribution to rural health and the building of local skills. Little credit is given for this fabulous service. Again with the use of **robotic surgery**, the need for medical hands on locally can be removed. Currently NZ nurses are being trained in Australia to do this.  I would make 4 e “support **health care providers uptake of technology** for communication with consumers whanau and other health providers’ Consumers have been ready for years, they skype their grandchildren, use email and internet banking as well as buy and sell on trade me.  4f should also be changed to recognise the need for **health providers to become health smart** so they can better understand the issues faced by consumers and recognise when and why interventions are successful or otherwise. |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The goals appear to imply that this is not already happening. I would have thought that you would be at a point where you could actually **state what the accepted situation would be**, that is it should be outcomes focused.  For example (7) is there any onus on anyone to know that ‘developing implementing and the reviewing of treatment injuries for ACC’ will indeed lead to improved health outcomes or quality of life? It just states that services should be enhanced. It assumes that they stay in their current shape but just need enhancing. It may be that the way they are configured is why they are not successful (anyway by what measure are they in need of enhancing?).  For example they should be enhanced to a point where:   * the rate of hip fractures are reducing * there is an increasing rate of quality of life * the proportion of people returning to their own homes following rehabilitation increases * each general practice has a clinician trained in rehabilitation…. Etc. .   **Big data** is used to plot the progress of initiatives in achieving the goals of the strategy. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Again I would like to see **more outcomes focused here**. A vision should include what you are hoping to see. Just using terms like ‘better’ ‘enhance’ and ‘develop’ do not give a sense of actually what you are trying to achieve, what is the vision as a result of these adjectives? How will those doing this know what they have enhanced is better than it was before?? What proportion of the health workforce should be Kaiwhena, RNs, etc. What ratio of kaiawhena do you need per people over 70 years? Etc.  **InterRAI** data would provide an ideal measure for many service improvements. Which ones should be focused on? |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The goals somehow shift responsibility to the individual. I would like to see a preface before each one that that ‘**Health services will be incentivised to**: …………….. ‘ ) Maybe a step too far! But imagine if the goals were worded that way?? Would there be no end to the innovations they may come up with and of course the evidence to prove it. A win win! |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| **Access to health services needs to be addressed here.** Currently after hours access is abysmal and exceptionally costly. The sooner that primary care is available 24/7 or at least 12 hours/day 7 days a week the better. The development of service delivery models that enable nurses, pharmacists and telehealth consultations and assessments should extend access to care particularly for those with chronic conditions that later in life require urgent attention regardless of time of day. The savings in emergency transfer and hospitalisation should pay for the cost of increased access.  Maybe investigation of the impact of alternative funding models should be explored here.  The cost of access to primary care needs to be addressed here. There must be cheaper models. **An outcome could focus on reducing the individual’s expenditure on health care**. That way the provider and consumer work together to achieve the outcome.  There needs to **be investment in new service delivery models that are outcomes focused**. This means that the process to achieve the outcomes can be personalised. Technology can assist here. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Reading the goals, I would have thought that this should be in the NZ Health Strategy. All NZers should be able to have this now. You need to focus on the specific relating to the aging population. For them **access to services** will be the big issue. All of the goals state in this section should be a given. I should hope that we do not have to await until out health becomes so debilitating to have these goals met. However, if we had not been able to, we would likely achieve ill health quicker. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| I challenge you to read through each of the actions in this section and say that they should only be applicable to those with high and complex needs. The inverse care law is a good read <http://www.kingsfund.org.uk/publications/articles/inverse-care-law> .  Hence you need to focus on the specifics that relate to those in their later years with high and complex health needs where they are likely to be challenged in relation to access to health services because they are more likely to:   * be more isolated and living alone (if they are in their own home) * have unreliable transport * have poorer living conditions * have poor mobility * have poor senses of vision and hearing * have poor nutrition * be less financial * have a more fatalistic approach to their future (basically they will not have years of life ahead of them to look forward to or plan for).   Those who have been living in ill health for some time are less likely to have accumulated significant savings for their ‘old age’. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Again there are cross overs here with the end of life goals in the NZ health Strategy. You would hope that anyone facing end of life regardless of age would hope for the same goals. The focus needs to be on the specific for those who are in their latter years facing end of life. All mentioned above. |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Again this is repetitious of a palliative care strategy. Basically whatever age, you would expect the same goals. The focus should be on the complexities added by old age. |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| It would be a shame to find that this strategy was expecting different sets of outcome measures from other strategies. The health sector is already capturing huge amounts of data. interRAI should be a good source of data to measure the impact of health care/services. |

### Other comments

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| Thanks for the opportunity to comment. |

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| **Submission 111** |

**Submitter: Christchurch City Council**

**Christchurch City Council (The Council): Commitments to creating an inclusive and well-connected city for older people**

* Ageing Together Policy

The Council’s Ageing Together Policy is about creating a better life for older people in Christchurch. The Policy’s goals include a commitment to older people having access to information, access to places and spaces, and opportunities for participation and contribution. The Council is an advocate for improved wellbeing of its ageing population and works collaboratively with other community and health providers to support healthy, safe, and respectful communities for older people.

* Equity and Access for People with Disabilities Policy

This Policy states that it will endeavour to remove the barriers to participation and contribution to community life for people with disabilities and their families/whanau. The Policy is focused on developing an inclusive city where diversity is celebrated. The Council notes that in Statistics New Zealand’s Disability Survey: 2013, there were 59% of people aged over 65 who identified as having a disability.

* Disability Advisory Group

The Council’s Disability Advisory Group has been operating for ten years, and consists of people from disability and older people’s community organisations who work in the community. The group provides guidance and “lived experience” advice in the planning and implementation of Council services, to ensure that the needs of the wider disability community are taken into consideration. The Disability Advisory Group membership includes expertise from the older adults and dementia community sectors.

* Council Staff

The Council employs a Metropolitan Community Advisor – Disability/Older Persons who holds the portfolio for the older persons’ sector interests. The Advisor supports equity of access for the older people to information, support services, decision making, and participation in the Council’s democratic processes. The Advisor works with other Council units to ensure policies and programmes meet the needs of, and provide equal opportunities for, older people of all abilities.

* Lifemark official star rating for Council Social Housing

Christchurch City Council works with the Lifemark star standards to ensure the Council’s social housing stock meets the standards for adaptable, safe and accessible design principles. The Council’s social housing tenants include a significant number of older adults.

* Community Grants Funding

A wide range of older persons sector organisations receive Council community grants funding.

* Partnerships with the Older Persons Community Sector

The Council works collaboratively with older people’s community organisations, and regularly consults with the sector.

In the Council’s Wards there are weekly social connection and leisure activities for older people. Some Council Ward teams publish directories about local services and activities for older citizens, and facilitate older adults’ advisory groups.

The Library’s CINCH (Community Information Christchurch) data base provides information about activities relevant to older people; and the Libraries have an older adult’s champion librarian in each site. The Libraries provide lifelong learning courses and a wide range of resources and services relevant to older people.

**Staff Comments on the Draft Refresh of the Health of Older People Strategy 2016**

The Council is pleased to have the opportunity to comment on the draft Health of Older People Strategy and supports, in principle, the refreshed Strategy. We look forward to working with the Ministry of Health, the CDHB, and other key partners, to support the implementation of the Strategy at a local level.

The draft vision for the Strategy (page 13) states that: *Older people live well, age well and have a respectful end of life in age-friendly communities.* This vision aligns with the Council’s Ageing Together Policy which values and encourages the contribution of older people to the wider community, and commits to respecting people as they age, upholding their rights to independence, participation, and access to opportunities and resources.

The Strategy explains that the reduction in those requiring aged residential care, indicates that older people are increasingly healthy and better supported to live well at home (page 4). The Council acknowledges its responsibility to ensure all citizens have access to meaningful and accessible community activities. We deliver a wide range of recreation and leisure services for older people, and work collaboratively with partner organisations to reduce social isolation, and promote supportive environments. The Council’s community grants schemes provide funding to community organisations that support older people to ‘live well at home’. The Council considers it would be worthwhile for the Health of Older People Strategy to acknowledge the role that local governments play in ensuring their older citizens live in inclusive, safe, and respectful communities and neighbourhoods.

The ‘Healthy Ageing’ section in the Strategy (page 14) discusses the importance of *growing age-friendly communities that enable older people to positively age;* and also acknowledges that *healthy older people make a significant contribution to our society, including as mentors, leaders, skilled workers, carers, and volunteers.* The Council consults regularly with older adults in the neighbourhoods in which they reside, and works collaboratively with a wide range of community organisations and clubs led by older people. Older people are respected leaders in many communities. In the Foreword to the strategy (page iii) the Associate Minister of Health says that *the draft strategy is the result of a highly collaborative process, involving many people and organisations with a stake in how we maintain and improve the health of older people. This reflects the multiple influences on older people’s health and wellbeing, and illustrates a shared understanding … and commitment to the vision …* The Council acknowledges its responsibility as a stakeholder in improving the health of older people, and ensuring that Christchurch’s communities are inclusive, safe, diverse, and accessible.

In the Healthy Ageing section (page 16) the vision calls for communities that are *age-friendly with initiatives to keep people healthy, well-connected, independent, respected and able to participate fully in their communities and with family and whanau.* In acknowledgement of the increased rate of disability for people aged over 65 years, the Council’s Disability Advisory Group has representatives from Age Concern Canterbury and Alzheimer’s Canterbury. (In Statistics New Zealand’s Disability Survey: 2013, there were 59% of people aged over 65 who identified as having a disability). Because accessible, supportive environments are critical to older people maintaining well-connected and independent lives, the Council would like further information added to the Strategy about the principles of Universal Design, and the importance of developing facilities, events, communities, and services, that meet the needs of people of all abilities.

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| **Submission 112** |

Greetings

I am 68 and have attended and participated in two workshops held in Hamilton and have also made an on-line submissions.  Thank you for the opportunity to do so.

I think in general terms what has been developed is very good, however I am now under the impression that Government is not going to provide any additional funding for the health of older people rather that Ministry of Health will have to fund the development of strategy as well as implementation out of general Health budget funding.  This very sad as the Strategy is such an important foundation development in New Zealand's history.  If it is to have good and successful outcomes for an ever increasing demographic it needs additional funding.  My advice is to do it once and do it well.

Further there were two specific aspects in strategy document that looks as though they were developed by accountants and not by or for any benefit for older people whatsoever.  These were in relation to "Acute and Restorative Care" on pages 17 and 18:

1. "When older people experience delayed discharge from hospital they face a slower recovery ...."  I do not know what empirical evidence you have for this but my experience is that hospitals discharge older persons before they are ready and this is detrimental to their health and well-being and frequently leads to re-admission.

2. P18 and 34 - Ambulance officers ... make a medical decision on whether to transport someone to hospital.  To an extent this has always been the case however I have witnessed this intervention in respect of an elderly man who was unable to adequately convey the pain he was in and was not assessed as being worthy of hospital treatment and left at home, then a week later when he could not move was eventually taken to hospital where x-rays showed he had a broken back and was in hospital for 3 weeks.  I have heard of other instances as well and would hope that this is not going to be the new standard for assessing older people.

Thank you once again and I hope that this very important strategy receives the backing of all politicians.

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| **Submission 113** |

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| Organisation (if applicable): | Kapiti Coast Grey Power Association Incorporated |
| Position (if applicable): | Health Representative and support Reps |

This submission *(tick one box only in this section)*:

comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

√ **is made on behalf of a group or organisation(s)**

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Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

Academic/researcher √ Other *(please specify)*: Interest Group. Kapiti Grey Power

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The health aging vision is comprehensive and we look forward to its implementation.  Under Vision and Objectives respectful end of life. P13 We would like to see the word ‘respectful’ replaced by the word ‘dignified’.  A prime issue is the ability of people to be/become knowledgeable about their health. The means health promotion in older people needs community support via education, excellent primary health and timely secondary services. |

1b. the draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The impact of the social environment on health is well documented, ( Dunedin  Study 1972). Thus actions1. a, and b, should be enacted concurrently. 1.d is already actioned so **promote** should become **strengthen.**  2. a. mobility is a vital factor in healthy aging and living independently and the programmes need wide advertising as do other mobility / exercise programmes already in the community.  Vision which related to elective surgery; hearing and podiatry are related issues.  3. C needs an earlier action time as elder abuse in occurring each day in NZ. A priority over3b.  4. a. Needs to be concurrent with 4.e.4f. For improved communication. Multi media needed for all communication.  A public awareness campaign is needed.  5. We are concerned that ‘oral health’ is included but not visual or hearing both of which can have a major impact on healthy aging. Projects involving strength, balance and physical exercise need to be affordable easily accessible and publicised.  In Kapiti a number of programmes for older people are available but usually there availability is spread by ‘word of mouth’.  Foot care, hearing vision and dental health are essential to older peoples’ well being. In light of this subsidies need to be considered. |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| **i.** More emphasis needs to be placed on Primary Health Care, especially GP.  Services  **Ii .**Allied health services which maximise mobility need greater prominence.  This is a key to living independently and ageing well. Associated with mobility is  ‘Vision and foot care’ (Podiatry).  **iii.** The document places great faith in family/whanau assistance however there  needs to be a much greater understanding and recognition of our very mobile  society which translates to large numbers of the older population with no  access to family. Alongside this is the increasing number of single person house-  holds.  6. a. ‘A system of approval for NGOs to be funded for service provision.  Acute & Restorative Care: requires communication, collaboration and coordination between and within the Secondary and Primary Health Care services. Frequently the older person is not supported in a timely manner. They may have been assessed by several specialists but no holistic view emerges, no one person being responsible. Key contact personnel are an imperative. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 6a is a priority as is action 7.  Discharge Planning: Has a poor history of effectiveness and inclusiveness of  needs.  There needs to be improved communication such as a team meeting for discharge planning which includes the persons key support people/whanau and Primary Health worker. This could be by Skype. The interface between hospital and home is critical as is who the person responsible is. Need a consistent person to navigate discharge and follow up.  **NB.** It would have been helpful to have the non-regulated role of ‘Kaiawhina’ defined for this document |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| **i .** It is a great ideal however a significant proportion of the population are unable  to manage their Long Term Conditions. (Eg. Correct medication).  **ii.** It assumes that everybody is, or will be, computer literate. Experience  indicates, that across the board, in many households, only one spouse is  Computer literate.  A MSD survey found that 10% of people over 75 had access to a computer.  **iii.** Changes in technology are a constant and rapid. Older persons are often  left out of this loop.  **iv.** A barrier for older persons is the cost of technology on a finite income.  **v.** Many GPs are not signed up to the MMH system. (Manage my Health)  **vi.** Learning opportunities need to be supported.  Eg. Libraries. Access to computers; these are usually monopolised by youth.  Senior Net requires financial support. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| We suggest that you review/ reorder the identified asterisks. Point 9 is inclusive of training, recruitment/retention as well as utilisation of allied health workforce. So that the primary themes become lost.  Alternatively divide point 9 into:   1. Training for support workers and Kaiawhina 2. Training for qualified health professionals 3. Training for carers   (9.g)is equally as important as training for care staff.  10.Differences in services provided by the varying DHBs needs addressing. Standardisation and equity as principles.  11. Dementia needs greater emphasis in the community re diagnosis and services for support.  11.c. Those who are diagnosed with type 2 diabetes need to have dietary education about how to put the disease processes into remission.  13. Education for technology needs to be local. Promote resources already there. Library, Senior Net. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We support services closer to home.  There are barriers to **‘access’** eg. Kapiti.  Lack of Transport & the cost impinges on **‘affordability’** and is inefficient.  Many people have extreme difficulty getting to Wellington hospital for outpatient clinics. By public transport it takes over 1 ½ hours each way. The DHB provides no transport from Kapiti but does from Kenepuru. Why not a shuttle from Kapiti to Kenepuru. A survey could identify how many times a day would be needed.  Discharge from hospital after hours creates horrendous anxiety and sometimes fear.  (A taxi for after hours discharge is in place at CCHDHB but staff do not share this information with patients or staff awareness is problematical).  The advanced Para Medic service is of great assistance needs greater publicity and of the access to expertise. This service is only available 7am to 7PM.  There needs to be an urgent expansion of outpatient services at the DHB Kapiti Health Centre. When a person travels to Wellington for an appointment that takes 15 minutes one must ask what is the sense of this. There could be increased use of Advanced Nurse Practitioners, Skype, and sharing of medical expertise so a number of clinics can be held without a number of medical staff travelling. Plus more outpatient clinics at Kenepuru.  **Availability** of Health services in Kapiti is variable; more services need to be provided. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| A tool is a good idea but frequently tools inhibit listening and observing.  **i.** The current older people are programmed to overestimate their abilities.  **ii.** We suggest that as an initial ‘frailty tool’ those 75 + fit this category. ( we are  all aware of the exceptions to this, but they are exceptions).  When an octogenarian is caring for an octogenarian, or younger, trouble is looming.  Caring for oneself is one thing, being responsible for another is a vastly different proposition and can result in two people being hospitalised. It takes a wise head to increase services in a timely manner.  We have concerns re the perceived standardisation of the application of the InterRAI Assessment tool.  The sharing of records and information needs to be enabled across the health sector. (CRISP)  Choice is very often unavailable. Eg. Choosing a Rest Home.  Support for complex needs is unavailable in all communities.  Respite care is absent from the document yet vital for many.  18. If aged residential care services are able to provide a wider range of services then staffing levels are critical and need to be regulated. (One RN to sixty six patients at hospital and rest home care is unacceptable). The current regulations do not support extension of services for example staffing numbers and qualifications. Vastly more resources would need to go into this sector. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The person should be the focus and not the service therefore we recommend that the word ‘Respectful;’ be replaced with the word ‘Dignified’  **RATIONALE** The word respect is not inclusive of ethicalness which implies action.  Recommend that 22a. And 23a are concurrent to maximise support systems. This would help break down barriers to care. The workforce needs to include psychologists. |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| **I**t is disappointing that the actions are distanced from reality given that the MOH  are the lead group. (But perhaps this is addressed by the Palliative Care Advisory Group)?   1. Frequently Hospices’ are at capacity and people have to remain at home, & or are admitted to Stage 2 Rest Homes, if available, where staffing is: 2. Inadequate for dignified care. 3. Skill capacity is insufficient 4. Hospice overview is limited 5. Support at home can be limited.   Whilst we appreciate the need for Advanced Care Planning we believe that it is inappropriate to be a lead action.  What publicity has been afforded ACP? What media channels have been used, how has this been presented? and to whom?  The need for palliative care is increasing and government funding covers only 50% of running costs. This places a heavy burden on low income communities & their families. |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| 25 . Implementation, this is vital to the success of the proposal.  26.a This is a critical action point and needs to be the first in this section.  Older persons focus on their immediate health needs being met, which sadly is not always the case. |

**Other comments**

We appreciate the time and effort put into the development of the document which when implemented will improve the lives and well-being of older people.

It is pleasing to note that older persons experience will be used to plan services.

Throughout the document we are reminded of sustainability, resources, funding, best value, whilst considerable cost is being placed on the individual.

Transport. Access to health services for Kapiti residents is compromised by lack of suitable transport. For some time a goal for HOP strategy has been provision of health services ‘closer to home’. Unfortunately in the Kapiti region this has not matched reality.

The community have made considerable effort to organise a reliable health transport system however costs have proven to be prohibitive. The time involved in travelling to appointments, often multiple times for the same condition, is very often detrimental to the individuals well-being draining energy and resources..

If health services are unavailable locally then a comprehensive transport system needs to be provided. Ie. an affordable system, such as a gold coin donation, which is linked into the Kenepuru service.

Statistics are constantly reminding us, that we, as a group, are a huge cost on the Health system and that these costs will rise exponentially over the next few decades. We are also informed that the Health funding has been increased. A brief review of the increased funding identifies that it has not kept pace with inflation, or population growth.

A cost benefit analysis needs closer scrutiny. Eg. Access to elective surgery. Surgery delayed, as experienced by many of our members such as joint replacements, cataracts etc. impact on their ‘well-being’. Members spend time and money being shuffled between GPs, Specialists & Allied health professionals not to mention pre anaesthetic appointments which can occur several times before the actual surgery which provides false hope, and increases the costs on the health system. Costs of these practices to our Health system have not been evaluated. The cost to the individual is deteriorating mobility, (a key to ageing well is mobility), depression, and in the case of cataracts, falls, often ending in fractures. The $ costs relate to increased home care and other social services. Individuals are bearing a considerable cost.

The population based funding formula is another concern as it is a very rough formula for subsidised GP services. i.e. If over 50% of a community is categorised as a ‘high deprivation’ community the whole community receives the higher rate for GP services. Therefore some 49% of that community, who may not be deprived, may be earning a six figure income, still receive the subsidy. NB Where GP practices have over 50% of their clientele categorised as ‘high deprivation’ that practice will also receive a higher subsidy. For many of our low income members, the cost of visiting a GP is prohibitive, which delays visits and this often leads to more costly health needs. Some people are not able to pick up their prescriptions and may also not make an appointment with their GP. A community services card could be used to access subsidized GP services for the holder.

ACC funding and extra GP charges. Some older people may need their wound dressed by the nurse at their GP practice, an additional charge of $27.00 is a current charge over and above ACC. The GP charge on top of ACC is also prohibitive. While GP practice is a business and set their own fees’ can there be a limit set re the extra charges? Other health agencies such as Physiotherapy vary in their extra charges.

Funding of services differs across the DHBs. Services provided by one DHB have to be paid for in other DHBs, (‘Post Code’ health), questioning equity and access. We expect this to be addressed. Crest and Start programmes need to be rolled out nationally.

Social and health disparities. The Dunedin Health study from 1972 indicates the importance of the social environment on later health thus some emphasis needs to be directed to assisting children living in poverty, thereby reducing future health costs. The health problem remains even when there is upward mobility. Given the current housing crisis, and decreasing home ownership, not to mention financial crises beyond individual control, the future will see larger numbers of older people requiring social housing.

There is no mention in the document of respite care, this is a critical support service for carers.

MOH and National DHB buy in to the World Health Organisation’s ‘Age Friendly Cities’ (Communities) programme would support older people’s healthy life styles.

Training: there is a dearth of knowledge re the ageing process among Health Professionals and older persons alike. Given the projected increase in the over 65 aged group, all Health and Allied Health professional curricula need reviewing.

Given staffing issues consideration of a bonding similar to the rural hard to staff medical/nursing scheme could be useful.

Research on outcomes must include qualitative aspects.

How does the Ministry plan to give feedback to the community?

Reviewing the plan every 2 years is a really positive action.

Thank you for the opportunity to comment on the plan, we look forward to further dialogue.

KAPITI COAST GREY POWER Assn Inc.

August 2016

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| **Submission 114** |

This submission *(tick one box only in this section)*:

comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

Academic/researcher  Other *(please specify)*:  
Undertake ACC contracts

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| It should be made more explicit that older adult populations are supported to age well no matter where they reside (that is, at home, in residential care facilities, those who are homeless). Suggest addition of these words in italics:  “All older populations are supported to age well in ways appropriate to their needs *no matter where they reside*” |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| It’s good to see a focus in the Strategy on health promotion and prevention. There is a stigma associated with aging that comes from many angles in society, including older adults themselves. Exploring thoughts around what it means to age is a common theme for psychologists working with older adults because it has a significant influence on their mental and physical health. There is a missed opportunity in this Strategy for considering the role of stigma, like other campaigns such as the Like Minds Like Mine has done for mental illness. |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| There appears to be a focus in this Strategy on older adults living in their own home, with family support, and this goal demonstrates that through no mention of ensuring older adult rehabilitation needs are addressed where-ever they can best have their needs met. I agree that living at home is desirable for many people and families/whanau, but the Strategy should also acknowledge that after some acute incidents residential care is an appropriate outcome and careful discharge planning and support for their needs in these settings is perhaps even more essential given it requires an adjustment to a new physical environment for the older adult and their family. Getting this right and supporting smooth transitions is becoming more complex as people present with more complex needs, including physical, mental, emotional and behavioural needs. |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Good to see a specific paragraph on dementia in here, as it can be a very complex illness that affects not just cognitive but also behaviour and emotional responses which are difficult for family/carers, Support Workers and many health professionals to know how to manage. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Agree with actions focusing on training to be a priority, but not just with the Kaiāwahina/Support Worker workforce. Many of those with long term conditions may come into contact with other Government and NGO providers, from WINZ to Social Workers, and training on illness and disability should be for them too. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Good to see a vision for this vulnerable population. However the vision does not make clear that there are currently gaps in services for this population. There are increasing demands on aged care residential services to provide care that meets the needs of people with a wide range of health concerns, presentations and behaviours, which they cannot within existing models. Older adults with high and complex needs require higher staff ratios, trained staff, environmental considerations and flexible options. Try finding suitable care for a 70 year old man with a 15-year history of Traumatic Brain Injury who until recently lived at home but because of increasing nursing care (due to medical issues) his needs became too much for his wife and home supports, and upon entering hospital level care came a rapid acceleration of dementia with behavioural and psychological symptoms (BPSD). No level of aged care fit his needs, and neurological-physical disability residential care providers generally will not take someone over the age of 65 without a pre-existing relationship with them (and even if they did take over 65’s are no available beds within 12 months). Why? Because aged care providers are available to them. Another common example of a gap in services is finding suitable care for those people with young on-set dementias with BPSD, who are physically strong and in stage 5 dementia units can cause significant harm to older frail patients. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The actions under “With service users, their families and whānau, review the quality of home and community support services and residential care in supporting people with high and complex needs and involving family and other caregiver “ don’t actually recommend first exploring the current gaps in services. Providing a choice in care (a) is miles away from where we are currently. A priority goal would be to first provide appropriate care for the high needs and complex cases that don’t fit current models. (see comments above) |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| Good to see consideration of inclusion of older adults and families in service design and development. What is a major gap in this section is a focus on *evaluation* in terms of a scientific approach to measuring effectiveness of new services.  “Develop a system to evaluate progress against the goals of the Health of Older People Strategy and support the health system to be person centred and focused on maximising healthy ageing and independence”.  There is no detail around this goal, so I can’t tell if it is referring to a gold standard of evidence (built in evaluation of each new service), or a binary tick box process. |

### Other comments

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| Overall this is rightly an ambitious 10 year Strategy and Action Plan. It has a focus on inclusion, and health promotion and prevention is a positive feature. The issues facing us are well described, including the areas I see in clinical practice: increasing numbers of people with high and complex needs, an aging workforce supporting them, and unsustainable funding models. Does the Strategy respond to all of these? I’ve already provided comment about a lack of acknowledgement that there are currently gaps in services for those with high and complex needs and the aim should be to fill these before realising an admirable goal of providing choice. I’m also concerned about the aging workforce, from specialists to support workers. Traditionally a woman’s role, caring for the vulnerable in our society is an area of work that is undervalued at every level, but especially so at carer level. The undervaluing occurs on two fronts; monetary and in a cultural sense. We won’t tackle the workforce issue until this is addressed, and I can’t see any provision for it in this Strategy. Finally, funding models are not my area of expertise but we all know we will need to find ways of doing more with less but it does not appear this Strategy addresses it or makes links to other avenues for doing so. |

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| **Submission 115** |



SUBMISSION TO NZ MINISTRY OF HEALTH

September 2016

HEALTH OF OLDER PEOPLE STRATEGY CONSULTATION DRAFT

**EXECUTIVE SUMMARY**

* **Aging populations and hearing loss prevalence grow together**[[2]](#footnote-2). In the general community 20-40% of people over age 50 have hearing loss; 63% of people over age 70 have age related hearing loss, and 80% of people over age 80 have hearing loss.

We have no specific data about the prevalence for those in care settings or end-of-life but it is expected to be greater.

* **Hearing Loss** **impacts on quality of life** by affecting communication, safety in the environment and psychosocial well-being. There is a relationship with depression and diminished functional ability. Multiple chronic conditions become more common with age and are synergistic with hearing loss e.g. deaf-physical, deaf-blind or deaf-cognitively disabled.i
* **Age related hearing loss can impair communication about symptom management, goals of care and end-of-life decision-making**[[3]](#footnote-3) with 88% of health carers recalling a situation where hearing loss created a communication issue with a patient. Only 23% of palliative and hospice care providers ever check for hearing loss in their patients and 79% of staff in these settings had no training in hearing loss and its implications, nor in hearing aid use and care.
* **Suitable hearing rehabilitation improves quality of life[[4]](#footnote-4)** by using technology, if necessary, along with information and support. Audiologists cannot offer restorative care but rather ameliorate to the best possible degree any remaining hearing.
* **WHO (2016)iii asks for raised awareness among decision-makers and the public about the high prevalence of hearing loss and its social and economic impact.** NZ Audiological Society is delighted to take this opportunity to ensure that the Ministry of Health includes due consideration of the hearing-related needs of our population as they enter older age and end-stage care. We also hope to highlight the need for awareness of hearing related issues to the medical care system and the community based carers.

**AGING POPULATION and HEARING LOSS**

In the report of the USA National Academy of Sciences, Engineering and Medicine (2016)[[5]](#footnote-5), recommendations have been made to better promote hearing health care by looking at its accessibility, affordability and transparency. These issues are highly relevant in NZ also.

Any senior should have information and care around their hearing and communication status provided well and in a manner that is in accordance with their wishes. Information should be shared, with agreement, between their primary and other health carers, their family and/or their friends. As Weinstein (2016)iv adds, health outcomes depend on communication success and are measured by issues such as adherence to treatment, trust in health providers, persons self-efficacy and self-care, and as well in the person’s ability for continuing social engagement. If an older person cannot hear easily or well, then none of these factors can occur easily and yet all of these factors are critical to mortality and morbidity.

Keidser (2016)[[6]](#footnote-6) outlined the factors considered paramount to the delivery of patient centred hearing health care as trust and empathy, a sense of personal connection with the deliverer of the care, perceived expertise of the audiologist and that ongoing management arrangements are made with the audiologist. A NZ survey in 2015 (Doherty) concurs.

**SENIOR CARE AND AUDIOLOGY**

Given the high prevalence of hearing loss with increasing age over 50 years of age (rising from 20% at age 50 to 80% at age 80), primary carers should be encouraged to increase information to their patients about the need to have a baseline hearing check once they reach age 50-60.

From personal experience with patients and family, it has become obvious that in NZ we have severe short-comings in the hearing care of our older, most vulnerable, persons when they enter the residential care assessment system. It seems ludicrous that no sensory assessments are made to enable the Drs and assessors to know what capabilities the older person is working with.

Persons who cannot hear well will often fail verbal dementia screen tests simply because they have not heard properly or appear confused.

In dementia and other general wards, there is not enough knowledge from staff or maybe their time pressures mean they do not make the effort to ensure the older persons’ hearing aids are 1) functioning properly and 2) are a regular part of the care plan with insertion, removal, cleaning, and battery change plans.

**PALLIATIVE CARE, END-OF-LIFE CARE and AUDIOLOGY INPUT**

Palliative is defined[[7]](#footnote-7) as “anything used to alleviate pain and anxiety” and is different from end-of-life care e.g. hospice care which is defined as “a home for people who are ill (especially terminally). These words are often used interchangeably but palliative care focuses on improving quality of life at any time of distressing symptoms not just at end-stage, while hospice care is for any person in their last stages of life with treatment aimed at neither hastening nor prolonging life[[8]](#footnote-8).

Though not recognised as part of this interdisciplinary team, audiologists quietly provide care in end-of-life situations where communication is central to quality of care”[[9]](#footnote-9). The first study of audiologist involvement in palliative settings (Rickey and English, 2016) found that 98% of audiologists believe that having hearing loss would affect the quality of the person’s palliative care and yet only 21% have ever been invited by carers or family to become involved in this care situation. There is, however, also some reluctance to become involved in this work as 66% of audiologists felt uncomfortable about working in these situations. This might reflect the fear of youthful audiologists who have not yet experienced family illness and death and/or also a lack of education and knowledge of the area.

This care would either be direct care in the palliative or end-of-life care situation, when visits are made to the older person, or alternatively indirect care help and advice from the audiologist, which can be delivered via family and/or carers. Examples of these direct and indirect acts include loan aids, or assistive devices like headphone listeners which are provided as short-term loan.

Care situations require education about hearing loss at end- stage of life and also about possible options. Palliative and end-of life care hospice centres should own assistive devices to lend and then sanitise after each use e.g. they must change earphone covers and clean the control box. Perhaps, alternatively, the centres could make contact with local audiology services, which would manage this safely for the person by ensuring there is no over-amplification creating annoyance or discomfort.

Audiology services can add value and must be involved to best serve our older persons.

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| **Submission 116** |

Dear Committee  
  
I wish for Advance Care Plans to be used much more often in older persons. Discussion of these should be strongly encouraged at a General Practice level, also in hospitals, and should be routine for all rest home residents. Maybe a financial incentive for GP's (along with their practice nurses) to tackle them would increase their use. it takes time and the right opportunity to initiate the discussion, then considerable time for the patient and their family/whanau to work through the details and complete the forms, and the cost of this to patients would deter them from this.  
  
In many cases, people wish for less rather than more expensive technology at the end of life, so there could well be a significant cost savings for secondary and tertiary care institutions if Advance Care Plans were completed more often.  
  
Thank you for considering this.

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| **Submission 117 withheld at submitter’s request** |

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| **Submission 118** |

To the Primary Healthcare Team,

**Draft Health of Older People Strategy**

Thank you for providing the Royal New Zealand College of General Practitioners (the College) the opportunity to comment on the draft *Health of Older People Strategy.*

***Introduction to general practice and the College***

General practice is the specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand’s specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical College in the country. The College provides training and ongoing professional development for general GPs and rural hospital generalists, and sets standards for general practice. The College is committed to achieving health equity in New Zealand. To achieve health equity, we advocate for:

* A greater focus on the social determinants of health (including labour, welfare, education and housing).
* A greater focus on measures to reduce smoking and to increase healthy food options for low-income families.
* Health services that are better integrated with other community services.
* A review of the funding model for primary care to ensure that funding is targeted towards the most disadvantaged.
* Free primary health care for low-income families, because health inequities begin early and compound over the life course.

***Submission***

The College is supportive of the general direction of the strategy and appreciates its orientation towards addressing the social determinants of health for older people. While this preventative and community-based focus is admirable, the critical role of the medical profession – particularly general practitioners, geriatricians, psychiatrists, and palliative care specialists – is somewhat overlooked. The provision of adequate, prompt treatment for minor ailments and the medical treatment of chronic conditions is an important factor in healthy aging.

According to the latest report from the NZ Health Survey, more than 90% of adults aged 65 years and over had visited a GP in the past 12 months. [[10]](#footnote-10) GPs play a critical role for older people in:

* coordination of care and referral to relevant services
* monitoring and management of chronic and complex conditions
* preventative measures such as immunisation
* Recognition and diagnosis of illness (including age-related illness such as cognitive impairment)
* Palliative care
* General health promotion activities including brief interventions and advice on healthy lifestyles.

Importantly, primary carers develop long-term relationships with patients that foster an increased level of trust, more efficient and effective communication, and often mean that the clinician knows what a patients ‘normal’ is and any deviations from that. As well as working in the traditional practice setting, GPs provide care in aged care residential facilities, in patient’s homes, in mobile care units, in ‘urgent care’ centres, in various specialist are facilities’ (e.g. in psychiatric care facilities) and in hospital settings – particularly rurally. Increasingly, GPs are working with a number of other health professionals in an integrated manner and provide oversight to maintain care continuity.[[11]](#footnote-11) This type of team-based care is referred to throughout the strategy and is a model that the College supports. In particular, we advocate that for health professionals and services to be integrated, they must utilise a shared Patient Management System (PMS) or at least be using applications that connect/interface with the PMS.

###### Patient Values

One aspect of the strategy and action plan that could afford greater attention is increasing the frequency and robustness of discussions with older people and their families about treatment options and the probable outcomes (usually in secondary care settings). One member recounted the story of a patient who had fallen, had an expensive operation followed by a prolonged hospital stay. She was then discharged from rehab and finally, after several weeks, to her home in a condition she did not wish for. Ensuring that care is centred on the patient’s values and needs is crucial to reducing unnecessary procedures. On a similar note, as part of recognising the autonomy and individuality of older people, it is important to consider that not everyone wants to have their chronic illness found and labelled. Specifically seeking out diagnosis may lead to people aging with an illness that they would rather not have recognised.

###### Independence

Throughout the strategy, the goal of achieving and maintaining *independence* in older age is strongly repeated. The College urges caution with the use of this term which is not always a helpful or culturally sensitive concept to use. It is important to consider that there is a full scale of culturally acceptable independence and co-dependence of older people within families. That is, independence is a very Eurocentric value and does not fit with many Asian, Pacific or Māori culture in which interdependence is valued and central to family structures. Older people take on highly valued roles including as social leaders, caregivers, and cultural teachers and co-dependency within families is increased as people age. Total independence – that is the idea that older people should be able to live alone, without any assistance from family or carers – is often unrealistic, a path to loneliness and isolation, and can contribute to the psyche that it is not ok to ask for help. Therefore, while the College understands where this concept has come from, it urges caution in how it used contextually.

###### Carer’s Health

The College is pleased to see that the Ministry is mindful of carers’ health. For older carers (e.g. one half of a couple) co-reliance at this stage influences their health choices. Ideally, some funding would follow the carer so that they could have double appointments i.e. when they bring in their loved ones, their health needs could be dealt with at the same time. Additionally, it should be acknowledged that carers are often looking after the whole of their family, including children with illness (where both parents are working), which exposes the elderly to increased stress and disease burden. To this end, respite care needs to be of a s**t**andard that the carer can relax.

As a strategy for the next ten years, there is a notable lack of consideration of the incoming broader influences on the health of older people. Two issues that are most likely to impact older person health are climate change (most notably the impact of extreme weather events e.g. heat waves, storms[[12]](#footnote-12)) and antimicrobial resistance which is already prevalent in many Asian countries.[[13]](#footnote-13)

***Action Plan: General Feedback***

The cross-sectoral approach is required to promote healthy living and aging. While the strategy section focuses on the social determinants, there is little translation of this focus into the action list. For example, developing ‘age-friendly’ communities that encourage older people to stay physically active should involve prioritisation of green spaces and safe side-walks by local councils. Currently, very few actions appear to have explicit involvement from non-health entities.

There is no indication of funding/resourcing levels for the strategy and action plan. Consequently, it is very difficult to comment on the likely effectiveness of actions. The health sector is currently operating in a very tight fiscal environment as well as a GP workforce shortage [ref w/f survey]. Providers have a limited capacity to deliver the additional interventions, create partnerships and infrastructure with other service providers, offer health promoting resources, increase competence through training and so forth. Thus, for all of these actions to come to fruition as well as continuing business as usual, additional funding and resources must be available.

One member commented that in the current high-pressure system, general practitioners – particularly employed doctors – have a strong onus to see a minimum of five patients per hour which is not conducive to the longer appointments often required by older persons who require patience. As a result, there is a risk of increased hospital referrals, diagnostic tests, and self-referrals by the patient to alternative treatment. This type of resource pressure must be considered in the development of any primary-care based intervention.

As was conceded by Ministry staff at the consultation workshops, there are several actions that are already happening in the sector. Currently, these actions are written as though they are new rather than acknowledging and building on past progress. For example action 4b, “encourage services and providers to promote healthy eating, physical activity and healthy lifestyles and prevent alcohol-related harm.” General practice staff commonly provide brief interventions for unhealthy behaviour and provide health promotion advice and service referral as part of normal practice.

###### Action Leadership

Many of the actions are broad and immeasurable (e.g. Actions 11b and 11i), with multiple high-level ‘leads’. As well as potentially hindering action implementation, having multiple leads reduces accountability and is likely to obscure any outcome monitoring (although as noted earlier, many actions are so broad that monitoring would be very difficult to start with). The College suggests that the actions and their assigned lead are made more specific so as to be achievable.

To this end, it is noted that DHBs do provide leadership, funding, and population health programmes for their region, however the majority of funding and focus of DHBs is directed towards achieving hospital-based targets. PHOs, while more variable in their size and capacity, may provide a better leadership avenue for many of the health promotion programmes being proposed throughout the action list with the caveat that they are appropriately funded.

***Healthy Ageing***

An additional action that the College advocates should be continued under this goal is the government-funded free influenza vaccinations for those age 65 and over.

*Action 1d: Promote volunteering, networking and paid work among older people, as a means to support their self-worth and encourage social connection.*

Two innovative models we are aware of are:

* Professor Chris Phillipson, a professor of gerontology at Manchester University has suggested the appointment of older person ‘Cultural Champions’ whose role was to find out what cultural activities and performances were happening in the local community and disseminate this information to other older people. This has been highly beneficial in increasing older person participation in society and also boosted support for artists and events.
* Another interesting Dutch model that New Zealand might explore, is having students in respite care homes where they receive free accommodation in exchange for spending time (30hours per month) interacting with the resident neighbours.[[14]](#footnote-14)

*Action 3b: Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme.*

The College notes that Ministry of Social Development is the lead for the cross-government Ministerial Group on ‘Family Violence and Sexual Violence Work Programme’. The College is committed to reducing Family Violence and its harm in New Zealand and reducing harm is part of the general practice vocational training curriculum. As key people in the identification and treatment of family violence cases, the College advocates that Health staff are heavily involved in the development of this work.[[15]](#footnote-15)

*Action 3c: Update the 2007 Family Violence Intervention Guidelines: Elder Abuse and Neglect, and promote their uptake by a wider range of health professionals.*

To this end, the College can recommend a review paper on elder abuse that is written from a primary care perspective and summarises research and clinical evidence on the extent, assessment, and management of elder abuse:

Lachs MS, Pillemer KA. Elder Abuse. N Engl J Med, 2015; 373: 1947- 1956. (<http://www.nejm.org/doi/full/10.1056/NEJMra1404688?query=TOC>)

*Action 3d: Work with local government to increase understanding of, and local direction of age- and disability-friendly housing models.*

*And 3e: Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development.*

Housing is a particular vulnerability for older people who can be forced out of their communities as market-forces increase rents and living costs (i.e. gentrification of neighbourhoods). Ensuring housing remains accessible and of good quality should be a high priority in this plan as a key health determinant for older people (and indeed everyone).

***Acute and Restorative Care***

*Action 6a: Promote rehabilitation partnerships with primary care workers, allied health, nurse practitioners, pharmacists, kaiāwhina and family and whānau to support discharge planning for and ongoing rehabilitation and restoration of older people at home.*

*And 18: particularly Action 18a: Develop standard referral and discharge protocols between aged residential care facilities, pharmacists, primary care (including providers of after-hours services and medicines advice), ambulance and hospital services.*

*And 19: Improve integration of information from assessment and care planning with acute care services, and with those responsible for advance care planning.*

There are two key types of ‘integration’ that the College considers vital to comprehensive and continuous patient care:

1. Integration of services – this improves patient access and can help bring services closer to home. In the College’s experience, the greatest successes with integration have started at the local level as a result of clinical leadership and teamwork in a well-organised system.
2. Integration of health professionals – it is the College’s position that continuous and comprehensive care is best provided by a collaborating multidisciplinary team of health professional with oversight, delegation and leadership by the patient’s usual health provider (normally a GP). As noted earlier, a shared patient management system is paramount to ensuring all healthcare providers have appropriate access to a patient’s history (e.g. long term medications list).

Integration of care services and the transfer of older persons between home, facilities and care teams is an area in special need of attention and should be prioritised. Flow of information back to the primary carer after an elderly patient has had an acute incident is critical in helping them move back into their home, rather than extended hospital stays where the patient loses quality of life and increased risk of nosocomial infection. Barriers to integration commonly include inadequate funding mechanisms; a lack of appropriate infrastructure, such as IT interoperability; a silo mentality; and systems that create more work for clinicians, rather than less.

Information flow and referral should be complete regardless of the type of care transfer which might be from tertiary/secondary back to primary care, from one residential aged care facilities to another, from home to/from a respite care facility, between providers, and between health professionals. This is supported by the recent Health and Disability Commissioner (HDC) report, Complaints to the Health and Disability Commissioner about Residential Aged Care Facilities: Analysis and Report 2010-2014, which notes that “inadequate communication between providers is the second most commonly complained about issue in the HDC complaint data, being at issue in 33% of cases”.[[16]](#footnote-16) The report accurately identifies the reliance of GPs and other health professionals on communication from residential aged care facilities about changes in patient conditions and health needs.

The most feasible way to improve information flow would appear to be universal uptake and use of e-referral systems. However, while e-referrals allow many aspects of a referral template to be automatically populated from the PMS (e.g. medical events, allergies, medications, chronic conditions), it is the 5000 or so ‘free text’ words are where social isolation, recent life events, or changes in home situation are included, that can make a significant difference to care.[[17]](#footnote-17) For secondary care, being provided with this information can be alter the patient’s discharge plan, while discharge summaries to GPs should include not only any medications that the patient has been prescribed, but the expected length of the course, any complications, and so forth.

Another critical information flow, highlighted in the recent HDC report is the communication back to older person’s families.[[18]](#footnote-18) Failure to communicate effectively with family was the most common issue raised by complainants in regard to RACFs, being present for over half of the 514 cases analysed by the HDC between 2010 and 2014. It is probable that in cases where there was insufficient/no contact with a vulnerable patient’s family, were where healthcare teams were not well integrated, and there was no clear allocation of responsibilities. Clinician-led, integrated teams with strong communication lines and quality processes are vital to the complex care often required by older people.

On the theme of providing care closer to home; the College generally agrees with this philosophy but cautions that this should not go beyond its level of usefulness so that someone is often having to wait at home for different people to visit. Time is very valuable at this stage of life.

*Action 7b: Make use of big data to identify older people at risk of falls and fractures, to target and coordinate investments and interventions.*

Interventions to reduce the risk of falls and fractures should also include diagnosis and treatment of sensory impairment. For example, age-related macular degeneration is increasingly common and, if untreated, can lead to functional blindness. This is an issue for older person quality of life in itself, but also contributes to the likelihood of a fall. The college also supports the use of analytics to identify patients who are at high risk of hospital admission and deterioration prior to adverse events occurring.

*Action 8a: Support other initiatives to reduce acute admissions, for example by extending paramedic roles, improving after-hours triage for aged residential care facilities, developing acute geriatric care pathways and applying technological solutions.*

A strong primary care system is fundamental to cost-effectively reducing acute hospital admissions.[[19]](#footnote-19) Acute admissions can often be prevented if there is good health monitoring in place, and a good longitudinal doctor/NP-patient relationship exists. The type of clinical relationship developed in primary care enables the clinician to pick up on indicators that a patient is heading towards an acute episode, and provide support or treatment before it gets to that point. A strong, well-qualified primary care workforce means having enough vocationally registered general practitioners, nurse practitioners, clinical pharmacists, registered practice nurses and allied health staff that are working in an integrated fashion with sufficient funding to implement public health / health promotion programmes.

Currently, we are heading towards a GP workforce shortage (particularly rurally) and general practices are often having to find work-arounds to ensure that their patients are able to access services. Older person access to primary care is somewhat aided by programmes like free immunisation, community services cards / high use health cares, care plus, VLCA (although this programme is flawed), and some practices have lower fees for 65+ age groups. However, distance to the practice remains a key barrier to care for less mobile patients and those with limited transport options. This strategy provides an opportunity to remove such barriers through the development and support of existing ‘health taxis’ / ‘Driving miss Daisy’ type services, supporting local governments to set public transport routes that don’t leave some areas isolated, and advocating for funding of home visits for those older persons not in residential care.

***Living Well with Long-term Conditions***

*Action 9a: Regularise and improve training of kaiāwhina workforce in home and community support services*

The College particularly supports the regularisation and improved training of the kaiāwhina workforce as this lays the foundation for many other actions under 9. Regularisation and training demonstrates the value that this workforce contributes and the remuneration and support they should be receiving. It is also found to be an important contributor to patient care. In a study of residential aged care facilities, research concluded that resident satisfaction was best enhanced by staff satisfaction, emphasising that staff must be valued as an important resource, and be trained, encouraged and empowered to deliver excellent care.[[20]](#footnote-20)

*Action 10b: Share educational resources and good practice on effective ways to increase physical activity levels among older people with debilitating health conditions to support service improvement.*

The College may be able to assist in the sharing and consolidation of educational resources and good practice on effective ways to increase physical activity levels among older people with debilitating health conditions between general practices through its website and publications. Currently, the College provides a guide for members on [*Care of Older People*](http://www.rnzcgp.org.nz/RNZCGP/Dashboard/Resources/Guides_modules.aspx)(due for review in 2017) although this is notably not specific to increasing physical activity. BpacNZ also provides useful best-practice guidance for general practices on promoting health in older people.

*Action 10c: As part of the implementation of the Pharmacy Action Plan 2016 to 2020 (Ministry of Health 2016), improve medicines management and encourage better liaison across pharmacists and other health professionals including through:*

* *increased use of brief interventions, screening, assessment and referral in primary care, including by pharmacists*
* *shared examples of innovative models of care that can be adopted to support pharmacist and pharmacist prescribers’ delivery of medicines management.*

The College has submitted on the Pharmacy Action Plan[[21]](#footnote-21) and in particular reiterates its support for medicines management programmes where the pharmacist works closely, in an integrated fashion, with the GP (or NP) to reduce the number and side effects of prescription medications. A relevant resource the Ministry may find useful on this topic is the RNZCGP Policy Brief on Polypharmacy and Deprescribing.[[22]](#footnote-22)

*Action 11a: Strengthen the implementation of the New Zealand Dementia Framework, and the actions specified in Improving the Lives of People with Dementia (Ministry of Health 2014)*

*And 11b: Encourage health, social services, and communities to become more dementia friendly.*

Cognitive decline in older age can be delayed and sometimes prevented through healthy lifestyles, however it is a predominantly inevitable health condition that is going to be a substantial challenge for New Zealand in the coming years. The strategy relies heavily on the implementation of the NZ Framework for Dementia Care.

The role of GPs in caring for older people with dementia is identifying whether there are other possible explanations or triggers for concerning behaviours e.g. other psychiatric conditions, medications, pain or other medical conditions, factors or unmet needs in the patient’s living environment. Following this assessment, the GP will work with the older person and their carers/family to work through non-pharmaceutical management of any inappropriate behaviours before exploring and monitoring antipsychotic medication options. While family and carers require training and support in enabling older people living with dementia to retain as much normality as possible, the GP and primary care role is also critical and should not be overlooked.

*Action 11d: Develop commissioning and funding approaches for home and community support services that describe core aspects for national consistency, but allow for flexibility at the local and individual level.*

The College strongly supports the principle behind action 11d. As noted earlier, funding can be a serious restriction in the ability of primary care to provide services to individuals with complex or chronic health needs. While this action pertains specifically to community support services, the College would be very interested in the model that the Ministry produces and in whether it can be transferred to other services.

*Action 13: Use new technologies to assist older people to live well with long-term conditions (and its sub actions 13a-c)*

There is great diversity in the levels of tech-literacy of older people as well as physical ability to use smart-devices. While there is evidence to indicate older persons are taking up new technologies, it is important that no system or process is dependent on its use. This is particularly relevant for smart-phone based technologies which have small buttons and can be hard to use.

One suggestion raised at a consultation workshop was a telephone-based support service similar to health line (i.e. an ‘Elder Line’) as this does not rely on tech-literacy and would allow a central place for older people and carers to gain information about services (health navigator role), conditions, or otherwise. This could be the same service as that developed under Action 18b.

***Support for People with High and Complex Needs***

*Action 16a: In specific locations, trial commissioning one organisation to coordinate health and support services for frail elderly people...*

Many general practices (and other organisations such a Geneva Health) are already coordinating health and support services and so it may be counterproductive and a waste of resources to commission another agency for this purpose. It may be more efficient to formally recognise those already doing this role through training and specific funding streams.

For GPs that undertake this role, one member noted that it can be difficult to stay up to date with what services are available for their older patients, what they provide, and how to access them. A suggested solution is a quick view flow chart that is integrated into GP’s PMS, identifying national and locally available services.

*Action 16c: Develop referral systems for older people at risk of or experiencing social and economic isolation through their contact with primary care, aged care needs assessors, social housing, the ACC and the New Zealand Transport Agency.*

The development of any referral system should involve a clinical (GP) lead, and have an interface that sits within general practice Patient Management Systems. Time is a barrier to the uptake of any new system in primary care, and so any new system needs to be user-friendly, time efficient, and integrated with other existing applications and systems.

*Action18d:* *Explore options for aged residential care facilities to become providers of a wider range of services to older people, including non-residents***.**

This is a novel idea that is certainly worth exploring. The College notes that there would be considerable staffing challenges in terms of employing a full time GP or NP for such a service. One possibility that may be worth investigating under this model, would be to have a GPEP2/3 Registrar (a doctor in their final year of general practice vocational training) work part-time in a residential care facility with their work continuing to be supervised by the GP in their main training placement. A model like this would enable a residential care-based service model while simultaneously providing excellent experience for the registrar.

*Action 19c: Ensure home and community support staff and, where appropriate, social workers, are able to contribute to shared care plans and interdisciplinary teams.*

The College envisions that, eventually, all shared care plans will be secure online applications, based on InterRAI data, that can be accessed and contributed to from anywhere by secure login (possible linked to the older person’s patient portal) and integrated into the primary care facility’s PMS. As noted earlier, the College advocates that shared information systems are critical to successful integrated care.

*Action 20: Improve medicines management.*

As the College noted in its submission on the Pharmacy Action Plan in November 2015[[23]](#footnote-23), we are supportive of the delivery of medicines management services by clinical pharmacists where they are delivered in an integrated team environment. Integration must include the use of a common view of medication information by those in healthcare team including the pharmacist. The use of a common view is integral to prevent fragmentation of care, to protect patient safety and to ensure oversight by the primary carer. The provision of Medication Management Services by non-integrated pharmacists (i.e. without clear, mandated communication with a patient’s GP/primary carer) risks fragmentation of care and is not appropriate. We support the use of regional shared care plans and ongoing development of the NZ e-Prescription Service as enablers for a shared view of medication data.

***Respectful End of Life***

The role of GPs in the palliative care workforce ‘closer to home’ is highlighted. Palliative care is a core part of General practitioner training and practice, and GP involvement in care has been shown to improve outcomes and be valued by patients’ families.[[24]](#footnote-24) GPs want to be involved in palliative care of patients, with rural GPs currently providing considerable levels of care in their communities.[[25]](#footnote-25),[[26]](#footnote-26)

The College advocates for greater resource to be invested in the development and support of Palliative Care Medical Specialists and Palliative Care Specialist Nurse workforce. Vocational training in palliative medicine is undertaken through the Royal Australasian College of Physicians (RACP). We strongly advise that the Australasian Chapter of Palliative Medicine (a Chapter of the RACP) is contacted regarding the development of national standards and an outcomes framework for palliative care (email: [PallMed@racp.edu.au](mailto:PallMed@racp.edu.au)).

We hope you find our submission helpful. Should you require any further information or clarification please contact the College’s policy team at [policy@rnzcgp.org.nz](mailto:policy@rnzcgp.org.nz).

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| **Submission 119** |

**ASMS submission to the Ministry of Health on the Draft Health of Older People Strategy**

**7 September 2016**

Background

The ASMS is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent more than 4,000 members, mostly employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all DHB-employed senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

Introduction

The health of older people involves a wide range of factors. Due to the restricted timeframe and availability of resources, this submission concentrates on matters to do with access to, and provision of, medical specialist services.

Vision

The document’s vision is outlined as to:

* prioritise healthy aging and resilience throughout people’s older years
* enable high-quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events
* ensure people can live well with long‑term conditions
* better support people with high and complex needs
* provide respectful end-of-life care that caters to personal, cultural and spiritual needs.

This ‘vision’ is too limited to promote good health for older people. First, it does not acknowledge the importance of the ‘life course approach’, as outlined in the document. Second, the vision should surely be to see high quality health care across all health and disability services, not just acute services. We also have concerns about the use of the term ‘resilience’, as discussed below. For the purpose of the vision statement, these recommended changes could be addressed simply by amending the first and second vision bullet points to:

* prioritise healthy aging throughout people’s lives
* enable timely, high-quality health care and restorative care as needed.

These elements of the vision need to be incorporated in the detail of the strategy.

Workforce development

Shortages of geriatricians and ‘some other medical specialists’ are acknowledged in the draft strategy. The Association’s recent national surveys on ‘presenteeism’ and burnout among district health board-employed senior doctors indicate the senior medical workforce in general is under great stress.[[27]](#footnote-27) [[28]](#footnote-28) Long-term shortages have been acknowledged by HWNZ in its report *The Role of Health Workforce New Zealand.*Specifically:

The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.[[29]](#footnote-29)

The 2014 report *Health of the Health Workforce*, noting the high numbers of senior medical officers (SMOs) approaching retirement age, identified a wide range of specialties and sub-specialties considered ‘vulnerable’. The Department of Immigration’s long-term and immediate skills shortage lists even more specialties where there are ‘sustained and ongoing shortage…both globally and throughout New Zealand’, or where ‘there are no New Zealand citizens or residents available’. Together they reflect medical specialist shortages across the board. [[30]](#footnote-30) [[31]](#footnote-31)

New Zealand’s specialist workforce is especially vulnerable because of our heavy dependency on international medical graduates (43% of the specialist workforce), which HWNZ has also acknowledged and indicated this needs to be reduced to around 15%. The relatively poor retention rates of IMGs are well documented in the Medical Council’s annual medical workforce surveys. This places New Zealand in a precarious position when considering looming international specialist shortages. Our dependency on IMGs is especially significant when taking into account that the medical workforces in most other OECD countries are even older than New Zealand’s. OECD data show in 2013 25% of New Zealand doctors were aged 55 or over, whereas the OECD average was 33%.[[32]](#footnote-32)

The Association supports the ‘action’ to ‘Develop a range of strategies to improve recruitment and retention of those working in aged care,’ but such strategies are needed to address senior doctor shortages across a comprehensive range of specialties. We reiterate our invitation to work with Health Workforce New Zealand to develop recruitment and retention policies and implementation plans as a matter of urgency.[[33]](#footnote-33)

Integration in the health sector and across agencies

The Association has always supported the goal of better service integration and collaboration. There is strong evidence to show the best way to achieve this is through distributed clinical leadership.

Too often the talk around integration focuses on money and systems, with too little appreciation that integration ultimately depends on people and culture. There is no top-down, imposed way to integrate care; it will be done through distributed, engaged leadership or it will not be done at all.*[[34]](#footnote-34)*

International evidence shows integrated care is possible only if it comes from the ‘bottom up’ through the development of specific ‘micro-level’ interventions by a small number of providers. Organisational integration then comes as a consequence rather than a cause.

Canterbury DHB’s incremental moves to better integrate hospital and community services over the past six years or so is, according to one analysis, one of ‘a small stock of examples’ where integration appears to have resulted in some measurable positive changes.[[35]](#footnote-35)

Notably, the process at Canterbury involved a number of different initiatives developed and implemented ‘from within, by empowering clinicians and others who are prepared to take responsibility for changing the way things work, instead of seeking to drive change through external stimuli…’. Clinical leadership was ‘not focused on just a few heroic individuals in formal leadership roles’, but was shared and distributed as a collective responsibility.[[36]](#footnote-36)

In summary, the literature is clear that for integration of health services to succeed, clinical leadership needs to be firmly established across the system.

Resilience

The proposal to ‘prioritise … resilience throughout people’s older years’ is problematic because the specific intent is unclear. ‘Resilience’ can be conceptualised in numerous ways.

Many researchers have raised concerns about how social policies promoting ‘resilience’ can be interpreted as representing an individual’s personal attribute and ‘pave the way for blaming the individual for not possessing characteristics needed to function well’. This, in turn, can lead to political decisions to limit support for people who have not (for any number of reasons not necessarily connected with their own behaviour) achieved ‘resilience’ in the eyes of the state.[[37]](#footnote-37)

While one cannot argue with a strategy that aims for the best - with ‘a vision where older people age well and are healthy, connected, independent and respected’ - equal attention must be afforded those who do not reach the ideal state.

As researchers J. Davey and K. Glasgow comment in a critique of New Zealand’s Positive Ageing Strategy, compared with those in Australia and the United Kingdom:

Those who are ageing in good health and are engaged in productive activities may benefit from increased opportunities if the strategies achieve their objectives. But the approach is problematic for those who are not, or who can no longer be, self-reliant and independent. Those who make demands on health and welfare services may be stigmatised and blamed for not making sufficient preparation or taking due responsibility for their health and wellbeing.[[38]](#footnote-38)

To help avert any negative consequences from accentuating the positive, researchers recommend that policies or reports relating to ‘resilience’ should include ‘a clear operational definition … and explicitly clarifying that it is not a personal characteristic of the individual’.

We note that: ‘Positive psychology approaches that build people’s strengths and capabilities are another important element to building mental resilience, increasing optimism and hope and reducing the potential and impact of depression, anxiety and cognitive decline.’

We suggest one important ‘positive psychology’ approach would be to provide older people with a security of knowledge that if they are in need of any health service or disability support, it is available in a timely manner, it is affordable and it is of high quality. This should be a priority of the Action Plan.

Respectful end of life

We support proposals to promote advance care planning and more effective end-of-life care in general. This requires senior doctors’ time, which in turn requires an adequate workforce.

A Royal Australasian College of Physicians (RACP) survey of fellows’ and trainees’ attitudes, knowledge and practice concerning end-of-life care and discussions with patients about future health care options through Advance Care Planning processes found many patients nearing the end of life are provided with treatment that is inappropriate or against their wishes.[[39]](#footnote-39)

Of all respondents to the RACP survey, 34% had commenced an Advance Care Plan conversation with a patient in the past six months and 32% had not done any. The survey identified the following potential barriers to undertaking Advance Care Planning:

* • time constraints (62%)
* • insufficient relationship with patients (46%)
* • health literacy of the patient or family (41%)
* • lack of skills of the doctor (30%)
* • discomfort in having end of life or Advance Care Planning conversations (26%)
* • unavailability of appropriate place for discussions (20%)
* • patients aren’t interested (18%)
* • language barrier (16%).

Most of these identified barriers are directly or indirectly related to the doctor’s time – whether it is time to have the (sometimes many) conversations with the patient and family, especially if the patient has difficulty understanding the information, or whether it is time for the doctor to undertake skills training or obtain other support as needed.

The doctor’s time factor arises frequently in the literature discussing barriers to patient centred care.[[40]](#footnote-40)

‘Social investment approach’

The social investment approach – assuming it is based on the ‘investment approach’ currently used by the Ministry of Social Development (MSD) – uses techniques from the insurance industry to calculate long-term costs to the government of health and social services.[[41]](#footnote-41)

However, it fails the test of being an investment approach. A true investment approach should take a long-term view of both the costs and the benefits of public services in order to reduce costs while maintaining or improving effective services and benefits. It is the idea of spending now to reduce future costs.

Instead, far from being an investment approach to social welfare, MSD focuses only on costs and benefits to the government and not on the benefits to individuals and the communityThe Productivity Commission recommended that the investment approach “should be further refined to better reflect the wider costs and benefits of interventions” and called for independent evaluations. It noted that “slavish application of an investment approach based purely on costs and benefits to government might lead to perverse outcomes.

Council of Trade Unions economist Dr B. Rosenberg’s analysis of the ‘investment approach in social welfare concluded:

It treats citizens as liabilities [the draft strategy calls chronic health conditions a ‘burden’] unless they are employed, and even then they are not regarded as assets. This is the logic of the approach and is being demonstrated in harsh, poorly conceived welfare policy which ironically is short-sighted because it ignores human need. Based on commercial insurance actuarial methodologies, it confuses public services with private insurance. It places no value on the purpose for having public services such as social security. It promotes an impoverished approach to public policy which can be dangerously wrong.[[42]](#footnote-42)

Action Plan

Notwithstanding the matters raised in this submission, many of the proposed actions listed in the ‘Action Plan’ as a whole make sense, but there is no indication as to whether there is a budget for each of the ‘actions’.

The earlier, more candid Ministry of Health draft strategy on the mental health and addiction workforce plan acknowledged ‘All actions in the draft are tentative’ depending on the availability of funding.[[43]](#footnote-43)

Given that, as the draft strategy states, “We currently spend 42% of the … health budget on people aged 65 years and older,” the amount of money to fund the Action Plan is likely to be considerable.We note that since 2009/10 the population of those aged 65+ has increased by an estimated 24% while DHBs have accumulated substantial funding shortfalls and health spending per GDP has dropped.[[44]](#footnote-44) [[45]](#footnote-45) If implementation of the Action Plan is, like the draft mental health workforce plan, dependent on funding being available, and current health funding trends continue, many of the goals are unlikely to be achieved.

Evaluation

We note the Ministry of Health will “Develop a system to evaluate progress against the goals of the Health of Older People Strategy...” There are many players and many activities involved, so an evaluation is likely to be no small task – though of course it is crucial. Again, there is a question of budget. There is also a fundamental question of the availability of baseline data on which to base an evaluation.

Finally, assuming a robust evaluation programme is able to be put in place, with the necessary funding, we question whether the Ministry of Health is the appropriate body to be given responsibility for it. As the Prime Minister’s Chief Science Advisor comments:

It is important to separate as far as possible the role of … evaluation from the role of those charged with policy formation.[[46]](#footnote-46)

If the Ministry is to have responsibility for evaluating the progress of the strategy, in order to ensure public accountability, the evaluation should be undertaken as an annual report to Parliament.

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| **Submission 120** |

In May 2016, NEAC provided advice to the Minister on what people with dementia and their families need, what the wider community can do, and how the health and social support workforce needs to behave.

In June 2016, NEAC received a response to this advice from Hon Peter Dunne, Associate Minister of Health. The Minister agrees that work is needed on an ongoing basis in building support in communities, planning ahead, supporting families, whānau and friends, delivering quality health and social support services, and developing a skilled health and social support workforce. The Minister also said that he would direct the Ministry to ensure that it gives detailed and careful consideration to all of NEAC's recommendations as part of the consultation process for the Health of Older People Strategy.

Given this, we have attached NEAC's advice to the Minister and the Minister's response for your consideration.

Regards

NEAC Chair



**NEAC’s Advice on Dementia to the Associate Minister of Health**

**5 May 2016**

**Executive summary**

1. Dementia is a priority health issue for New Zealanders. It is a major cause of disability and dependency, and in recent years, it has received much international[[47]](#footnote-47) and local attention. Most people with dementia are living in the community, with support from families, whānau and friends. The financial and personal costs are significant.
2. Understanding what is important to people with dementia and their families is the focus of the National Ethics Advisory Committee’s (NEAC’s) work. Our advice considers what people with dementia and their families need, what the wider community can do, and how the health and social support workforce needs to behave. Getting these things right will ensure better health outcomes and wellbeing for people with dementia, as well as for those providing support and care.
3. NEAC recognises much is already being done and what is effective should continue to be supported. However, we consider that current activity could be strengthened and focused through a dementia action plan.
4. NEAC recommends:
5. a dementia action plan with specific actions and measures of performance across central and local government, businesses and communities.
6. NEAC’s work indicates that New Zealand can do better in ensuring people with dementia are valued and supported to maintain their independence. We can also do better in recognising and supporting families so that they can provide the best support and care possible. An important part is ensuring all health and social support services are high quality, delivered by skilled workers.

*Building a supportive community environment*

1. NEAC recommends:
2. development of a cross-sector dementia friendly initiative that includes:
   * a programme to increase social inclusion and reduce stigma
   * addressing the needs of people with dementia in urban redevelopment plans
   * support for local government initiatives
   * incentives for businesses to become dementia-friendly
   * design of hospitals, health and social support centres, and residential care facilities to meet the needs of people with cognitive impairments and dementia.

*Planning ahead*

1. NEAC recommends:
2. an improved system of data collection on the incidence and prevalence of dementia to inform national and local planning, alongside research that captures the views of people with dementia and their caregivers
3. increased promotion of advance care planning and training for health care professionals
4. a national approach to actively promote Enduring Powers of Attorney including widespread availability of information and use of subsidies to remove any financial barrier
5. education of attorneys so that they understand and can act in a way that is consistent with a supported decision-making model, with a particular focus on communicating with a person with dementia
6. a consistent and streamlined process for appointing a Welfare Guardian and/or Property Manager or Administrator where there is no Enduring Power of Attorney, including access to an adequate pool of paid or voluntary welfare guardians, managers or administrators.

*Supporting families, whānau and friends*

1. NEAC recommends:
2. that resources developed by Alzheimers New Zealand are widely available and consistently used by health and social support providers
3. all DHBs be required to include navigator roles in their Cognitive Impairment or Dementia Pathways
4. that a family meeting and planning for the future becomes an integral part of normal clinical practice at the time of diagnosis, with referrals to Alzheimers New Zealand or other community support organisations
5. all DHBs increase availability of respite services that better meet the needs of people with dementia (including younger people) and their families.

*Delivering quality health and social support services*

1. NEAC recommends:
2. development and implementation of easy to follow instructions for hospital staff admitting someone with dementia, alongside good pathways for managing confusion
3. incentives to encourage adoption of person-centred care programmes in aged residential care
4. that the Health Quality and Safety Commission and the Health and Disability Commissioner develop mechanisms to encourage health and social support providers (including aged residential care) to focus less on risk and more on quality of life

*Developing a skilled health and social support workforce*

1. NEAC recommends:
2. Health Workforce New Zealand leads the development of a comprehensive, national workforce development plan for dementia covering all current and future health and social support workers
3. that dementia training for health and social support workers include understanding and implementing person-centred care
4. the Age Related Residential Care Services Agreement and contracts for home-based support services include mandatory dementia training and qualifications for all caregivers and managers
5. remuneration for all caregivers is commensurate with increased requirements for dementia training and qualifications.

**Introduction**

*About dementia[[48]](#footnote-48)*

1. Dementia is the term used when a person experiences a gradual loss of brain function due to physical changes in the structure of the brain. There are many causes of dementia, with the most common single cause being Alzheimer’s disease; other causes include vascular dementia, dementia with Lewy bodies and fronto-temporal dementia. The most common form in clinical practice is a combination of Alzheimer’s disease and Vascular dementia. Dementia symptoms include loss of memory, impaired reasoning, reduced language and loss of daily living skills. People with dementia do not all have the same experience; the age of onset varies, symptoms can occur in different combinations and there are differing rates of deterioration. There is a very high rate of behavioural and psychological complications during the course of dementia (up to 90% in Alzheimer’s disease) including depression, psychosis, disorientation and night walking, and aggression.
2. People with dementia are able to manage relatively well in the early stages, with support from family, whānau and friends and small lifestyle changes. People may manage with basic support for a number of months or years. Over time, more support is needed as symptoms increase and abilities change.
3. Based on the World Alzheimer Report 2015, [[49]](#footnote-49) Alzheimers New Zealand estimates that 60,000 New Zealanders had dementia in 2015. By 2030, an estimated 96,000 New Zealanders will have dementia, an increase of 60 percent. The total financial cost of dementia in 2011 was estimated as $954.8 million; health system expenditure accounted for $596.3 million (63%). Individuals with dementia and their carers bore 33% of the financial costs, the Government 55% and other payers 12%.[[50]](#footnote-50)
4. Most people with dementia are living in their own homes in the community. Alzheimers New Zealand estimates that 35,000 New Zealanders with dementia are currently living in the community and 25,000 in residential aged care (rest home and specialist dementia care). Between 60-80% of people in residential aged care have dementia.

*NEAC’s work on dementia*

1. NEAC provides independent advice to the Minister of Health on ethical issues of national significance in respect of health and disability matters. NEAC’s advice is based on a view of ethics that involves identifying what matters, explaining how the sector can act, and encouraging ethical decision-making.
2. NEAC’s work on dementia focuses on the role of families, whānau and friends in providing support and care for people with dementia, particularly those living in the community. Good support and care contributes to better health outcomes and wellbeing for people with dementia. Supporting people to remain safely in their own homes helps maintain a sense of self and personal identity. It also reduces expenditure on residential aged care ($371.9 million or 62% of health system expenditure on dementia in 2011).
3. Providing support and care for a person with dementia can result in significant stress and poorer psychological and physical health for caregivers.[[51]](#footnote-51) With the right help it can be a positive experience. Ensuring families, whānau and friends are well-supported will contribute to better health outcomes and reduced heath care costs.
4. NEAC has met with a range of stakeholders including family carers and people with early stage dementia to explore the ethical issues associated with providing good support and care. An important part is about having timely and appropriate access to good quality health and social support services. Increasing social inclusion and reducing stigma is also important and this will lead to a more positive community response to people with dementia and their families.

*Ethical values*

1. Ethics is about the underlying values that should govern our behaviour. A significant part is about what people do, think and believe. Important values for dementia are:

* respect/mana – every person has an inherent value or mana; mana places an expectation on others and New Zealand communities to recognise and uphold the value of each person throughout the course of their life
* people first – knowing the person with dementia and what is important to them is essential
* independence – doing things for ourselves, doing what we enjoy or find important and making our own choices helps maintain a sense of self and wellbeing; people have a right to make decisions that others might disagree with or think unwise
* interdependence – we are all dependent on each other in everyday life; the person with dementia and their family, whānau and friends can be more reliant on each other and therefore these relationships are even more critical
* best interests – any person’s best interests are a balance between what is important to them and what is important for them; there are no absolutes and what is important may change over time
* solidarity – supportive communities and environments are important for people with dementia and their families, whānau and friends; everyone has a role to play.

**ADVICE**

1. NEAC’s advice is about what needs to change for people with dementia and their families and whānau, whether this is strengthening current actions or starting new ones. Our advice is based on an analysis of what stakeholders told us and the ethical values that are important. It has been informed by a range of articles and publications on ethics and dementia, and best practice dementia care (see Bibliography). NEAC’s advice sets out what needs to happen for people with dementia to have lives that embrace the ethical values described above.
2. NEAC recognises that much is already being done. For example, Alzheimers New Zealand’s Let’s Get Our Heads Around Dementia campaign aims to increase understanding and the importance of timely diagnosis, and in April 2015, they adopted a new strategy to achieve a dementia-friendly New Zealand. The New Zealand Framework for Dementia Care (Ministry of Health, 2013) is supported by action in nine key areas (Improving the Lives of People with Dementia, Ministry of Health, 2014). It is important that this work is evaluated, and where effective, continues to be supported.
3. NEAC recommends an action plan for dementia to strengthen and focus activity across central and local government, businesses and communities. Work on the new Health of Older People Strategy and the revision of the New Zealand Disability Strategy provides an opportunity for dementia issues to be highlighted and a plan developed with specific actions and measures of performance.
4. A good international example is Prime Minister David Cameron’s challenge on dementia 2020. It sets out the UK Government’s key aspirations for 2020 and associated actions in dementia care, support for carers, awareness and understanding, and research. Specific measures of performance are attached to each action, for example, by 2020 all National Health Service staff will have received training on dementia appropriate to their role.
5. NEAC recommends further action to ensure:

* a supportive community environment
* planning ahead
* good support for families, whānau and friends
* quality health and social support services
* a skilled health and social support workforce.

**Building a supportive community environment**

1. While recognising that dementia is a medical condition, quality of life is significantly affected by the wider social context. Disability is what happens when society and the environment do not take account of the impairments people have. We can reduce the disabling impact of dementia through community action.
2. People with dementia often experience a change in the way people see them and this can have a marked impact on their wellbeing, social inclusion and independence. Many stakeholders talked about the stigma and discrimination associated with a diagnosis of dementia.

*There is a perception about what dementia looks like (from 50 years ago) and it’s important to show people that it’s not like that.*

*Friends and community do not understand dementia takes over your brain, some expected me to go doolally straight away, others asked if I was still driving, others would prefer to ignore me, it would have been easier for them to accept my situation if I had lost the plot quicker.*

*If people know I have alzheimers, they will think I don’t know anything. They will look for problems, things I’m doing wrong.*

Comments from people with dementia

1. The language used can also be misleading. People with early stage dementia talked to us about needing support, not care. They said they were reliant on others for some things, not dependent. Their families were reliant on them for some things too. Maintaining independence was very important, with support to make decisions if required.
2. Increasing understanding of dementia and how best to assist people with dementia goes hand in hand with the dementia-friendly communities model. Dementia-friendly communities are characterised by a physical environment and social community that enhances inclusion and enables people with dementia to maintain greater independence and have greater choice and control over their lives. A whole of community response is required with local government and businesses playing a key role.
3. There is an opportunity to build on work that has already been done. For example, the New Zealand Bankers Association’s 2009 guidelines to assist banks to meet the needs of older and disabled customers could be reviewed and amended, if required, to address the particular needs of customers with dementia. Rebuilding, such as that underway in Christchurch, offers unique possibilities to consider how to design-in dementia-friendly features, which would also benefit the wider disability community and others such as tourists and families.
4. There are many international examples of dementia-friendly community initiatives. For example, Scotland’s Dementia Friends programme encourages people to learn about dementia and the small things they can do to help. Eighty-two communities across England have signed up to the national Dementia Friendly Communities recognition process. Activities include setting up regular groups for carers and people with dementia, and community awareness events in schools and libraries.
5. Local businesses can play a key role in promoting community inclusion. For example, in 2014, all Marks & Spencer’s staff became dementia friends and they are now training Dementia Champions for each store. These people will be better able to recognise and help people showing signs of dementia while shopping. They will also be active in raising awareness in their local communities.
6. In the broader context, dementia-friendly cities improve their street signage, footpaths and public transport systems to better meet the needs of people with dementia. They are designed in a way that encourages everyone to remain active, walk more, and use active transport where possible.
7. Similarly, health and social support centres can be designed to enable and support people with dementia. In the UK, the King’s Fund has developed assessment tools for hospitals, care homes, primary care premises and specialist housing providers to encourage improvements in the physical environment and the way the environment encourages people to behave and interact.[[52]](#footnote-52) Relatively inexpensive interventions, such as changes to lighting, floor coverings and signage can have a significant impact on decision-making, agitation and distress, and independence and social interaction.

*What is currently happening*

* Alzheimers New Zealand’s dementia awareness campaign – *Let’s Get Our Heads Around Dementia* – focuses on raising awareness of dementia symptoms, available support services and the advantage of an early diagnosis.
* Karen Smith, a Registered Nurse trained in dementia studies in Scotland, interviewed people with dementia in a research project[[53]](#footnote-53) about what would improve their quality of life in a rebuilt Christchurch. Based on the findings, she recommends that New Zealand adopt a dementia-friendly cities approach.
* Initial discussions in Auckland have explored how the needs of people living with dementia can be included in the Auckland Design Manual (a best practice resource on design and the built environment).
* As part of its commitment to community based dementia friendly services, Alzheimers Canterbury offers normalised activities for people with dementia including gardening at the botanical gardens, and book and art appreciation groups.
* Westpac became New Zealand’s first dementia-friendly bank in 2015; trained staff will be better able to assist where needed and a clear layout with signs, displays and lighting will help support independent navigation.
* The Office for Senior Citizens is encouraging New Zealand communities to become age-friendly.
* Alzheimers New Zealand is currently developing a programme to formally recognise organisations as being dementia-friendly and expect to launch the recognition programme by mid-2016. They are also planning a dementia friends programme to recognise individuals who are making a contribution to dementia-friendly communities.

*What does NEAC recommend?*

1. NEAC recommends:

* development of a cross-sector dementia friendly initiative that includes:
  + a programme to increase social inclusion and reduce stigma
  + addressing the needs of people with dementia in urban redevelopment plans
  + support for local government initiatives
  + incentives for businesses to become dementia-friendly
  + design of hospitals, health and social support centres, and residential care facilities to meet the needs of people with cognitive impairments and dementia.

**Planning ahead**

1. Having good information on New Zealanders currently living with dementia and expected numbers in the future helps us to plan ahead so that we can better meet the full range of needs for people with dementia and their families.
2. New Zealand does not collect reliable data on dementia. We are currently reliant on Alzheimer’s Disease International’s estimates of the global prevalence and incidence of dementia (the most recent updates were included in the World Alzheimer Report 2015).
3. Planning ahead is also important for individuals, no matter what age or health status. It is good for us all to think about what we want to happen should we no longer be able to make decisions for ourselves. A timely diagnosis of dementia is important for this reason. It enables families and people with dementia to talk about the future and what matters to them. It also means that people can record the things that are important to them, when they are still able to do so. It is important that all health care providers are aware of and able to access any such information.
4. The advance care planning process, involving discussion and shared planning for future health care between a person and health professionals, helps people to explore their wishes, values and preferences. An advance care plan, advance directive and Enduring Powers of Attorney (for both personal care and welfare, and property)[[54]](#footnote-54) are ways in which a person’s specific preferences can be recorded. These mechanisms provide a way for people to have some say about how they want to be treated, how they want decisions to be made as their illness progresses (eg, progressing from supported decision making to decisions being made on their behalf) and who they want involved in this
5. Enduring Powers of Attorney can also provide some protection against abuse. They need to be something that all New Zealanders pay attention to, not just people with dementia.
6. Many of the family carers we talked to told us about how the process of decision-making changed over time. People with early stage dementia were able to make decisions with little or no support. As the disease progressed, more support was required until the carer took responsibility for making decisions.

*It used to be ‘us’ when making decisions, now it’s ‘me’ – what I think is best. I try to include my partner but sometimes that can just make it too difficult. It is still good to ask; sometimes they will have a great idea.*

*A trusted family member can make a huge difference to the length of time that a person can continue to do things. My husband used to change his bank account pin number and it was really difficult when he couldn’t remember it. The bank was really resistant to me being involved but it means that my husband can continue to use his bank account.*

*Enduring Powers of Attorney needs to be about assistance, not ‘them’ or ‘me’. Currently the carer either has to be completely responsible or the person is completely responsible.*

Comments from family carers

1. Stakeholders raised concerns about:

* the response of GPs to memory and behaviour concerns, and in particular, their reluctance to make a diagnosis of dementia
* lack of information and cost acting as barriers for setting up Enduring Powers of Attorney
* lack of advice on the role and challenges of being an attorney
* the all or nothing nature of Enduring Powers of Attorney - this does not adequately recognise that capacity is decision-specific
* insufficient guidance and lengthy process for DHBs when applying for the appointment of a Welfare Guardian and/or Property Manager or Administrator where a person does not have an Enduring Power of Attorney
* lack of legal recognition for supported decision-making.

1. Internationally, there is a growing demand for supported (rather than substituted) decision-making systems based on the person’s will and preferences, not what might be perceived as his or her best interests.[[55]](#footnote-55) The Australian Law Reform Commission’s review of equal recognition before the law and legal capacity for people with disability recommended reform of laws and legal frameworks based on decision-making principles and guidelines.[[56]](#footnote-56) The principles and guidelines are aimed at ensuring that supported decision-making is encouraged, representative decision-makers are appointed only as a last resort, and the will, preferences and rights of individuals direct decisions that affect their lives.

*What is currently happening?*

* Work is underway to ensure standardised assessment and diagnosis in primary care. For example, the Northern Region Cognitive Impairment Clinical Pathway promotes early identification and intervention, and encourages collaboration with specialist services to support cognitive impairment diagnosis and treatment by GP teams. The pathway is a collaborative effort with Waitemata PHO, Procare, Alzheimers Auckland and the University of Auckland.
* Advance care planning tools and resources are available through the National Advance Care Planning Cooperative’s website. The Ministry of Health has developed ‘Advance Care Planning: A guide for the New Zealand healthcare workforce’ and NEAC has produced advice for health professionals on the ethical challenges in advance care planning. To increase awareness about advance care planning, the Cooperative promotes a ‘Conversations that Count Day’.
* The Office for Senior Citizens has developed a range of resources on Enduring Powers of Attorney, how to set one up and what an attorney does. Other resources include a checklist of things to do before seeing a legal professional and copies of the standard forms that need to be completed.
* Alzheimers New Zealand has partnered with the Public Trust to offer people with dementia and their families a free half hour consultation where they can access advice on, for example, writing or updating a will and setting up an Enduring Power of Attorney.
* Amendments to the Protection of Personal and Property Rights Act 1988 are currently being considered by the Government Administration Committee as part of the Statutes Amendment Bill. The amendments and new regulations will result in simpler forms and a standard explanation of the effects and implications of an Enduring Power of Attorney. Changes are also being made to make the witnessing requirements less cumbersome for people appointing each other as mutual attorneys. The Committee is due to report back in June 2016.
* The Office for Disability Issues is leading work, supported by the Human Rights Commission, on what is needed to ensure that disabled New Zealanders can experience their right for equal recognition before the law (under Article 12 of the Convention on the Rights of Persons with Disabilities). Analysis and recommendations will be presented to the Ministerial Committee on Disability Issues. A first step is developing a shared understanding of Article 12, and as part of this, the Office is working with Auckland Disability Law to bring together and promote good practice in supported decision-making.

*What does NEAC recommend?*

1. NEAC recommends:

* an improved system of data collection on the incidence and prevalence of dementia to inform national and local planning, alongside research that captures the views of people with dementia and their caregivers
* increased promotion of advance care planning and training for health care professionals
* a national approach to actively promote Enduring Powers of Attorney including widespread availability of information and use of subsidies to remove any financial barrier
* education of attorneys so that they understand and can act in a way that is consistent with a supported decision-making model, with a particular focus on communicating with a person with dementia
* a consistent and streamlined process for appointing a Welfare Guardian and/or Property Manager or Administrator where there is no Enduring Power of Attorney, including access to an adequate pool of paid or voluntary welfare guardians, managers or administrators.

**Supporting families, whānau and friends**

1. Good information and support for families, whānau and friends is critical, not only for the person with dementia but also for those providing care and support. Family carers commonly talked about feeling very stressed, alone and unsupported. There was also a sense that each family had to work things out for themselves, even though the issues they faced were similar.

*People don’t understand what it is like. I am not sleeping very well and people just say that’s normal for older people.*

*It is very hard to have a life. I am still married but it’s not a marriage; he is no longer my husband. Sometimes I feel I have mortgaged my life to the illness.*

*It can be very lonely; people stay away and there is a lot of judgement from people who are not living with the situation every day.*

*Friends and family may not understand why the person is in residential care as he seems alright to them. I also get it from my partner, why are you leaving me alone? I feel very guilty.*

Comments from family carers

1. Support needs to be flexible to meet the needs of individual families and whānau. The family carers we talked to wanted:

* accessible, easy to understand information on dementia and providing care
* someone to talk to about their situation, help them identify options and make decisions
* someone to help them access social support and health care
* practical advice and support at transition points (eg, understanding responsibilities of an enduring power of attorney, deciding on residential care)
* more respite as well as a greater range of respite options, including age-appropriate respite for younger people with dementia.

1. Information and support is available from local Alzheimers organisations or similar community groups. Stakeholders spoke very highly of the support provided by such groups, but noted that not everyone has access to a good level of support. NEAC understands that one of the reasons for variable support is an inconsistent approach to contracting such services across DHBs.
2. The importance of a navigator or first point of contact for the person with dementia and their family and whānau is recognised in New Zealand’s Framework for Dementia Care (Ministry of Health, 2013). A navigator is expected to provide active support and information throughout the dementia journey including on health and social support services, reducing or preventing challenging behaviours, the role of enduring power of attorney and transitions of care. In the UK, specialist dementia nurses (called Admiral Nurses) fill this type of role, giving practical, clinical and emotional support to families living with dementia. They help join up different parts of health and social care, offer advice on referrals, and can liaise with health and social care professionals on a person or family’s behalf.
3. All family carers we talked to experienced difficulty in accessing day programmes and residential respite. One couple had to wait seven months before there was a vacancy on a day programme. Another carer told us they had to approach five different residential facilities before they were able to making a booking for residential respite.
4. Families wanted access to short-term, ad-hoc respite so that they could have time out from caring. This is critical for the wellbeing of carers.
5. DHBs contract with residential care facilities to provide respite, but as there are not designated beds for respite, availability is variable and it can be difficult for families to plan ahead. Some DHBs are supporting innovative ways of providing respite (eg, people providing home-based respite for small groups of people with dementia) but we understand this is very limited.

*What is currently happening?*

* Alzheimers New Zealand is leading work to update and increase accessibility of information for people with dementia and their families. *About Dementia* provides easy to understand information on dementia, getting a diagnosis, support following a diagnosis and planning ahead. Other resources are being developed on providing good care, long-term residential care, and the later stages of dementia and end of life care.
* Providing navigation of services and increasing the quality of dementia information and education is one of nine Ministry of Health actions. [[57]](#footnote-57) NEAC understands that progress is slow with establishing navigator roles.

*What does NEAC recommend?*

1. NEAC recommends:

* that resources developed by Alzheimers New Zealand are widely available and consistently used by health and social support providers
* all DHBs be required to include navigator roles in their Cognitive Impairment or Dementia Pathways
* that a family meeting and planning for the future becomes an integral part of normal clinical practice at the time of diagnosis, with referrals to Alzheimers New Zealand or other community support organisations
* all DHBs increase availability of respite services that better meet the needs of people with dementia (including younger people) and their families.

**Delivering quality health and social support services**

1. People with dementia and their families and whānau interact with a range of health and social support services. It is important that all services are high quality, with a focus on understanding and meeting the needs and wants of the person with dementia and their families and whānau.

*Impact of poor quality care*

1. Poor quality care can have a significant impact on health and wellbeing. This is particularly apparent in hospital settings.
2. Australian research indicates that people with dementia are more likely to be admitted to hospital and experience worse clinical outcomes including longer stays in hospital and higher mortality.[[58]](#footnote-58) UK research found that 47% of people with dementia who went into hospital experienced a deterioration in their physical health (eg, weight loss, malnutrition, dehydration) and 54% had an increase in dementia symptoms (eg, becoming more confused, less independent and more distressed).[[59]](#footnote-59)
3. Family carers that NEAC talked to shared their stories about inadequate care in hospitals and how this had a major impact on health outcomes. One of the carers talked about how she was unable to visit her father in hospital because of a norovirus outbreak and when she finally got to see him he was severely dehydrated (water was available but he did not drink it). Another talked about the unwillingness or inability of staff to manage behavioural issues such as night walking and their insistence that the person be discharged early to avoid the disruption of their behaviour.
4. Others carers talked about how nursing staff would assist with or take over functions that the person with dementia was able to perform without assistance and this could result in a rapid deterioration in independence.
5. Poor quality care can also impact on the health and wellbeing of family carers. Carers commonly talked about how stressful it was when the person with dementia was in hospital (or respite care). For them, caring responsibilities did not stop and they were constantly worrying about level of care.

*Ethical values for high quality care*

1. High quality care is underpinned by the six ethical values: respect/mana, people first, independence, interdependence, best interests and solidarity. Of particular interest to NEAC is how to ensure care is based on:

* knowing the person with dementia (people first)
* supporting their independence
* recognising the interdependence between the person with dementia and their family, whānau and friends.

1. People first is about treating the person as an individual with their own values, interests, likes and dislikes. Knowing the person with dementia and what is important to them means that care and support can be tailored to meet their particular needs and interests. An important part is helping to maintain the person’s identity through environmental cues and appropriate activities.

*I like to have a shed to make things in, being able to go for a walk and spending time on the computer.*

*I used to enjoy bringing in the hay. I would love to do that again.*

*My husband is still intellectually on the ball. He is not interested in going to the park and eating his lunch on a bench. One of the art galleries ran a tour for people with early stage dementia and he really loved that.*

Comments from people with dementia and family carers

1. Living well is about much more than physical health. It is also about social inclusion and maintaining independence as much as possible. This is particularly important for people living in the community; there needs to be good access to a range of community and home based services and support to enable the person to live well in the community for as long as possible. This includes age-appropriate services and support for younger people with dementia.
2. Maintaining independence is also important for people living in residential care. NEAC heard about residential care facilities where a focus on minimising risk was having a detrimental impact on quality of life for people with dementia. Some stakeholders suggested that policies and rules limit the ability of staff to support residents to maintain daily living skills.
3. It would appear, at face value, that the contractual requirements in the Age Related Residential Care Services Agreement adequately cover the need for services to reflect the values of people first, independence and interdependence. For example, services must be resident centred and promote independence and quality of life.[[60]](#footnote-60) However, such minimum standards do not ensure best practice in dementia care.
4. While some residential care facilities have adopted best practice models for dementia care, more needs to be done to ensure this is the expected standard. People with dementia and their families, whānau and friends need to be able to make choices about residential care facilities based on the model of care.
5. NEAC also considers there would be value in exploring how dignity of risk could be applied in residential care. Dignity of risk is about the right of people to take risks when engaging in life experiences and the right to fail. Upholding such a principle in residential care would require a shift from a focus on protection and prolonging life, to promoting and enabling residents to exercise their right to take risks in order to have a higher quality of life.

*Recognising the role of families*

1. Finally, recognising the role of families is integral to quality care for people with dementia. Family carers know a lot about what the person needs day to day and if health and social support workers can tap into this knowledge, care will be much improved.
2. Some family carers wanted to have an active caring role when their family member was in hospital and suggested that New Zealand should have something similar to John’s Campaign in the UK. This campaign is about carers having the right, but not a duty, to have 24-hour access to a patient in hospital with dementia.
3. Others talked about how they were not consulted before medical treatment was provided even though, in some cases, they were the personal care and welfare attorney. One family carer talked about her husband receiving regular enemas to relieve constipation without her consent. This meant that other, less intrusive treatments that had worked in the past were not tried first. She was also concerned about the distress her husband may have experienced from the treatment.

*What is currently happening?*

* The National Health IT Board is leading work to establish a single electronic health record that will enable clinicians, working in hospitals and in the community, to access patient information in one place. A single electronic health record is expected to improve care coordination. A Health Information Governance Framework will set the standards on information sharing and privacy, including access controls and ways that sensitive information can be withheld.
* All DHBs are required to develop Cognitive Impairment or Dementia Pathways. The working plans need to support better and more timely diagnosis of dementia and initiation of a comprehensive management plan. The Better Brain Care Programme in Auckland DHB hospitals includes cognitive assessments for all patients over 75, engaging with families/carers, providing appropriate care, and ensuring safe discharge and follow-up.
* The Spark of Life, the Eden Alternative and the Dementia Care Mapping approach are the main programmes for enhancing person-centred care in aged residential care in New Zealand.
  + The ‘Spark of Life’ philosophy focuses on meeting the social and emotional needs of people with dementia – to feel appreciated, joyful, loved and involved. It has been adopted by several residential care providers in New Zealand eg, Enliven, Presbyterian Support Central; Mercy Parklands, Ellerslie, Auckland; Kingswood Healthcare, Waikato.
  + The Eden Alternative aims to reduce loneliness, helplessness and boredom through loving companionship and meaningful activities. Elizabeth Knox Home and Hospital, Epsom, Auckland achieved full Eden Alternative registration in February 2014.
  + Dementia Care Mapping involves developing action plans for individuals or groups based on observing behaviours, mood and engagement, and the quality of interactions with staff.

*What does NEAC recommend?*

1. NEAC recommends:

* development and implementation of easy to follow instructions for hospital staff admitting someone with dementia, alongside good pathways for managing confusion
* incentives to encourage adoption of person-centred care programmes in aged residential care
* that the Health Quality and Safety Commission and the Health and Disability Commissioner develop mechanisms to encourage health and social support providers (including aged residential care) to focus less on risk and more on quality of life.

**Developing a skilled health and social support workforce**

1. The person with dementia and their family will have contact with a wide range of health and social support workers. This includes, for example, general health professionals (podiatrists, dentists, physiotherapists), day to day care workers and community support workers. All health and social support workers need to have a good understanding of dementia and how to provide high quality care. More in-depth training is required for those working with people with dementia. People first or person-centred care knowledge is critical as people living with dementia often face challenges relating to stigma and capacity-eroding aspects of their care.
2. For aged residential care there are some training requirements but these are primarily for staff in dementia units. In particular, there must be a registered nurse with experience and training in the care of people with dementia, and all caregivers (not including registered or enrolled nurses) must have passed specific unit standards no later than 12 months after their appointment. The unit standards cover knowledge of dementia, person-centred care, managing the effects of dementia and supporting people when their behaviour presents challenges.
3. While it is good to see such contractual requirements, they need to be strengthened. It is simply not good enough to have caregivers in dementia units with no training on dementia. In fact, all caregivers in residential care need such training because 60-80% of people in residential care have dementia.[[61]](#footnote-61)
4. For other workers, including those working with older people, there do not appear to be any specific training requirements. Understanding dementia and providing quality care should be included in all undergraduate courses for health professionals. There also needs to be accessible training for all current health and social support workers and ongoing development plans.
5. Further, it is important that those working with people with dementia have access to specialist support such as dementia nurse specialists and psychogeriatricians.
6. NEAC considers there would be value in developing a training framework that sets out the expectations for all health and social support workers. A good example is the UK Dementia Core Skills Education and Training Framework[[62]](#footnote-62) that sets out the essential skills and knowledge necessary for all UK health and social care staff. This Framework is based around three tiers: 1 – awareness for all workers in health and social care settings; 2 – basic skills for those having regular contact with people with dementia; 3 – knowledge, skills and attitudes for managers and other leaders working with people with dementia.
7. Several stakeholders noted that the lack of recognition for paid carers of people with dementia has a significant impact on what can reasonably be expected in training. The pay levels for community and residential care and support workers are not commensurate with the knowledge and skill required to provide high quality care for people with dementia. NEAC notes the current negotiations over pay rates for care and support workers and the joint working group on pay equity principles that was expected to report to Ministers by the end of March 2016.

*What is currently happening?*

* Increasing the quality of information and education for the workforce is one of nine Ministry of Health actions (*Improving the Lives of People with Dementia*, August 2014). $1.2 million was committed in Budget 2013 to increase dementia training for support workers.
* Walking in Another’s Shoes, a New Zealand dementia care training programme, is operating in three Central DHBs and all five Southern DHBs. The focus is on training aged residential and home-based carers.
* Careerforce, in partnership with Alzheimers New Zealand and Walking in Another’s Shoes, have developed a brief person-centred care-informed training package for all home-based care workers called ‘Open Minds, Open Doors’
* DHBs are responsible for dementia behavioural support and advisory services. The objective of these services is to provide a consultation, liaison, advice, information and education service by experienced clinicians, to the community including people with dementia, carers, and other service providers. In addition, geriatricians and gerontology nurse specialists provide support and education to primary health care and aged residential care health professionals.

*What does NEAC recommend?*

1. NEAC recommends:

* Health Workforce New Zealand leads the development of a comprehensive, national workforce development plan for dementia covering all current and future health and social support workers
* that dementia training for health and social support workers include understanding and implementing person-centred care
* the Age Related Residential Care Services Agreement and contracts for home-based support services include mandatory dementia training and qualifications for all caregivers and managers
* remuneration for all caregivers is commensurate with increased requirements for dementia training and qualifications.

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(This bibliography is a list of published work that has informed NEAC’s work on dementia.)

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| **Submission 121 withheld at submitter’s request** |

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| **Submission 122** |

Thank you for the opportunity to submit on behalf of the Health Quality & Safety Commission. We support and commend the intent and contents of the strategy, which will be a welcome, positive step forward for the whole sector. The way forward looks positive and beneficial.

A general obversation from us is that the draft Strategy would benefit from acknowledging the statutory role the Commission has in leading and coordinating quality and safety in the health and disability system and the overview and assessment of this. In addition we think more emphasis is required on the importance of co-design and advance / anticipatory care planning to facilitate consumer empowerment, particularly for people with long term conditions. We would also like to see more detail of how consumers, family / whānau will be contributing to the Strategy.

**Strategy comments**

* (**p.4**) You will obviously re-check all the figures, but your reference to ‘the $11,000 million health budget’ is unusual. Why doesn’t it tally with the 2016/17 Vote Health total of $16.1 billion? It’s also worded unusually: why not ‘$11 (or 16) billion’?
* (**p.9**) It’s great to see the Triple Aim included. We suggest modifying the ‘Individual’ description to match the Commission’s updated text: ‘Improved quality, safety & experience of care for people *and their whānau*’.
* (**p.10**) You may wish to explain the statement that ‘expenditure on older people will account for 50 percent of DHB expenditure by 2025/26’ if the health system continues to fund services the way it currently does. How was this figure calculated? You should consider references explaining what a social investment approach entails, because general readers won’t be familiar with the term.
* (**p.10**) Under ‘Workforce development’, we have identified the increasing need for training in geriatric medicine across the whole workforce as a key component of addressing the needs of primary care and older hospital users, and ensuring good quality health care for older people.
* (**p.11**) Your ‘Families and communities’ section should explain in more detail what an age-friendly community looks like and what developing one entails. You may also wish to explain yourself more fully in the second paragraph under ‘Integration across the health and social sectors’.
* (**p.14**) The health ageing discussion contains quite a lot of repetition, and would benefit from an example to show how individuals’ health and independence can be enhanced.
* (**p.15**) The resilience section could include a longer-term perspective on events earlier in individual lives, because events as early as childhood play a role in determining people’s resilience. People’s ability to adapt to other adverse events in their lives such as the loss of a partner or loss of a home is both influenced by their current resilience and can also affect their future resilience.
* (**p.16**) The description of age-friendly communities should be framed with a whole-of-government approach, which has great potential but will also be challenging to coordinate. Working with social housing providers to ensure houses are warm, safe and dry will be a positive step, but how will this work in practice?
* (**p.18**) Your brief section on quality is welcome but doesn’t go into detail and doesn’t mention the Commission’s role. It could provide more detail about the importance of measuring quality to drive improvement in older people’s health.
* (**p.21**) Under prevention and detection the text should emphasise the importance of creating an environment that enables individuals to understand much more about their health and be empowered to take charge of their health issues. To do this we need to provide individuals, families/whanau and carers with information about preventing long term conditions, in ways that best suit their needs rather than the system’s needs.
* (**p.22**) The enabling technology section could place more emphasis on health workforce teamwork and teamwork with consumers and the community. And, as above, it could reference the importance of people being empowered with the right information to make informed decisions about their own care.

**Specific action plan comments**

* (**Action 26d**) The action plan includes some roles for the Commission, usually with partner agencies. The one action the Commission is listed as leading, incorporating home and community support users’ experiences into Commission-led patient experience work, is dependent on Ministerial decisions to implement and fund an aged residential care patient experience survey. Costed options were provided to the Associate Minister of Health, Hon Peter Dunne, on 30 June 2016 for his consideration. On 10 August he advised that this work should be progressed as part of the refreshed Health of Older People Strategy, including allowing further consultation about developing a survey through this process. We look forward to early discussions with the Ministry to incorporate home and community support users into our patient experience work. (Please note that the Commission has no funding allocated for this work in its baselines).

Brief comments on other actions:

* Establishing age-friendly communities is a commendable goal, but could **action 1a** in particular express a more specific action, given it’s a short-term target?
* We wonder why **action 4a** isn’t listed as a short-term target, given its importance and because this work has already started.
* More effective health literacy information (**action 4d**) needs a cross-sectoral approach not limited to just MOH and HPA.
* Suggest you specify that the work in **action 6a** ‘improves the quality of discharge planning’, not just ‘supports’ it – currently such planning leaves a lot to be desired.
* The workforce section (**action 9**) needs a specific action point on teamwork and integration.
* In **action 12**, how will an action listed as being led by ‘all’ work in terms of accountability?
* In the goals listed for support for people with high and complex needs (**p.37**), we prefer ‘information and education’ rather than ‘education and training’, because the former is less prescriptive and more empowering. Note also that we can identify who has fallen but only at the population or individual level. We can’t successfully identify which specific individual will fall.
* We suggest that you consider redefining **action 19** to focus on anticipatory care planning rather than advance care planning. This has a broader scope, but in simple terms expands the concept beyond merely planning for a good death.
* In **action 26**, we would welcome the use of the phrase ‘service co-design’ rather than just ‘service design’, because this indicates a stronger and more equal partnership with consumers, family / whānau and carers.

Under **action 27**, the quality and safety markers monitoring work is led by the Commission, as this is our statutory role.

**Other general comments**

* We would like to see the Ministry of Health lead the elder abuse work within the cross government ministerial group on family violence and sexual violence work programme. This would help the development of policy (and possibly contribute to the consideration of a Care Act). It would also guide the implementation of a multi-sectorial response to this often ‘hidden’ but serious issue.
* The action plan would also benefit from including:
  + improvements to workforce training and communication, including:
    - more focus in post graduate training and education in all specialties about the elderly and changes in physiology, etc
    - narrowing down the number of assessment tools we use, making them more uniform nationally and incorporating this into a better single overall assessment rather than many different individual assessments forms
    - promoting better coordination of care in the community to minimise intrusions on the elderly; this is a workforce issue in terms of scope but also a service coordination role.
  + discussion of the importance of co-design and anticipatory care planning for long term conditions
  + an explanation of Healthy Families NZ: its work and place in the sector
  + better descriptions of coordinated services, such as more preparation for transitions for elderly (often at 65) from a specialty to elder services
  + discussion of the importance of nutrition and heating to overall wellbeing and health
  + planning for getting older, medico-legal aspects such as enduring power of attorney, advance / anticipatory care plans

We would of course be happy to discuss or elaborate on any of these points.

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| **Submission 123** |

Below is the HOP Strategy feedback from the Northern Region.   
   
The HOP Strategy should not be developed and implemented in isolation to the Disability Strategy and Carers Strategy which are also currently in the process of being refreshed. There is no reference to partnerships with other agencies such as MSD. A ‘continuum of care’ from other funding services (i.e.: mental health, LTS-CHC, DSS etc) to health of older people services needs to be developed to ensure that services are both age and care appropriate. For example, a number of people with long standing mental health or addiction conditions are being placed under Health of Older People as they turn 65 years old. Action Plan 17 attempts to address this but does not take into account a 65 year old with mental health or addiction issues being placed into an Aged Residential Care service, where the average age is 82 years old, and the need to investigate alternative models of care.   
   
Integrated service delivery is an important outcome. However this may or may not require integrated funding; the latter should not be an outcome in its own right. Current wording implies it is. (Action Plan 16)   
   
If the intent of the strategy is to provide a 20 year horizon it does not take into account the rapidly ageing population in the Northern Region. The key actions will need to be addressed in the next five years. The Strategy contains may references to “exploring” options. It could be more meaningful to have a shorter list of actions that all agencies are committed to achieving. Further clarification is required around how workstreams are prioritised and timeframes established. We acknowledge that the proposed work plan is complex, so robust and realistic timeframes need to be established to ensure that all parties understand the proposed workload and responsibilities. The Strategy indicates that there are strategic relationships between agencies. There needs to be a formal commitment for all agencies to work together around the Strategy and its implementation, with a single lead agency, and secondary agencies clearly defined.   
   
It is a “safe” strategy with no transformational change to address other corresponding significant population changes. The strategy is very light on workforce development. The Strategy references enhancing the workforce capability and training pathways to reflect the cultural mix of the population. As there will be significant changes in the overall population mix during the lifespan of the Strategy, the wording of the Actions should reflect the changing population.   
o e.g. Northland will not have an accessible population of working age to provide home and community services, and while Maori are younger, they cannot be seen as an automatic solution for growing a lower paid workforce versus options for mobilising whanau networks and encouraging natural supports.   
o e.g. Counties Manukau region will have significant growth in the cohort of the population who are ageing with a chronic health condition and mental health condition. Publically funded support for this cohort can be inconsistent and fragmented across different sectors. Actions should be considered to ensure that models of care are consistent and sustainable, not just for the funder sector, but also for the consumer on a fixed income. Funding and contract model reviews should be seen as a priority within the Action Plan to ensure people have consistent access to services which meet their individual needs (residential, independent living, community services/supports) regardless of their diagnosis.   
   
The Strategy as it stands puts limitations on development of new models of care. An example of this is Action 18d: “*Explore options for aged residential care facilities to become providers of a wider range of services to older people including non-residents.”* This is a much broader action than the overarching Action 18 – “*Better integrate services for people living in aged residential care, and is well placed to include a wider range of services than residential care*.” New models of care don’t need to be health models, they could also include social models of care e.g. health services around social housing.   
   
The HOP Strategy does not specifically identify the area of financial literacy. There is significant potential risk to the ageing population on a fixed income e.g. superannuation when the costs associated with healthcare are not fixed e.g. GP services, ambulance, prescriptions. An emerging issue, particularly in Auckland, is emergency housing for at risk older people. Housing as a major determinant of health is not well acknowledged.   
   
Technology is a key theme, in an environment of fragmented, protracted solutions. There is no clear/strategic information/technology aspiration.   
   
It would be useful to include a glossary in this document to define some terms used within the document which may be subject to interpretation to ensure all parties are working within the same parameters.

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| **Submission 124** |

Graduate School of Nursing, Midwifery and Health

Victoria University of Wellington

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| Organisation (if applicable): | Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington |
| Position (if applicable): | Director |

This submission *(tick one box only in this section)*:

comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

X is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

X Academic/researcher X Other *(please specify)*:  
Education provider

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Any 'vision' is not clearly elucidated or communicated on page 14 (and onwards). This page outlines outcomes and importance, and the information about any 'vision' is unclearly represented in regards to the information contained on this and subsequent pages. If the intended question is intended to refer to the outcome areas, these appear appropriate and the information contained within the subsequent pages adequately highlights the importance of each that is stated.. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Pages 31 and 32 contain frameworks that do, at face value, appear to address the stated goals. We have concerns about the reliance on NGOs in section 1, and the ability of various departments to capably lead the action plans (e.g. capacity of Office for Seniors to oversee all stages in section 1, ACC to oversee section 2). Further, there is no clear strategy to address physical capability, and although section 2 attempts this we believe further development of this section would be useful. There is also no emphasis on housing, though we suspect this may fall under the remit of another government department. There is no reference to partnership with tertiary education providers, whose input into the sector may be beneficial. The asterisked action for 1 appears appropriate; the second (availability of strength and balance programmes) seems very narrow in focus and addresses a single user group rather than a wider section of the elderly demographic. |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| As per our first comment, no vision is explicitly stated - goals are outlined. The importance of the outcome areas are adequately explained. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an🟏 are the right actions to begin with?

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| The actions appear appropriate, though limited (6). We again question the stated delivery leads; for 7 this appears to be multiple groups and the resulting management via multiple agencies may prove difficult. Number 6 appears to require further development. The asterisk for 7 states focus on injury treatment, not prevention - further focus on prevention is perhaps required for 'at risk' groups. |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| See earlier comments regarding vision. The importance of the outcome areas are adequately explained. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Section 11 appears to have multiple aspects and is therefore potentially at risk of delivery issues due to managerial difficulties associated with coordinating a large number of agencies. We wonder whether this could be divided into two separate themes, for clarity. 'Early detection' is mentioned as a goal however there is no subsequent focus on providing or supporting a New Zealand-specific model to allow or facilitate this. The asterisk for section 9 is comendable, however we wonder whether there is an evidence-based framework in place to provide such a skilled workforce; engagement with tertiary education providers would support delivery of specialised workforces, yet this appears absent. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We support this goal however feel that the linked statements as previously are more outcomes than vision. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| A general comment is that the large number of actions creates significant challenge in being able to deliver on the vision. We assume that the starred actions are already in progress or built on work done elsewhere to be able to meet the time frames suggested. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We support this goal however feel that the linked statements as previously are more outcomes than vision. |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| It is pleasing to see the actions build on other work in this area. 23a would benefit from the inclusion of tertiary education providers and specific mention of paramedics. |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| More clarity around the need for detailed workforce planning would enhance this section in our view. The data set for Kaiawhina workforce seems a very challenging action given the transient and fluid nature of this workforce – the ministry could consider working in partnership with NZQA as the recorder of qualification completions in the health and wellbeing area which are commonly aligned with this work. |

### Other comments

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| The draft strategy does not specifically address the funding challenges that drive service design i.e. funding contracts on an annual basis can be a barrier, investment is limited due to lack of certainty.  There is an opportunity in this strategy for a clear workforce strategy that considers a levelled approach to service provision based on consumer need. This could be seen as an all, many, some, few approach to the skill mix and requite education and support for all parts of the workforce. The NZ health strategy could have been more overtly linked within the document vision and objectives in our view. There could also be value in coordinating some actions with involvement of the tertiary sector - if NGOs are referred to and viewed as a potential partner, it seems plausible tertiary institutions may also be worth including or consulting with.  There is a lack of consistency in the use of terminology throughout the consultation document; this hinders interpretation and comment on the content. Some of the actions for individual parts appear not to be congruent with the goals; it would be helpful for each action to be linked with specific goals (e.g. by number) so as to make it very clear how they relate to each other. In addition, it would be useful to clarify what each individual part / section / goal was by being very specific with terminology; e.g. objective, strategy, action, etc. in order to make the framework more user-friendly and transparent. For example, this submission form refers to 'vision' consistently, yet the term is never used in the consultation draft and it is unclear what this term refers to given the consultation document refers to 'outcome areas' and follows with an explanation of 'importance' - only in the action plan are outcome areas then refered to as 'goals'; the action plan (p31 onwards) has numbered 'initiatives' yet how these should be refered to (or what they are) is unclear.  Overall, we commend the strategy for placing health ageing as a core goal and look forward to the final outcome of the consultation. |

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| **Submission 125** |

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| Organisation (if applicable): | Family Centre Social Policy Research Unit |
| Position (if applicable): | Coordinator |

This submission *(tick one box only in this section)*:

comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

√ is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

√ Non-governmental organisation  Union

Primary health organisation  Professional association

√ Academic/researcher  Other *(please specify)*:

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Of the 5 goals set out in the draft Strategy, this is the one that addresses social relationships specifically. However, it still reads like a health, rather than a social strategy. We need both. In particular we need health goals to move out of their silos to address the social determinants of health intelligently as they are reflected in the evidence on morbidity and mortality. In the last 6 years research on social isolation and loneliness reached a point of scientific confidence that these two factors are linked with negative morbidity and mortality ((Luo, Y., Hawkley, L.C., Waite, L.J., Cacioppo, J.T. (2012) Loneliness, health, and mortality in old age: A national longitudinal study. Social Science & Medicine 74 (2012) 907-914; Steptoe, A., Shankar, A., Demakakos, P. and Wardle, J. (2012) Social isolation, loneliness, and all-cause mortality in older men and women. PNAS, April 9, 2013 , vol. 110 (15) 5797–5801; Holt-Lunstad, J., Smith, T.B., Baker, M., Harris, T., and Stephenson, D. (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. Perspectives on Psychological Science, Vol. 10(2) 227– 237). In their most recent (2015) meta-analytic review Holt-Lunstad et. al. state that a large body of evidence now shows that individuals who either lack social contacts or feel lonely are at risk of an earlier death. The risks to mortality of these two factors are comparable with well-established risk factors including those identified by the U.S. Department of Health and Human Services (physical activity, obesity, substance abuse, responsible sexual behaviour, mental health, injury and violence, environmental quality, immunization, and access to health care). This critical information is only implied in the goals. In our view it is unintentionally shrouded in generalisations and ‘health speak’. Social goals are critical to addressing health goals and we would like to see a bolder expression of this in the enunciated goals. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 1. Build social connectedness and wellbeing in age friendly communities. Yes we agree with the \* in statement a, but it is so general that it doesn’t really constitute an action. An action really requires a social strategy. Local Authorities are not referred to but they are critical for transport, seats and resting places, safe footpaths and road crossings, facilitating local leisure groups as well as service providers. We need community development strategies, age attractive recreational facilities, intergenerational initiatives and popular activities that value the stories and historical experiences of older people. These will contribute to health and wellbeing just as much as traditional specific health focused strategies. There is an issue of funding. A social strategy in partnership with a health strategy needs to be funded centrally but ring fenced for local initiatives, because local authorities are not well-endowed and vary considerably throughout the country. Cultural strategies are fundamental to addressing social connection and loneliness. This also requires highlighting in the text, so that cultural groups can address these matters within their different cultural contexts. Surely there could be a Māori focus as a result of modern life impacts on whānau and hapū relationships and similar impacts on Pacific families who have immigrated here.  The emphasis of this submission is on the social strategy required to partner with the health strategy in an effective action plan. 1. 2. 3. 4.and 5. don’t really address these issues. |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| We agree with the \* and note the emphasis on social sector partners. While these include service providers, local authorities should be emphasised. Local Government New Zealand could be at the heart of the social strategy. Leisure, arts, libraries and sports organisations have a role in connecting people through their interests rather than case work. These help build age friendly communities. So too do cultural organisations as noted earlier. In our view, the social sector should be fully participating in the design, measurement and review of the strategy. |

### Other comments

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| This is a great initiative and we support the overall thinking behind the draft Strategy. However, the social strategy, that will be critical to its success, is not adequately visible or bold enough. |

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| **Submission 126** |

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## IHC submission – Health of Older People Strategy Consultation Draft

IHC welcomes the opportunity to give feedback on the refresh of this Strategy that follows the updated New Zealand Health Strategy, which provides a framework for the health and disability system to achieve equitable outcomes for all New Zealanders.

There is a well established body of evidence that demonstrates people with intellectual disability have higher levels of unmet health need and significantly poorer health outcomes than the general population. They experience disparities in access to health promotion initiatives and deficits in service provision (Mirfin–Veitch & Paris, 2013). These inequities occur across the life span.

People with intellectual disability have the same health needs as their peers in the general population. They also have some additional and different health needs to people without intellectual disability. People with intellectual disability are at risk for, or experience a higher prevalence of a broad range of health conditions. Consequently, efforts to ensure that the health needs of this group are met require recognition of both these facts (Mirfin-Veitch & Paris, 2013).

The life expectancy of adults with intellectual disability is increasing but is still significantly lower than that of the general New Zealand population. Currently 33% of people supported by IDEA services (IHC’s service arm) are over 50 years of age compared with 25% in 2009. We predict there will be an increase in numbers aged over 65 years so that by 2033 the numbers will be one in five.

Our comments in response to the consultation questions draw from our experiences in supporting older people with intellectual disability, IHC’s Successful Ageing initiative and the health and ageing focus adopted in IDEA services and from what we know from research.

## Consultation questions

### Healthy ageing

1a. Vision for the goal of healthy ageing

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| IHC endorses the priority given to ‘healthy ageing’, proactive and preventative health promotion and actions to promote functionality, build resilience, address physical, social and environmental risks, achieve equity and enable older people to be contributing and connected community participants.  Across the lifespan people with intellectual disability experience among the poorest health outcomes of any population group. While there is recognition of inequity and vulnerable groups in the ‘talk’ of the draft Strategy this needs to be strengthened in the vision and actions in this and subsequent sections. As things currently read the vision and actions to reduce disparities and achieve equity are light. For example p. 15 states “We know financial security is also important for mental wellbeing and healthy ageing” and goes onto make suggestions about linking people to budgeting and financial planning advisors. We know a lot more than that about the social determinants of health and the negative impacts of living in poverty and on low incomes. People with intellectual disability are over represented in those on low incomes, have one of the lowest rates of paid employment of any population group, where they have paid work it is more like to be part-time and most will be beneficiaries for all their adult lives.  The ‘Healthy environments and age friendly communities’ section (pp.15-16) speaks to improving social, economic, and physical factors environmental factors, achieving equity and removing barriers to participation. Attention also need to be paid to attitudinal barriers faced by people with intellectual disability that result in discriminatory practices and diagnostic overshadowing (where problems are attributed to intellectual disability and health and mental health conditions are overlooked and not treated).  We acknowledge getting the ‘right’ terms and descriptors can be difficult and that there are also dangers in narrowly defining age ranges for eligible groups. In the international literature older people with intellectual disability are seen as being in the 50 plus age range. Having prescriptive ages for eligibility criteria (which typically in NZ sets the dividing line at 65) is counterproductive, places people in silos and too often denies people access to services and supports that would be beneficial. However, in the draft Strategy there is a mixing of terms – ‘healthy ageing’, ‘older people’, ‘health sector, social systems’ - that are at times confusing and in places the meaning needs to be made clearer.  IHC suggests replacing ‘age-friendly’ with ‘inclusive’. While we understand the intent and use of ‘age friendly’ the term could be read and interpreted as ‘separate’. For example - ‘age-friendly’ communities could suggest that older people are best served through ‘separate’ communities. ‘Inclusive’ better captures housing/environments/communities which are accessible and benefit all people – older people, people with disabilities, those for who English is a second language. It would also provide greater consistency and alignment with the NZ Health Strategy (close to home and communities), Ministry of Health principles of ‘ageing in place’ and the United Nations Convention on the Rights of Persons with Disabilities (CRPD) which was ratified by New Zealand in 2008. |

1b. Actions that are intended to achieve the goal of healthy ageing

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| It is well established that social connectedness is a significant contributor to wellbeing. As in our response to 1a actions would be better focused on ‘inclusive’ communities rather than ‘age friendly’ communities.  There should be a greater emphasis and priority on cross government work with local authorities and community groups to co-develop, implement and review actions.  2a may be better placed or at least linked to actions in section 2 (acute and restorative care) as is related to injury prevention and treatment and section 3 (living with long term conditions)  We suggest that 2b be reworded to along the lines of ‘All health promotion initiatives and services to increase resilience contain plans for including and reaching Maori and other vulnerable older populations who have poorer health status and “expand the provision of targeted initiatives…...(as in 2b p.32). This would shift thinking and actions to a starting point that includes all from and from which targeted approaches are developed.  3 (d) would be better stated as housing and community design (environmental factors) rather than housing models if is to increase accessibility, reduce stress and promote community participation  4 (e) needs to include MoH given they fund communication aids technology for disabled people.  4 (f) needs to be done with representation from people with disabilities and families and whanau along with others – different ethnic communities, where English is a second language - to ensure accessibility for all populations. Cost is a significant issue for many and affordable technology options need to be available. While technology can bring many benefits we caution against it being seen as the only or dominant means of ageing ‘health smart’ goals. We note UK research that reported technology as being effective in maintaining people with intellectual disability’s independence but having a negative impact in increasing social isolation as support staff are important in people’s networks |

### Acute and restorative care

2a. Vision for the goal of high-quality acute and restorative care

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| IHC endorses the vision of coordinating care, getting the right balance in discharge to support better recovery outcomes and shifting from doing things for to working with.  There are a number of examples given under the heading ‘Supported discharge and restorative care’ that have outcomes that include reductions in acute admissions. While there is much to be gained in reducing the need for admissions for individuals and hospitals this should not be at the expense of getting a quick response where acute medical attention is needed. Through IDEA services we have reports of experiences of great difficulty in getting individuals successfully through triage of ambulance and acute assessment at hospital. This has often resulted in repeated attempts to get acute medical attention that have neither been efficient or effective and certainly have not been reflective of high quality acute and restorative care. Confusion and misunderstanding about consent can also delay treatment. There needs to be a better understanding of the provisions of the Health and Disability Code, particularly section 7.  Quality measures need to be reviewed and accommodations made so that they are appropriate for people with intellectual disability. For example someone’s ability to dress may be related to their disability in that they have always needed help to dress rather than being a result of acute illness/episode. Individuals may also have communication difficulties in both understanding and expression (including being non verbal). Satisfaction measures should not be reliant on verbal reports.  As in 1b we acknowledge technology may be assistive but it must be accessible for all users and not be used in ways that could increase people’s isolation. |

2b. Actions that are intended to achieve the goal of high-quality acute and restorative care

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| As with our endorsement of the vision we support the intent of actions to implement best practice restorative rehabilitation strategies and that enable effective rehabilitation at and closer to home.  IHC recommends that that 6a and 8a include disability support services and staff (residential services and supporting people in their own homes) in the partnerships that support effective rehabilitation and initiatives to reduce acute admissions. While the term ‘primary care workers’ is used this could be read as meaning care workers in health or aged sector only. This would also cover workforce development across the health, aged and disability sectors.  As in section 1b, action 2a there are links between the actions in 7 to improve outcomes from injury prevention and treatment and also with section 3. It is not clear where more preventive actions to falls sit. It is also not clear what evidence is being drawn on to validate implementation of a national hip fracture registry assists with acute and restorative care (7A second dot point) and what is the link to improved outcomes? |

### Living well with long-term conditions

3a. Vision for the goal of living well with long-term conditions

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| The introduction to the draft Strategy states that an inclusive approach is being taken that includes benefits to “people who have had long-term or chronic health conditions or disabilities during their earlier years and whose needs become more complex as they age” (p.1) “Some population groups experience long-term conditions at earlier ages and therefore need more targeted services (p.20)”.  We note the use of the World Health Organisation definition of long term health conditions that include diabetes, cardiovascular and chronic pulmonary disease, cancer, asthma, arthritis, stroke, chronic pain, obesity, dementia and mental illness and addiction. While mental illness is listed in the long term conditions it does not appear on the graph that shows some long term conditions are more common in older people (p.21). It would be useful to include relevant information on the graph.  As we have highlighted in previous sections people with intellectual disability have higher prevalence rates of many health conditions. There are many studies showing people with intellectual disability are vulnerable to a range of health conditions (many life-long) such as sensory impairments (hearing and vision), epilepsy, cardiovascular disease, diabetes, mental health conditions and dementia  (in a nutshell seemingly almost all health conditions).  Respiratory disorders caused by swallowing and choking risks, and epilepsy have been identified as two preventable causes of death by the NSW Ombudsman (2014).  Patja et al 2000 reported on a long terms study of the risk of respiratory disease (namely pneumonia) to people with intellectual disability, and risk of pneumonia increases in older people.   Cooper et al, 2007 reported an overwhelmingly higher prevalence of mental health disorders than for the non disabled population. Onset and type of disorder tends to vary with the particular syndrome but can manifest in childhood and become prominent during their lifespan. At the International Scientific Study of Intellectual Disability (IASSID) World Congress in Melbourne August 2016 Stuart Todd reported on study of deaths involving 38 providers and 222 deaths from 13,200 people in the UK.  People with intellectual disability have high death rates compared to the general population.  In general population main cause of death is cancer and coronary heart disease whereas there were other causes of death for people with intellectual disability.  IDEA Services experiences of people we support aligns with these findings. Epilepsy is often commonly life-long and has associated risks including obesity (medication related), falls, fractures and other injuries, Sudden Unexpected Death from Epilepsy, frequent hospitalisations, drowning and mental health disorders.  Around 20% of people we support have a swallowing or choking risk which increases to nearly 29% for people over 65 years old.  Epilepsy is not listed as a long-term condition and IHC strongly recommends that it is explicitly mentioned. Evidence would show epilepsy is a significant long term condition particularly for people with intellectual disability. Bowley & Kerr (2000) reported that 18% of people with intellectual disability have a diagnosis of epilepsy compared with 1% of the general population. Given people with moderate to severe intellectual disability have significantly reduced lifespan than non disabled peers the life time impacts of epilepsy and its treatment must be considered a priority if it is desired for health outcomes of vulnerable populations are to be more equitable with those in the non disabled population.  Indexes of frailty may not pick up on lifelong long aspects that are associated with disability and as a consequence appropriate preventative or interventions may be missed. At the International Scientific Study of Intellectual Disability (IASSID) World Congress in Melbourne August 2016, there were several papers presented regarding issues involved in getting valid measurement of frailty for people with intellectual disability. These included the need to factor in often life-long disability in mobility, cognition and activities of daily living. A 3 year study in Rotterdam of measuring frailty of people with intellectual disability aged 50 using an index (Rockwood & Mitnitski) included signs and symptoms, diseases, laboratory results with each item scored either 0-1.  Some items were excluded such as behavioural problems and doing laundry which left 51 items in the index.  General findings showed people with intellectual disability (at 50 years old) to be equivalent to 70 year olds in the non disabled population. Another presentation from Katherine McKenzie from Ontario reported on frailty measurement in older adults with intellectual disability.  She found many lifelong deficits are at risk of being seen as new.  Katherine McKenzie reported findings from analysis of interRai in Ontario, Canada which showed the profile of adults with intellectual disability aged 45 years often resembled those aged at 75 years.  Such findings speak to the need to establish validated measures for people with intellectual disability and having a focus the pre-frail so that interventions can occur to avoid frailty.  While dementia is in the WHO list for long-term health conditions we suggest would be better placed in section 4 - high and complex. In a presentation to the International Dementia Care Conference in Sydney June 2016, Professor Sube Banjeree stated the prism of dementia is a complex world.  From his research in UK he reported that most people with dementia have multi morbidity with only 9% having dementia only.  He reported on his findings of  multimorbidity including poor pain control, frequency of BPSD in dementia, high rates of depression, high rates of diabetes (39% have diabetes) and polypharmacy and 45 % having 2 or more health conditions.  We reiterate our points in earlier sections about use of accessible technology and our support of workforce development and intersectoral/interagency partnerships. |

3b. Actions that are intended to achieve the goal of living well with long-term conditions

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| It is unclear what is meant by and who is the target for the “regularise” the home and community support workforce and why this applies only to the kaiawhina workforce and their training. Without clarification of meaning it is not possible to comment on this action as a priority area.  As a general comment across a number of actions wording needs to be changed to better reflect the broader group of people working with the older people and this is not confined to the health and aged care sectors. As examples - 9b should be more inclusive of NGO, non health professionals involved and 11c targets for diabetes prevention work should be broader than just for aged residential services.  IHC notes that current the Careerforce plan focuses exclusively on the aged care sector and perpetuates a siloed, unconnected approach. Training packages available through Careerforce may not be adequate for wider application.  There is no priority action identified in 10 ‘Enhance cross-sector, whole system ways of working’. We suggest there should be a priority action related to getting more connected ways of working.  10c – The problem of polypharmacy for people with intellectual disability has been a long standing and was identified in the National Health Committee’s (NHC) 2003 ‘To have an Ordinary Life’ report along with recommendations for needed actions. This recommendation to improve medicines management in the Pharmacy Action Plan should link to the NHC report and recommendations to reduce polypharmacy that come from the current Disability Action Plan work to improve health outcomes for people with intellectual disability.  11a – Needs to include a focus on people with on people with early onset dementia – though as indicated in 3a dementia may be better placed in section 4 high and complex. There is an urgent need for development work for people with early onset dementia which the dementia guidelines are intended to accommodate but are poorly served in our experience of working with people with intellectual disability.  11e - As InterRAI is not used in disability sector for MoH funded disability support services and NZ has decided not to implement the ID tool it is and is it is not clear how this action would benefit people with life-long disability.  13a Again we repeat our caution that health apps may not be accessible for people with most vulnerability (English as second language, vision impairment, cognitive impairment), so any acceptance on MOH library must ensure the applications are suitable across all needs not just selected groups. |

### Support for people with high and complex needs

4a. Vision for the goal of better support for people with high and complex needs

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| Not all people with intellectual disability have high and complex needs but a greater proportion do than in the general population. As already referred to people with intellectual disability experience high levels of multiple impairment and morbidities. People with profound and multiple impairments (high and complex needs) are particularly vulnerable. Breathing and airways problems, eating problems, epilepsy and pressure care are among the some of the concerns that are often not well recognized or responded to for this group. Some etiologies of intellectual disability are associated with and carry increased risks for complex conditions e.g. Down syndrome with unique vulnerability to Alzheimers.  This section of the Strategy appears to be the least developed and has the least explicit goals and vision compared to other sections of the draft. It is not clearly defined as to what the criteria for high and complex needs means and to whom it applies. The goals are very general, most apply to all older people and there is a lack of focus on the particular needs of the high and complex population group. |

4b. Actions that are intended to achieve the goal of better support for people with high and complex needs

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| As with our comments in 4a we consider that the actions in this section needs a substantive rethink. We cannot see how the actions as currently stand will lead to improved outcomes and reduction in disparities. Actions need to include timely access to specialist supports and services. Identifying and establishing networks of clinical and specialist expertise (profound and multiple impairments, intellectual disability and dementia) who able to give consultative advice would be beneficial.  Again many of the actions focus on aged care sector and in particular residential services rather encompassing the than community, including disability, sector in ways that enhance cross sector and collaborative ways of working.  14a - Frailty is at the upper end of spectrum of high and complex need and we suggest that this is not a priority action. We recommend that the priority needs to be on earlier intervention and prevention.  IHC recommends 20b to be elevated to priority action – and be inclusive of people with intellectual disability receiving home, community and disability support services. |

### Respectful end of life

5a. Vision for the goal of a respectful end of life

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| IHC endorses the vision in this section and the value of early planning so that a person’s wishes and preferences are known.  Much of this section is premised on the assumption that people have known terminal conditions and time to plan. This may not be the typical experience people with intellectual disability as illustrated in our response to 4a with higher rates of sudden, unexpected deaths and reference to S. Todd’s study of deaths of people with an intellectual disability in the UK. His study found that the length of illness prior to death for people with intellectual disability is frequently less than 6 months and showed that many staff did not believe the person should know what was happening to them (that they were dying). This highlights the value of early advance care planning so people’s wishes and preferences are known and that considerable improvement is required to provide responsive quality support and ensure a respectful end of life.  We note that the draft Strategy appears to be promoting enduring powers of attorney (EPOA). We would be concerned if EPOA were to become entrenched as a requirement for all people as this would be discriminatory for those unable to exercise EPOA as they are lack the competency to make those decisions. Policies and practices that recognise supported decision making and provide safeguards in ways that are consistent with the United Nations Convention on the Rights of Persons with Disabilities should be the basis of understanding and responding to people’s wishes and preferences.  The draft Strategy is largely silent on the role that the NGO sector in residential and other support services may take in end of life. Is it intended only people in the ‘health sector’ are active in end of life care and support?  Why does the goal of effective responses to different cultural needs feature only in this section? |

5b. Actions that are intended to achieve the goal of a respectful end of life

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| We support 22 – Ensure widespread and early participation in advance care planning but as in our comments above 22a needs to be broadened to include as a priority raising understanding of supported decision making principles and practices.  23b – Is as equally applicable to long term conditions  24c It is not clear as to how such action will inform quality improvement. This action will only be effective if subsequent action taken on the basis of feedback so that it is not simply a tick box exercise |

### Implementation, measurement and review

6 Proposals for implementing, measuring and reviewing the proposed actions

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| IHC endorses the priority of completing an implementation plan in the first three months post the Strategy’s release and the actions to include older people in service design, development and review and other decision-making processes. We anticipate that this will be inclusive and that needed accommodations are made in design, development and review processes so that people with intellectual disability can participate and contribute.  27a – This needs to include establishment of baseline for population groups where an improvements in equity have identified and impairment specific information is required i.e. not grouping all disabled people together.  28c – Alignment needs to include commitment to research use to inform practice through evidence based interventions |

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| **Submission 127** |

New Zealand Ministry of Health – *Health of Older People Strategy*

September 2016



RANZCP New Zealand National Committee submission to the Ministry of Health on the *Health of Older People Strategy*

# About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP has more than 5000 members, including around 3700 fully qualified psychiatrists and almost 1200 trainees.

Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support people in recovery, including pharmacological and psychological treatment. There are several subspecialties in psychiatry such as the Psychiatry of Old Age (POA) or Psychogeriatrics. POA is a psychiatric subspecialty focusing on the mental health of older people. Mental health disorders in older people are associated with age-related biological, psychological, social and developmental factors. These factors include physical illnesses, cognitive decline, grief and loss, resilience, vulnerability, role changes, aged residential care and end-of-life care.

# Introduction

This submission has been developed by RANZCPs New Zealand Branch of the Faculty of Psychiatry of Old Age (FPOA) in consultation with the New Zealand National Committee/Tu Te Akaaka Roa.

The RANZCP has previously provided feedback on an earlier draft of the *Health of Older People Strategy* (the Strategy; RANZCP, 2016). In responding to this most recent iteration of the Strategy, the RANZCP will focus on a number of key areas to ensure:

* the needs of older people with long-term conditions including mental health disorders are addressed
* older people with complex needs are given due consideration
* mental health issues are adequately addressed in the Strategy.

The RANZCP has provided feedback on three of the six objectives that are most relevant to topics we have noted above:

* living well with long-term conditions
* support for people with high and complex needs
* implementation, measurement and review.

**General comments**

Thank you for the opportunity to comment on the Ministry of Health’s draft consultation document – ‘*Health of older People Strategy*’ (the Strategy). In general we are supportive of the principles outlined in the Strategy and the supporting Action Plan.

We agree with the Strategy’s vision to take a person-centred approach to develop systems and services around the needs of the older person. This approach fits well with the ‘*people powered’* theme outlined in the *‘New Zealand Health Strategy’* stating that health consumers should be involved at all levels of the health system and included in those decisions that impact upon them (Ministry of Health, 2016). With a person-centred approach the foci of care is upon the individual’s need and supporting their choices. The RANZCP fully supports a model where services are more individually tailored and the consumer works in partnership with service providers and health-care professionals (RANZCP, 2012). We make the observation that implementing a person-centred model will require a transformation of services so that systems, processes, resources and the workforce can meet the challenges of the new model (RANZCP, 2012).

Māori and Pacific older people have their own cultural perspectives on ageing and older age and we note that throughout the Strategy there is sufficient reference to the particular needs of these populations. The literature reports that Māori continue to experience significant barriers in accessing health services and this may be amplified for older Māori (Jensen, 2008). Therefore, particular attention needs to be given to understanding the specific needs of older Māori (e.g. they may not wish to be placed in a residential home away from their whanau) and developing solutions to resolve current barriers. We are confident that the Strategy is able to address these concerns.

The RANZCP is pleased to see that the Strategy (as described under Action 4) makes the connection between health literacy and empowering consumers to be involved in their health-care decisions. Health literacy was an issue raised by the RANZCP in our initial response to the Strategy. We noted that older patients and their carers needed to first understand their own health status and relevant health data before they were able to be actively involved in decision making around their health. We observe that the Strategy also seeks to promote programs to encourage older people to access technology as this would be beneficial to older people with physical disabilities or those located in rural settings where physically visiting health providers may be challenging. The plan articulated under Action 4 seems comprehensive.

In our view the Action Plan clearly demonstrates how the Strategy will be implemented and we understand the linkage between this Strategy and the *‘New Zealand Health Strategy’.* The Actions are well defined but we note in some instances several agencies are assigned as a ‘lead’ on a particular Action. While this approach is inclusive, it may result in accountability issues or conflict around methodologies when implementing the Action, hence we suggest that a ‘primary lead’ is identified for each Action and this agency has overall responsibility for delivering the Action outcome. We would argue that all ‘leads’ must be Government bodies to ensure there is appropriate oversight in developing, implementing and reporting back on the Action. For example, research to improve the knowledge base is assigned to ‘research agencies’ but these agencies would be working under the auspices of a Government department therefore the relevant Government would be responsible for the Action outcome.

The Action Plan, while it identifies the next steps in implementing the Strategy, is unclear how the identified goals will be funded. There will be cost implications in implementing the Strategy and this cost will be borne in greater part by the DHBs who are currently working within a constrained financial environment.

The RANZCP is of the view that mental health issues are adequately addressed within the Strategy and the Action Plan but we have some concerns regarding the prioritisation of the Actions. We are pleased to see that Actions 9, 10, 11, 12 and 17 have elements acknowledging the importance of mental health and addictions issues. Below the RANZCP identifies possible gaps in the Action Plan.

**Suicide**

Since 2008 the number of deaths attributable to suicide have increased (Ministry of Justice, 2014). Physical illness and functional impairment are established risk factors for suicide in older people (Fässberg, 2016) and older men have been identified as a high-risk group. Therefore, the Strategy should specifically address ways to reduce suicide and ensure that these actions are aligned with the Ministry’s refresh of the Suicide Prevention Strategy (RANZCP, 2015; RANZCP, 2011). Suicide remains an enduring social and health issue therefore prevention strategies should be considered across all populations, with the older population not being excluded hence we recommend the inclusion of suicide prevention programs that are effective with older people (RANZCP, 2015).

**Workforce**

The RANZCP advocates for a greater emphasis on the medical workforce who will be closely involved in supporting and managing the ageing population. We agree with the principles outlined in Action 9, describing the need to develop a workforce that is able ‘*to deliver high-quality and person-centred care’.* Action 9 appears to focus predominantly on the kaiāwhina and allied health workforce. We are well aware of the critical role these providers play in supporting older people in the community, but the medical workforce – comprising general practitioners, psychiatrists, palliative care physicians and geriatricians – will be working with those older people presenting with increasingly complex conditions. A highly trained medical workforce is required to manage these complex conditions in the community, otherwise delays in diagnosis and treatment will occur resulting in rapid deterioration in the older person’s health outcome. The Strategy should include some reference addressing the current and long-term shortages experienced by the above medical specialities (ASMS, 2010; ASMS, 2015; RNZCGP, 2015).

The Strategy states that the workforce *‘will need to become more adept at caring for older people and more knowledgeable about what keeps older people healthy*’’. The medical practitioners previously mentioned have a part to play in implementing the vison articulated above, by upskilling and guiding other health providers so they are able to better understand the conditions and needs of the older consumer and become confident in managing these individuals (Croucher, 2010). The RANZCP has noted that older patients require particular care and consideration and cannot be ‘subsumed under adult health or ageless services’; this is our rationale for ensuring old age psychiatrists and geriatricians along with GPs with an interest in old age and palliative care physicians are recruited and retained (RANZCP, 2015).

Action 9 does not acknowledge the leadership role of medical practitioners who often have responsibility for managing the overall health outcomes for older people with complex presentations and would wish to see Action 9 expanded to include this information.

**Feedback on Specific Sections of the Strategy**

**Living well with long-term conditions**

The RANZCP is pleased to note that the Strategy has included *‘dementia, mental illness and addiction’* as long-term conditions.

We are strongly supportive of Strategy goals to improve the detection of long-term conditions, particularly in relation to mental health and addiction. In our earlier submission we highlighted our concerns that dementia in older patients is not well detected resulting in a delay in diagnosis. Subsequently people suspected with the disease do not receive the support they need.

Technology, e.g. use of smartphones, apps and other electronic devices, will play an increasing role in assisting older people to manage their own health in the community. We can see how technology may greatly benefit people with physical conditions such as diabetes but there may be challenges for people with mental health issues. In reality people with mental disorders (e.g. chronic schizophrenia) may have memory impairment or cognitive difficulties and due to their living conditions or financial situations are unable to access technology. Although we support the advancement of technological innovations we ask that consideration is given to developing solutions for those populations who may struggle to use or access technology as an increasing reliance upon technology may further disadvantage this group.

In regards to the actions that are prioritised under this section we have provided feedback on each Action.

**Action 9**

* We support the principle ‘*developing a range of strategies to improve recruitment and retention of those working in aged care’.* We suggest a slight rewording to the bullet point *‘those working with and supporting older people to live healthy lives’*. For example, pharmacists are not working in aged care but are supporting older people in the community to live good lives.
* The proportion of older Māori and Pacific in the population is increasing therefore it is a priority to develop strategies to recruit Māori and Pacific into this workforce.
* There is no action point or priority given to developing the medical workforce. We argue for an additional action point specifically addressing the medical workforce as stated in our feedback in ‘General Comments’ on page 4.

**Action 11**

* We agree that strengthening the implementation of the New Zealand Dementia Framework would be timely.
* The RANZCP advocates that Action 11.i is made a priority along with Actions 11.a to 11.h.The early identification of mental illness and addiction will result in overall better health outcomes for older people. The World Health Organization reported that in high-income countries mental disorders account for 21% of the burden of disease and that alone should signal the importance of prioritising mental health in the Strategy (WHO, unknown). We also point to increasing evidence that ‘successful’ ageing is interwoven with maintaining good mental health and contend there is ‘no health without mental health’(RANZCP, 2015; Department of Health, 2011). We trust that the evidence presented by the RANZCP here and in our previous submission will lead to a revision of Action 11.i and it is prioritised accordingly.

**Action 12**

* We are pleased to see that the Strategy acknowledges that older people with mental health and addiction issues experience stigma. We highlighted this issue for inclusion in our earlier submission and described the impact stigma has upon people as it is a significant barrier for some individuals when seeking services for their mental disorder or addiction. The RANZCP is heartened by this inclusion as older people with mental illness and dementia can experience discrimination and isolation. A British Study found that stigma has *‘a profound impact on older people’s mental and emotional health and well-being’* (Centre for Policy on Ageing, 2009).

**Action 13**

* The RANZCP agrees that technologies can be implemented to assist older people to live well but we ask that special consideration is given to people with dementia, serious mental health disorders, neurological difficulties (e.g. traumatic brain injury) as they may find these methods of monitoring and communicating troublesome.

**Support for people with high and complex needs**

Although most older people rate their health as good[[63]](#footnote-63) some will not live their later years in good health. Therefore, the RANZCP is pleased to note that the Strategy identifies older people with high and complex needs as a specific group requiring tailored support and interventions. Statistics from Canterbury District Health Board provides useful data revealing that 62% of the general medicine admissions were for people of 65 years of age, noting that 32% of these admissions were for people over 80 years old (Croucher, 2010).

We are pleased to observe that Action 17 includes ‘*improving the physical and mental health outcomes for older people with long-term mental illness and addiction’.* We strongly contend that this Action is prioritised within the Action Plan. The RANZCP has commissioned research demonstrating that people with mental illness experience significantly higher rates of premature mortality and morbidity due to reduced access to health care relating to stigmatisation and discrimination, and poor management of their physical co-morbidities (RANZCP, 2015). We recommend that the Strategy explicitly addresses the current inequities that exist for these people by giving this issue greater attention including the capacity to measure progress in reducing the gaps in health care access and delivery. This is particularly important for older people as they are more likely to have a long-term physical condition, e.g. they have had a cardiovascular incident giving rise to depression and there are other older people who have been prescribed anti-psychotic medication for a significant time resulting in metabolic syndrome (RANZCP, 2015). The RANZCP’s view that mental health is inextricably linked to long-term physical conditions is supported by Equally Well[[64]](#footnote-64) and a significant body of research so we trust that this Action will be revisited and re-prioritised (RANZCP, 2015). For example, integrative/collaborative primary mental health care can improve mental health and physical health outcomes in older people with physical conditions.

In regards to the actions that are prioritised under this section we have provided feedback on each Action.

**Action 14**

* We support the development of a frailty tool that will assess these individual’s needs and provide adequate treatment. Earlier interventions will lead to a timely coordination of services ensuring frail people receive the support they need. Evidence indicates that frailty is often not diagnosed until the person presents to health care services and in addition frail people can decline rapidly in a short period of time resulting in very poor health outcomes (Oliver, 2014).

**Action 18**

* We support this action as better integrated care and services are required between aged care facilities and other providers such as pharmacists, primary care professionals and hospitals. Information sharing between the various agencies is probably one of the key processes to examine when considering ways to improve continuity and coordination of care. Because the older people living in these facilities are often the most dependent upon assistance, due to their complex co-morbidities including dementia, it is important their needs are prioritised in the Action Plan.

**Action 20**

* We support models of care to improve medicine management of aged people living in residential homes or in their own homes. British research reported that 44% of those living in older care homes did not receive a regular planned review of their medication (Oliver, 2014) indicating there is a need to improve medicine management. The RANZCP points to evidence that older people with mental disorders have anxiolytic, hypnotic and sedative drug prescriptions approximately 500% that of the general population (RANZCP, 2011). There is clear evidence that this group of older people would benefit from specialist review of their care plans and medication.

**Action 21**

* There is not sufficient context to provide comment on the prioritisation of 21.b

**Implementation, measurement and review**

We are pleased to note that the Ministry has included within the Action Plan a number of activities focusing on measuring and reviewing the Strategy. Evaluating and reviewing the Strategy is critical in ascertaining if the Strategy is effective in meeting its goals.

Action 26 is of particular importance as this Action acknowledges the role of older people (as consumers) in reviewing the progress and the efficiencies of the Strategy in bettering their lives.

We are anticipating that further work will be undertaken to quantify the indicators as currently they remain undefined.

**Conclusion**

In summary we are satisfied with the Strategy’s overall objectives. In our view the Action Plan clearly articulates how the Strategy will be implemented and we clearly see the linkage between this Strategy and the ‘New Zealand Health Strategy’.

Mostly the Actions, that operationalise the Strategy, are well defined.

We observe that many of the issues we raised in our earlier submission have been incorporated into this iteration of the Strategy. In reviewing the Strategy we are heartened to see a greater emphasis on mental health disorders and addiction. As psychiatrists working with older people living with dementia we argue it is important to acknowledge the burden of this disease and the impact it will have on an ageing New Zealand population. We note there are several Actions relating to managing and supporting those individuals with the disease and in addition that Action 11 specifically addresses strengthening the New Zealand Dementia Framework. The RANZCP would be available to assist with this work.

We do have concerns regarding the prioritisation of some Actions. We understand that some Actions will be implemented in the first 2 years of the Strategy but it is not clear to us how the next tranche of Actions will be prioritised.

We advocate that the following areas are given a higher priority within the Action Plan:

* Supporting and developing a viable medical workforce to manage older people with dementia, complex and co-morbid presentations including mental disorders and addiction. British research indicates that increasing older people’s access to specialists, such as geriatricians and psychiatrists, reduces hospital admissions and improves health outcomes (Oliver, 2016; Centre for Policy on Ageing, 2009). A well-resourced medical workforce, working collaboratively with other health providers, would support many of the Actions and assist in meeting the Strategy’s goals. We believe it is an omission not to include this Action and make it a high priority.
* Improving the physical and mental health outcomes of older people with long-term mental illness and addiction should be a priority for the next 2 years.

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| **Submission 128 withheld at submitter’s request** |

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| **Submission 129** |

**Re Health of Older People Strategy Draft for Consultation 2016**

Many thanks for the ability to comment on this draft strategy proposal.

I am currently employed as a geriatrician and general physician in Hawke’s Bay District Health Board and was previously Clinical Director for Older Person’s Health within the same organisation. My perspective is from 35 years of exposure to both the “front line” of acute medical practice as well as rehabilitation and community services, during which time I have observed major changes in the demand from an ageing population.

My perspective however differs from many of my peers and management colleagues. Ageing of our population is the result of many changes in health and societal practices over many years but more recently, during my practicing lifetime, is from the widespread adoption and practice of “effective” medicine. Our population ages as we prevent many dying prematurely but there is a material cost to this ageing, borne largely by the health sector, in terms of accrued morbidity, disability and dependency.

“Ageing well” is clearly of prime importance for medicine and our community but unfortunately, within increasingly constrained health budgets, Older Person’s Health Services will, obligitarily, need to commit increasing resources to the growing number of our most vulnerable older population. This “reality” therefore must become the prime target for an effective OPH Strategy.

Given that lifespan is finite the “promise” of prevention for illness or disability is ultimately overstated. The real paradox is that “prevention” merely postpones - for another episode, illness or event to occur another day – unless death intervenes.

Frailty, or in simplest terms progressive dependency, though not entirely dependent on age, increases as age at death increases with ~80% of females over 90 significantly dependent in the months prior to death. The cost to society for each and every each individual dying increases as age at death increases. Progressive frailty is a major driver of this cost and, as such, is the specific clinical target for all OPH Services. Frailty however is poorly understood, let alone articulated, as the unifying “concept” or “state of health” which bedevils health care in an increasingly older population.

Frailty is the work of geriatric medicine.

Frailty is correlated to social determinants of health, is accelerated by multimorbidity and with increasing severity signifies increasing risk of mortality. Frailty can and does occur without underlying significant disease hence “disease prevention” alone will not prevent ultimate development of frailty as “the final common pathway” towards the end of life for our human population. Studies such as “Global Burden of Disease” clearly demonstrate the price for increased longevity is greater increase in disability and dependency, hence the prospect of modern medicine achieving “compression of morbidity” (compression of dependency?) is questioned as valid health policy or objective.

The anticipated increase in our oldest population within the next 30 to 40 years requires policy makers and involved clinicians to focus specifically upon the challenge of rise in frailty that will predictably occur. Frailty is now compromising the landscape of acute medical and hospital practice and, without a more enlightened approach, has the potential within the foreseeable future to overwhelm our health system.

Our health system must facilitate geriatric service’ abilities to provide specific input to clinical areas in which frailty is an increasing issue, eg acute medical and surgical hospital beds, ED, orthopaedic wards and in the community supporting primary care to increasingly manage the frail elderly who would otherwise require acute hospitalisation.

An approach to frailty will be enabled by development of frailty pathway(s) in which a common and understood language of frailty is adopted. With progressive decline in physiologic reserve increasing frailty is associated with uncertainty of benefit, as well as likelihood of adverse outcomes, with medical intervention. Clinical decision making in this context will be facilitated by communication and understanding of the impact of individual frailty; inappropriate expectations within our community can only be modified if clinical practice adapts to a more rational approach in sufiicient and visible scale.

***In summary*** both “health” and society have yet to fully appreciate, let alone accommodate, the material and substantial cost of population ageing which modern medicine is achieving. Paradoxically, the more “effective” modern medicine becomes in terms of increasing life expectancy, the more necessary specific Older Person’s Health Services will be. Demand on “health” increases as prevalence of morbidity increases within an older population; progressive dependency (frailty) compounds these demands.

Planning for the future should be based on the predictable increase of these demands, with rational clinical practice facilitated by a systematised approach to frailty. Planning informed by simplstic or wishful analysis will serve not only to delay an effective response but may ultimately compromise the foundations necessary to achieve such a response. Workforce development, community and clinician education and modification of expectations cannot be achieved overnight. These can only be expedited by clarity of strategic planning.

I would be very happy to elaborate further on any of these points.

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| **Submission 130** |

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| Organisation (if applicable): | Eldernet & Care Publications |
| Position (if applicable): | Director |

This submission *(tick one box only in this section)*:

comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

**√** is made on behalf of a group or organisation(s)

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Māori  Regulatory authority

Pacific  Consumer

Asian  District health board

Education/training provider  Local government

Service provider  Government

Non-governmental organisation  Union

Primary health organisation  Professional association

Academic/researcher **√** Other *(please specify)*:  
*Independent information provider.*

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Make this a universal design – using “age friendly’ defines older people as “other”.  Working in consultation with whom? Social sector? Community? Volunteers? Businesses?  Oral care – should be included in health/medical budget; e.g. could use mobile school dental clinics for residential care. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 4(e) – How will this be done?  4(f) – Don’t duplicate existing website information; define government information boundaries clearly. Only online mentioned; need print and phone too. |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Collaboration is difficult while funding is in silos. Investigate Individualised Funding. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| More elective surgery, e.g. hip & knee replacement, would quickly address often long standing disability issues. |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Individualised Funding may be more conducive to assisting the goal of self-management.  Self-advocacy is variable from person to person (depending on their personality, skills, etc.) so some ‘navigator’ type assistance may be required. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 9(d) – Recruitment and retention: Incorporate InterRai assessment into Nursing training/qualifications; pay more & ensure the funding allows this to happen.  We support the Dementia Care Framework. Universal Design standards make all public places suitable for a range of abilities.  11 – Yes, do all this but do ensure client choice.  13 – Health apps: To be sure that these are appropriate for this group (i.e. that they will use them), talk to Grey Power. They have extensive membership, are a good representative demographic and well placed to talk about the reality of technology uptake by older people. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We note that all the leads are government: Why is this being driven by government? Can it be more collaborative?  Explore the Whanau Ora navigator model. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 14(a) – We support the frailty tool.  18(a) – We support the Canterbury model already in place.  18(d) – Elevate this action to within 2 years.  21(b) – As long as there is government funding to ensure people are not disadvantaged. Also need to ensure their employability is not affected. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| This is a difficult subject; cultural taboos need to be carefully considered and planned around. |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 22(a) – Review cost of EPOA.  24(c) – Lower the priority of this one. |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| Don’t spend time reinventing things.  26(a) – Most important. |

### Other comments

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| 28(b) – There is already a significant amount of research work on this subject. Fund the successful models.  Need to start from the premise that caregiving does impact on carers/families/whanau.  What sectors are being collaborated with? Private? |

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| **Submission 131** |



# PSA Submission: Draft Health of Older People Strategy

### 7 September 2016

Introduction

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| *Who we are*  *Our membership*  *Submission structure*  *The strategy lacks detail …*  *… in particular, on funding issues*  *… what the investment approach means in practice is unclear*  *… and fails to state how a fragmented sector will be brought together in an effective system*  *Workforce*  *There is a place for telehealth, but those unable to access it must not be left behind*  *Health workers must be trained and supported to use technology*  *Individualised Funding must be backed up with good employment practice, preferably through providers*  *The in between travel case shows the way forward for regularising the care and support workforce*  *People in rural and remote areas must not be disadvantaged*  *More clarity is needed about how the Maori and Pacific peoples’ health needs will be met*  *Contracted services must maintain skills, specialisms and service quality*  *Health and safety is a real issue for our members*  *Underfunding of $1.2 billion since 2009 is ignored*  *Large scale private provider are becoming ever-bigger players, putting downward pressure on wage and service levels*  *Do they leave the client’s dishes in the sink?*  *PSA has experience of high performance work practices*  *Involving the workers who do the jobs, and harnessing their ideas is the way to deliver high performing services*  *Sustainable Work Systems is the PSA’s high performance programme*  *Kaiser Permanente in the USA is a model*  *The one team approach must value and use the skills of all health workers*  *Data systems must be designed around people*  *The challenge of integrating systems must not be under-estimated*  *NGOs, and their workers, must be supported to develop IT capability*  *Unions must be involved in the impact of technology on jobs* | The New Zealand Public Service Association: Te Pūkenga Here Tikanga Mahi (PSA) is the largest trade union in New Zealand, representing 62,000 members who are taxpayers and users of the health system. We are a democratic organisation with members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities, state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.  Of these members, around 17,000 work for DHBs as allied health, mental health and public health professionals and support workers, and as administration and clerical support. We also have around 6,000 members who work in community-based public services, providing home support to elderly and disabled people, providing mental health and drug and alcohol services, and residential disability support services. They are employed by not-for-profit and private providers who are funded through contracts to DHBs and, in some cases, directly by the Ministry of Health.  Through the New Zealand Council of Trade Unions: Te Kauae Kaimahi, we work closely with other affiliated health sector unions on matters of common interest. We are an associate member of AHANZ, the peak body for allied health professional associations, and maintain close links with organisations and consumer groups in disability, home support and mental health. We participate in the Health Sector Relationship Agreement and the National Bi-partite Action Group, which are national health forums.  We note that the draft strategy’s structure reflects its five proposed objectives, and that the five themes[[65]](#footnote-65) of the New Zealand Health Strategy are woven throughout the section on each objective. This submission is structured around the themes of the New Zealand Health Strategy to avoid the repetition that would arise from commenting on each theme for each objective.  The submission starts with general comments, then discusses each theme, and finally provides specific comments on some of the proposed actions. General comments The document acknowledges that it is intended to provide overarching direction for the system for 2016-2026, and proposes actions to support the achievement of the strategy.  The strategy takes a life course approach, which is reflected in the proposed the vision and objectives.  The proposed vision is, “Older people live well, age well and have a respectful end of life in age-friendly communities.  The proposed five objectives are:   * Healthy ageing * Acute and restorative care * Living well with long-term conditions * Support for people with and complex needs * Respectful end of life.   The themes from the New Zealand Health Strategy are woven into these five objectives.  All of which is useful and we can in principle agree, but there is a worrying lack of detail and specificity about many of the actions, and how the desired objectives will be achieved. Many of the actions are at a high-level.  The proposed strategy does not deal with the issue that, in real terms, the health budget has been underfunded by around $1.2 billion since 2009/10 according to research undertaken by the CTU and ASMS, and this is a conservative estimate[[66]](#footnote-66). There is no acknowledgement of this shortfall, just an assumption that the funds must be stretched even further. We do, of course, support getting value for money and better performance but continued underfunding is not the answer.  This does not give us confidence, especially when the challenges section notes the growing health needs arising from our ageing population and the growing complexity of need.  There is considerable vagueness about the “investment approach”’ and what this will actually mean in practice and what the likely impacts on current funding arrangements will be. We would be concerned if it is a narrow focus on cost reduction, with the hope that better health, economic and social outcome will eventuate; or if it is about managing risk by shifting it to contracted providers and the voluntary sector.  The reviews commissioned by the Director-General of Health on Capability and Capacity and Funding had plenty to say about funding issues, and recommendations, but very little has been carried through to the draft strategy. The funding review commissioned to support the New Zealand Health Strategy was clear about the proposed direction, and envisaged a greatly increased role for the private sector in competition with DHBs for contestable funding. The private sector will not be interested in the difficult and intractable issues; they will cherry pick the easier and more profitable services, reinforcing health inequities.  We have a highly fragmented health system with 20 DHBs and hundreds of NGO and private providers, including PHOs. Having all these elements functioning as a coordinated and aligned health system will be necessary to support the achievement of the strategy’s objectives, but the strategy and actions do not provide any concrete or specific information about how this will come about.  In general we agree with the challenges and opportunities, but there are some gaps. The paragraph on page10 on Workforce Development needs to identify the challenge of ensuring we recognise the contribution, and fully utilise, the skills of the entire workforce, not just doctors and nurses but also allied health, technicians, home and community support workers, clerical and administrative support people who are integral to the ‘one team’ approach that is part of the strategy. This would reinforce the elements of the strategy that deal with workforce development. We comment in more detail on workforce issues throughout the submission ThemesPeople Powered We support the focus on people as individuals, as co-producers and co-designers of their health and well-being, supported by informed choice. However, there are two assumptions that concern us in particular:  There is a heavy emphasis on telehealth and technologies, assuming that people will in future engage with health services through technology. There is no doubt that technology developments offer significant opportunities, and for some people this will provide benefits. But others will struggle; they will not be able to afford to buy and run the devices so will be disadvantaged vis-à-vis the tech savvy, assertive and affluent sections of the population (who will be predominantly Pākehā). Others will be disadvantaged by their age and/or disability, so supports must be in place for them.  The other aspect of telehealth is the need to ensure that health practitioners are supported with up to date technology for their jobs, and are fully trained and supported in its use to maximise its benefits. Protocols to maintain the security of personal health information will be important.  Our members who work in home support have expressed concerns about technology being used for surveillance purposes. For example, GPS on cars or phones to track location and the time spent with a client.  Is it envisaged that individualised funding (IF) will be used to maximise people’s choice and flexibility? IF is seen as one way forward for a people power centered system, and is currently used in the disability sector. It can enable people to gain a greater measure of personal independence, and direct their own services. Research[[67]](#footnote-67) supports the proposal that it provides better outcomes for people with disability. For the PSA the concern with individualised funding is not with the concept or the ambition, but with the lack of consideration of the workforce required to provide independence for the person with disabilities. These concerns centre around employment relationships, wages and conditions, training and qualifications, and health and safety.  Under the New Zealand model of IF, many disabled people will directly employ their support staff. There is no doubt that many will be good employers, but generally small employers struggle with the capacity and capability to deal with employment matters well. From a worker perspective it is best that support workers under IF are employed by providers. This would provide them with greater employment security, access to training and health and safety support, and probably make it easier to ensure regular hours. We note the Australian Disability Insurance Scheme introduced in 2013 that serves as a useful model for offering choice to those needing support whilst supporting good employment practive - while there are some situations where workers are directly employed by the person with a disability, most are employed by a provider.  Care and support work is often seen as ‘women’s work’, done by family members, neighbours or friends and is not valued for the skills, knowledge and responsibilities that are required. Having a provider employ the worker means that there is more scope to negotiate fair wages and conditions that are consistent across the sector. There is a growing realisation that better training and higher level qualifications are required for the care and support workforce and this was part of the in-between travel case settlement reached by the PSA and the Ministry of Health, where work is now underway to regularise the workforce. The changes are significant and when achieved will ensure guaranteed hours for the majority of the workforce, paid training to enable support workers to gain level 3 qualifications, wages based on the required levels of training, and fair and safe workload allocations. This needs to be explicit in the strategy and actions, and needs to be funded.  Negotiations also underway as a result of the Kristine Bartlett equal pay case and all parties hope that a settlement can be reached soon. The PSA seeks recognition of the skills and equal for aged care residential and home support workers. This needs to be factored into the strategy and funded.  Workers must not bear the cost of greater flexibility in service delivery for older people. Our experience in the home and community care sector is that those workers, bear the cost of client flexibility. A client can cancel a scheduled visit by a support worker at very short notice, the provider is not funded for non-utilisation, and so the worker is not paid for the work they did not perform through no reason of their own. This can place significant financial pressure on that worker (and their families), who are already low paid with uncertain hours of work. The high degree of client choice has been a significant challenge in the regularisation of the workforce resulting from the in-between travel settlement. The lack of guaranteed hours of paid work also risks non-compliance with the new statutory provisions on employment standards. Closer to Home Again, we support this theme in general, and we know that it is what people and their families want. Members however have questions about equitable access for older people in rural and provincial areas, and it would be good to see more detail on how the strategy will ensure that they do not miss out. In effect this theme is a challenge to the DHBs about where services are best delivered and how they are configured.  Māori and Pacific peoples have a greater degree of health inequalities; and accessible and affordable community, primary and whanau services are important in supporting better outcomes. The strategy does acknowledge Māori and Pacific health as a priority, which we agree with. But again, the strategy is short on detail.  We have concerns about moves to further contracting out of services to community organisations. If this happens it must be balanced with measures to ensure that skills, specialisms and service quality are maintained. For example, one member from a remote area reported that emergency services are being run by aged care nurses, which may be adequate for low-level emergencies but may well also carry risks for the public and for the health workers. The other issue in more contracted services is more fragmentation of services.  The PSA supports the aim of workforce capability and capacity in primary and community services to provide high-quality care as close to home as possible. However, the strategy needs to recognise the community services workforce requires training to raise qualification levels, equal pay and conditions, job security, and adequate health and safety. It must also be respected and valued for its important contribution to peoples’ well-being and health, and not just seen as low-value ‘women’s work’.  In terms of health and safety, issues for our members include working alone, dealing with challenging (and sometimes violent) behaviours, dealing and lifting heavy clients. The drive towards community based care means that this will increase and will heighten the need for safe staffing levels. The strategy will need to ensure that workers have adequate and safe working conditions in the community/  Our comments above about telehealth are also pertinent to this theme. Value and high performance As noted above, the strategy does not deal with the issue that, in real terms, the health budget has been underfunded by around $1.2 billion since 2009/10. There is no acknowledgement of this shortfall, just an assumption that the funds must be stretched even further. We do, of course, support getting value for money and better performance but continued underfunding is not the answer.  As they struggle with their own deficits, DHBs have consistently underfunded contracted providers through mechanisms such as increasing service levels within the same (or decreased) funding, or dropping services.  Given the emphasis in the draft strategy on the shift to primary and community services, it is crucial that any shift is properly funded. We note that, over time, community and NGO providers are often taken over by large, for-profit organisations with puts even more pressure on the wages and service levels. The experience of the residential aged care sector, where large scale foreign owned companies attracted by the guaranteed government funding have entered the New Zealand market, are germane here. The private sector is focused on maximising the return to its owners and shareholders; the risk to public value is that the government has to step in in case of service failure, as we have seen in the private prisons debacle with Serco.  To illustrate this point, our community public service members have many examples of provider management solutions to dealing with funding shortages: for example, a client who previously had an hour for home management being cut back to 45 minutes – ostensibly as part of the restoration model encouraging independence, but not taking into account the importance of the relationship with the client and the fact that the client may not be capable of some tasks. Should the worker leave the client with a tub full of dishes because the 45 minutes is up?  Members also point out times where one home support worker is expected to use a hoist on their own, where in a rest home or hospital situation, two workers would be assigned. Qualified workers are trained not to use hoists on their own. Not sending a second worker is a cost saving to the provider.  Our comments above about what the investment approach means in practice being unclear are also relevant here.  The PSA is also committed to high performing workplaces in both the community sector and the health sector with a view to creating a climate and culture where frontline workers, including those who might qualify as public entrepreneurs, can flourish. We have two principal objectives:   * Enabling PSA members to have good jobs, within a workplace culture of meaningful and substantive engagement of workers and their union with the employer on how the work is organised and carried out * Supporting the delivery of high quality public services that provide value for money and good outcomes for New Zealanders.   A high performing workplace is one where our members can mobilise their knowledge to improve the efficiency and quality of services and embed positive and productive workplace relationships and practices with a view to creating sustainable services, sustainable jobs, and productive workplaces.  The PSA believes that high performance workplaces can be achieved through a culture of engagement and collaboration by direct, meaningful and regular engagement with the workforce on all matters over which the workforce directly influences performance. This is essential for sustained high performance and for achieving the productivity gains that employers (and members) seek in a time of scarce resources. In the highly unionised public sector the union is central to improving productivity and innovation and the PSA wants to be involved.  For example, we have developed Sustainable Work Systems (SWS) as a programme for putting the high performance workplace agenda into practice. SWS sits within our wider agenda, and is an important and effective tool for realising high performance in workplaces where the conditions are right for it. We have a number of projects underway with employers to implement this programme. It has been running with bookers and schedulers at Bay of Plenty DHB since 2009, where the introduction of SWS reduced (and sustained) the time taken for scheduling acute appointments from 5 hours to 1.5 hours, significantly reduced the need to rebook appointments at short notice and allowed patients to choose their appointment times so that they are much more likely to turn up.  We have visited Kaiser Permanente in the US, where the health company and a coalition of unions have a long-standing formal partnership based on a shared commitment to high performance through employee involvement[[68]](#footnote-68). This has delivered significant benefits and savings to the company, to the workers – and to their clients and patients. If the government is serious about high performance, it needs to work with unions to promote and participate in such approaches. One team Our members support the principle of working together in local teams and across the system. However, there is a real problem about how the clinical professions view the contribution of the full range of health workers. Allied health and technical workers need to be seen as integral and equal participants in multi-disciplinary care teams; and clerical and administrative workers and home support workers need to have their roles and ideas respected and valued.  This theme has a focus on workforce development, including the skills necessary for integrated care. We support this, and expect that unions will be fully involved in implementation. Adequate support for training and qualifications must be part of this. There must be a clear understanding – from all parties – that the health workforce is wider than the clinical workforce, and includes the non-regulated workforce which is a key component of ‘closer to home’. This should be more explicit in the strategy, as well as the role of unions in supporting workforce development. Smart System Much is made throughout the document about the need to improve data analytics and collection, as well as the transformative potential of technology. However, the systems need to be designed around people – both clients and service users and the staff who use and operate them. We have made points above about the currently fragmented DHB / provider system and this is starkly shown up in the proliferation of incompatible IT systems.  For example, Health Benefits Ltd (HBL) was set up to deliver national programmes for ‘back office’ shared services between DHBs, including IT procurement and integration. It failed to deliver, and was disestablished. The Auditor-General’s report into HBL makes for salutary reading; she notes[[69]](#footnote-69) that:  *‘The change required had been underestimated … The (IT) programme’s goals were ambitious, requiring creating a single system that could replace 20 systems and different ways of operating. It appears that HBL underestimated the health sector’s fragmentation. This made achieving the programme’s objectives in the time allotted particularly challenging.’*  The strategy needs to be realistic about the challenges that must be overcome to deal with the fragmentation if it is to realise its objectives and supporting actions. The strategy also glosses over IT and capacity and capability deficits in NGOs and providers – if they are to be part of an integrated national information and data system, they will need considerable capacity and capability building, as well as training for staff.  The draft strategy silent on the potential impact of technology on jobs and changed work practices. Good planning and communication with workers and their unions must be part of implementation, as well as ensuring that any changes to jobs are done with – and not to – the workers, so that they are supported into new areas of work and new roles as needed. Proposed Actions Overall, the proposed actions are a curious mix of detailed, small-scale actions on one hand, and of large, high-level ambitions on the other; of what is currently happening and of what a desired future looks like; thereby making it difficult to comment. Specific comments on some of the actions are provided below: Healthy ageing The actions and body of the strategy need to be clearer that healthy ageing begins from birth, rather than from a particular age later in life. Healthy lifestyles and choices can maximise the chance of a person staying well for longer as they age. Living well with long-term conditions Please see our comments about the regularisation of the workforce and funding throughout the submission, especially pp. 5-7.  We support **Action 9: Ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person centred care** in principle, but believe that the sub-actions are at high level and lack specificity.  **Action 9a** refers to the regularisation of the kaiāwhina workforce in the home and community support services. Is this referring to the regularisation process occurring as a result of the in between travel case? If so please see our comments above (pp.5-7). Regularisation is significant and when achieved will ensure guaranteed hours for the majority of the workforce, paid training to enable support workers to gain level 3 qualifications, wages based on the required levels of training, and fair and safe workload allocations. This needs to be explicit in the strategy and actions, and needs to be funded.  If achieved, regularisation will go a long way to addressing some of the actions listed in this section concerning the capacity and capability of kaiāwhina workforce, recruitment and retention, and better skill utilisation. The home and community care sector has a high turnover, which is a cost to both worker and employers, and impacts on the quality of care to clients. The strategy must have retention measures, including equal pay (p.6), in place.  Other measures to support the achievement of these actions are the implementation of high performance work practices and employee engagement described at pp. 8-9 of the submission.  Many of the actions have either the Ministry of Health or DHBs listed as the leads. Unions and providers/employers must also be closely involved if these actions are to be successfully implemented.  **Action 11c: Develop commissioning and funding approaches for home and community support services that describe core aspects for national consistency, but allow for flexibility at the local level** –  Is this referring to individualised funding? If so, please see our comments on p.5. Or is this about a broad commissioning process or simply contracting out?  The PSA views commissioning as a broader strategic process to:   * Identify the broader social outcomes that need to be achieved * Assess the needs of people in an area, with those people * Design a service that will meet these needs and outcomes, and * Deliver a service in a way that best meets these needs and outcomes   Commissioning is distinct from privatisation or contracting out, which is only one option when deciding on the best way to provide a service. There is much to be gained from a more strategic, integrated and long-term service design and implementation discipline that draws heavily on programme evaluation, ongoing service planning and cross-sector data, and emphasises the public sector capabilities needed to make this a reality.  When services are contracted to not-for-profit providers, they need to be fully funded so they can invest in the training, systems and tools needed to deliver social services. The capability of not-for-profit providers also needs to be built so they can effectively participate in the commissioning process.  Data and evidence must be used to assess the effectiveness of those services, including the impact on the public sector to deliver services. Support for people with high and complex needs **Action 15c: Promote contracting models that enable people to move freely to different care settings most suited to their need.**  Please see our comments directly above regarding Action 11c under Living well with long-term conditions  **Action 16a; In specific locations, trial commissioning one organisation to coordinate health and support services for frail elderly people** etc  Please see our comments directly above regarding Action 11c under Living well with long-term conditions.  **Action 18d: Explore options for aged residential care facilities to become providers of a wider range of services to older people, including non-residents.**  We have some concerns about this, please see our comments at the end of p.6. |

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51. Alzheimer’s Australia. 2015. *Caring for someone with dementia: The economic, social, and health impacts of caring and evidence based supports for carers.* Australia: Alzheimer’s Australia [↑](#footnote-ref-51)
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53. Smith K. Developing a Dementia-Friendly Christchurch: Perspectives of people with dementia. URL: <http://ageconcerncan.org.nz/media/files/Developing_a_Dementia-Friendly_Christchurch.pdf> (Accessed 3 September 2015) [↑](#footnote-ref-53)
54. Personal care and welfare covers health, accommodation and associated care decisions, and comes into effect only if a medical professional or the Family Court decides the person has become ‘mentally incapable’. Property covers money and assets and can come into effect before the person loses mental capacity. [↑](#footnote-ref-54)
55. United Nations Committee on the Rights of Persons with Disabilities, 2014 *General comment No 1 (2014) Article 12: Equal recognition before the law*. [↑](#footnote-ref-55)
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57. Ministry of Health. 2014. *Improving the Lives of People with Dementia*. Wellington: Ministry of Health. [↑](#footnote-ref-57)
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59. Alzheimer’s Society. 2009. *Counting the cost: Caring for people with dementia on hospital wards.* London: Alzheimer’s Society. [↑](#footnote-ref-59)
60. Services must also maximise potential for self-help and involvement in the wider community, and acknowledge, value and encourage the involvement of families/whānau in provision of care. Additional requirements for specialist dementia services include providing support and care that is flexible and individualised, focused on promoting quality of life and minimising need for restrictive practices through managing challenging behaviour. [↑](#footnote-ref-60)
61. In Alzheimers New Zealand’s 2008 Dementia Economic Impact Report it is assumed that people with dementia comprise 100% of people in specialist dementia services and 55% in all other residential care levels. URL: <http://www.alzheimers.org.nz/getmedia/fecb6fcd-c93c-4647-89ed-9949b9c53e15/Dementia_Economic_Impact_Report2008.pdf.aspx> (accessed 2 September 2015) [↑](#footnote-ref-61)
62. http://www.skillsforhealth.org.uk/images/projects/dementia/Dementia%20Core%20Skills%20Education%20and%20Training%20Framework.padfiton [↑](#footnote-ref-62)
63. 80% of New Zealanders over 75 years old rated their health as good, very good or excellent. Ministry of Social Development (2016) *The Social Report 2016.* [↑](#footnote-ref-63)
64. The Equally Well Collaborative. Further information can be accessed here: [www.tepou.co.nz/initiatives/equally-well-physical-health/37](http://www.tepou.co.nz/initiatives/equally-well-physical-health/37). [↑](#footnote-ref-64)
65. The five themes of the New Zealand Health Strategy: People Powered, Closer to Home, Value and High Performance, One Team, Smart System. [↑](#footnote-ref-65)
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68. <http://www.lmpartnership.org/sites/default/files/2012_national_agreement.pdf> [↑](#footnote-ref-68)
69. Para4.12, p17. <http://oag.govt.nz/2015/inquiry-hbl/docs/health-benefits-ltd.pdf> [↑](#footnote-ref-69)