MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

Summary of Public Consultation on the Update of the Health of Older People Strategy

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Purpose

1. Between 13 July and 7 September 2016, the Ministry of Health (the Ministry) consulted the public on the draft update of the New Zealand Health of Older People Strategy (the Strategy). This report presents our analysis of the messages we received from consultation.

Summary of main points

2. There was strong support for the proposed goals in the Strategy, and also for the proposed actions to achieve these goals. In particular, submitters commended the Strategy for its life-course and person-centred approaches; for addressing the social determinants of health; and for giving full weight to the end-of-life phase.

3. Those providing feedback typically focused on what they viewed as priorities that need to be addressed in the Strategy. In most instances, the draft document already identified the area in question as a priority and included actions to address the issue.

4. Leading stakeholder concerns expressed in feedback were the importance of:

    a. ensuring that the health and disability sector has enough suitably trained people to provide the health and related care needed by older people. Of particular concern from a workforce perspective were specialist areas such as geriatrics and palliative care; carers in aged residential care (ARC); and home and community support carers

    b. having well-integrated health services, with comments addressing the need for better integration between:
        - primary and secondary health care
        - secondary health care and restorative care and rehabilitation services
        - primary health care and aged residential care
        - the Ministry and other government agencies
        - district health boards (DHBs), service providers and non-governmental organisations (NGOs)

    c. having a health sector and wider community in that understands and is prepared for the increasing number of older people with dementia, as well as other long-term conditions

    d. having a primary health care sector that is well-positioned to carry out its crucial role in overseeing and co-ordinating care (with particular reference to its ability to take on a multidisciplinary and person-centred approach).

5. People also commented frequently on the need to:
   - provide more support for family and whānau caring for older people
   - deliver health services to older Māori and older members of other ethnic populations in a culturally appropriate manner
   - ensure equity of access to health services for older people (particularly those living in remote locations)
   - develop age-friendly communities
   - address issues of social isolation for older people
   - make the best use of opportunities offered by technologies.

6. As well as expressions of overall support, we also received many suggestions for changes to the Strategy. These were largely directed at the detail of the action plan in the Strategy, and included suggestions for alternative actions, modifications to actions already in the draft, and reprioritising actions. Suggestions that came up most frequently were:
   - the need to make actions more specific (including a variety of suggestions about who should lead actions and more clarity about what was being proposed)
   - increase the number of actions
   - re-prioritise individual actions.

7. A large number of submitters asked whether the government was prepared to provide the resources needed to give effect to the actions in the Strategy.

8. The title of the strategy was frequently discussed in feedback. The weight of opinion was that 'Healthy Ageing', 'the Healthy Ageing strategy', or 'Ageing well' were titles that better complemented the vision, and goals of the strategy than 'The Health of Older People Strategy'. A few submitters cautioned that a title such as 'Healthy Ageing' might be (mis)understood to exclude those who end up in poor health and label them as failures.

Introduction

9. In 2015, the Associate Minister of Health, Peseta Sam Lotu-Iiga, requested an update of the 2002 New Zealand Health of Older People Strategy to ensure that it reflected current issues and opportunities for improving the health of older people. A review of the 2002 document was also needed to ensure alignment with the New Zealand Health Strategy 2016.

Consulting on the draft Health of Older People Strategy

10. In 2015-2016, the Ministry engaged with stakeholders on the contents and direction of an updated Strategy. Those involved included:
    - clinicians and peak professional organisations
    - consumer organisations
    - district health boards
    - primary health organisations
    - non-government organisations
    - Māori, Pacific peoples
    - other ethnic communities
    - older people and their family/carers
    - people with disabilities
    - aged care service providers
    - the general public.

11. In July 2016, the Ministry released a consultation draft of a proposed new Strategy. Stakeholders and the general public were invited to provide input by making written submissions, attending workshops held in five main centres around New Zealand, holding their own local workshops, or by participating in an online forum. Ministry officials also held discussions of the draft Strategy at standing meetings of sector groups.

12. In total, 214 written submissions were received and an estimated 600 people attended discussions of the Strategy at workshops and standing meetings.

What our stakeholders told us

The Strategy framework

Strategy title

13. A proposal to change the title of the Strategy was put up for discussion part way through the consultation process. We received feedback on this proposal from workshops and standing meetings, and also in some written submissions. Most comments on the proposal supported changing the title to: 'New Zealand Healthy Ageing Strategy'. The new title was regarded as being better aligned with the approach incorporated in the document seeking to maximise health and wellbeing for all older people. A minority of submitters were concerned that the change might be read as excluding people who were already experiencing some form of health condition (and therefore could be regarded as 'not healthy').

New Zealand Health Strategy

14. The most common theme in feedback relating to the New Zealand Health Strategy was that there was good alignment between the draft Health of Older People Strategy and the New Zealand Health Strategy, with person-centred and end-of-life care being mentioned as areas where the two strategies reinforce each other well.

15. Some submitters wanted more clarity about how the two strategies aligned, including in the areas of prevention and detection and a whole-of-life approach. The New Zealand Health Strategy was cited as supporting the involvement of consumer representatives in the design and measurement of services, and also the inclusion of oral health amongst important health issues for older people.

Life course approach, outcome areas and goals

16. There was strong support for the proposed outcome areas in the Strategy and their associated goals. The goals were generally regarded as well-targeted and comprehensive.

17. Stakeholders in particular commended the use of an inclusive life-course approach that includes addressing the social determinants of health, health behaviours and intrinsic capacity (resilience), and a respectful end of life. Structuring the draft Strategy on the basis of outcome areas was also widely supported. Some submitters proposed amendments to the goals in the draft.

18. Submitters observed that government policy and community attitudes needed to adjust to demographic changes which see older people living longer, working longer and contributing more to society. These changes would have major implications across a range of areas; for example, housing, vocational and other training (eg, training in IT), and the overall composition of the workforce.

Defining terms used in the Strategy

19. A number of submitters thought that the Strategy needs a definitions section. Terms that submitters suggested needed to be defined included 'older people', 'palliative care', 'frailty' and 'resilience'.

Topics that were relevant to all or most outcome areas

20. A number of topics discussed in feedback were relevant to all or most outcome areas. These are summarised below.

Voice of older people

21. Many submitters told us that it was important that the Strategy reflect older people's perspectives on what is important to them for their health and wellbeing. They want older people, family and whānau to be involved in the design, implementation, monitoring and evaluation of actions that impacted on their lives. This involvement needs to be at all levels: from decisions about an individual's health care, to the design of systems, to setting national goals for the health of older people.

> 'Including older people in the service design, development and review would be crucial to implementation. It is also important to involve Māori and Pasifika people in the planning.'
>
> – Zonta Club of Mana

Human rights and healthy ageing

22. For a number of submitters, the Strategy's overall aim of healthy ageing was a fundamental human right. Some expressed of this right in terms of a 'right to health' and/or the right to access to adequate levels of health care. Effective legal safeguards for older people who lack the capacity to make decisions on their own behalf were seen as a human right.

Independence

23. There was support for the Strategy aim of maximising independence for older people. Submitters referred to:
    - the impact of dementia on the individual's capacity to be independent
    - the importance of older people having access to affordable transport and adequate housing to enable their independence as a goal for all older people, including those with physical and mental disabilities and people living in aged residential care
    - the role of appropriate physical activity as an enabler of independence
    - the role of suitably trained service providers and carers (health and associated professionals, family and whānau) in supporting independence.

24. IT and other technologies were also seen as being a valuable aid to independence. Some submitters cautioned that relying on technology to support independence could mean that late adopters would miss out on a significant source of support.

25. A small number of submitters suggested that independence as an aim implied isolation from others, and that 'interdependence' should be considered as a preferred alternative.

Equity

26. There was support for the Strategy's aim of continuing efforts to reduce inequities in health. A number of submitters thought that goals and actions in the Strategy needed to have a more explicit emphasis on reducing inequities.

27. Different aspects of equity were identified and discussed in feedback. These included:
    - equity of access to health services for people living in rural and remote areas
    - reducing inequities in health outcomes for Māori and Pacific peoples
    - addressing disparities in access and levels of service delivered between regions
    - reducing inequities in health outcomes for lower socioeconomic groups
    - reducing inequities in health outcomes for vulnerable people, and for people with particular health conditions (eg, long-term conditions)
    - disparities in levels of rehabilitation services funded by the wider health system and by ACC
    - the link between poor health outcomes and inadequate housing and household incomes
    - the need to achieve equity and access to levels of service, irrespective of the cultural group to which individuals belong
    - the link between inequities in health outcomes for older people and inequities for the wider population.

28. There was discussion of the scope of 'equity,' with some submitters advocating setting equity goals in relation to achieving equality in outcomes rather than equality in access to services.

29. The comment was made that the Government would need to commit additional funding to achieve the Strategy's aim of reducing inequities in health outcomes for older people.

Population groups

30. We received a large volume of feedback discussing health issues from a population group perspective. Groups most frequently mentioned included: people living in rural/remote areas; ethnic communities (including Māori, Pacific peoples, and Asian communities); vulnerable people; people with high and complex needs; and people with physical and mental disabilities.

31. Such groups were seen to have specific, characteristic, health-related issues and related service needs, and it was considered that the Strategy should acknowledge and make provision for these.

32. The health-related issues concerned vary according to population groups. For people living in rural /remote areas, the characteristic issue was difficulty of access to health services (principally because of the distance between where people normally live and where services are located). For ethnic communities, major issues include the importance of having access to services delivered in a culturally appropriate manner, and in some instances, potential language barriers. For vulnerable people and people with high and complex needs, issues include difficulties negotiating a complex health system.

> 'A failure to appreciate the impact of culture on clinical realities has often led to misdiagnosis and mismanagement among ethnic minorities.'
>
> – Te Putahitanga o Te Waipounamu

33. For some population groups, health-related issues are particularly pressing because they already experience relatively poor health outcomes (eg, Māori, Pacific peoples, vulnerable people, people with high and complex needs, people with disabilities). There was also some overlap between population groups; for example, Māori are disproportionately represented in the population of people with disabilities.

Cultural responsiveness

34. Different aspects of cultural responsiveness were discussed in feedback. Cultural responsiveness will become more of a challenge for the health sector as our population becomes more culturally diverse. Several submitters considered that the Strategy needs to show more commitment to ensuring that our health system is culturally responsive. Cultural responsiveness is seen as an area where those providing health and associated services need specialised training. Being able to communicate with people receiving care in their own language was particularly emphasised. Māori and Pacific peoples were mentioned most often as groups that need to have access to services that have been designed to meet their cultural needs and support their perspectives. Services for Māori should be whānau-based. A number of submitters referred to the importance of recognising and respecting different cultural perspectives on end-of-life.

35. Submitters suggested that more research is needed into the cultural requirements of different groups.

Treaty of Waitangi, He Korowai Oranga[1]

36. We received feedback acknowledging that the Strategy recognises and respects the special relationship between Māori and the Crown through the principles of the Treaty of Waitangi, and that the action plan includes specific actions in relation to the health of older Māori. However, some submitters considered that the Strategy needs to provide more detail about the practical implications of this. They asked what the Strategy would specifically do to build Māori capacity to actively contribute to better health and wellbeing for their own iwi, hapū and whānau improve Māori participation and decision-making in the health and disability sector; ensure that health and disability services are effective for Māori as well as all New Zealanders; and incorporate responsive ways to involve Māori in measuring improvements and reduced inequities into the strategy reporting and evaluation process.

[1] *He Korowai Oranga* is the recently refreshed Māori Health Strategy, URL: www.health.govt.nz/publication/guide-he-korowai-oranga-maori-health-strategy

37. One submitter suggested that the draft Strategy reflected a watered down interpretation of He Korowai Oranga, particularly in relation to what the two documents have to say about increasing capacity and capability of Māori providers and inequity as a key challenge for the New Zealand health system. It was suggested that the Strategy text should more closely reflect that of He Korowai Oranga.

38. Submitters wanted services to be designed in consultation with Māori. They wanted services to be provided by Māori health professionals or by those trained and skilled in Māori practice and knowledge of Pae Ora – healthy futures. A number of submitters thought it was important that the delivery of health services be integrated with other related services, preferably through the Whānau Ora programme.

39. We received feedback that Māori support the actions in the Strategy relating to services for Māori, and also the draft's pledge to achieve equity of outcomes for Māori. There were comments that actions need to be more detailed.

> 'Ensure the strategy carries a strong equity focus and health priorities are articulated specifically for Māori.'
>
> – Mid Central DHB

Meeting the health needs of older people of other ethnic groups

40. Some submitters advocated on behalf of people in individual ethnic groups, including Pacific and Asian populations, for them to be able to access health services designed to meet their cultural needs.

41. Comments under this heading emphasised the need for suitable training for health staff and/or for involving people of the appropriate ethnic background in the provision of services, and also for the need to design and deliver public health messages in population-appropriate ways. One submitter suggested that health services need to have better access to translators to aid communication with people for whom English is not their first language. Submitters commonly referred to the increasing number of people of diverse ethnicities living in New Zealand, particularly in the greater Auckland area.

Workforce

42. The single message that came through most strongly in the feedback we received was the importance of ensuring that New Zealand has enough well trained, motivated people in the paid workforce to achieve the aim of healthy ageing for older people.

43. This theme came up in relation to the majority of topics discussed elsewhere in this report. Training and remuneration were the aspects of the workforce theme which occurred most often. Other aspects included current and projected staff shortages (referring to both demographic trends and projected increases in international demand for specialist skills); the need to overcome barriers to some categories of health worker being allowed to take on expanded roles and higher responsibilities; and the need for better integration to enable a 'one team' approach.

> 'NZACA believes that the health workforce is likely to reach a crisis point regarding future availability of enrolled and registered nurses and kaiāwhina and agrees that the Strategy needs to 'prioritise attracting, retaining and making best use of the skills of all in the health workforce to meet the need of an older population.'
>
> – New Zealand Aged Care Association

IT and other technologies

44. We received a significant amount of feedback about making the best use of opportunities offered by recent advances in technology, particularly in the IT area.

45. Submitters commented that the Strategy should do more to increase the capacity of IT and other technologies to:
    - improve integration between different parts of the sector; allow access to patient information
    - help people in remote areas access health services
    - assist the delivery of services through, for example, patient assessment.

46. A number of submitters commented that more use should be made of interRAI, by using more of its modules and requiring more national consistency in its use.

47. Some submitters expressed concern that the Strategy's emphasis on self-management, often assisted by various technologies could leave less technology-capable older people under-supported by the health system. It was noted that such people are likely to fall into the 'vulnerable' category.

Topics relating to the 'Healthy Ageing' outcome area

Healthy lifestyles and resilience

Resilience

48. There was strong support for the Strategy's focus on mental and physical resilience. A number of submitters commented that resilience-related actions in the Strategy currently focus on physical resilience, and that there should be more focus on building mental wellbeing.

Healthy lifestyles: health literacy, health promotion, being health smart

49. We received feedback supporting the Strategy's goal of optimising older people's health through healthy lifestyles. Comments included that there should be more actions to support a move to healthier lifestyles, and that there should be more emphasis on early promotion of a healthy lifestyle (healthy eating, physical activity, moderate consumption of alcohol, giving up smoking tobacco). Support was expressed for the Green Prescription program, as a way of motivating and assisting older people to maintain and sustain a

healthy lifestyle. They described the programme as being effective and worth not only retaining but also expanding.

> 'For our ageing population, the Green Prescription programme is very effective. It supports and motivates older people to maintain and sustain a healthy lifestyle.'
> – Age Concern Rotorua

50. It was noted that poor diet, lack of exercise and excessive consumption of alcohol are associated with a higher risk of dementia.

51. Some submitters noted that malnutrition is common in older adults and contributes to increased risk of falls, fractures, frailty and functional decline. Suggestions for addressing nutrition issues included training and upskilling health professionals, care providers and community organisations. In the ARC sector, independence and choice for residents were identified as ways of improving nutrition.

52. An additional action point was proposed: 'Improve healthy eating and food and nutrition knowledge of older people living independently'.

53. We received related feedback supporting the Strategy's emphasis on improving health literacy. This included support for initiatives to increase public education for a wide range of issues, including how older people can prevent health issues arising, how to manage long-term conditions, caring for people with high and complex needs, and supporting older people in the last stages of life.

54. It was suggested that the Strategy give higher priority to actions to improve health literacy.

55. Primary health care providers such as GPs and nurses were identified as an important source of health information. Some submitters commented on the importance of health literacy in the health-related workforce. It was thought that health promotion materials need to be promoted and tailored for ethnic communities, particularly those where English was commonly a second language. The point was made that health promotion needed to start early, before the onset of older age, in the interests of prevention.

56. A number of submitters commented on the need for health information to be available in an age-appropriate form (including use of larger fonts, and availability of print material for non-users of electronic media).

Prevention and early identification of health issues/conditions

57. There was support for the provisions in the Strategy for the prevention and early identification of health issues and conditions. One suggestion was that the Strategy should place more emphasis on prevention and adequate primary health care strategies, education, social stimulation, nutrition and exercise. A small number of submitters qualified their support by cautioning that an emphasis on prevention and early identification should not be allowed to result in a shift of focus away from the need to manage existing conditions.

58. Some submitters thought that the Strategy's treatment of early prevention and identification needed to be supplemented by more detail on early identification of frailty and dementia, suicide prevention and the role of screening, assessments and public health campaigns.

59. There were also comments on the important role played by primary health care in prevention and early identification as the usual point of first contact between an individual and the health system. There was a suggestion that prevention and early identification should be supported by earlier referrals to home-based support, social services and access to navigators.[2]

Role of primary health care

60. It was widely agreed that primary health care services were critical to the success of much of the Strategy. There was strong support for extending the role of those providing primary health care services including:
    - ensuring that older people are well-informed about health issues associated with ageing
    - focusing on early diagnosis for certain conditions
    - taking a person-centred approach to the needs of individuals and their family and whānau
    - collaborating with other parts of the health sector to provide an integrated health service for older people
    - helping to open discussion about what can be expected at the end-of-life stage
    - participating in advance care planning (ACP).

Physical, social, economic and environmental determinants of health

61. There was strong support for the Strategy's emphasis on addressing the social and environmental determinants of health.

62. A number of stakeholders thought that the action plan could go further in identifying how issues arising from social and environmental determinants of health would be tackled. In particular, they wanted the Strategy to include more detail about how the Ministry intends to work with other agencies in areas beyond the provision of health services.

63. Some workshop attendees commented on the need for clear accountability for actions and assurance that other government agencies are equally committed to achieving the Strategy's goals. It was suggested that, to ensure government agencies coordinate their efforts to address the social and environmental determinants of health effectively, the Strategy should assign each action to a single lead agency, with others in the role of 'supporting agencies'. Some NGOs also noted they were well placed to take either lead or supporting roles in some actions.

Social isolation, social connectedness, loneliness

64. There was support for the Strategy's recognition of social isolation and loneliness as risk factors for the health of older people. Social isolation was seen as a particular problem for some groups of older people: members of ethnic communities; people with dementia and other forms of mental disability; vulnerable and/or homeless people; those with sight or hearing impairment; the recently bereaved; and people living in remote and rural locations. Submitters identified a variety of factors connected to social isolation, including mobility/transport, access to leisure and recreational facilities, seeing and hearing

[2] Navigators guide people through the health system. The navigator role is discussed further below, paragraphs 137–139.

capacity and oral health, and geographical isolation. Connections with whānau, iwi and hapū were major factors for older Māori.

65. It was suggested that the term 'social isolation' should be more positively framed, ie, as a lack of 'social inclusion'.

66. Some people agreed that technology could be used to reduce social isolation. Others cautioned that new technology should not replace earlier-model solutions completely, since not everyone would be able to make use of technological solutions. One submitter commented that an increased reliance on technology can lead to increased social isolation (because of reduced contacts with support staff).

Housing and health

67. Submitters agreed that the Strategy needs to highlight the importance of affordable, age-appropriate, good-quality housing for older people as a health-related issue. The current housing environment, particularly in larger cities, is seen to be under-serving vulnerable older people and older people with affordability issues in particular.

68. Individual issues that came up included:
    - a perceived lack of suitable supported housing options for older people (ie, other than retirement villages) especially where older people are not asset rich
    - concerns regarding the availability of social housing
    - the increasing number of older people who are renters (sometimes associated with difficulty getting maintenance and basic improvements done)
    - homelessness as an issue that affects some older people
    - building codes and related processes acting as a barrier to better housing design and town planning
    - the importance of home modifications such as grab rails, level access, wet area showers, etc, improve the safety, health, mobility, independence and confidence of older people.

> 'Accessible housing is a huge priority and needs to take precedence. If people don't have a safe, healthy home and the ability to cover the cost of living then their health is subsequently affected.'
>
> – Age Concern Auckland

Transport and health

69. A number of submitters referred to the need to recognise transport as a health-related issue for older people, who may not be able to drive themselves and may not be able to afford alternatives.

70. Convenient, low-cost transport was seen as a factor in enabling social inclusion and also in access to health and social services. It was noted that transport issues are more likely to affect those living in remote areas (and is therefore an aspect of the equity of access theme discussed elsewhere in this report).

Elder abuse and neglect

71. There was support for the Strategy's aim of preventing, identifying and reducing elder abuse and neglect, and also for the associated action (participation in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme). Submissions from groups representing older people in particular demonstrated a strong awareness of elder abuse and neglect as a problem.

72. A number of submitters referred to the need to strengthen legal safeguards against elder abuse and neglect. In particular, they flagged the need to provide stronger protection for older people who may have diminished competence to give informed consent.

73. They also discussed the role of enduring power of attorney (EPOA) as protection against neglect and suggested that steps should be taken to better inform the public about the availability and function of EPOA, and to reduce the cost of EPOA.

Financial capability, personal finances, income and poverty

74. Submitters agreed with the Strategy identifying the connection between income and health and wellbeing. This connection was discussed from two main perspectives: people in lower socioeconomic groups tend to have poorer health outcomes than the population as a whole and older people may experience a fall in income and also have less financial flexibility after retirement. The cost of health services was presented as a barrier to accessing those services (some examples mentioned were the cost of dental care, and the cost of visiting GPs), with consequences for health and wellbeing. Other living costs were mentioned as impacting on health and wellbeing, with the cost of housing, and particularly the cost of renting, being mentioned as a leading example.

75. Some submitters thought the Strategy should include an action to improve health literacy and security, for example, promoting access to independent, competent financial planning services. There were a number of suggestions that specific health and related services should be subsidised or that subsidies should be increased (eg, for hearing aids). Others suggested broader measures to address income issues, for example, an old-age savings and care policy.

Employment and volunteering

76. Older people have knowledge, skills and wisdom that they can contribute to the community, either in a paid or unpaid capacity, and submitters supported the idea of the Strategy promoting volunteering and employment among older people. Some submitters thought that the Strategy needed to give more recognition to the fact that demographic trends suggest that older people will represent an increasing proportion of the paid and unpaid workforce in the future.

77. One submitter wanted workplaces and community roles to provide for the specific needs of older workers with long-term conditions, for example with time off to attend appointments, flexible work hours.

78. One submitter thought that the Strategy did not give enough recognition to the role of young and old volunteers as service providers (drivers, home visitors, computer trainers, special outing assistance, shoppers, etc). The same submitter pointed out that volunteers are key to many older people remaining independent at home and recommended including volunteers as service providers in actions where relevant throughout the strategy, with NGOs as the lead on any action involving volunteers.

79. Some submitters thought that the Strategy should provide more detail about its resourcing and funding commitment to training and support for whānau and volunteers as carers of older people with high and complex needs and approaching end-of-life.

Age-friendly communities

80. Feedback on the Strategy goal of establishing age-friendly communities was largely positive. A significant number of submitters expressed reservations about the goal or commented on what they considered was required to progress the goal.

81. A common message in feedback on the age-friendly community goal was that active involvement on the part of local organisations and entities was crucial to success. The importance of the involvement of local authorities was emphasised. Other local groups specifically mentioned as having an important contribution were those involved in leisure activities, arts, libraries, and sports.

82. There were a number of comments on the scope of age-friendly communities. Some submitters suggested that such communities also needed to be explicitly 'dementia-friendly'. Factors such as access to age-friendly transport and housing were seen as crucial. 'Age-friendly' needed to include people with all kinds of physical, sensory, communications and cognitive issues. One submitter asked whether the Strategy was drawing on the World Health Organization model of 'age-friendly cities,' or whether 'age-friendly' had a wider, more flexible scope (including, for example age-friendly employers and hospitals).

83. Intergenerational initiatives were seen as strengthening the links between people of different ages, increasing mutual understanding, creating opportunities for older people to contribute to the life of the community, and also improving social inclusiveness/ combating social isolation for older people.

84. Some submitters thought that the term 'age-friendly' seemed to imply grouping older people together in specialised settings, rather than integrating them in the wider community. Others asked that the Strategy define 'age-friendly'. Alternative terminology such as 'inclusive' communities was proposed, as was replacing the goal of age-friendly communities with a wider emphasis on coordinating central and local government action to address the physical and social determinants of health.

85. Support for the concept of age-friendly communities was qualified in some cases by comments that related actions are not sufficiently detailed.

> 'Age-friendly environments are welcoming for elderly people and facilitate community connectedness and mobility. Key features of age-friendly environments include adequate signage and street lighting, provision of public seating, doors which open automatically, community identifiers including small gardens and murals, seats in bus stops and removal of physical barriers etc. These features make spaces user-friendly not just for older people but everyone.'
>
> – Stroke Foundation of New Zealand

Built environment, outdoor spaces and buildings

86. We received feedback on the importance of the built environment being accessible to older people. Buildings, public facilities, spaces and transport needed to be accessible to the less physically abled (for example, people in wheelchairs). Signs need to be accessible to those with impaired sight, or for whom English is a second language. Facilities such as hospitals and libraries need to ensure that their physical infrastructure is fit for people with mental disabilities such as dementia, and that staff were trained in meeting the needs of such people. Submitters noted that it is important to recognise the connection between environmental access and urban design and the health and wellbeing of all New Zealanders.

87. Some submitters considered that staff in public facilities received inadequate training in communicating with people with sight and hearing impairments. One submitter recommended that assessment/pre-admission programmes in elder care include screening for all sensory disability – sight, hearing, smell, touch and taste, with any deficiencies to be addressed before any placement decisions are valid. Another recommended that adding an action point to support early detection of sight and hearing impairments.

Local government

88. Feedback on the role of local government focused on the importance of local authorities taking an active part in the development of age- and disability-friendly communities. A number of submitters discussed the activities and facilities that local authorities could use to help establish such communities, eg, local government policy and planning, social housing, public transport, parks and reserves, public facilities. Some had a clear idea of the physical features of age-friendly communities, eg, adequate signage and street lighting, provision of public seating, doors which open automatically, community identifiers including small gardens and murals, seats in bus stops and removal of physical barriers.

89. One submitter commented that amendments to the Local Government Act (2002) in 2012 led to the removal of local government's focus on promoting social, cultural, economic and environmental wellbeing of communities. This was represented as a potential barrier to local authority involvement that needed to be addressed.

Ageing in place

90. There was support for an ageing in place approach, with submitters also commenting on implications of this approach.

91. Ageing in place was linked to the need for more age-friendly communities which maximise opportunities for older people to contribute to the life of the community. Access to adequate (affordable, healthy, age-appropriate) housing was seen as crucial to the success of an ageing in place approach. There were also significant funding, workforce and training implications, since ageing in place gives rise to demands on home and community support services and on family and whānau caring for older people at home. While older people tend to prefer to live in their own home, it was pointed out that there will continue to be strong demand for ARC facilities.

Valuing older people

92. We received positive feedback on the Strategy's vision of a society where older people are 'highly valued'. A small number of submitters thought that the Strategy needed to place more emphasis on the importance of valuing older people.

93. Submitters endorsed the view that older people have valuable knowledge and skills to contribute to the community, for example, as employees, volunteers, and carers. Some referred specifically to the contribution older people can make to the Strategy's goals, through involvement in the design, implementation and measurement of actions. One suggestion was that all DHBs should use focus groups of older people as part of their quality improvement process.

94. Another theme was that it was important to value older people, including people with conditions such as dementia, and that this can lead to greater social inclusion and better health overall. There were positive suggestions for how the valuing process could be assisted; for example, through intergenerational initiatives and popular activities that enable older people to share their stories and experiences. It was pointed out that ensuring that older people are highly valued would require resources, including health and social support services and support from family and whānau.

95. Cultural differences in the value placed on older people were remarked on. Kaumatua were described as being hugely valued by whānau and the wider community.

> 'Older people have much to offer the rest of society. We suggest that the draft strategy better reflects the value of older people as taonga. This could take the form of considering what older people give to society, and ways to harness these contributions.'
>
> – New Zealand Medical Association

Topics relating to the 'Acute and restorative care' outcome area

Transition between acute care and the home setting

96. A large number of submitters identified gaps in integration leading up to and following the point of transition between acute care in hospitals and an older person's return to their home setting (including forms of residential care). Feedback covered a range of possible problem areas, including:
    - claims that the timing for discharge from hospital may be dictated by considerations other than the best interests of the individual (eg, cost saving)
    - transport issues for those leaving hospital associated with cost or organisational difficulties
    - delays in arranging post-discharge restorative care or rehabilitation
    - the lack of consistent discharge planning
    - issues with funding and/or integration in relation to post-discharge care.

97. Regional examples of good rehabilitation practice were discussed at some workshop sessions. Stakeholders wanted to see these examples replicated in other areas.

> 'Discharge planning should be more than planning for discharge, but actually include the support and care required to transition a person home, and through their recovery period.'
>
> – Lakes DHB

Reducing acute admissions

98. There was support for the Strategy's aim of reducing acute admissions. Suggestions for how to achieve this aim included:
    - extending paramedic roles
    - improving triage of care in emergency departments (EDs) to allow access to specialist investigations and avoid admission to other wards; having allied health staff (social workers, occupational therapists, physiotherapists, etc) in ED 24/7
    - improving after-hours triage for ARC facilities
    - developing acute geriatric care pathways
    - building mutual understanding between GPs, ARC facilities and DHB hospital/ED clinicians and managers of respective pressure points
    - identifying practical educational opportunities between specialist services and ARC facilities improving work-force training to improve recognition of managing of delirium (delirium is often undiagnosed, extending periods of hospital care and increasing risk of complexity in health presentation and morbidity); promoting primary health care capability for comprehensive geriatric assessment and care coordination.

99. One submitter suggested establishing a national information data base for health of older people services, which could guide the development of initiatives to reduce acute admissions as well as support the use of best practice restorative rehabilitation strategies, discharge planning and follow-up support.

100. One submitter did not support the aim of reducing acute admissions and older people, describing it as a form of institutional elder abuse whereby older people were made to feel unwelcome as a burden on the system.

> 'Multidisciplinary approaches for acute and restorative care require responsive and adaptive services, and training in different skills and expertise to meet health needs of older people. Additional capacity is required and allied health professions, such as occupational health, speech and language therapists and dietitians.'
>
> – Royal Australasian College of Physicians

Rehabilitation

101. We received feedback supporting the Strategy's emphasis on improving rehabilitation and restoration outcomes. Submitters agreed that current issues included lack of integration of services, inconsistency of services between regions, and the need to train family and whānau. Rehabilitation closer to home was seen as having cost-saving benefits as well as benefits for those receiving care in terms of independence and wellbeing. It was noted that there is a current shortage of professionals with rehabilitation-related skills, particularly in rural areas.

102. One submitter thought that there was scope for better integrating ARC professionals in the rehabilitation process, because of the skills they can deploy. It was noted that some DHBs are already working well with ARC facilities.

103. A number of submitters commented on the Strategy's aim of supporting rehabilitation closer to home. They suggested that this aim should be furthered by ensuring that:
    - enough suitably trained people are available to work with elderly people on their rehabilitation
    - the older person has a satisfactory home environment to return to and has supports in place for managing their financial and social situation suitably
    - referral pathways for pharmacists and from pharmacists are supported
    - there are systems in place to enable pharmacists to contribute to the care of house-bound older people
    - pharmacists can access the New Zealand Electronic Prescription Service (NZePS), the shared Electronic Health Record (EHR) system and discharge summaries
    - best practice on rehabilitation programmes is shared across DHBs (eg, a national information data base for health of older people services)
    - early supported discharge schemes (accessible for frail older people) are developed in all DHBs
    - disability support services and staff (residential services and supporting people in their own homes) are included in the partnerships that support effective rehabilitation and initiatives to reduce acute admissions
    - positive relationships and respectful, effective communication flows are set up between DHB clinicians and ARC providers.

Topics relating to the 'Living well with long-term conditions' outcome area

People with disabilities

104. A number of submitters commented on issues in relation to the needs of older people with disabilities. The number of older people with disabilities will increase as older people as a group become a high proportion of the population overall. Older people with disabilities are disproportionately likely to have unmet health needs and poor health outcomes, to be in the high and complex needs group, and to need home and community support services. A disproportionately high proportion of people with disabilities are Māori.

105. The distinction was made between people who develop disabilities as they age, and people with disabilities who are reaching older age; while the issues involved in supporting both groups overlap, there are also some differences, for example in respect of early identification and prevention.

106. People with disabilities were identified as being likely to have particular issues in relation to housing, with a relatively high proportion of people with disabilities renting accommodation. Boundaries between health, disability and mental health funding streams were seen as an obstacle to providing well-integrated services.

107. There was feedback on the importance of aligning the Health of Older People Strategy with the Disability Strategy.

Dementia

108. Many submitters emphasised the need for the Strategy to address the health needs of people with dementia. The discussion covered issues including:
    - the need for earlier diagnosis of dementia
    - the need to train health professionals in all aspects of identifying and helping people manage dementia
    - the value of improving understanding of dementia within the wider community through public information
    - the need to collect more data to assist with the management of dementia
    - the need to ensure that hospital environments are dementia-friendly.

109. Feedback suggested the Strategy needed to talk more about the impact of dementia on people's lives. There was support for the actions aimed at addressing dementia-related issues, as well as comments that actions in the draft at present do not go far enough to address such issues.

110. Some submitters advocated development of developing a separate 'Dementia Plan'. There was support for the existing New Zealand Framework for Dementia Care (the subject of an action in the draft), and a mix of favourable and more qualified comments on having an action (number 11a) based on the Improving the Lives of People with Dementia plan.

> '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.'
>
> – National Ethics Advisory Committee

Diabetes

111. The Strategy's commitment to reducing the incidence of complications from diabetes was supported. Some submitters interpreted the Strategy as prioritising people with diabetes in residential care as distinct from other settings, and challenged this.

Obesity

112. Submitters identified obesity as a major and growing health problem affecting all ages but with a significant impact on the health of older people. One submitter suggested that the Strategy should include an action related to obesity as a health issue for older people (eg, provide bariatric equipment in ARC facilities).

Musculoskeletal conditions, including arthritis

113. The high prevalence of arthritis in the older age group was noted, as was the importance of people learning to live with and manage pain. There was support for the action to provide community-based, early intervention programmes for people with musculoskeletal health conditions, particularly if programmes include resistance training, balance and flexibility exercises, and cardiorespiratory training.

114. One submitter expressed concern about the number of claims declined by ACC on the grounds of age-related degeneration, and agreed with the priority of developing, implementing and reviewing prevention and treatment of injuries for ACC. The same submitter advocated service development plans for people with long-term conditions as a priority. Such plans should include a range of conditions including musculoskeletal conditions.

Depression

115. Submitters observed that depression is common in older adults, but is often under-diagnosed, and untreated or under-treated. Depression was linked to a number of other health issues, including sight and hearing impairment, alcohol abuse dementia, cardiovascular disease, social isolation, and suicide. When depression is recognised and adequately treated, quality of life is enhanced. There was support for prioritising Strategy actions associated with addressing the incidence of depression.

Oral health

116. There was support for the Strategy's commitment to improving oral health in all community and service settings. The relatively high incidence of poor oral health amongst older people, and particularly amongst people in lower socioeconomic groups, including Māori and Pacific peoples, was recognised, as was the connection between good oral health and other aspects of wellbeing including pain and loss of appetite. There were references to particular issues of poor oral health amongst rest home residents. A number of submitters referred to affordability as a major barrier to older people getting adequate dental health care.

117. Suggestions for actions in relation to improving oral health care for older people included:
    - making oral health care plans a requirement for ARC certification/audit
    - increasing undergraduate oral health/dental training and post-graduate geriatric dentistry
    - training updating current education material and caregiver training in oral health care
    - giving caregiver oral health care training NZQA status, and including oral healthcare in care plans as a matter of course.

118. We also received submissions that the Strategy should not single out oral health for positive action over other areas of sensory health/disability, for example, vision and hearing.

Vision and hearing

119. A number of submitters commented on the impact of impaired vision and hearing on health and wellbeing, and on the high incidence of sight and hearing impairment amongst older people. These impairments can impact on safety, communications, including communication with health workers about symptoms, goals of care, and end-of-life planning, and on social isolation. They are related to depression and diminished functional ability, and are relatively common in older people with intellectual disabilities and with high and complex needs. Sight and hearing impairments can impact on older people's ability to take advantage of IT support.

120. Cost was identified as a major barrier to older people seeking help for sight and hearing impairments. There were suggestions the current subsidy for hearing aids was insufficient.

> 'Hearing loss impacts on quality of life by affecting communication, safety in the environment and psychosocial wellbeing. There is a relationship with depression and diminished functional ability.'
>
> – New Zealand Audiological Society

Workforce

Home and community support workers

121. The largest volume of submissions received on this theme related to the need for the Strategy to prioritise improving training and/or remuneration (typically both) for home and community support carers.

> 'More real support and training must be provided for home carers, family and whanau members. This includes the group less likely to receive training for whom English is often the second or third language.'
>
> – National Council of Women of New Zealand

Medical specialists, including geriatricians, psycho geriatricians

122. References in the Strategy to shortages of geriatricians and other medical specialists were endorsed. It was pointed out that those currently occupying such positions are prone to burn-out. The specialist workforce was described as especially vulnerable because of our heavy dependence on international medical graduates, particularly in an environment of international specialist shortages.

123. The action in the Strategy to develop a range of strategies to improve recruitment and retention of those working in aged care was supported, with one submitter noting that such strategies would need to prioritise addressing senior doctor shortages across a comprehensive range of specialties.

Allied health workforce

124. There was support for the Strategy's aim of making better use of allied health workforces such as occupational and speech language therapists, dieticians and physiotherapists. It was noted that the skills of all parts of the workforce, including allied health, needed to be fully utilised to improve health and wellbeing for older people.

125. Some submitters emphasise that allied health workers need to be treated as integral and equal participants in multi-disciplinary care teams. This would include sharing information about patients.

126. One submitter suggested that access to allied health assessment, advice, aids and equipment to maintain independence should not be limited to after-hospital discharge but should be linked to a Needs Assessment and Service Coordination service (NASC) / interRAI assessment for people who are experiencing early decline in independent function or cognitive impairment.

Pharmacists

127. There was strong support for the Strategy's aim of making better use of pharmacists' expertise. Submitters commented that pharmacists are often an early contact point for people with health issues; they already play a triage and early referral role and need to be linked to the rest of the health care team and to electronic information sources (eg, a shared EHR) to make full use of their skills.

> 'Community pharmacists and other healthcare professionals are seen most often, they are the first point of contact into the primary healthcare system for the majority of health consumers.'
>
> – Pharmacy Guild of New Zealand

Topics relating to the 'Support for people with high and complex needs' outcome area

Family and whānau caring for older people

128. There was support for the Strategy's goal of building the resilience and capability of family and whānau, volunteer and other community groups supporting people with high and complex needs, as well as those with end-of-life care needs.

129. The majority of those providing comment under this heading wanted the Strategy to signal an increase in respite care (access to paid relievers who can give family and whānau caring for older people 'time off' to do other things). Some submitters also referred to the need for more training for family and whānau in caring roles.

Frailty

130. The Strategy's focus on reducing frailty in the community was supported. There was also support for using a frailty identification tool. A number of submitters suggested that such tools are already available, with several mentioning a function in interRAI. They considered that the priority is building responsiveness to frailty rather than exploring the best use of an identification tool.

131. Some submitters thought that frailty should be defined as a long-term condition; others thought that an agreed definition of frailty was required. Issues relating to establishing of effective and evidence-based measures of frailty were noted.

Long-term mental illness and addiction

132. There was support for the Strategy action to improve physical and mental health outcomes of older people with long term mental illness and addiction. It was noted that people with mental illness experience significantly higher rates of premature mortality and morbidity. This is due to reduced access to health care relating to stigmatisation, discrimination, diagnostic overshadowing (where problems are attributed to intellectual disability and health and mental health conditions are overlooked and not treated), and poor management of their physical co-morbidities.

133. Submitters endorsed the goal of improving the detection of long-term conditions, particularly in relation to mental health and addiction. One submitter recommended giving this goal higher priority and improving the capacity to measure progress in reducing the gaps in health care access and delivery for people with these conditions.

134. Submitters also recommended supporting and developing a medical workforce to manage older people with dementia, complex and co-morbid presentations, including mental disorders and addiction. Research indicates that increasing older people's access to specialists, such as geriatricians and psychiatrists, reduces hospital admissions and improves health outcomes.

> '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.'
>
> – Royal Australian and New Zealand College of Psychiatrists

Integrating services for people living in aged residential care

135. There was support for the Strategy's goal of better integrating services for people living in aged residential care. This is a significant area of work that is complicated by the variety of models of primary health care provided to ARC residents after hours, the complexity of funding arrangements between ARC and primary health care providers, and challenges of sharing care records (eg, between ARC records, pharmacy, primary health care, after hours teams, etc). Suggestions for achieving this goal included:

- developing standard referral and discharge protocols between ARC facilities, pharmacists, primary health care (including providers of after-hours services and medicines advice), ambulance and hospital services

- exploring options for providing telephone advice and triage for ARC facilities, especially after hours
- ensuring systems, resources and training are in place that allow ARC facilities to communicate with and involve family and whānau at the point of discharge from hospital or where urgent care is needed
- exploring options for ARC facilities to become providers of a wider range of services to older people, including non-residents
- integrating and align pharmacist services contracted to ARCs
- ensuring that discharge summaries from hospital and ARC facilities are accessible to community pharmacists
- encouraging the sharing of electronic health records.

136. Submitters supported the Strategy's aim of ensuring the use of models of care that improve medicine management for older people living in their own homes or ARC facilities and suggested other areas where the use of new models of care should be explored, including in ARC facilities, to improve the residents' quality of life and possibly introduce shorter hospital stays and discharge back to home after an extended period of focused rehabilitation.

Navigators

137. Submitters reminded us that people with high and complex needs are often the clients of multiple government agencies, which may not coordinate support or share information as well as they could. This can also result in equity of access issues, as people with high and complex needs or those responsible for them need to deal with multiple services and agencies.

138. A number of submitters supported providing navigators to assist older people, particularly those with high and complex needs, to find their way through a complex health and social services system. Those who would benefit from access to navigators include people with cognitive impairment or dementia and their families, people with long-term conditions, Māori and Pacific peoples. It was noted that navigators need to be trained and to receive adequate remuneration. Successful examples of navigator services in New Zealand (including the Whanganui DHB's Haumoana service) and overseas were identified.

139. One submitter recommended that all DHBs be required to include navigator roles in their cognitive impairment or dementia pathways.

> 'We note Whanganui District Health Board's report on a successful innovation: the Haumoana (navigator) service introduced to support families and staff, 24 hours, 7 days a week. The service provides support to families as they navigate their way through the DHB services and links them with community providers on discharge.'
> – Retirement Policy and Research Centre, University of Auckland Business School

Topics relating to the 'Respectful end of life' outcome area

Educating the community for a respectful end of life

140. There was a high level of support for promotion of planning and education for the end of life. It was widely agreed that people needed to understand, talk about, prepare for and accept the end-of-life process as something natural and inevitable. Submitters thought that at present, community attitudes meant that this ideal was not being achieved.

Advanced care planning, enduring power of attorney, Protection of Personal and Property Rights Act 1988

141. Most feedback we received on this topic area supported the Strategy's actions to increase awareness about and use of ACP and EPOA. These actions should cover not only the public but also health professionals and attorneys. A number of submitters thought that people should be made aware of these facilities earlier, well before they need to be implemented. Submitters also agreed that cost was currently a barrier to greater use of EPOA, and that the Strategy needed to address this. There are proposals to amend the Protection of Personal and Property Rights Act 1988 to make EPOA simpler to use.

142. One submitter wanted a consistent and streamlined process for appointing a welfare guardian and/or property manager or administrator where there is no EPOA, including access to an adequate pool of paid or voluntary welfare guardians, managers or administrators.

143. Not all submitters supported greater use of EPOA. It was suggested that the case has not been made for the effectiveness of EPOA in Māori, Pacific and Asian communities. One submitter noted that making the use of EPOA mandatory would be discriminatory.

144. Some submitters thought that there should be a database of ACP and EPOA, to ensure that the relevant people are involved when the individual concerned is unable to participate in discussions around care.

> 'People with a long-term condition need to control, plan and articulate choices about their current and future care, treatment and setting early rather than at a time of complexity and/or crisis later in their trajectory and possibly when they are no longer able to make critical choices.'
>
> – Hospice New Zealand

A workforce trained to support a respectful end of life

145. We received feedback on the need to address the shortage of health professionals with specialist palliative care training and provide training for end of life across relevant disciplines in the health system. Some submitters commented that the work and outcome of the current review of adult palliative care services needs to inform the Strategy.

146. Some submitters spoke of a lack of consistency in the quality of palliative care between different providers.

147. Submitters cited successful initiatives in palliative care training in Australia and the United Kingdom.

148. Submitters also identified a need for all health workers, particularly GPs, to be trained in advance care planning and in how to communicate with individuals and their families and whānau about providing care that meet the individual's cultural, emotional and spiritual needs and preferences. People supported the need to spread palliative care skills across the broad workforce.

149. Submitters told us that the Strategy needs to allow for different cultural approaches to what constitutes a respect for end of life and including family and community in end of life care and decision making. Some submitters felt that the Strategy lacks a specific vision for a respectful end of life for older Māori.

Bereavement support for carers

150. Some submitters suggested that the health system does not adequately support family and whānau after the death of the person they have been caring for, and that the Strategy needs to address this.

Topics relating to implementation, measurement and review

Implementation plan

151. Many submitters commented that individual actions in the Strategy's action plan were short on practical detail. The Strategy provides for the early development of an Implementation Plan that would include more details about actions. Some submitters acknowledged this but thought that the Strategy document itself needs to include more detail about individual actions.

Resourcing the Strategy action plan

152. Many submitters who supported other aspects of the draft Strategy – the vision statements, the analysis of issues, and/or the proposed actions – commented that the action(s) in question could only be given effect if the government was prepared to commit sufficient resources to it. In particular, they considered that the action plan can only be successfully implemented if there is the necessary workforce capability and an integrated response from those funding and providing services.

> "I think these ideals are sound but wonder just how they would be delivered or are they just going to be another 'policy'."
>
> – Individual submitter

People-centred, people-powered: Involving stakeholders in designing, implementing and monitoring the action plan

153. We received feedback supporting the Strategy's person-centred approach, which is important for people with all kinds of health conditions, including those with dementia and other forms of diminished capability. One submitter supported a person-centred approach but linked it to the use of IT and other technologies, with the associated risk that less 'tech-savvy' people might miss out on the benefits of person-centredness.

154. The point was made that all types of staff involved in the care of older people need to be appropriately trained for a person-centred approach to succeed.

155. Many submitters emphasised the importance of involving consumers, family and whānau, those involved in providing care and NGOs in developing the detail of service design; in deciding how the Strategy will be implemented; and in monitoring progress. The engagement of older people in the design, implementation and monitoring phases needs to be inclusive and include the perspectives of people with all types of disabilities, Māori and Pacific peoples, vulnerable people and people living in rural and remote locations.

Quality of services

156. Some submitters were concerned about the quality of the health and related services provided to older people. They linked quality of services to staff training and remuneration, with inadequate training and remuneration being likely to result in poor service quality either directly or as a result of high staff turnover.

157. The need to ensure that services are of adequate or better quality was raised as an issue specifically in relation to dementia and delirium. One recommendation was that New Zealand needed to improve its data on dementia, in order to better enable planning, funding, monitoring and quality improvement. Another observation was that the Ministry could help improve delirium care by raising medical staff and the public's awareness of the condition and by providing incentives to promote research, quality improvement and better collaboration between stakeholders.

> '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.'
>
> – Health Quality & Safety Commission

Commissioning and contracting

158. A number of submitters discussed provisions in the Strategy for approaches to purchasing services that enable further local flexibility and choice, while retaining national consistency. Comments included:
    - the need to ensure that contracts fund not-for-profit providers sufficiently to enable them to invest in the necessary training, systems and tools
    - the importance of having a strong and sustainable NGO sector (with the sector being described as vulnerable and struggling to secure reliable and sustainable funding and therefore staff)

- the need to consider arrangements other than contracting to support a sustainable health sector delivering quality services
- the importance of using a consistent commissioning practice and matching needs assessments to resource allocations.

159. Some submitters questioned whether DHBs' current approach to contracting services is working for providers and clients. They cited the recent New Zealand Productivity Commission report as supporting the use of a range of approaches to commissioning health and social services.

160. One submitter thought that centralised contracting and monitoring would ensure that services are being provided to consistently high standards nationally.

161. Some submitters were concerned that more extensive contracting of services could have adverse impacts for provider staff, for example in terms of training, staff levels, and remuneration.

Outcome and measurement framework

162. There was support for basing measurement of the implementation of the actions in the Strategy on an outcomes framework.

interRAI[3]

163. There were numerous references to interRAI in submissions. Submitters supported the Strategy's interRAI-related action and suggested that more use should be made of the interRAI suite of assessment tools (eg, the interRAI Quality of Life tool).

164. Some submitters suggested that the Strategy does not demonstrate an understanding of the potential for interRAI data to inform service development and delivery and, at present, interRAI data is not being used effectively by clinicians in the day-to-day care of older people, particularly in ARC facilities. They considered that interRAI systems and processes are user friendly for clinicians or integrated and proposed an additional action to improve the user interface with interRAI.

> 'interRAI data should be considered a key component of service development – it has been developed not only as a means of assessing, but to capture all relevant information at client and aggregated level, at the point of care delivery.'
>
> – Central Region Technical Advisory Services Ltd

Research

165. There was support for the Strategy action in relation to the New Zealand Health Research Strategy, and also widespread agreement that the Strategy needed to be evidence-based. Individual submitters suggested that more research is needed into specific issues, including:

[3] interRAI = International Resident Assessment Instrument (comprehensive clinical assessment for aged care needs).

- aspects of the dementia experience
- factors in caring activities that generate dependency and create isolation
- primary and secondary eye care for older people
- workforce data to inform workforce planning
- the cultural requirements of different people/groups to find the most culturally appropriate methods for holding advance care planning-type information within the whānau (kinship group)
- reducing acute admissions
- aspects of elder abuse involving ethnic people
- why people tend to die in hospital and in care facilities rather than at home
- assistive technology and the ethical implications of its use.

166. One submitter suggested that the Strategy's proposed action of promoting research about social isolation is unnecessary; rather, what is needed is funding for successful models.