Summary analysis of submissions received on the draft

Health of Older People Strategy

Health Sector Action to 2010 to Support Positive Ageing

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Introduction

Consultation

The draft *Health of Older People Strategy* was released for public comment on 27 September 2001. The consultation period was to have closed on 9 November, but following representation additional meetings were held, the last being a forum group for Pacific peoples on 7 December. The last written submission was received on 3 January 2002.

Analysis

Comments on the strategy were extremely wide-ranging and comparatively detailed with few consistent themes emerging. This report provides a summary of the major themes that arose in the analysis of the submissions. Given the wide range of comments a degree of judgement has been used in grouping together comments that implied similar points of view.

Submissions

Comments on the draft Strategy for the Health of Older People were obtained in a variety of ways. Over 400 people attended one of 10 public meetings, three hui, three fono or two focus groups (one for Māori and one for Pacific service providers). The outcome of each of these meetings has been treated as a separate submission. There were also 113 written submissions. The majority of these (77) were on behalf of organisations. The remainder (36) were individual responses.

At most public meetings people were asked to comment on three broad questions:

- Are the objectives and actions in the strategy the right ones?
- Are there any gaps?
- What barriers do you see to implementing the strategy?

Written submissions could be provided in a variety of forms. Only 12 respondents chose to use the electronic submission form provided on the Ministry of Health website. Approximately half of the submissions used or closely followed the format set out in 'Questions to Guide Making a Submission' in the draft strategy. Most of the written submissions that did not follow this format were focused on particular aspects of the strategy.

The Vision Statement

The vision statement was generally well received. Fifty-nine of the 62 respondents who commented on the vision, supported, or were in general agreement with, the vision statement.

In particular, the holistic nature of the vision was supported. It was suggested that the vision incorporate non-medical aspects of older people's health including mental, physical, social and spiritual dimensions.

A small number of submissions suggested that the vision statement was too broad and a number of issues or groups were highlighted for specific inclusion, for example 'older people with disabilities'.

A few submissions suggested that the vision should focus more on empowering older people and encouraging participation. One submission considered the vision did not 'clearly involve older people as partners' and needed to be linked more with the positive ageing vision.

The Principles

The principles were also well supported. Sixty-five submissions commented on the principles. Twenty-four submissions supported the principles without further comment. Another 20 supported them, but suggested some amendment.

Several submissions suggested that the principles included insufficient recognition of gender differences.

Several submissions requested additional principles covering specific topics, such as empowering older people, consulting older people, equitable access, mental health and spiritual development.

Principle 11 – Being affordable to the individual and the state, attracted the most comments, the majority of which expressed concern about interpretation of the term 'affordable'.

Objectives

Fifty-four written submissions and all public meetings made general comments on the objectives. Most were positive, but several either queried their achievability, the timeframe, or made suggestions for amendments or additions. Comments have been grouped under the headings of general comments, gaps/lack of emphasis in the strategy and limitations of the strategy. The final section includes comments on each objective.

General comments

The timeframes for implementation were commented on by a significant number of respondents. Most respondents applauded the inclusion of timeframes in the strategy. However, opinion was divided as to whether they were generally too long or too ambitious.

There is concern about funding: where it will come from and whether the objectives can be achieved without new funding. How objectives/services would be prioritised was a common question.

Four submissions suggested that the strategy would require an 'all political party buy-in', especially as some timeframes run up to 2010.

It was suggested that there were weaknesses in accountability mechanisms. The way in which the strategy would be translated into action at District Health Board (DHB) level was also questioned. It was suggested that practical implementation will require Ministry of Health leadership and evaluation/ monitoring. Regular reviews of the strategy and a flexible approach to future strategic planning were requested.

Seven submissions pointed out that successful implementation of the strategy will require good intersectoral service collaboration. Several other submissions implied a similar point of view in response to Objectives Five and Six.

The ‘Examples of Initiatives’ boxes within each objective received support, although several additional initiatives were suggested, and a number of changes were recommended.

Gaps/areas with a lack of emphasis

A large proportion of submissions highlighted perceived gaps in the strategy or areas that they believed should receive greater weight in the final document.

Eight submissions requested a stronger focus on consumers, independence and positive ageing (possibly a separate objective pulling together actions relating to informing and empowering older people to make informed decisions about their own health and to participate in planning decisions that affect their health).

Several submissions suggested that the strategy should be less medically focused, and should incorporate a greater acknowledgement of the social determinants of health, including spirituality. This includes additional recognition of the importance of lifestyle and health decisions earlier in life for health in older age; the need for life-long health promotion and personal responsibility were highlighted.

Five respondents requested greater gender analysis and identifying key issues for both women and men.

Fourteen submissions made the comment that the strategy should recognise the needs of older people from other ethnic groups (eg, Asian and Middle Eastern, as well as refugees and migrants).

Participants in the fono for Pacific peoples made a strong plea for more ethnic health workers, educators and trainers to work with Pacific peoples in the relevant Pacific languages. This included health promotion and health service information being available in at least the six main Pacific languages for it to be accessible to Pacific peoples, particularly Pacific elders. Pacific peoples also need to be involved in service planning and development within their communities. One group proposed including a separate objective for Pacific issues within the strategy.

Other groups requiring greater recognition in the strategy were:

- family and whānau (in particular, the need for more support, including financial support)
- carers and caregivers
- volunteers and volunteer groups
- older people with disabilities
- older people in rural areas.

A greater emphasis on mental health and integrating mental health with personal health and support services (possibly a separate objective focusing on mental health and dementia) was requested by a number of respondents.

A greater recognition of some specific health issues for older people, including dental care, vision and hearing loss, strokes and dementia was also requested.

Three submissions suggested that there should be more emphasis on equitable access to services and nationally consistent standards.

Limitations

A significant number of respondents (five) suggested that there is an apparent lack of consultation with older people in the development of the strategy, and a lack of a consumer representative on the expert advisory group.

A smaller number of submissions expressed concern about the complexity of the document and that the strategy needs to be more accessible to older people. A simpler, more concise version for general public distribution may be required.

Seventeen respondents raised concerns about confining the strategy to people 65 years of age and over. The main concerns were the significant numbers of Māori and Pacific peoples under the age of 65 with high health and support needs who also need better access to, and co-ordination of, services. Eight submissions suggested that need rather than age should determine access to services.

Comments on each objective

Objective One – Policy and service planning will support the development of quality health and support services integrated around the needs of older people

Eighty-two submissions commented on Objective One, the majority of which focused on Action 1.4 – Workforce issues. It was widely agreed that workforce development is a significant issue, and there was general support for the way it is dealt with in the strategy.

There was a clear consensus that there is a need to raise the profile of the older people's health workforce. There is a need for greater recognition of gerontology specialists, for greater remuneration and improved working conditions. Educational bodies need to be involved along with DHBs and the government, in planning for and implementing changes to develop health and support services for older people.

A number of submissions suggested that older people's health needs to be adequately covered in basic training for all health professionals, including changing ageist attitudes, particularly towards people with delirium, dementia or communication difficulties. Many educational courses place older people's health at the beginning of the syllabus, which may reduce students' perception of the importance of the area.

Several submissions focused on particular groups of the workforce that need increased training and resources for working with older people. Specifically mentioned were residential care workers, home support workers, GPs and other health professionals with periodic contact with older people. There is also a need for training for family, whānau and volunteers.

The retention of rural health workers is a problem that was frequently mentioned.

There was divergence of views on the merits of nurse prescribing. Some were opposed to what they considered to be a nurse replacing a doctor; others saw it as a key step in addressing recruitment and retention of clinical specialists in rural areas.

A smaller number of submissions made comments on other actions in Objective One. Seven submissions offered suggestions for the proposed conference.

Seven submissions also referred to the need for DHBs to consult with older people when developing their plans.

The need to collect good data was generally well supported, and 18 respondents commented on problems with existing databases, the cost of data collection, what data should be collected and the need for good data.

Several submissions commented on the importance of developing a workforce that is more responsive to the needs of older Māori and Pacific peoples.

Objective Two – Funding will be managed and services delivered to promote timely access to quality integrated health and support services for older people, family, whānau and caregivers

The majority of comments on Objective Two were in response to Action 2.1 – Funding for older people's health. Eight submissions stressed the urgent need for a review of the current funding structure and highlighted inequities in the present system. Six respondents suggested that the review should be based on thorough analysis and widespread consultation.

There were conflicting opinions on ring-fencing funding for older people. Seven submissions were in favour of that kind of funding. However, two respondents were cautious about separate funding, citing the creation of new gaps within service provision as a potential outcome.

Nine submissions commented on the funding of long-term care and rest homes. There was disagreement about whether asset testing for residential care should be removed, with two submissions supporting removal and two cautious about its removal.

Six submissions pointed out that additional resources will be required to achieve this objective, especially in the initial stages, and some questioned where those resources would come from.

Thirteen submissions also expressed support for Action 2.2 – The development of a comprehensive specialist needs assessment process. It was generally agreed that the assessment procedure needs to be intersectoral and multidisciplinary in format. Several submissions specifically mentioned that assessment must take into account the older person's social and medical needs as a whole. A few submissions also suggested that a single, national assessment tool was necessary.

The review of specialist mental health services for older people was supported and several respondents highlighted the chronic lack of mental health specialists in New Zealand. It was suggested that this would be a barrier to the successful implementation of this action.

The provision of information on health and support programmes and services was specifically targeted as a critical area of importance. Another frequent comment was that the way in which information is communicated would be crucial. Radio, church groups, marae and websites were all suggested.

Several submissions were also supportive of Action 2.6 – Increasing collaboration with the Accident Compensation Corporation (ACC).

Objective Three – The hauora needs of older Māori and their whānau will be met by appropriate health and support programmes and services that recognise and support the unique position of Māori living in Aotearoa as Māori

The treatment of Māori health issues in the strategy was generally well supported. As mentioned earlier, a significant number of respondents pointed out that Māori (and Pacific peoples) tend to develop conditions associated with older age earlier than age 65.

Eight submissions highlighted the need for more trained Māori health professionals, including Māori community and whānau workers. Others commented on the need for development opportunities to be made available to caregivers.

Seventeen submissions focused on the need for services to develop specific strategies for supporting older Māori. Examples included:

- the co-location of mainstream health services on the marae
- programmes that encourage social interaction and positive ageing, such as meals on the marae rather than the traditional 'meals on wheels'
- community, respite care and residential care options for older Māori that are initiated and run by Māori and which include Māori aspects of physical, psychological and social realities in assessment processes.

Five submissions commented on funding issues. Key points included:

- the need for clarity about the level of service the Government can afford
- capacity building
- sufficient government funding for successful service provision and access to culturally appropriate mainstream and Māori provider services.

Education, especially at a young age, and adequate, culturally appropriate information are imperative if the health of older Māori is to improve.

The health of older Māori living in rural areas was of particular concern to a number of respondents. Key issues included:

- the lack of specialist services
- the poor availability/high cost of transport to services
- the lack of support services
- the lack of information.

Objective Four – Public health initiatives and programmes will promote health and wellbeing in older age

Seventy-six submissions commented on Objective Four. Twelve of these expressed unequivocal support for the action. However, several submissions thought that the strategy should include a greater emphasis on, and more initiatives to promote, the concept of positive ageing and retaining independence. Two submissions considered that the concept of personal responsibility for health should be actively promoted.

Seven submissions also suggested that health education and promotion should begin at a young age and should continue throughout life.

A further seven submissions questioned where resources would come from and the way in which initiatives would be prioritised in relation to this objective. One submission considered that the primary aim of preventive measures should be to improve the health and wellbeing of older people and it is important that they are not required to be cost-saving.

The inclusion of the nutrition of older people in the strategy was generally supported, especially the initiative to improve labelling of food for older people, although one submission pointed out that initiatives to increase the consumption of fresh fruit and vegetables would be better. Several submissions stressed the close relationship between good nutrition and dental health, and a number of others cited the higher cost of healthy food as a barrier to good nutrition in older people.

Four submissions welcomed the intention to support community initiatives that may reduce depression and social isolation, but pointed out that such programmes rely on volunteers and are underfunded. Lottery Aged funding is contestable every year, which makes it difficult for groups to plan ahead. The details of several other initiatives that may help reduce depression and social isolation were provided.

Twenty-one submissions commented on Action 4.4 – Reduce falls. The majority of these highlighted the major factors that caused falls or outlined initiatives (many evidence-based) to reduce the number and impact of falls. Initiatives included hip protectors, Tai Chi programmes or classes, muscle strengthening and balance retraining (home-based) and home hazard assessment and modification.

Fifteen respondents commented on transport issues. In particular, the lack of accessible transport for people in rural or isolated areas was highlighted, and the suggestion made that the problem needed to be addressed urgently.

Objective Five – Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning

Seventy-one submissions included comments on Objective Five. The majority were supportive of this objective and associated actions. Several respondents highlighted a range of health promotion issues that they would like to see emphasised more, including:

- vision loss
- influenza immunisation
- dental care
- spirituality
- nutrition.

Several of the submissions that supported the objective expressed the view that the emphasis must be on preventive health measures rather than reactive initiatives.

Four submissions suggested that screening for dementia should be promoted – that it should be carried out earlier than age 65 and that the age of eligibility for free breast screening should be extended beyond 65.

Seven submissions made the comment that service co-ordination is crucial to the success of this strategy. However, there was a lack of consensus about who should perform the service co-ordination role. The use of information technology to support greater communication between services was considered to be a key ingredient.

The aim of reducing cost barriers for primary health care, proposed in Action 5.3, received strong support. Five submissions identified the cost of medications as a barrier that needs to be reviewed. The same number of submissions welcomed the review of the Community Services Card system.

Eleven submissions suggested that access to primary health care is not the only concern for older rural people and that the strategy does not give enough weight to the issue of rural versus urban needs. Several submissions suggested that access to health care is inequitable for people in rural areas.

Objective Six – Hospital services will be integrated with any community-based care and support that an older person requires

Sixty-seven submissions included comments on Objective Six. The majority were in support of the objective, although Action 6.4, the provision of intermediate care, attracted some criticism.

Ten submissions supported the assessment of options for intermediate care, although three suggested that the 2006 timeframe is too late. Ten submissions were not in favour of intermediate level care as outlined in the strategy. A clearer definition of intermediate care was sought, as it was not clear if this meant step-down convalescence or something similar. Respondents advised a degree of caution when examining the UK example.

Four submissions highlighted the risk of 'client capture' when rehabilitation is undertaken in residential care, and stressed that measures should be put in place to ensure residential homes do not retain patients for financial incentives.

Seventeen submissions commented on the process of patient discharge and discharge planning with the majority of them suggesting that improvements to the discharge planning process are urgently required. Patients returning home to poor conditions was identified as a major problem.

Twelve submissions commented on Action 6.1, the review of specialist services for older people. It was suggested that access to dietetic services, gerontological clinical nurse specialists and palliative care specialists be included under this action. Two submissions considered that widespread consultation needed to be part of any planning for specialist services for older people.

Objective Seven – Flexible, timely co-ordinated services will provide older people, their caregivers, family and whānau with a wider range of support options

Seventy submissions included comments on Objective Seven. The most common comment was that older people should have a range of choices of residential care and that this should be considered in future planning for residential care development. Six respondents made recommendations for the provision of long-term care for older people, including the Abbeyfield housing model, day care and residential care services that are dedicated entirely to respite care. Several submissions made the point that the focus of long-term care should be to provide the best quality of life, which is often not the case due to a lack of funding.

Five respondents were concerned that the strategy outlines the development of quality standards for residential care but there is no such plan for home care, community care or non-dementia services. A small number of respondents were also concerned that the quality standards that are to be developed will partially duplicate existing standards or current Ministry of Health work.

Greater emphasis on the role of caregivers (especially family caregivers) was recommended in the strategy. Three submissions suggested new solutions to the problem of inadequate carer support.

Twelve respondents suggested that funding for caregivers and payment of carers, whether family or not, is insufficient at present and should be increased. A review of current funding policy was requested.

Four submissions commented that resources for providing palliative care or using palliative approaches to care for older people are inadequate. Problems have arisen from the failure to integrate palliative care into health and disability services.

The recognition in the strategy of abuse of older people as a growing problem, particularly in rural and isolated areas, received strong support.

Other Comments on the Strategy

Respondents were invited to make any other general comments on the strategy. These included specific issues such as:

- the provision of services for the group of people under 65 years of age with chronic conditions
- any additional initiatives to integrate health and support services for older people.

Comments were made on the monitoring and supporting change, and glossary sections of the document.

Chronically ill under 65

Nine submissions suggested that it is important that care for this group of people is not contained within older people's services. Placing younger people requiring residential care in residential facilities for older people was considered inappropriate.

Eight submissions recommended that this group of people should have similar access to services regardless of age. The definition of 'older person' should be determined by need rather than on a chronological basis.

A similar number of respondents suggested that service delivery should be flexible enough to meet the needs of this group of people. The document should acknowledge that there is a group of people over 65 years of age who have disabilities and a group of people under 65 who require services similar to those for older people.

Additional initiatives to integrate health and support services

Thirteen additional initiatives were recommended for inclusion in the strategy, although none of them were recommended more than once. There were also a number of comments on the examples of initiatives included in the draft document.

Monitoring and supporting change

There were few comments on this section of the document. However, several submissions agreed that monitoring the strategy is an important step towards successful implementation.

Three submissions recommended specific areas for research, including:

- delaying the onset of disability in older people
- emotional and spiritual dimensions of health
- training schemes to facilitate workforce research.

Glossary

There was general agreement that more key terms need to be defined in the glossary (eg, holistic – does it include spiritual aspects of health?).