

# **Health of Older People Strategy**

## **Health Sector Action to 2010 to Support Positive Ageing**

**Draft for Consultation**

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# Contents

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Foreword .....	vii
How to Have Your Say .....	viii
Questions to Guide Making a Submission .....	ix
Executive Summary .....	xi
Introduction .....	1
Overview .....	1
Need for a strategy .....	2
Who the strategy is for .....	5
The Treaty of Waitangi and the health of older Māori .....	5
Scope of the strategy .....	6
Health and support services for older people in 2010 .....	8
The Strategy .....	9
Vision .....	9
Principles .....	9
Objectives .....	10
Objective 1: Policy and service planning will support the development of quality health and support services integrated around the needs of older people.....	11
Objective 2: 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 .....	16
Objective 3: 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 .....	21
Objective 4: Public health initiatives and programmes will promote health and wellbeing in older age.....	23
Objective 5: Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning.....	32
Objective 6: Hospital services will be integrated with any community-based care and support that an older person requires .....	38
Objective 7: Flexible, timely co-ordinated services will provide older people, their caregivers, family and whānau with a wider range of support options .....	44

Monitoring and Supporting Change .....	51
Monitoring and evaluating progress .....	51
Research and information needed .....	51
Glossary .....	53
Appendix 1: Key Factors in Successful Integration .....	57
Appendix 2: Draft Timeline for Implementing Health of Older People Strategy Actions ...	59
Appendix 3: Members of the Expert Advisory Group and the Sector Reviewers .....	63
Appendix 4: Relevant Government Strategies .....	65
Health of Older People Strategy and other strategies .....	65
New Zealand Positive Ageing Strategy .....	66
New Zealand Health Strategy .....	66
New Zealand Disability Strategy .....	67
He Korowai Oranga Māori Health Strategy Discussion Document .....	68
Draft Pacific Health and Disability Action Plan .....	68
Primary Health Care Strategy .....	69
New Zealand Palliative Care Strategy .....	70
Looking Forward: Strategic Directions for the Mental Health Services .....	71
Appendix 5: Demand for Health and Support Services .....	72
Population ageing .....	72
Health care and disability support costs .....	76
Service utilisation .....	76
Level of disability .....	79
Health status .....	80
Mortality rates for Māori and Pacific peoples .....	81
Issues for women .....	84
Socioeconomic inequality .....	84
References .....	85

## Figures

Figure 1: Projected New Zealand population 65+, 75+ and 85+ as a percentage of the total population, 1996–2051 .....	3
Figure 2: Functional capacity over the life course .....	4
Figure 3: Sources of support for older people .....	7
Figure 4: Range of support options for different levels of need .....	45
Figure A1: Relationship between strategies .....	65
Figure A2: Projected population pyramids for New Zealand in 2001 and 2051, by five-year age groups .....	73

Figure A3:	Projected population pyramids for Māori in 2001 and 2051, by five-year age groups .....	74
Figure A4:	Projected Māori population 65+, 75+ and 85+ as a percentage of the total Māori population, 1996–2051 .....	74
Figure A5:	Projected population pyramids for Pacific peoples in 2001 and 2051, by five-year age groups .....	75
Figure A6:	Projected Pacific peoples population 65+, 75+ and 85+ as a percentage of the total Pacific peoples population, 1996–2051 .....	75
Figure A7:	Estimated per capita expenditure on health and disability support services, by age group and sex, 2001/02 .....	76
Figure A8:	GP utilisation per capita, by age group and sex, 1998/99 .....	77
Figure A9:	Medical and surgical hospital discharge rates per 1000, by age group and sex, 1999/00 .....	78
Figure A10:	Discharge rates and costs per capita for AT & R hospitalisations, by age group, 1999/00 .....	79
Figure A11:	Prevalence of disability, by age and severity level, 1996/97 .....	79
Figure A12:	Residential distribution of people aged 65 and over, by disability status, 1997 .....	80
Figure A13:	Mortality rates for people aged 55 to 64, by ethnicity and cause group, 1996–98 .....	82
Figure A14:	Mortality rates for people aged 65 to 74, by ethnicity and cause group, 1996–98 .....	83
Figure A15:	Mortality rates for people aged 75+, 1996–98 .....	83

## Tables

Table A1:	Actions for completion by July 2003 .....	59
Table A2:	Actions for completion by end of 2006 .....	61
Table A3:	Actions for completion by end of 2010 .....	62
Table A4:	Life expectancy at birth and at age 65 .....	81

# Health of Older People Strategy

## Vision

Health and support services and programmes will facilitate the wellbeing of older people, their control over their lives and their ability to participate in and contribute to social, family, whānau, and community life.

## Objectives

1. Policy and service planning will support the development of quality health and support services integrated around the needs of older people.
2. 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.
3. 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.
4. Public health initiatives and programmes will promote health and wellbeing in older age.
5. Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning.
6. Hospital services will be integrated with any community-based care and support that an older person requires.
7. Flexible, timely, co-ordinated services will provide older people, their caregivers, family and whānau with a wider range of support options.

# Foreword

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New Zealand, like most other countries in the world, has a population that is ageing. From around 2010 the number of older people will start to grow more quickly as the baby boomers enter retirement. We want sustainable health and support services that can meet the needs of current and future generations of older people and support them to age positively. That means starting to plan those services now, so that the structures and funding are in place by 2010.



The Health of Older People Strategy sets out Government's policy for the future direction of health and support services for older people. It identifies the need for significant change in the way health and support services are provided for older people. Some changes that need to occur right now are:

- improved co-ordination of health and support services around the needs of older people
- a greater emphasis on health promotion and disease prevention to assist older people to age positively
- planning for culturally appropriate services to meet the needs of rapidly increasing numbers of older Māori and Pacific people from 2010
- more emphasis on community-level health care and support services to support older people to 'age in place'.

Refocusing health and support services in this way is essential to make the best use of the funding available for these services.

In developing the Health of Older People Strategy, we are following in the footsteps of other countries that have undertaken national planning for health and support services for their older people, including the United Kingdom and Australia.

The draft strategy provides a framework for the changes we need to make to provide the health and support services we want for our older people. Making the strategy a reality calls for the Ministry, District Health Boards, health professionals and all with an interest in health services for older people to work together to make the changes we need by 2010.

The Government is seeking feedback on the proposals outlined in this document. I encourage you to comment on this draft strategy.

Hon Ruth Dyson  
Associate Minister of Health and  
Minister for Disability Issues

# How to Have Your Say

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This draft strategy is being distributed to health service providers, representatives of the health sector workforce, government agencies, older people and community and voluntary organisations with an interest in older people's health and support issues.

This document is also posted on the Ministry of Health's website. A large print version is available on request from Pam Fletcher (contact details below).

You can provide comment by making a submission on your own behalf or as a member of an organisation. Submissions can be made:

by completing the submission form via the Internet at:  
[www.moh.govt.nz/hopstrategy](http://www.moh.govt.nz/hopstrategy)

or

by writing or emailing your comments, using the guide for making a submission that is provided on the next two pages.

All submissions received will be available under the Official Information Act 1982. If you are an individual (as opposed to an organisation), the Ministry will omit your personal details from the submission if you include the following statement at the front of your submission

'I do not give permission for my personal details to be released to persons requesting my submission under the Official Information Act 1982'.

Submissions should be sent to:     Draft Health of Older People Strategy  
   Personal and Family Health Directorate  
   Ministry of Health  
   PO Box 5013  
   Wellington  
   Fax: (04) 496 2340

The closing date for making a submission is 9 November 2001.

If you have any queries please contact Pam Fletcher at the Ministry of Health, at the above address, by phoning (04) 496 2316, or by emailing [pam\\_fletcher@moh.govt.nz](mailto:pam_fletcher@moh.govt.nz)



# Questions to Guide Making a Submission

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## Question 1

This draft Health of Older People Strategy sets out a vision and principles to guide the future development of health and support services for older people.

Do you agree with the suggested vision and principles? Are they appropriately focused on the needs of older people? Are they appropriately focused on the different needs of older women and older men? Do you think any principles should be deleted or others added?

## Question 2

This draft strategy identifies seven objectives for improving the planning, funding and provision of health and support services for older people.

Do the objectives, in total, cover all the areas that need to be improved? Are they appropriate for achieving greater co-ordination across the range of services that older people use (for example, primary health care, public health and health promotion, hospital care, mental health, community-based and long-term care services)? Are there objectives that should be added or replaced?

## Question 3

This draft strategy proposes actions and key steps for the Ministry of Health and District Health Boards to take between 2001 and 2010.

Are there other actions or key steps you think should be included? If so, what actions and key steps and why? Are the timeframes, where specified, realistic?

## Question 4

In addition to identifying issues that apply to all older people, the draft strategy identifies particular issues for older Māori and, where appropriate, particular issues for Pacific peoples.

Do you agree with the issues and actions identified? Are there other actions that need to be included? If so, what actions and why?

## Question 5

This draft strategy identifies a number of workforce issues for improving the quality of services and support available to older people.

Are the workforce areas adequately covered? If not, what is missing? Do you agree that training to develop a specialist workforce for older people is a key area for development?

## Question 6

This draft strategy looks at ageing as part of the life course and defines older people as those aged 65 and over.

There is a group of people under age 65 with chronic health conditions or disabilities who have similar needs for integrated health and support services. The Ministry of Health will be doing separate work on this. What key issues do you think need to be included in planning for this group?

## Question 7

Are there effective initiatives that you consider useful to include as additional examples in the strategy? If so, please provide information about them.

General comments on any aspect of this draft strategy are welcome. If you do not want to comment on some of the questions, you do not need to.

It would help us to analyse the submissions if you present your comments with reference to the questions asked and/or the specific chapter headings, or objectives, actions, key steps in the draft strategy.

# Executive Summary

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The vision driving the development of the Health of Older People Strategy is that health and support services and programmes will facilitate the wellbeing of older people, their control over their lives, and their ability to participate in and contribute to social, family, whānau and community life.

This vision builds on, and provides a health focus to, the New Zealand Positive Ageing Strategy (Minister for Senior Citizens 2001).

New Zealand has a comparatively young population, with only 11.5 percent of people aged 65 and over. By 2010 around 13 percent of the population will be aged 65 and over and thereafter the proportion of older people will rise significantly (to 22 percent by 2031 and 25 percent by 2051). Increases in Māori and Pacific older people will be particularly significant over the next 50 years, with a 270 percent increase in the proportion of Māori aged 65 and over and a more than 400 percent increase in the proportion of Pacific people aged 65 and over.

Most older people are fit and healthy. A minority are frail and vulnerable and require high levels of care and support from a range of services. This is usually during the last few years of their life, or as a result of a chronic illness or disability that may have been present for many years.

Older people are high users of health and disability support services, with per capita expenditure increasing with advancing age. While older people may be healthier for longer in the future, demand for health and support services is likely to increase, because of the rapid growth in the number and proportion of older people, particularly between 2010 and 2040.

Current health and support services for older people lack a coherent policy and funding framework. Because of this, they are often fragmented and have inconsistent access criteria. This can be confusing for older people and caregivers trying to identify their health care and support options.

This strategy sets out a demanding work programme to refocus health and support services for older people to better meet the needs of older people now and in the future. The work programme has been developed to put in place a comprehensive framework for planning, funding and providing health and support services to provide an integrated continuum of care. Work will begin in 2002 and implementation of the strategy will be complete by 2010.

Development of the Health of Older People Strategy is a key health action in the New Zealand Positive Ageing Strategy Action Plan for 2001/02. The principles and philosophy under-pinning the development of the Health of Older People Strategy are also derived from the New Zealand Health Strategy and the New Zealand Disability Strategy.

The strategy sets out objectives, actions and steps that are key to achieving its vision. Where possible, changes sought in the action steps are illustrated by using examples of New Zealand or overseas initiatives. The strategy is organised around seven objectives as follows:

1. Policy and service planning will support the development of quality health and support services integrated around the needs of older people.
2. 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.
3. 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.
4. Public health initiatives and programmes will promote health and wellbeing in older age.
5. Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning.
6. Hospital services will be integrated with any community-based care and support that an older person requires.
7. Flexible, timely, co-ordinated services will provide older people, their caregivers, family and whānau with a wider range of support options.

A key theme in all of the work streams under these objectives is provision of culturally appropriate services for the growing number of older Māori and Pacific people and other ethnic groups.

Both the Ministry of Health and District Health Boards (DHBs) have responsibility for implementing the strategy. The strategy sets out the longer term vision for integrated health and support services for older people. This will require the Ministry and DHBs to work closely together to integrate their respective policy, planning, funding and service provision functions to achieve the best value for the available funding. Many of the actions require DHBs to take a leading role. Each Board will need to work through how it will do this as part of its planning process.

The draft strategy poses challenges to service providers and the health sector workforce to change the way services are delivered to meet the needs of older people. The Ministry of Health will be working closely with these groups on ways that service providers, professional bodies and representatives of the health sector workforce can contribute to a more integrated approach to health and support services for older people.

The Ministry will monitor implementation of the Health of Older People Strategy annually. The Ministry will also undertake a broader evaluation of the extent to which the strategy's objectives are being achieved. This will coincide with Ministry of Social Policy reports on progress towards implementing the New Zealand Positive Ageing Strategy.

# Introduction

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## Overview

Development of the Health of Older People Strategy is a key health action in the New Zealand Positive Ageing Strategy Action Plan for 2001/02 (Minister for Senior Citizens 2001). Its development has also been guided by the aims and principles of the New Zealand Health Strategy and New Zealand Disability Strategy (Minister of Health 2000; Minister for Disability Issues 2001).

Building on those three overarching strategies, the Health of Older People Strategy is focused on achieving the following vision:

Health and support services and programmes will facilitate the wellbeing of older people, their control over their lives and their ability to participate in and contribute to social, family, whānau, and community life.

This will be achieved by 2010 by putting in place a comprehensive framework for planning, funding and delivering health and support services for older people that are focused on providing an integrated continuum of care to support 'ageing in place'. Ageing in place means the ability to make choices in later life about where to live, and to receive the support needed to do so<sup>1</sup>. Services are integrated when they are funded and provided within a consistent philosophical, policy and practice base and provide flexible responses to clients' varied and changing needs (Appendix 1 identifies the 'Key factors in successful integration').

Population ageing is an international phenomenon. Countries with older populations than New Zealand have undertaken considerable work to identify and address the issues associated with older populations. Some countries, such as the United Kingdom and Australia, have developed national plans for meeting the health care needs of their older people. The Health of Older People Strategy draws on these plans and on work undertaken by the World Health Organization (WHO), the OECD and other countries with older populations.

The Health of Older People Strategy identifies principles underpinning the provision of quality health and support services and sets out the objectives, actions and steps, that are key to achieving the vision. These form the basis for progressive action to be undertaken by DHBs and the Ministry of Health to develop an integrated continuum of care for older people to promote positive ageing. In order to implement the Strategy, the Ministry of Health and DHBs will need to work together to progressively review service and programme priorities within the available funding. This will

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<sup>1</sup> Ageing in place is also an important concept in the New Zealand Positive Ageing Strategy.

involve the Ministry and DHBs working to gradually focus more on health promotion, disease prevention, early intervention, rehabilitation and co-ordination of care to reduce avoidable hospitalisation and long-term residential care.

A draft outline of work to be achieved over the next nine years is provided in Appendix 2. This will form the basis of annual work programmes from 2002 to 2010. Details of the work programmes will be developed in discussion with DHBs, service providers, representatives of the health sector workforce and older people. They will draw on innovative New Zealand programmes and overseas experience, and will also take advantage of opportunities to collaborate with social sector agencies on work to reduce social determinants of health such as inadequate housing, transport and income.

The Health of Older People Strategy has been developed in collaboration with an expert advisory group and comment from sector reviewers (see Appendix 3). It complements other recent strategies, including the Primary Health Care and Palliative Care strategies and the draft Māori Health Strategy and Pacific Health and Disability Action Plan (see Appendix 4).

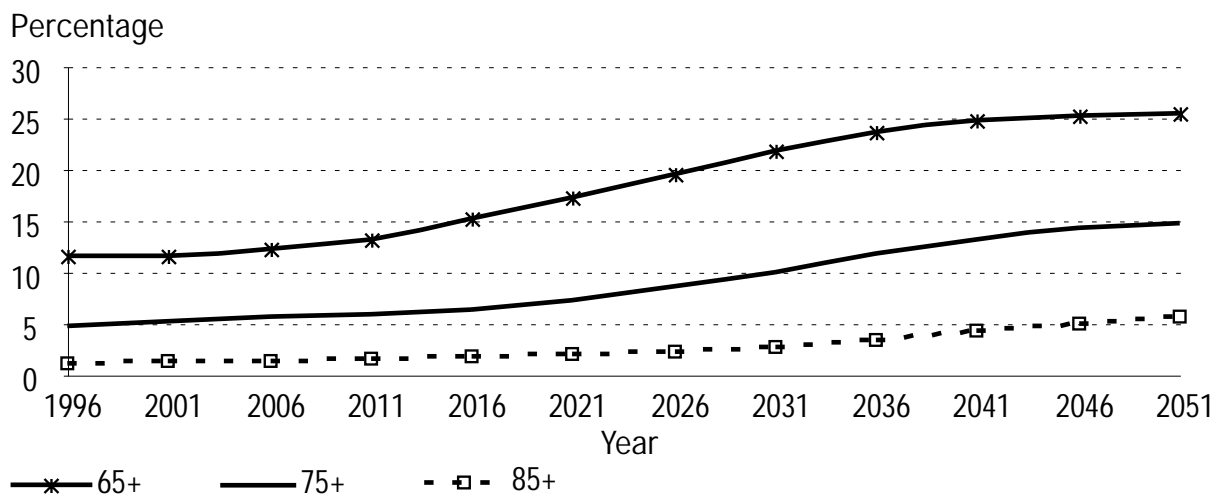
## Need for a strategy

Most older people consider themselves to be relatively healthy and free from disability. A minority are frail and vulnerable and require high levels of care and support from a range of services. This is usually during the last few years of their life, or as a result of a chronic illness or disability which may have been present for many years (sometimes from birth).

There have been several reports over the last five years that have identified problems in the provision of health and disability support services for older people (the most recent are National Health Committee 2000 and Cunningham 2000). These reports highlighted service gaps and overlaps, inconsistent access to services and a lack of flexibility in packaging services to meet older people's diverse needs. The reports identified a need to integrate policy, funding and service provision to address these issues.

Older people are high users of health and disability support services, with per capita expenditure increasing with advancing age. In the future older people may stay healthier for longer but demand for health and support services is likely to increase simply because of the rapid growth in the number and proportion of older people, particularly between 2010 and 2040 (see Figure 1). Increases in Māori and Pacific older people will be particularly significant over the next 50 years, with a 270 percent increase in the proportion of Māori aged 65 and over and a more than 400 percent increase in the proportion of Pacific peoples aged 65 and over. Further information on growth in the older population, their health status and service utilisation is provided in Appendix 5.

**Figure 1: Projected New Zealand population 65+, 75+ and 85+ as a percentage of the total population, 1996–2051**



Source: Statistics New Zealand, Population Projections

It is already a challenge to meet demand for health and support services within available funding. It is therefore essential that services are structured and provided to make the best use of available health funding if we are to meet the increased demand for health and support services in the future.

A 1999 Ministry of Health paper (Johnston and Teasdale 1999) concluded that an average growth in health expenditure of 3.6 percent per year over the next 50 years would be required to meet increased demands for existing services arising from population growth and the greater proportion of older people. It is inevitable that demand for health service expenditure will increase with the growth of the older population, but the rate of increase is difficult to project because of the impact of other factors, which can work to either increase or decrease funding pressures. These include changes in the availability of informal caregivers, technological advances, rising expectations for more and better services, and changing rates of disability among older populations.

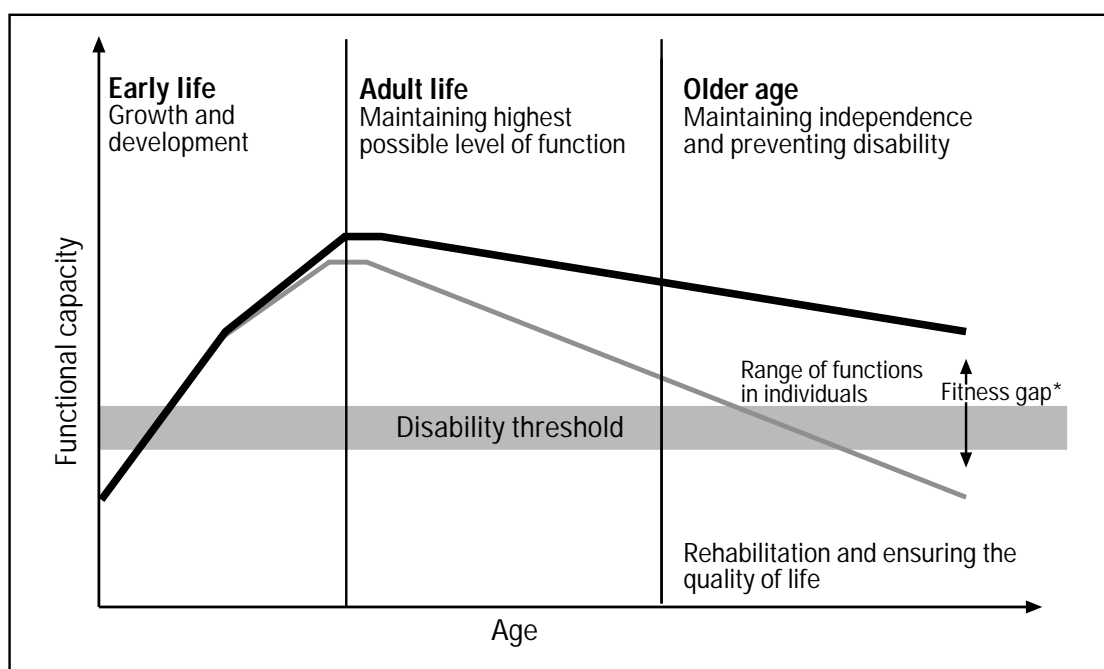
Policy decisions also have a major impact on support costs. An OECD multi-country study on the relationship between disability levels in people over 65 years of age and the need for long-term care services (Jacobzone et al 1998) noted the usefulness of an ‘active’ strategy towards ageing:

This active ageing strategy focuses on reducing the prevalence of disability with more emphasis on prevention. It also considers that ageing, far from being a pure demographic phenomenon, is a dynamic process which social policy and care systems may certainly influence ... Decisions taken now in terms of the balance of care, support for informal care and choices offered to older people will also largely determine the future.

Future demand for health expenditure will also be influenced by policy decisions and individual lifestyle choices made for and by people at younger ages. Individual diversity tends to increase with age and interventions that create supportive environments and foster healthy choices are important at all stages of life.

This life course approach supports activities in early life that are designed to enhance growth and development, prevent disease and ensure the highest capacity possible. In adult life, interventions need to support optimal functioning and prevent, reverse or slow down the onset of disease. In later life, activities need to focus on maintaining independence, preventing and delaying disease, and improving the quality of life for older people who live with some degree of illness or disability (WHO 2001). Figure 2 illustrates the potential impact of an active approach on ageing throughout the life course.

**Figure 2: Functional capacity over the life course**



Source: WHO 2001

\* The fitness gap illustrates the impact that factors related to adult lifestyle (such as smoking, level of physical activity, diet and alcohol consumption) and external environmental factors can have on functional capacity.

A rapid reduction in functional capacity may result in early disability. However, loss of functional capacity may be reversible at any age through individual as well as policy measures. Also, changes to the environment through the development of 'disability-friendly' and 'age-friendly' policies can decrease the extent to which older people experience disability (represented by a lower disability threshold in Figure 2).

Within the context of the life course approach outlined above, the Health of Older People Strategy is aimed at people aged 65 and over. Other strategies, which focus on health promotion and disease prevention across age groups, are the New Zealand



Health Strategy, the draft Māori Health Strategy and the draft Pacific Health and Disability Action Plan.

## Who the strategy is for

The Health of Older People Strategy focuses on people aged 65 and over. Older people do age in different ways and at different rates, and ageing can be measured in terms of four key dimensions:

- chronological ageing (based on birth date)
- biological ageing (based on physical changes)
- social ageing (based on society's expectations of older people)
- psychological ageing (the age people inwardly feel, based on the level of developmental maturity).

So, a person's chronological age is not necessarily a good indicator of biological, physiological or social ageing. However, because chronological age is the simplest and most commonly used definition to determine access to social services it is used in this strategy despite its acknowledged limitations.

There are people under the age of 65 with chronic health conditions or disabilities who also need integrated, seamless health and support services. Māori and Pacific people, in particular, have comparatively high rates of chronic ill health and disability at younger ages (Appendix 5). The approach to integrating services set out in this strategy could be effective for younger people with multiple health and support needs. The Ministry of Health will be separately advising the Government on how best to manage services for those people under 65 years who could benefit from this approach. The Ministry will also be advising the Government on options for disabled people who reach 65 to ensure continuity of service provision.

## The Treaty of Waitangi and the health of older Māori

The Health of Older People Strategy has been developed within the framework of the New Zealand Health Strategy, which has as one of its five underlying principles acknowledging the special relationship between Māori and the Crown. This principle recognises the Treaty of Waitangi as New Zealand's founding document and the Government's commitment to fulfilling its obligations as a Treaty partner. It also recognises the basic premise that Māori should continue to live in Aotearoa as Māori (Minister of Health 2000). In the health and disability sectors, this relationship has been based on three key principles:

- participation at all levels
- partnership in service delivery
- protection and improvement of Māori health status.

The Health of Older People Strategy also recognises that many Māori have a distinct holistic view of health, or hauora<sup>2</sup>, and acknowledges the unique position of older Māori and kaumātua<sup>3</sup> in New Zealand.

Māori have a shorter life expectancy and earlier onset of disease than non-Māori. Addressing this inequality is a priority for the whole of the health and disability sector. Māori under the age of 65 who need co-ordinated health and support services because of chronic disease and/or disability should have those needs met as part of the drive to reduce inequalities in health, not by being defined as 'old'. Ministry of Health advice to the Government on issues for people under 65 receiving multiple health and support services will include specific advice on issues for Māori under 65.

## Scope of the strategy

The Health of Older People Strategy covers the full range of health and disability support services for older people, their family, whānau and caregivers, including:

- population-based initiatives and key linkages with social service agencies to promote the health and wellbeing of older people
- individually based health improvement, disease prevention, assessment, rehabilitation, treatment, long-term support, and palliative care.

Health and support services provide part of the support older people may need to maintain their health, participate in the community and make choices to support ageing in place. Other important sources of support include families, whānau, friends, social clubs and support groups, as Figure 3 illustrates.

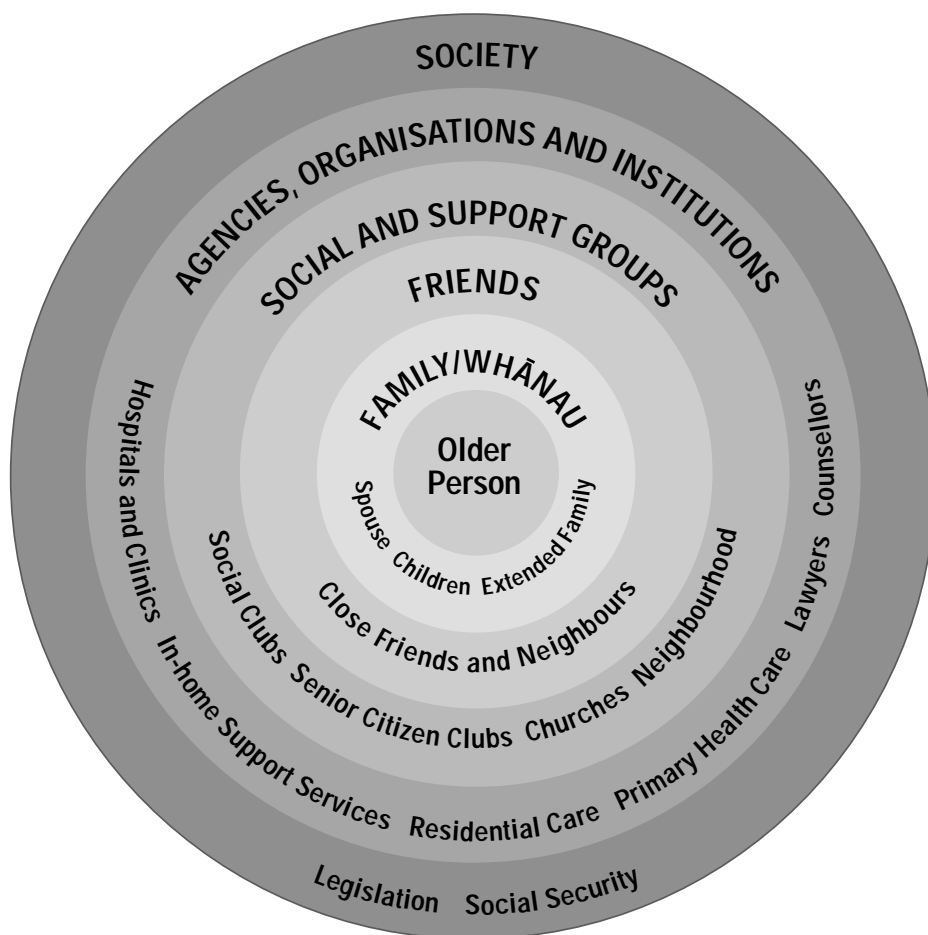
Developing an integrated continuum of care for older people which also supports their caregivers, family and whānau can only be achieved by involving representatives of the community as well as service providers in decision making.

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<sup>2</sup> There are several models that characterise hauora. A frequently used framework is Te Whare Tapa Whā, that is based on four dimensions of health and wellbeing, taha wairua (spiritual health), taha tinana (physical health), taha hinengaro (emotional, psychological health) and taha whānau (family health) (Durie 1998).

<sup>3</sup> Kaumātua is a status within the whānau associated with cultural practices of older age, wisdom, experience and often knowledge of tikanga Māori. Not all older Māori see themselves or are seen as having kaumātua status.

Figure 3: Sources of support for older people



Adapted from Damon-Rodriguez 2001

The Health of Older People Strategy is based on an understanding that need for health and support services in older age is influenced by socio-economic conditions. For example, research on the Living Standards of Older New Zealanders (Fergusson et al. 2001) found that people most at risk of poor living standards (one of the determinants of poor health) were characterised by a mix of low income, history of economic stress, no savings, high accommodation costs, poor housing, being of Māori or Pacific ethnicity and having held a low-status occupation.

There is evidence that socioeconomic inequalities have a cumulative health impact over time (National Health Committee 1998b). This is coupled in older age with the effects of lifetime deprivation (for example poor nutrition in childhood) and disease. These factors tend to disproportionately affect Māori and Pacific peoples and also women.

While women consistently have a longer life expectancy than men, they also tend to have proportionately higher rates of chronic illness and disability in later life. Older women tend to have fewer resources than men, being more likely to be widowed, live alone, have a lower income, live in social or rural isolation and/or be caring for a frail

partner or elderly parents. Older Māori women are particularly disadvantaged as they are more likely to have a combination of being widowed, living in a rural area and having a low income.

## Health and support services for older people in 2010

The vision of health and support services and programmes facilitating the health and wellbeing of older people will be achieved through developing an integrated continuum of care focused on promoting positive ageing. The service framework that will be in place by 2010 to support an integrated continuum of care is envisaged as one in which:

- service priorities are refocused on health promotion and disease prevention through public health, primary health care and ongoing initiatives
- older people have access to a range of living options and support services to assist them to age positively
- there are well developed specialist health services for older people
- older people with high health and support needs have access to timely and comprehensive assessment, and appropriate treatment, rehabilitation and support
- services respond flexibly to the diverse needs of older people, including the cultural needs of Pacific peoples and other ethnic groups with increasing numbers of older people
- there are culturally appropriate services for the increasing number of older Māori
- support services work with caregivers to strengthen informal support and support networks
- older people receiving multiple services are provided with a co-ordinated package of care
- there is a smooth transition between services when an older person's needs change.

# The Strategy

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## Vision

The vision for older people's health by 2010 is that:

Health and support services and programmes will facilitate the wellbeing of older people, their control over their lives and their ability to participate in and contribute to social, family, whānau and community life.

## Principles

The vision focuses on supporting and empowering older people to age positively. It also recognises the importance of their family and whānau. Health and support services will support this vision by:

- fostering a positive attitude to growing older
- working within the framework of the Treaty of Waitangi to address issues for Māori
- using a holistic, person-centred approach that empowers older people, caregivers and family and/or whānau to make informed choices about health care
- supporting caregivers in ways that strengthen the older person's family, whānau and informal support networks
- working with other key sectors to reduce barriers to positive ageing and increase service integration for the benefit of older people
- recognising and responding to cultural and social diversity and health inequalities among Pacific and other ethnic and social groups
- providing timely, equitable, needs-based access to a comprehensive and integrated continuum of good-quality care with an emphasis on promoting wellness
- encouraging personal responsibility for maintaining health while providing appropriately for older people who are disadvantaged through ill health, difficulty accessing services, or socioeconomic circumstances
- responding to changing individual and community health needs in ways that are innovative, collaborative and flexible
- being based on best practice and supported by research
- being affordable to the individual and the state.

# Objectives

The following seven objectives identify areas where change is essential if the vision is to be achieved.

1. Policy and service planning will support the development of quality health and support services integrated around the needs of older people.
2. 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.
3. 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.
4. Public health initiatives and programmes will promote health and wellbeing in older age.
5. Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning.
6. Hospital services will be integrated with any community based care and support that an older person requires.
7. Flexible, timely, co-ordinated services will provide older people, their caregivers, family and whānau with a wider range of support options.

Significant changes are needed to achieve these objectives. The following sections identify actions and key steps for each objective, with proposed completion dates. Other actions will be developed as progress is reviewed and further work identified. Specific actions have been identified for older Māori and Pacific people, but all of the actions require specific consideration of issues for older Māori and Pacific people, as well as other groups of older people experiencing health inequalities.

Many of the actions require DHBs to take a lead role. Each DHB will work with its community to decide how the Health of Older People Strategy should be included in its annual and strategic plans. This will then be set out in annual funding agreements between the Minister of Health and DHBs.

The Ministry of Health will develop a work programme to support implementation of the strategy. Both the Ministry and DHBs will work with service providers and representatives of the health sector workforce on how they can contribute to a more integrated approach to delivering health and support services for older people.

## Objective 1

### **Policy and service planning will support the development of quality health and support services integrated around the needs of older people**

Actions to develop the policy, planning and administrative infrastructure necessary to support an integrated continuum of care for older people are identified below.

#### **Actions**

- 1.1 Each DHB will outline in its strategic plan how it will develop an integrated continuum of care for older people.
- 1.2 From June 2002 the Ministry of Health will have a work programme to support the implementation of the Health of Older People Strategy.
- 1.3 By June 2003 the Ministry, in collaboration with DHBs, will have established a comprehensive system for collecting reliable data to model current and projected demand for services.
- 1.4 By 2010 the Ministry will have implemented a planned approach to meeting the health workforce needs of an ageing population that has been developed in collaboration with DHBs, the education sector, service providers, representatives of the health sector workforce, and older people.
- 1.5 By June 2006 the Ministry, in collaboration with relevant DHBs and the Ministry of Pacific Island Affairs, will have planned for Pacific and mainstream health and support services to meet the needs of older Pacific peoples and their families.

#### **Key steps**

##### **1.1 DHB plans to implement the Health of Older People Strategy and respond to population ageing**

- 1.1.1 Each DHB will outline in its strategic plan its broad approach to services for an ageing population and developing an integrated continuum of care to implement the Health of Older People Strategy.
- 1.1.2 The Ministry of Health will work with 'early leader' DHBs to develop and test models for delivering an integrated continuum of care. Their experience will inform development in other DHBs.
- 1.1.3 To assist DHBs in their planning, the Ministry of Health will work with them to:
  - improve quality (coverage and accuracy) of data needed for policy development and service planning

- improve co-ordination between hospital services, primary care and community-based support
- develop an expanded role for primary health care as signalled in the Primary Health Care Strategy
- review provision of specialist health of older people's services.

1.1.4 The Ministry of Health, in collaboration with DHBs, will progressively review priorities for services in anticipation of growth in older age groups and to support ageing in place. This will require projecting future demand for services by age group and reallocating funding to match changes in the pattern of demand.

## 1.2 Ministry of Health work programme

1.2.1 The Ministry of Health will develop a work programme to support implementation of the Health of Older People Strategy. Key components of the work programme include:

- the projects listed above
- sponsoring a conference in 2002 for DHBs, service providers, representatives of the health sector workforce, and older people to provide the stimulus to implement the Health of Older People Strategy (the key focus will be on actions to share information and experiences to support integrated planning, funding and provision of quality health care and support services).

Other projects are identified under each objective. Most of these projects will involve joint work with DHBs.

## 1.3 Comprehensive data to model demand

1.3.1 The Ministry of Health will draw on several databases to model demand for services for people aged 65 and over. Key components of the model will be demographic change, health status, and service utilisation trends and projections, including information on older Māori and Pacific people. The first stage of this work will be the publication of a statistical reference report.

1.3.2 In developing the Nationwide Service Framework, the Ministry of Health will work with DHBs to improve the availability and quality of data needed to model demand and develop performance indicators.

1.3.3 The Ministry of Health will publish preliminary statistics on mental health service utilisation by older people, drawing on the Mental Health Information National Collection (MHINC), by December 2002, with an updated statistical reference report by December 2004.

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<sup>4</sup> The Nationwide Service Framework sets out definitions, methodologies and processes that permit the use of a common language across agencies for planning, funding, analysing and monitoring services.



## 1.4 Development of the workforce for health of older people

The health sector workforce includes a broad range of workers contributing to the health of older people. These include health professionals such as doctors, nurses, and therapists; health aid workers<sup>5</sup> and orderlies, kitchen staff and social workers. Service providers are already experiencing difficulty recruiting and retaining specialists in the health of older people. Demand for the health aid workforce is rising significantly. There are also concerns about the lack of a consistent approach towards developing the skills required, with few training programmes registered on the New Zealand Qualifications Authority framework. Health sector workforce planning is important to ensure there are sufficient numbers of staff with the appropriate skill mix and training, and that they are provided with quality working conditions. These factors are all essential components of a strategy committed to high-quality health care for older people.

1.4.1 The Ministry of Health will lead work to plan for the specialist workforce required to meet the health and support needs of older people. The Ministry will work with the Ministry of Education, DHBs, and educational institutions, in discussion with service providers and representatives of the health sector workforce and older people. This planning will identify what action needs to be taken by the health and education sectors, and at what level (policy, funder or provider), to address the following issues:

- ensuring that older people’s health issues are adequately covered in the basic training of health professionals who work with older people (for example, medical students, general medical practitioners, nurses, therapists, pharmacists, public health professionals and social workers)
- updating the existing health workforce on older people’s health issues and appropriate interventions
- developing the specialist professional workforce in older people’s health, including:
  - specialist physicians and nurses in older people’s health,
  - psychiatrists of old age
  - allied health professionals with expertise in older people’s health issues
  - a greater emphasis on skills needed to work with older people, their families, whānau and caregivers in community and home settings
- developing the health care and home support workforce to establish quality standards and a focus on supporting the older person to maintain or regain functional independence where possible (this

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<sup>5</sup> Health aid refers to health care and home support workers. Health care workers provide hands on personal care in residential care or a client’s home, assisting them with activities of daily living and personal hygiene. Home support workers perform household tasks. The two roles may be performed by the same person.

includes development of New Zealand Qualifications Authority recognised courses)

- ensuring that mainstream services are culturally appropriate for the increasing ethnic diversity of older people
- promoting working conditions that support the development and retention of appropriately trained staff
- monitoring changes in the size, composition and competency levels of the workforce to feed back into policy decisions
- ensuring that the state, as a major health sector employer, models the Equal Employment Opportunity and good employer obligations of the New Zealand Public Health and Disability Act 2000 and the objects of the Employment Relations Act 2000.

1.4.2 Workforce planning will draw, where appropriate, on work being undertaken by the Ministerial Health Workforce Advisory Committee and within the Ministry. Work the Ministry is currently undertaking includes:

- nursing workforce development initiatives
- development of regulations for nurse prescribing, including nurse practitioners in aged care
- options for developing the health aid workforce, which will include providing training options specialising in particular clinical and support settings.

### **Examples of workforce initiatives**

Some workforce training initiatives are already under way in both basic training and specialist training. These include:

- modules developed by the Royal College of General Practitioners on the care of older people
- multidisciplinary postgraduate courses in gerontology, rehabilitation and social care at Wellington and Christchurch Schools of Medicine, and in gerontology and psychosocial aspects of ageing at Auckland University; all have provision for distance learning
- courses for health care and home support workers, such as the National Certificate in support of the Older Person, the National Certificate in Mental Health (Mental Health Support Work), Diversional Therapy programmes, and various regionally based programmes through polytechnics.

## 1.5 Health and support services for older Pacific peoples and their families

The seven DHBs with the largest proportion of Pacific peoples in their regions have taken a particular responsibility for Pacific peoples' health issues. These are: Auckland, Counties Manukau, Waitemata, Capital and Coast, Hutt Valley, Canterbury and Waikato.

By 2006 the Ministry of Health will have worked with DHBs, focusing on the above seven, to plan to meet the health needs of the rapidly increasing number of Pacific elders from 2010. This work will be undertaken in discussion with the Ministry of Pacific Island Affairs, Pacific health workers and Pacific peoples themselves. It will include:

- extending and enhancing culturally appropriate mainstream health and support services for Pacific elders
- developing the Pacific health workforce
- building on the Pacific provider development work in the Pacific Health and Disability Action Plan to develop Pacific providers of services for Pacific elders.

Key areas for development are building capacity in health promotion and primary health care. This work will be done in conjunction with implementation of the Pacific Health and Disability Action Plan.

## Objective 2

### 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

#### Actions

- 2.1 The Ministry of Health will provide advice to Government on future funding for older people's health and support services.
- 2.2 By 30 June 2002 the Ministry, in collaboration with DHBs, will have developed an implementation plan and guidelines for comprehensive specialist needs assessment for older people and their caregivers.
- 2.3 By 30 June 2002 the Ministry will have reviewed specialist mental health services for older people within the framework of the National Mental Health Strategy Looking Forward (Ministry of Health 1994) and the New Zealand Disability Strategy.
- 2.4 By 1 July 2002 the Ministry will have developed a service development plan for older people with dementia.
- 2.5 The Ministry and DHBs will make appropriate information easily available and accessible to older people, caregivers and professionals, about health and support programmes and services.
- 2.6 The Ministry and DHBs will work with ACC to manage access to, and transition between, services.

#### Key steps

##### 2.1 Funding for older people's health

- 2.1.1 The Ministry of Health will provide advice to the Government on future funding for health and support services for older people. This will include the level of public funding and individual contributions and incentives for clients and service providers in different funding regimes. It will also include consideration of issues associated with providing quality care. The Ministry is undertaking four funding projects in the short term that will contribute to this work by:
  - establishing separate DSS funding for older people to facilitate the development of a closer alignment of support services for older people with health services. This work will also include providing policy advice on service provision and funding for people with long-term disabilities when they reach the age of 65 (by October 2001).

- identifying and assessing methods for setting the overall level of funding, and advising on alternative sources of funding, for an improved and comprehensive publicly funded health system. Issues particularly relating to older people include the role of user charges in paying for health and disability services and whether financing methods should vary for different types of services or populations (to be completed by December 2001)
- analysing policy options for funding long-term care – this will include advice on proposals to remove asset testing for residential care (to be completed by August 2002). It will also include consideration of the option of older people selecting and employing their own support services
- removing cost barriers to primary health care (see action 5.3).

## 2.2 Integrated assessment

One of the three health actions in the New Zealand Positive Ageing Strategy is to 'ensure the availability of multidisciplinary comprehensive geriatric needs assessment throughout New Zealand' (Minister for Senior Citizens 2001).

The key component of an integrated system of assessment for access to health and support services is integration of assessment for physical, psychological and social needs. This includes considering the potential for reversing functional limitations through treatment and/or rehabilitation. The assessment process therefore needs to be clearly aligned with treatment and rehabilitation services.

2.2.1 As a first step in this work, the Ministry, in collaboration with DHBs, will review current assessment services and processes for older people, and develop an implementation plan and guidelines for specialist needs assessment for older people by June 2002. The guidelines will:

- include assessment of caregiver support needs, and culturally appropriate assessment for older Māori and ethnic minority groups with increasing numbers of older people (including Pacific peoples)
- map out potential trigger points for an assessment, the type of assessment that may be appropriate for given circumstances, and the competencies required to undertake that assessment.

## Examples of initiatives

- In Australia, Aged Care Assessment Teams (ACATs) provide assessment for access to residential care, intensive Community Aged Care Packages,<sup>6</sup> and, frequently, to inpatient, outpatient and rehabilitation services. They are staffed predominantly by health professionals, including geriatricians. They may be located within a variety of organisations, including hospitals, extended care centres, community health centres and domiciliary care services. In New Zealand, the needs assessment and service co-ordination services and assessment treatment and rehabilitation services perform similar functions, but there is no nationally co-ordinated approach focusing on older people.
- The Silver Network Home Care project in Italy, which is an integrated social and medical care programme, uses a comprehensive screening and assessment tool, the Minimum Data Set for Home Care (MDS-HC). This instrument contains over 300 items which explore all of an individual's problematic areas and are linked via a trigger process to 30 client assessment protocols. These protocols contain general guidelines for further assessment and individualised care plans. The validity and reliability of the MDS-HC have been documented and the instrument has been successfully implemented in other countries. A quasi-experimental study of the project in Vittoria Veneto, Italy, found significant reductions in hospitalisations and hospital days, resulting in a 29 percent reduction in costs (Landi et al 1999).

## 2.3 Review of specialist mental health services

- 2.3.1 By 30 June 2002 the Ministry of Health will set targets for older people's access to specialist mental health services as required by Moving Forward (the implementation plan for the strategy Looking Forward).
- 2.3.2 By 30 June 2002 the Ministry, in collaboration with DHBs, will develop a nationally consistent purchase framework for specialist psychogeriatric inpatient and outpatient services.
- 2.3.3 By 30 June 2002 the Ministry will review the range of specialist psychogeriatric services currently available across New Zealand, and develop a plan for achieving nationally equitable access.

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<sup>6</sup> Community Aged Care Packages provide intensive support for people who prefer to remain at home, but require care equivalent to that provided in a hostel.

<sup>7</sup> In this context psychogeriatric services means: psychiatric services provided to older people with functional and organic mental disorders (including people with dementia).

## 2.4 Service development plan for older people with dementia

2.4.1 By 1 July 2002 the Ministry of Health, in collaboration with DHBs, representatives of service providers, health sector workers and older people, will have produced a service development plan for people with dementia. This will include:

- working with the sector to identify the issues for dementia services for older people and developing strategies to address those issues
- developing dementia-specific standards for residential care services
- strengthening the audit process for dementia services.

## 2.5 Information on healthy living, service availability, eligibility and cost

The former Health Funding Authority published various information packs on services it funded. This material needs to be reviewed and updated and made widely available in a range of formats to better reach those who need it. Various organisations have also developed information on healthy living.

2.5.1 The Ministry of Health and DHBs will agree on a rolling programme to provide information for older people; their family, whānau or caregivers; and health professionals who may be advising them. The information will be provided in appropriate formats and languages, use appropriate channels, and include guidance about complaints procedures.

### Examples of initiatives

Initiatives to disseminate information to older people include:

- using Internet web sites – several organisations in New Zealand already have information tailored to the needs of older people (for example, the Age Concern web page provides an extensive database of resources and information for older people and caregivers.
- *Getting on with Life! An older person's guide to positive relationships and lifestyles* – an A5 booklet put out by Relationship Services Whakawhānaungatanga, with information about dealing with change, couple relationships, living alone and family relationships and information about other resources.
- *Fit for the Future: A selfcare programme for older adults* – a Hillary Commission booklet covering facts and myths about ageing, guidance on diet and exercise, leisure activities and community involvement, together with information about other community organisations.

## 2.6 Collaboration with ACC

ACC has responsibility for injury prevention and for the rehabilitation of people injured in accidents in New Zealand. On 1 July 2001 ACC separated payment for non-acute rehabilitation for older people from acute levy payments for hospital inpatient care and moved to direct payment for the rehabilitation services provided.

2.6.1 The Ministry of Health and DHBs will work collaboratively with ACC on:

- health promotion activities aimed at preventing injury (for example, physical exercise and falls prevention)
- rehabilitation initiatives
- management of the policy and service delivery interface with ACC for older people who have both accident and non-accident health and support needs
- management of transitions between ACC-funded services and health-funded services for those people with ongoing health and support needs
- provision of the above services in a way that is culturally appropriate for older Māori and Pacific peoples and other ethnic groups, as appropriate.



## Objective 3

**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**

### **Actions**

- 3.1. By 1 July 2003 the Ministry of Health, in collaboration with DHBs, will have developed a process for working with local iwi and Māori to develop culturally appropriate health and support services for older Māori.
- 3.2. By June 2006 the Ministry, in consultation with the Māori health workforce and Māori providers, will have established national priorities for Māori health workforce and provider development to meet the needs of rapidly increasing numbers of older Māori from 2010.
- 3.3. The Ministry and DHBs will fund a range of health and support service providers to give older Māori and their whānau a choice of culturally appropriate mainstream or Māori providers.
- 3.4. DHBs will facilitate the development of health advocacy structures for older Māori in their district.

These actions will be developed in conjunction with implementing the Māori Health Strategy ( see Appendix 4).

### **Key steps**

#### **3.1 Collaboration with local iwi and Māori to develop culturally appropriate services**

By 1 July 2003 the Ministry of Health, in collaboration with DHBs, will have established a process for working with local iwi and Māori in planning and developing culturally appropriate services for older Māori and their whānau.

#### **3.2 Māori workforce and provider development**

By June 2006 the Ministry of Health, in consultation with the Māori health workforce and Māori providers, will have developed a national service framework for Māori health workforce and provider development to meet the needs of older Māori.

### 3.3 Range of health and support services

There are currently few Māori providers of services for older Māori, and older Māori tend not to access mainstream services.

3.3.1 The Ministry of Health and DHBs will work with local iwi and Māori communities to develop appropriate services to provide:

- options for older Māori to continue to participate in and contribute to whānau life
- support for whānau caring for older people (this will include information on and basic training in caring for older people)
- easily accessible primary and community health care that meets the needs of older Māori
- long-term support for older Māori with high or complex care needs.

3.3.2 The Ministry of Health and DHBs will work towards all services provided by both mainstream and Māori providers for older Māori being clinically sound, culturally competent and well co-ordinated. This includes services that:

- are able to respond to diverse Māori need, including continuous quality improvement and accurate information systems and data collection specific to Māori health
- have culturally and clinically safe policy, practices and procedures
- actively promote Māori participation (for example, in provider activities, such as planning, service delivery, consultation and communication)
- improve co-ordination across the health and other sectors, including central and local government, to ensure that the range of health services are accessible and appropriate for older Māori.

### 3.4 Development of advocacy structures

3.4.1 DHBs will work with local iwi, Māori communities and existing older people's advocacy groups to facilitate the development of advocacy structures that promote issues for older Māori.

#### Examples of initiatives

Age Concern New Zealand is networking with iwi to develop culturally appropriate intervention services for elder abuse and neglect prevention. For example, Age Concern New Zealand worked with Tui Ora Limited in Taranaki in the development of a bicultural service.

## Objective 4

### Public health initiatives and programmes will promote health and wellbeing in older age

This objective largely concerns public health services that aim to prevent disease, improve and protect the health of *populations*, and reduce population health status inequalities. By contrast, personal health care services meet the needs of *individuals*.

Public health services typically demonstrate benefits in the long term, use several interventions to address associated determinants or risk factors (for example, physical activity and advocacy for safe public places, or oral health and nutrition), involve collaborative effort across agencies, and are delivered in community-based settings. Public health programmes focus on enabling people to make individual and collective choices, throughout life, which improve their health and keep them well.

Public health actions use a broad approach which encompasses: developing healthy public policy, creating supportive environments, supporting community action, developing personal skills, and reorienting health services (*Ottawa Charter for Health Promotion*, WHO 1986). The approach should also incorporate the Treaty of Waitangi principles of participation, partnership, and protection of Māori health.

Public health actions occur at national, regional and local levels.

#### Actions

Key public health actions for improving wellbeing in older age are:

- 4.1 Improve nutrition
- 4.2 Increase physical activity
- 4.3 Reduce depression, social isolation and loneliness
- 4.4 Reduce falls
- 4.5 Intersectoral collaboration on housing and transport.

In order to carry out these actions public health planners and funders will need to:

- assess service needs to:
  - improve population health status generally for older people
  - reduce inequalities in population health status (priority groups are Māori, Pacific peoples, and low socioeconomic groups; older women among these groups are especially disadvantaged, see Appendix 5)
- encourage the development of appropriate public health services
- contract with providers for services, monitor provider performance and evaluate new programmes

- develop collaborative national and regional relationships over public health services, provide intersectoral leadership and co-funding with other agencies, (for example, other government agencies, non-government agencies, local authorities), and become involved in planning services with providers.

## Key steps

### 4.1 Improve nutrition

Healthy eating and regular physical activity can reduce the risk of some diseases and so help to maintain independence. Being overweight in older people is an important risk factor for cardiovascular disease, stroke, diabetes and some cancers. Poor nutrition more generally compromises health status and is associated with increased hospital stays, post-operative morbidity and mortality, and readmissions. A large survey of 3000 Adelaide residents showed that lower socioeconomic status was characterised by a lower consumption of a diet that conforms with nutrition guidelines. Poor nutrition can also result from impaired digestion or absorption or utilisation of nutrients due to chronic disease or drug–nutrient interactions and/or dental problems (Ministry of Health 1993, 1996).

- 4.1.1 Work with the food industry to package meals for older people in more appropriate packaging that has larger print, has smaller portions, and is more easily opened.
- 4.1.2 Develop services that promote healthy eating and physical activity.

#### Examples of initiatives

The *Food and Nutrition Guidelines for Healthy Older People* (Ministry of Health 1993, 1996) identify a set of goals for nutrition education involving older adults

### 4.2 Increase physical activity

Moderate intensity physical activity (30 minutes per day of brisk walking, cycling, etc on all or most days) (US Department of Health and Human Services 1996) reduces the risk of cardiovascular disease, as well as the onset of many conditions (such as arthritis, osteoporosis, cognitive impairment), increases the period of independence (National Health Committee 1998a), and improves general wellbeing. Physical activity for older people should also emphasise resistance and strength training.

- 4.2.1 Support campaigns emphasising that it is never too late to start physical activity (Brown et al 1999), and advocacy for secure/comfortable environments for physical activity and walking (such as safe public places and footpaths (Step Ahead Project Committee 1999)).

- 4.2.2 Promote programmes which encourage physical activity (Owen et al 1995), including walking.
- 4.2.3 The *Healthy Food: Healthy Action: An integrated approach to nutrition, physical activity and healthy weight* strategy is expected to be completed by the end of the year. It will include issues of particular relevance to improving the health of Māori and Pacific peoples.

### Examples of initiatives

Examples include Kiwi Seniors, Push Play, Kiwi Walks Hikoi 2000 (Hillary Commission programmes), recreational fishing, gathering kai, waka ama (outrigging), line dancing, water-based, gentle exercise in groups, classes with trained instructors (Rowland et al 1994), Green Card prescriptions<sup>8</sup> and programmes to encourage physical activity in residential care facilities (NSW Health 1999).

## 4.3 Reduce depression, social isolation and loneliness

Depression causes loss of enjoyment and poor quality of life and can precipitate a cycle of social withdrawal and negative thinking, which in turn increases depression. The disorder can lead to malnutrition or dehydration, and become life threatening. It is more prevalent in those who are institutionalised. Depression is often missed at the primary care level or misidentified as loneliness, ageing or dementia (NSW Health 1999).

- 4.3.1 Develop services to address social isolation and loneliness. It has been found that effective programmes target specific groups (for example, women, widowed), use group activities, allow participants some level of control and use more than one method (Cattan and White 1998)<sup>9</sup>. Home visiting and befriending programmes<sup>10</sup> may also help to reduce depression.
- 4.3.2 Support community development approaches to improve the social connections of older people and their self-care skills. Health promotion programmes that involve key stakeholders, including older people and existing infrastructure (for example, Māori Women's Welfare League, Age Concern Councils), are more cost-effective and self-sustaining over time

<sup>8</sup> A Hillary Commission initiative where GPs prescribe exercise through, for example, attendance at local gyms. One Auckland leisure company, in partnership with local councils, offers subsidised fitness programmes for older people, which are well attended.

<sup>9</sup> One-to-one interventions, such as home visiting schemes, which were provided widely, were mainly judged to be ineffective or inconclusive. The apparent conflict between practice and research may reflect the difference between practitioners who based their activities on long-term experience of their target group, and evaluation studies, which were often short term and based on outcome measures, and did not usually include process measures.

<sup>10</sup> Examples are volunteer visiting by Age Concern, Presbyterian Support Auckland (also drive people to appointments or friends); daily phone chats by St Johns Auckland volunteers.

(Tang et al 1995; Alcohol and Public Health Research Unit 2001).

- 4.3.3 Develop services to reduce depression, such as programmes for bereavement support, stress management and skill development to deal with change, loss and grief issues, retirement or disability (Draper 1995).
- 4.3.4 Support approaches that raise community awareness of depression and suicide in older people and encourage them to seek help.

### Examples of initiatives

- In the northern region, the Ministry of Health has contributed funding towards health promotion projects run by seven Age Concern Councils over several years. Each programme is autonomous so that local issues are addressed. All projects increased their networks with other groups interested in older people, developed policy and advocacy approaches, and more holistic health approaches(Alcohol and Public Health Research Unit 2001).<sup>11</sup>
- Community education and awareness raising can be done using the 'Ageing is Living' programme, an education and training resource that aims to prevent reactive depression in older people.
- 'Beyond Blue' is an Australian national initiative to increase community awareness of depression; increase the community's capacity to prevent depression and respond to the needs of those with depression; improve the capacity of health, welfare, educational and other professionals to reduce risk factors for depression; and support priority-driven health services, health promotion and depression-prevention research ([www.beyondblue.org.au](http://www.beyondblue.org.au)).
- The Ministry of Pacific Island Affairs and the Senior Citizens Unit are undertaking joint work to identify appropriate strategies for promoting intergenerational initiatives in Pacific communities which involve Pacific communities in developing Pacific resources (an action in the Positive Ageing Strategy Action Plan for 2001/02).

## 4.4 Reduce falls

A third of older people living in private homes and about half of those in institutions will fall each year. Fall injuries are one of the most common causes of hospitalisation for older people. Falls may also lead to fear of falling, loss of physical functioning and increased dependence.

Although falls may appear to result from a single cause, they usually result from a combination of physical, lifestyle, environmental and social risk factors (Gillespie et al 2000). Several of these risk factors can be reduced by appropriate interventions. These include addressing reduced muscle strength, impaired balance and gait, overuse of psychotropic drugs, neurological disorders, near-

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<sup>11</sup> The project evaluation noted areas for future development were including workforce skill development, Treaty partnership application, and a focus on low socioeconomic groups.

vision loss, foot problems, depression, lack of social support, home safety and the effects of winter conditions and low temperatures.

Public health actions to reduce falls are linked to personal health interventions that screen people at risk (including a review of medication), and tailor interventions to address all the identified risk factors. A broad public health approach is recommended (Gillespie et al 2000; National Ageing Research Institute 2000; Tinetti et al 1996;).<sup>12</sup> There is no evidence that increased awareness or a safer environment alone is effective in reducing the risk of falls (Gillespie et al 2000; Robertson and Gardner 1997), and there is inadequate evidence for single interventions such as exercise or health education classes for the prevention of falls.

4.4.1 Develop services that address external risk factors; for example, support advocacy for safe environments such as footpaths (Step Ahead Project Committee 1999)<sup>13</sup> and support programmes to reduce home hazards; for example, home modifications (Age Concern North Shore and Public Health Promotion North 1999; McLean and Lord 1996).

4.4.2 Develop services that address intrinsic risk factors, for example, support programmes that provide moderate intensity muscle strengthening and balance training.<sup>14</sup> Women gain particular benefit from physical activity that improves muscle strength, muscle power and sidestepping movement. Programmes that are well matched to the individual and well supervised can lead to improvements even in those over 80 years (Robertson, McGee et al 2001; Campbell et al 1997). Poorly implemented, however, they increase the risk of falls.

### Examples of initiatives

- Older people are one of the priority groups in Safe Waitakere, a Safe Communities project which is a community-based, all age, all injury prevention programme run by the Waitakere City Council and Ministry of Health. Strategies for older people include promotion and education about safe homes and safe recreation, and advocacy and action for hazard reduction in the community.
- The ACC Train the Trainer programme is a community-based fall-prevention project targeting the young-old. It promotes the growing evidence of falls as

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<sup>12</sup> The McLean and Lord (1996) research into falls among older Australians indicates the most effective interventions entail individual risk assessment with targeted multi-factorial falls prevention approaches.

<sup>13</sup> This survey in central Auckland of the fall prevention needs of people 70 years and older in the community found that most falls occurred away from the home, especially due to poor footpaths and uneven surfaces. The report noted that this finding is consistent with current research among community-based older people.

<sup>14</sup> An ACC Injury Prevention fact sheet states that falls in older people are almost always associated with muscle weakness and impaired balance.

preventable rather than 'accidents'. The programme trains GPs, lay caregivers and others to address personal risk factors (such as vision, medication).

- Age Concern Ashburton Falls Prevention Programme is a multi-factorial approach for people living in the community who are over 55 years and have one or more risk factors for falling. It consists of a physical activity programme, health professional education, a socialisation programme, home and community assessment, and a review of diet, drugs and alcohol consumption. It found a decrease in the number of falls, a marked awareness of the risk factors, and visible improvement in self-confidence.
- Auckland Step Ahead Falls Prevention Programme (Step Ahead Project Committee 1999) runs interactive education on falls prevention to community based people 70 and over in Central Auckland. It is based on needs analysis that found that people preferred to be given information rather than a multifaceted fall prevention programme.
- Home Safe Home is a community falls and fire prevention project in North Shore and Rodney District (Age Concern North Shore and Public Health Promotion North 1999). This project includes fire prevention on the evidence that people are four times more at risk of injury from fire than falls. It also targets well, independent older adults (over 65) living in the community, in North Shore and Rodney District. The project provides information on safety in the home – specifically fire, falls, injury prevention and aids and appliances – and aims to increase the use of safety features in the home through modifications to the home environment.
- There are also various safety checklists for homes; for example, Home Environment Risk Check List (McLean and Lord 1996).
- Several successful falls-reduction programmes have been delivered in personal health settings including a Dunedin exercise and walking programme which targets women aged 80 years and over (Campbell et al 1997); and a West Auckland home exercise programme which targets women and men aged 75 years and older in the community (NZ Falls Prevention Research Group 2000). Three New Zealand centres have run individually tailored exercise programmes for people over 80, delivered by trained nurses from within general practices, which were effective in reducing falls (Robertson et al 2001).

## 4.5 Intersectoral collaboration on housing and transport

### Housing

Most older people continue to live independently or with relatives, but may need home care support services (Age Concern 1999). Accommodation costs, high energy costs, home maintenance difficulties for owner-occupiers on fixed incomes, and occupant behaviour (for example, not opening windows), and the fact that older people do not feel temperature changes as well as younger people can mean that homes may not be adequately heated or ventilated. This situation can lead to dampness, cold and mould (Howden-Chapman et al 1999), which are linked to high



rates of respiratory illness and asthma, and can lead to hypothermia in winter (Taylor et al 1994).

Given that housing tenure is linked directly to cardiovascular and all-cause mortality, older people in rented accommodation are likely to have higher death rates than owner-occupiers. New Zealand housing patterns mean that Māori and Pacific superannuitants are at greater health risk than Pākehā superannuitants... (Howden-Chapman et al 1999).

Older people who are mainly on fixed incomes are particularly affected by the level at which rents are set, as housing is the biggest item of household expenditure for low-income older people. 'Housing costs are the main determinant of how much food is on the table and, when it is cold, whether or not the heater will be turned on' (Howden-Chapman et al 1999).

- 4.5.1 Work with other agencies on low-cost housing for those on low incomes, subsidies for heating and insulation, and universal design of houses to suit all ages.

### Examples of housing initiatives

- The Waitakere City Council injury-prevention programme includes reducing home hazards by installing smoke alarms and handrails in council houses for senior citizens and kaumātua flats at the local marae, and providing information for kaumātua on safety in the home.
- The South Eastern Sydney Area Health Promotion Service has a long-term, multi-faceted approach to improving the health and quality of life of poor older people living in insecure accommodation in the inner city. The principal strategy is advocacy for policy and environmental change. This approach stresses the importance of respecting the identity and values of the disadvantaged group. Issues addressed include pedestrian safety, access to fresh food, affordable housing, and health and welfare services (Hill and Bassar 1998; Russell et al 1998).
- The Healthy Housing Programme recently launched in Auckland will improve state housing stock in Otara, Mangere, and Onehunga. Two hundred and fifty houses are to be extended and other modifications made to reduce dampness and improve ventilation. These improvements will help to reduce risk factors for falls among older members of the large number of Pacific families who live in state rental accommodation in south and west Auckland.

### Transport

Geographical isolation, especially in under-serviced rural areas, and lack of public transport limit older people's access to services and social activity (Dwyer et al 2000). Declining rural areas in Australia, for example, have experienced 'health service migration' of older people to urban centres in order to access

health services. Driver injury risk increases with old age, most steeply around the late 70s (National Road Safety Committee 2000). Walking accounts for almost a third of the journeys made by people over the age of 70. Unfortunately, older people account for around a third of pedestrian fatalities.

There needs to be intersectoral collaboration and advocacy for:

- measures to ensure driver safety, and to aid pedestrian mobility and safety, particularly for older people with physical limitations
- the provision of public transport and appropriate servicing in under-serviced areas for example, one-stop-shop and mobile health and social services in some rural areas.

4.5.2 Support community development approaches, for example, volunteer driver schemes.

### Examples of transport initiatives

- There are a number of volunteer driver schemes, such as those run by Age Concern, Presbyterian Support Services, and Lovelink, to drive older people to hospital appointments, health services and to visit friends. These should be encouraged.
- Local authorities should be supported to plan appropriately for older people. For example, Rodney District Council used the Through Other Eyes programme to assist council planners gain an insight into everyday difficulties experienced by older people and those with disabilities, in order to inform planning on issues such as bus design, street lighting, footpaths and kerb design, seating along pedestrian routes, disabled car parking, and signage.

## 4.6 Other areas for public health action

The following New Zealand Health Strategy priorities for all New Zealanders also impact on the health of older people. Public Health service planning and provision should also focus on the specific needs of older people when addressing these priorities.

- *Tobacco control:* stopping smoking at whatever age has great health benefits. Services that promote smokefree environments and smoking cessation initiatives, such as subsidised nicotine patches and gum, are effective.
- *Suicide:* WHO recommends a comprehensive approach to prevent suicide, from health promotion and early intervention, through to crisis support, treatment, and rehabilitation. Interventions need to include a focus on early detection of depression and identification of at-risk populations, such as the physically or chronically ill, males, the recently widowed or bereaved, and alcohol abusers (Draper 1995).

- *Alcohol abuse*: services should disseminate information on the possible effects of alcohol on older people due to changes in metabolism affecting their ability to process alcohol, and the interaction of alcohol with prescription medication (Khan 1998).

## Objective 5

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

A greater emphasis on primary and community health care will help minimise loss of functioning and facilitate older people's ability to make choices about where to live while receiving the support they need to do so, thereby reducing the risk of avoidable hospitalisation or inappropriate entry to residential care.

The Primary Health Care Strategy outlines a new direction for primary health care with a greater emphasis on population health, the role of the community, health promotion, preventive care and the need to involve a range of professionals. Primary health care has a key role in facilitating collaboration between and co-ordination across services. The key mechanism for achieving this expanded role is through the development of Primary Health Organisations.

#### Actions

The following actions will be taken as part of implementing the Primary Health Care Strategy (see Appendix 4).

- 5.1 The Ministry of Health, in collaboration with DHBs, will reinforce the roles of community and health providers in health improvement and collaboration with public health promotion programmes.
- 5.2 The Ministry of Health will facilitate work by DHBs and service providers to assess and develop active care management initiatives, including:
  - processes for early detection and management of disease and/or disability
  - service co-ordination
  - support for management of complex medical conditions.
- 5.3 By June 2002 the Ministry will have assessed options for reducing cost barriers for older people to primary health care as part of broader work to remove barriers to primary health care.
- 5.4 By June 2002 the Ministry will have facilitated the development of a plan for implementing the Primary Health Care Strategy in rural areas so that older people, along with other rural New Zealanders, have accessible and appropriate primary health care services.

## Key steps

### 5.1 Health improvement and collaboration with health promotion programmes

Public health programmes are most effective when supported and reinforced by consistent health education from primary and community health and support services. Complex behaviour changes are more likely to be maintained if there is a collaborative planning process between client and health care professional, combined with individualised assessment, counselling and written plans (Fax et al 1997; Scott 2000). Important areas for self-care education include promotion of a healthy diet; moderate physical exercise and weight control to reduce cardiovascular diseases (in particular, heart disease and stroke) and osteoporosis; smoking cessation; management of alcohol consumption; mental stimulation; management of incontinence; and oral health and foot care. Dental health is a particular issue for older Māori.

5.1.1 Service specifications for primary and community health services will include a requirement to:

- support and reinforce the messages of appropriate population health promotion programmes
- provide education and counselling for older people in self-care, including accurate information about preventive actions to maintain health (Richmond et al 1996)<sup>15</sup>
- link with community agencies and voluntary groups providing information, education and advice to older people, their families and whānau about healthy living options.

### 5.2 Active care management

#### 5.2.1 Early detection of disease and/or disability

The Ministry of Health will facilitate work by DHBs with primary health care providers and representatives of the primary health care workforce to evaluate the benefits of, and options for:

- identifying older people at risk of developing disease or disability
- providing preventive care
- feeding into a more comprehensive assessment where necessary.

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<sup>15</sup> This study among older adults found high levels of misinformation about lifestyle issues; for example, about causes of osteoporosis, use of vitamins, likelihood of developing dementia and the importance of exercise. The most important sources of information were perceived to be doctor, relatives/friends, and books/magazines (in that order).

This will include assessment of culturally appropriate options for Māori and Pacific peoples.

### Examples of initiatives

- The most promising approach to identifying people at risk appears to be the use of brief non-intrusive strategies for predicting health and disability problems during routine consultations (Tulloch 1987). This type of case finding, when combined with care management, appears to be more effective than blanket screening of the whole population, such as the '75-and-over' checks in Britain (Iliffe et al 1999).
- An example of an assessment tool is the EASYcare Elderly Assessment System (SISA 1999).

#### 5.2.2 Service co-ordination

Most older people do not need any assistance to access the health and/or support services they need. However, this becomes more difficult when multiple service providers are involved and/or the person's condition fluctuates. In such situations one service needs to take responsibility for co-ordinating a package of care for the older person. This co-ordination role could be located in a specialised agency (such as a needs assessment and service co-ordination agency or assessment treatment and rehabilitation service), in a hospital, or in a primary health care provider such as a Primary Health Organisation.

- Community-based health care providers will either develop the capacity to co-ordinate care and support for clients unable to do so for themselves, or will collaborate with an agency that performs this function.
- The Ministry of Health will facilitate work by DHBs with primary health care providers to develop a nationally consistent care plan template to be used for developing jointly held integrated care plans for older people accessing multiple services (see action 6.2.1).
- The Ministry of Health will work with DHBs, service providers and representatives of the health sector workforce to develop a nationwide core service framework for Primary Health Organisations.

## Examples of initiatives

- Early identification of people at risk of ill health, when combined with service co-ordination, permits a multidisciplinary approach, with nurses taking over focused tasks from doctors (Mundinger 1994). This can show benefits to patients with complex and difficult problems like cardiac failure (Rich et al 1995) and some evidence of downstream savings (Scott et al 1996).
- A New Zealand example of primary care-led service co-ordination is the Co-ordinator of Services for the Elderly (COSE) project being piloted by the Elder Care Canterbury Project.

### 5.2.3 Support for management of medical conditions

The Ministry of Health is developing tool kits to identify the types of actions different organisations need to take to address the priority population health objectives identified in the New Zealand Health Strategy. While none of the tool kits are specific to older people, many are relevant, particularly those relating to obesity, physical exercise, cancer, cardiovascular disease, and diabetes.

- The Ministry of Health will develop clinical governance tools for Primary Health Organisations and other primary health care providers. These will include continuous quality improvement methods, quality monitoring and guidelines for clinical best practice.
- The Ministry of Health will facilitate work by DHBs with primary health and community care providers to make provision for appropriate specialist advice and coaching to support best practice. There are already many examples of this, but the approach is ad hoc and variable. Particular areas for development include access to specialist mental health assessment services, early identification and treatment of dementia, and management of polypharmacy.
- The Ministry of Health will facilitate the development of referral guidelines to assist community based health professionals in making appropriate referrals to hospital elective services.

## Examples of initiatives

Various guidelines for primary health care have been developed already. These include:

- the *Care of Older People* handbook developed by the College of General Practitioners (RNZCGP 2000)
- the *Guidelines for the Support and Management of People with Dementia* (Sainsbury et al 1997)

- the *Chronic Care Management Policy and Planning Guide* developed by the Disease Management Working Group in Counties Manukau, which provides guidance on how to design interventions for opportunistic primary care screening, and diagnosis and management of patients once they present to primary care (Disease Management Working Group 2000).
- the Stroke Foundation of New Zealand comprehensive model of stroke services, which includes strategies for changing clinical practice, preventing stroke, and improving provision of community resources to improve outcomes for people who have had a stroke.

Other ways in which general practitioners and other primary health care professionals are being supported include:

- specialists in various clinical specialties (including health of older people) providing back up and coaching in diagnosis and treatment of complex or multiple conditions.
- initiatives to manage polypharmacy, such as Comprehensive Pharmaceutical Care currently being trialed through the Department of General Practice and Primary Health Care, Auckland. Comprehensive Pharmaceutical Care applies management principles to the process of medicines therapy. It focuses on the person rather than the product and involves five steps: gathering information; identifying, evaluating and resolving medicines-related problems; developing a care plan; monitoring outcomes; and reviewing documentation. Following training, pharmacists can interview clients, advise on multiple medication issues, and encourage best practice. Currently 80 pharmacists are accredited to carry out this work and more are expected to undertake accreditation.

### 5.3 Reducing cost barriers

- 5.3.1 The Ministry of Health is reviewing the current Community Services Card system and will be advising the Government on a system that more effectively reaches people experiencing cost barriers to essential primary health services.

The Government is committed to reducing cost barriers to accessing primary health care services. Over the next three to five years funding will be increased to improve access, starting with those with the greatest need. This initiative will benefit people with chronic conditions and limited means (including older people). Change will occur incrementally by working with those providers who are willing to participate in new initiatives.



## 5.4 Implementing the Primary Care Strategy in rural areas

5.4.1 The Ministry of Health will facilitate the development of a plan for implementing the Primary Health Care Strategy in rural areas by June 2002. The plan will develop a coherent approach to rural primary health service provision, including the difficult issues of attracting and retaining an appropriate workforce. Older Māori are more likely to live in remote rural areas than younger Māori or other older people. Strengthening primary health care services in rural areas will benefit older Māori along with other rural New Zealanders.

## Objective 6

### **Hospital services<sup>16</sup> will be integrated with any community-based care and support that an older person requires**

Many older people recover quickly from a period of hospitalisation and can be discharged with minimal support. Others have advanced medical conditions which seriously impair their ability to function and prolong their recovery. Some older people needing hospital services will already be receiving varying levels of ongoing care and support, including residential care.

Fragmentation of services is a particular problem for older people. An episode in hospital may involve acute services, specialist assessment treatment and rehabilitation (AT&R) services, mental health services, community-based support services, primary care, and community health services. Older people who take longer than average to recover from an illness or surgery may need access to a combination of health care and support services. These could include intermediate rehabilitation and convalescent care that is focused on returning people to the community with optimum quality of life.

#### **Actions**

- 6.1 By June 2003 the Ministry of Health, in collaboration with DHBs will have undertaken a review of specialist health services for older people.
- 6.2 The Ministry and DHBs, in discussion with health and support service providers, will develop systems for planning and co-ordinating care between hospital services, primary care community-based services and caregivers.
- 6.3 Hospitals will provide quality, age-appropriate care and treatment for older people.
- 6.4 By 2006 the Ministry, in collaboration with DHBs and in discussion with health and support service providers, will have assessed options for intermediate-level care.

#### **Key steps**

##### **6.1 Review of specialist services for older people**

- 6.1.1 By June 2003 the Ministry of Health, in collaboration with DHBs, will have undertaken a stocktake of existing specialist health services for older people and devised a plan for developing a specialist service that:

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<sup>16</sup> 'Hospital services' refers to high-intensity acute or planned services provided by a general or psychiatric hospital or unit.

- is integrated across assessment, treatment and rehabilitation in community, hospital-based and residential care settings
- provides local leadership for health services for older people
- provides support for primary and community care services in working with older people.

## 6.2 Planning and co-ordination between hospitals, community health and support services and caregivers

6.2.1 The Ministry of Health and DHBs will work with community-based health and support services, hospital service providers and older people to develop the infrastructure to support the use of shared care plans for older people with ongoing health and support needs.

- Jointly held integrated care plans (shared-care plans) will be developed to co-ordinate quality care for older people where more than one service is involved.
- The Ministry of Health will develop a system to facilitate the sharing of health information by service providers and the development of shared-care plans for older people.
- To support the development of integrated care plans, the Ministry will continue the development of best-practice guidelines for clinical decision making.<sup>17</sup> Further work will include guidelines to assist primary health care providers in the clinical management of patients to reduce or delay the need for referral to hospital services.

6.2.2 The Ministry of Health and DHBs will develop implementation plans for integrating hospital care into ongoing care, including arrangements for systematic monitoring and review focused on:

- shared-care plans
- rehabilitation and recovery
- preventing unnecessary or premature admission to residential care – ensuring that early work is targeted at those service users at highest risk.

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<sup>17</sup> Guidelines already developed are available from the New Zealand Guidelines Group. They cover the management of mildly raised blood pressure, congestive heart failure, support and management of people with dementia, management of stable chronic obstructive pulmonary disease, depression and anxiety disorders, and guidelines on management of diabetes. Information can be obtained from the Group's website: <http://www.nzgg.org.nz/library.cfm>

## Examples of initiatives

The Broken Hip Project developed by Elder Care Canterbury with Canterbury Health (now Canterbury District Health Board) focuses on developing greater integration between hospital and community services for older people with a fractured hip. Key components of the project have been:

- the development of an inpatient clinical pathway for acute admissions of people aged 65 or over with a fractured hip
- for patients with an uncomplicated fracture, the general practitioner undertakes the first post-discharge consultation, including review of a check x-ray, six weeks after the person has been discharged from hospital.

## 6.3 Providing age-appropriate care and treatment

6.3.1 The Ministry of Health and DHBs will work with hospital providers on quality improvement measures to provide services that are appropriate to the needs of older people. Areas of work will include:

- planning for facilities that are appropriate to the needs of older people and optimise their recovery
- developing and implementing clinical management tools such as clinical care pathways to systematise clinical decision making and co-ordinate care
- co-ordination of geriatric medical and mental health assessment treatment and rehabilitation services across hospital and community settings
- ensuring staff are properly trained and supported in the care of older people, including care of people with cognitive impairment
- ensuring services are culturally appropriate
- provision for older people who are admitted to hospital for assessment and stabilisation of a mental illness
- developing a discharge plan soon after admission, if not before
- implementing the plan prior to discharge, including providing appropriate information to primary health, community and support services to ensure a smooth transition between services
- providing older people with information about their conditions in an appropriate format and time, including a copy of their care plan.

## Examples of initiatives

### Age-appropriate facilities

- Two studies undertaken in the United States demonstrated improved outcomes for older people (aged 70 or over) who were admitted to specialist units, compared to those admitted to generic services. Key factors in one of the studies were a specially designed environment, a key role for nurses in initiating assessment and care management, planning for discharge, and review of care by a multidisciplinary team (Landefeld et al 1995). The unit in the second study used a risk-factor intervention strategy for older people at risk of developing delirium (Inouye et al 1999).

### Clinical care pathways

- Clinical care pathways are among the most widespread tools (Asplin and Lago 1995, 1996) used to enhance outcomes and contain costs (Dougherty et al 1999; Clare et al 1995; Capuano 1995).
- Auckland hospital has developed a computerised programme for postoperative care for people with a fractured neck of femur. The system can be modified to meet the needs of individuals or groups of patients. The system aims to facilitate establishment of collaborative partnerships between clinicians, patients and their families.

### Discharge planning

- The Hospital Today ... Community Tomorrow project undertaken by the Noarlunga Community Hospital in Adelaide developed and implemented a collaborative hospital discharge process involving early discharge planning; improving two-way communication and information transfer between the hospital and community (general practitioners and community service providers). The project also involved general practitioners and community service providers in the discharge decision-making process, and involved older people in service development decisions (Noarlunga Health Services 1998).
- Counties Manukau, in South Auckland, has a computerised hospital discharge notification system that automatically notifies the relevant general medical practitioner when a patient is discharged.

## 6.4 Assessing options for intermediate level care

- 6.4.1 The Ministry of Health and DHBs will assess the costs and benefits of developing intermediate-level care and rehabilitation for older people, to provide a continuum of care between acute hospital treatment and home-based support. Intermediate services include early treatment and rehabilitation to prevent disease or disability, and slow-stream

rehabilitation or convalescent care following discharge from hospital. Intermediate care can be residential, day programme, or home based.

Overseas research has shown that well-managed intermediate care can improve recovery rates, increase patient satisfaction, reduce the impact on primary and community care services of unplanned discharges from hospital, and avoid unnecessary admission to long-stay residential care. The *National Service Framework for Older People* released by the Department of Health in the United Kingdom has the provision of intermediate care as one of its eight standards (Department of Health 2001). Intermediate care, however, is not a substitute for acute hospital care and there has been criticism of the Department's approach (Grimley Evans and Tallis 2001). Intermediate care provides a link in continuity of care between high-intensity acute services and ongoing home-based support.

Key elements of intermediate care are:

- quick response teams combined with rapid provision of home support
- hospital at home (see below)
- slow-stream rehabilitation or convalescent care (residential or community based).

### Examples of initiatives

- Quick response teams assess older people presenting at emergency departments and explore a range of options for providing necessary care and/or treatment. Often community-based solutions can be found, provided they can be put in place quickly. An evaluation of the Quick Response Team in Auckland (Harris et al in press; Ashton et al in press) found this to be an effective alternative to hospitalisation, with higher client and carer satisfaction and lower stress than a control group admitted to hospital. Costs and outcomes were similar in both groups.
- Hospital at home provides specialist-level medical treatment and specialist nursing and allied health care for people with an acute illness or an acute exacerbation of a chronic illness who prefer to be cared for outside a hospital. A New Zealand example is the scheme established by MidCentral Health in 1999. An assessment of the scheme after six months found significant benefits in terms of client choice, improved continuity of care, and collaboration of a multidisciplinary team (Hansen et al 2001). Overseas research suggests that while patient satisfaction is increased with hospital-at-home provision, carer satisfaction may not be and it may not be more effective in terms of cost and patient outcomes than inpatient hospital care (Sheppard and Iliffe 1998).
- The extended care service run by Pegasus Health in Christchurch provides extra support and care to assist an unwell person at home (generally for up to three days) which may avoid the need to go to hospital. Services include practical

help such as Meals on Wheels, a night sitter, personal care assistance, tests and investigations, free home visits by the family doctor or practice nurse, and could include up to three days in a rest home.

- A five-bed observation unit, run by Pegasus Health, is located in the 24-hour emergency facility and can provide care and supervision for people who are too unwell to remain at home but do not need the full services of a hospital. People usually stay four to six hours and are referred by their family doctor. The unit can assist with tests to confirm or rule out a diagnosis.
- The state of Victoria in Australia has an aged and extended care service system that covers sub-acute, non-acute residential and community care, and provides a comprehensive range of integrated inpatient and community-based services that focus on rehabilitation, restorative care and community support services. The sub-acute service incorporates inpatient care in Extended Care Centres and in dedicated sub-acute units within acute hospitals, together with a range of specialist outpatient clinics, community palliative care and other home-based care such as rehabilitation in the home (Calder 1999).

## Objective 7

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

Development of a wider range of service options and accommodation will enable older people with long-term health and support needs to live in an appropriate environment.

#### **Actions**

- 7.1 The Ministry of Health and DHBs will fund a range of services to support older people and caregivers.
- 7.2 By 2004 the Ministry, in collaboration with DHBs, will have developed standards for quality support services for older people.
- 7.3 In line with the Palliative Care Strategy, the Ministry of Health will work with DHBs to facilitate smooth access to palliative care services for older people receiving long-term care.
- 7.4 The Ministry, in collaboration with DHBs, will review and strengthen provisions for protecting vulnerable older people from abuse.
- 7.5 Long-term support providers (in the community and residential care) will build in opportunities for appropriate health promotion and disability prevention and to support rehabilitation.

The Ministry of Health will also be undertaking related work to develop a plan for addressing issues for people aged under 65 who need integrated health and support services, and for disabled people over the age of 65 who have been receiving disability support services.

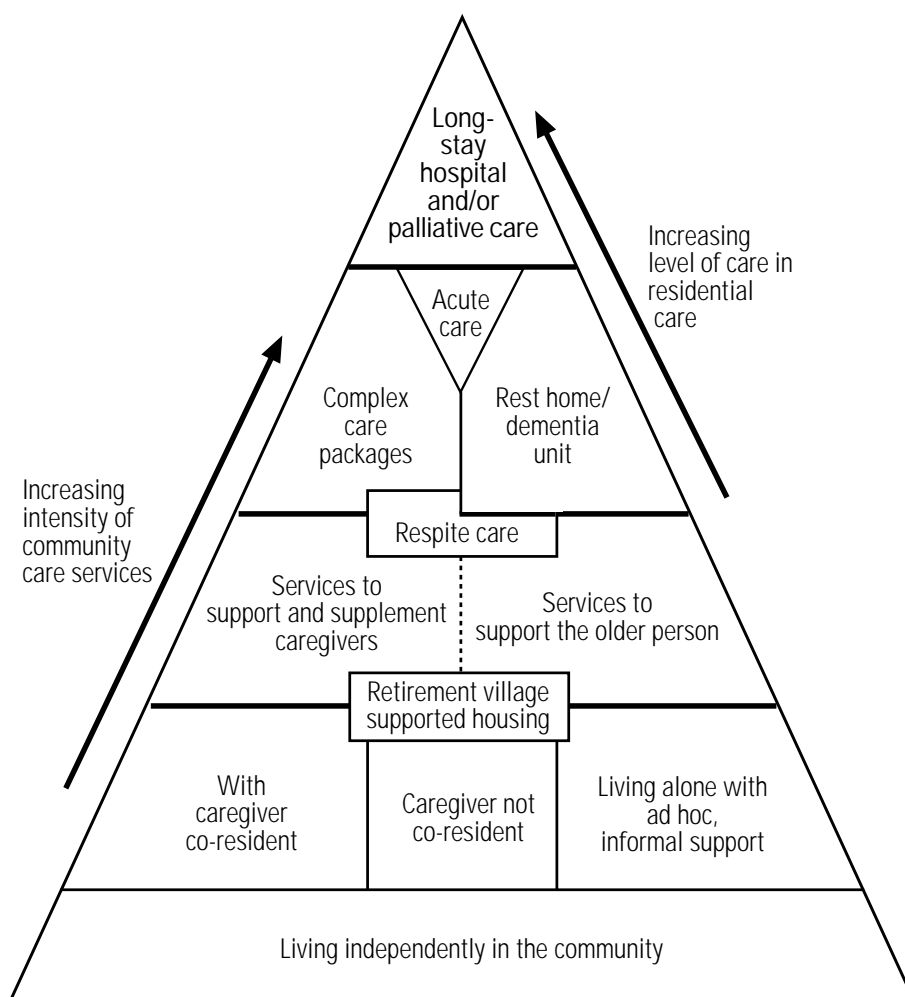
#### **Key steps**

##### **7.1 Funding flexible options to support older people in an appropriate environment**

Figure 4 illustrates the range of support options potentially available to older people at different dependency levels.



**Figure 4: Range of support options for different levels of need**



Source: Adapted from Howe 1996

The base of independent living in the community branches into a range of alternative care options, with social and personal care delivered in a variety of settings. Only at the highest levels of dependency, where there is a need for continuous nursing care, is there little opportunity to substitute other (community-based) care options.

A comprehensive assessment is needed before an older person moves between the support levels in the continuum of care depicted in Figure 4 (the levels are illustrated by a bold line).

7.1.1 By 2004 the Ministry of Health, in collaboration with DHBs, older people, service providers and health sector workforce representatives, will have specified the range of health care and support services needed to respond to the diverse needs of older people and their caregivers. This will include options for supporting:

- older people with high-level support needs, who would otherwise be admitted to long-term residential care
- older people with long-standing mental illnesses

- caregivers, through provision of information and basic training in how to care for the older person and themselves, as well as flexible respite care options. This will include the particular support needs of whānau caregivers for older Māori and family care for other ethnic groups, including Pacific peoples. Service specifications will be updated as necessary.

7.1.2 By 2004 the Ministry will provide guidelines for co-ordinating services for older people with complex and/or fluctuating health and support needs. This could include primary health or community care-based co-ordination such as the Elder Care Canterbury COSE project (action 5.2.2), an extension of assessment treatment and rehabilitation services, or a specialised service co-ordination agency.

7.1.3 By 2004 the Ministry will have collaborated with funders and providers of social housing to promote the development of supported living options for older people. This complements the work identified in action 4.5.1 on low-cost housing options and universal housing design to suit all ages.

Supported living arrangements provide independent accommodation with access to communal facilities and varying levels of support. Examples include units in retirement villages or attached to rest homes, and supported flats, typically administered by local authority or voluntary and welfare agencies. Usually additional assistance is available in the form of social support, liaison with other services, or home support.

Research and expert opinion (Royal Commission on Long Term Care 1999) suggests a need for a more co-ordinated policy, planning and practice approach to housing for older people. Community and individual care plans do not always focus on housing options and there is a need for more collaborative work at the local and national level.

## Examples of initiatives

### Assessment, care planning and co-ordination

- An analysis of 28 trials of comprehensive assessment of vulnerable older people suggested that evaluation followed by strong long-term management increased longevity and functional capacity (Stuck et al 1993). A programme of in-home assessments followed by recommendations and education in an American population aged 75 and older delayed the development of disability and reduced the number of nursing home admissions (Stuck et al 1995). This finding was repeated in a trial with explicit care management interventions in Italy (Bernabei et al 1998). The latter trial was the Silver Network Home Care project in Italy (referred to in the examples under action 2.2).

### **Carer support**

- The Marsden and Chelsea Day Care Trusts in Wellington run clubs for people with dementia to provide interesting activities for them and provide day relief for family caregivers (Nairn 2001).
- Lambeth Health Care in Britain provides night-time relief for families caring for an older person with dementia.

### **Supported housing**

Examples of supported housing include:

- Abbeyfield supported living options for older people in Nelson and Auckland
- kaumātua housing in Tairāwhiti and Christchurch
- Horowhenua, Ashburton and Christchurch District Councils permit high-density housing in some areas to enable clusters of more compact older persons' housing to be developed
- universal design housing in New Zealand and the United Kingdom: these are houses that include universal access which makes allowances for wheelchairs, walkers and other mobility aids
- Manukau City Council provides housing for older people, with a full-time administrator and three visiting wardens involving weekly visits to each housing complex and contact with families/tenants if required.

## **7.2 Development of quality standards for support services for older people**

7.2.1 By 1 July 2002 the Ministry of Health, in collaboration with DHBs, service providers and representatives of the health sector workforce and older people, will have identified quality issues in residential care for people with dementia and will have begun developing specific dementia standards for residential services (action 2.4.1).

7.2.2 By June 2003 the Ministry will have determined the need for further specific standards for consumer protection.

## **7.3 Implementation of the Palliative Care Strategy**

The Palliative Care Strategy recommends that palliative care should generally be available to people whose death from progressive disease is likely within 12 months (Minister of Health 2001a). Most recipients of palliative care are older people. For some, the need for palliative care comes at the end of a progressive disease, which has required long-term, often high-level and complex care.

A Ministry of Health review has identified lack of co-ordination between long-term care services and palliative care services as an issue to be resolved.

7.3.1 The Ministry of Health, in collaboration with DHBs, will undertake work to determine appropriate funding levels and service provision to support a seamless transition for people receiving long-term care who need palliative care to alleviate pain and other distressing symptoms, and/or provide support during the last months of life.

## **7.4 Protecting vulnerable older people from abuse**

Providing protection for vulnerable older people calls for strong relationships between health and other social support, community and voluntary agencies and clear mechanisms and processes for responding to incidences of abuse.

7.4.1 The Ministry of Health will participate in intersectoral work to review legislative protections for vulnerable people, including older people, such as the Ministry of Justice re-evaluation of human rights protection in New Zealand and review of the provisions for enduring power of attorney in the Protection of Personal and Property Rights Act 1988 (PPPR Act).

7.4.2 The Ministry of Health will support the development of protocols and training for health providers in recognising and responding to family violence and abuse.

7.4.3 The Ministry of Health and DHBs will work collaboratively with elder abuse and neglect prevention services and other relevant community agencies to:

- strengthen the community supports available to older people at risk of abuse
- increase community awareness through education to minimise the potential for elder abuse
- promote co-ordinated, timely and culturally effective responses by agencies when there is abuse
- encourage older people and their families to use the provisions of the PPPR Act to protect older people and to determine advance directives and proxies.

## Examples of initiatives

- Currently, government funding is provided through the Department of Child, Youth and Family services for 22 elder abuse and neglect prevention services throughout the country.
- Other interventions include programmes to change community attitudes, such as the Age Concern resource kit (Age Concern New Zealand Inc. 1992), and the Ageing is Living Resource; information on the protections and provisions of legislation, particularly the provisions of the PPPR Act.

### 7.5 Long-term support providers will promote clients' health, wellbeing and rehabilitation

Older people receiving long-term support can benefit from the public health actions identified in Objective 4, particularly from good nutrition, physical activity and a range of initiatives to reduce the risk of falls.

7.5.1 Contracts with providers of long-term home support and residential care will need to include the following quality components:

- Service providers will link clients with, or incorporate appropriate health promotion and rehabilitation programmes into, the service they provide.
- Rehabilitation programmes will be supervised or delivered by appropriately trained health professionals.
- Job descriptions for health aids will include a focus on maintaining the older client's functional ability.
- Health practitioners visiting residential care clients will be proactive in monitoring and assessing residents' health status to detect and treat conditions at an early stage.

These requirements will have implications for the training, supervision and remuneration of health aids and will increase the cost of the service.

Implementing this action will be dependent on funding being released from savings elsewhere in the service mix. If the strategy is to succeed in achieving its vision, it must be through a demonstrable reduction in preventable disease, injury and disability in older people, which is reflected in lower utilisation rates for high-cost hospital and long-term residential care.

## Examples of initiatives

- In a randomised control trial of home-based rehabilitation following an acute injury, the Home Treatment Team in Lambeth, Britain, found that patients could be discharged earlier, were more likely to remain at home one year later, and had a higher quality of life. The project used health care assistants trained in rehabilitation and led by two experienced nurses. All clients referred to the team underwent a multidisciplinary assessment and any problems identified as reversible were addressed through a prescriptive care plan. Appropriate therapists evaluated client progress and established new care regimes as required (Martin et al 1994).
- The Woburn and Horowhenua Masonic Villages in Lower Hutt and Levin provide multidisciplinary rehabilitation in specially equipped units. Older people may attend either as day or part-day patients, or stay in the rest home or hospital for a set period of time. The aim is to rehabilitate older people back to their own homes.
- The Presbyterian Support, Woburn Aged Care Complex in Lower Hutt provides a seven-days-a-week club for people with early dementia, catering for residents and day visitors. Informal feedback has indicated improved functioning, less aggression and better sleeping patterns (Sanders 2001).
- Studies have shown that Vitamin D replacement is effective in preventing fractures. All residents at Northbridge rest home in Auckland routinely receive multi-vitamin supplements. Research has also shown that by sitting in the sun for 15 to 30 minutes daily Vitamin D levels rise to optimal levels within one month (Reid et al 1986).

# Monitoring and Supporting Change

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## Monitoring and evaluating progress

An important component of the Health of Older People Strategy is the monitoring and reporting mechanisms that support implementation of this strategy. Progress in implementing the strategy will be monitored in the following ways:

- DHB plans will include milestones that will be reflected in performance measures in annual funding agreements.
- The Ministry of Health is required to report annually on progress made on actions specified under the New Zealand Positive Ageing Strategy Action Plan. An annual progress report on projects listed in the Action Plan will be provided to Cabinet and the Action Plan will be updated yearly. For the 2001/02 year the Action Plan includes development of the Health of Older People Strategy, including an implementation plan.
- The Ministry of Social Policy will prepare a report on the status of older people at approximately three-yearly intervals to assess progress towards implementing the New Zealand Positive Ageing Strategy. Evaluation of implementation of the Health of Older People will be staged to coincide with the requirements of the Positive Ageing Strategy.

Both the monitoring and evaluation processes will include specific consideration of implementation issues for older Māori and Pacific people and other groups experiencing health inequalities.

## Research and information needed

There is an extensive body of international literature on the impact of an ageing population and the health and support needs of older people. The New Zealand literature is also growing, but funding for research into ways of improving older people's health and wellbeing tends to be ad hoc and there are significant gaps in routine statistical information on service utilisation and health status.

The newly formed New Zealand Institute for Research on Ageing provides a vehicle for furthering research on ageing and for co-ordinating research and disseminating research findings throughout New Zealand.

Priority areas for research are:

- development and evaluation of interventions to promote the health and wellbeing of older people (this includes health promotion, injury and disease prevention, treatment, home-based, residential and environmental<sup>18</sup> support services)
- development and evaluation of rehabilitation initiatives
- assessing the effectiveness of health interventions to reduce and delay onset of disease and disability amongst older people
- assessing the effectiveness of service provision, in particular the effectiveness of different mixes of services and what works best to adequately support older people to remain in their own homes (particular areas of work are development of outcome measures and evaluation of early interventions for dementia)
- documenting and assessing the adequacy of staffing levels, skill mix, training opportunities and working conditions of the health sector workforce.

Priority areas for improved routine data collection are:

- improving the quality of the Mental Health Information National Collection (MHINC)
- information on demand for services identified by needs assessment
- information on utilisation patterns for support services
- health status and service utilisation for older Māori
- health status and service utilisation for older Pacific peoples
- information on the size and composition of the health workforce, particularly the Māori and Pacific workforces.

Research is also needed in the following areas:

- affordability and access to health and support services
- the extent of informal caregiving, and projecting future trends in caregiving to and by older people
- international comparisons of health service provision and utilisation patterns and health status
- the reliability of assessment tools for determining eligibility for services
- mechanisms for ensuring quality and preventing abuse.

Access to local and international information on issues and research relating to the health of older people has increased significantly in recent years, with most information sources now having web sites. Key organisations include WHO, government health and social welfare departments, universities and research foundations.

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<sup>18</sup> 'Environmental' support services include equipment, appliances and modifications to home or vehicle.



# Glossary

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Ageing in place	The ability to make choices in later life about where to live, and to receive the support needed to do so.
Annual plans	Operational plans covering a 12-month period.
Assessment Treatment and Rehabilitation Services (AT&R)	The aim of AT&R services is to: <ul style="list-style-type: none"><li>• identify and treat potentially reversible conditions with the potential for rehabilitation</li><li>• manage symptoms</li><li>• restore clients to their maximum possible level of function.</li></ul>
Caregiver (voluntary caregiver)	A voluntary caregiver or carer is a person, usually a family member, who looks after a person with a disability or health problem, and who is unpaid.
Continuum of care	Flexible service provision that provides a seamless transition between services in response to a person's changing needs over time.
Culturally appropriate services	Services responsive to, and respectful of, the history, traditions and cultural values of the different ethnic groups in our society.
District Health Boards (DHBs)	District Health Boards are organisations established to protect, promote and improve the health and independence of a geographically defined population. Each District Health Board will fund, provide or ensure the provision of services for its population.
Evidence-based practice	Clinical decision making based on a systematic review of the scientific evidence of the risks, benefits and costs of alternative forms of diagnosis or treatment.
Funding agreement	This is the agreement the Crown enters into with any person or entity under which the person or entity agrees to provide or arrange the provision of services in return for payment. For District Health Boards, this will include the District Health Board Annual Plan, funding schedules and the District Health Board Statement of Intent.
Health aid	Health care and home support workers. Health care workers provide hands-on personal care, in residential care or a client's home, assisting them with activities of daily living and personal hygiene. Home support workers perform household tasks. The two roles may be performed by the same person.

Hospital services	High-intensity, acute or planned, services provided by a general or psychiatric hospital or unit.
Independent nurse prescribing	A nurse who has obtained registration with the Nursing Council will be authorised to prescribe medicine independently from a specified list of medicines approved for their particular scope of practice. The lists of medicines will be set out in the regulations. The regulations define the aged care scope of practice for nurses who attain registration as a nurse prescriber.
Integrated services / care	Integrated services are funded and provided within a consistent philosophical, policy and practice base. Integrated services are centred primarily on the needs of the older person, but also on the needs of caregivers, family and whānau. For Māori operating within a framework of whānau ora, this means placing the whānau at the centre of health care and support for older Māori.
Intermediate-level care	Services to avoid preventable hospitalisation or support early discharge from hospital. They include early treatment and rehabilitation to prevent disease or disability, and slow-stream rehabilitation or convalescent care following discharge from hospital.
Lifestyle	Lifestyle is a way of living in terms of identifiable patterns of behaviour based on an individual's choice, and influenced by the individual's personal characteristics, social interactions, and socioeconomic and environmental factors.
Long-term care	Care provided in a residential setting (long-term hospital or rest home).
Long-term support	Care and support provided by voluntary caregivers and/or professionals to an older person who is not fully capable of self-care.
Monitoring	The performance and analysis of routine measurements, aimed at detecting changes.
Nurse Practitioner™ in aged care	A registered nurse practising at an advanced practice level in a specific scope of practice who has been prepared at master's level of education and has been recognised and approved by the Nursing Council of New Zealand.
Pacific peoples	The population of Pacific Island ethnic origin (for example, Tongan, Niuean, Fijian, Samoan, Cook Island Māori and Tokelauan) born in New Zealand as well as overseas.

Performance indicator	A measure that shows the degree to which a strategy has been achieved.
Positive ageing	This concept embraces a number of factors, including health, financial security, independence, self-fulfilment, community attitudes, personal safety and security, and the physical environment. Positive ageing means that older age is both viewed and experienced positively and involves changing attitudes and expectations amongst younger generations regarding ageing and older people.
Primary health care	Primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to and a central function of the country's health system, and is the first level of contact with the health system.
Primary Health Organisation	A Primary Health Organisation under the Primary Health Care Strategy is a collective of health care providers and health practitioners that provide a set of essential primary healthcare services to an enrolled population. At a minimum these services will include approaches directed towards improving and maintaining the population, as well as first-line services to restore people's health when they are unwell.
Programme	A programme is a group of activities directed towards achieving defined objectives and targets.
Psychogeriatric services	Also called psychiatry of old age, these are psychiatric services provided to older people with functional and organic mental disorders. Functional disorders include depression, anxiety, bipolar disorder and schizophrenia. Organic disorders include dementia, delirium, organic personality disorders and delusional states.
Second-level nurse	An interim term for a level of worker who will practise under the direction and supervision of a registered nurse. The Nursing Council of New Zealand is the statutory body responsible for approving all nursing education programmes.
Socioeconomic disadvantage	A relative lack of financial and material means experienced by a group in society, which may limit their access to opportunities and resources that are available to the wider society.
Strategic plans	Plans produced by District Health Boards and the Ministry of Health that will outline the strategic direction over a five-to ten-year period.

Supported living	Accommodation for older people that provides: <ul style="list-style-type: none"> <li>• an explicit focus on privacy, autonomy and independence, including the ability to lock doors and use a separate bathroom</li> <li>• an emphasis on apartment settings in which residents may choose to share living space</li> <li>• the direct provision of, or arrangement for, home support, personal care and some nursing services, depending on need.</li> </ul>
Whānau	Extended family including kaumātua, pakeke, rangatahi and tamariki. The whānau is recognised as the foundation of Māori society.
Wellness	A dimension of health beyond the absence of disease or infirmity, including social, emotional and spiritual aspects of health.

# Appendix 1: Key Factors in Successful Integration

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Under the current contracting and operating environment, many health and support service providers are focused on delivering discrete units of service based on specific medical conditions or types of intervention. Evaluation reports on integrated care projects, including demonstration pilots in New Zealand<sup>19</sup>, have identified the following key success factors in an integrated approach to health care and support.

1. The planning framework needs to encompass population-based health initiatives as well as health care and support services. This requires:
  - an inclusive approach to planning which accommodates a broad range of interests (including older people and caregivers)
  - key stakeholders having a clear understanding of integrated care and its implementation, and actively supporting integration
  - Māori and community involvement from the beginning of developing an integrated approach
  - the change process centring on improving services for older people and on changing attitudes at all levels of professional, service and management structures
  - a clearly defined structure for developing an integrated approach
  - planning and implementation structures and processes being sufficiently flexible and adaptable to respond to changes and find ways forward
  - evaluation and feedback loops built in from the beginning.
2. The funding agency needs to be able to transfer funding between services to promote the most effective and efficient use of those services.
3. Services need to be:
  - focused on the needs and goals of the older person, family, whānau and caregivers
  - culturally appropriate
  - easily accessed by older people, who are provided with good information about availability and location
  - based on a co-operative, collaborative approach between all service providers, older people and family, whānau, caregivers and the community

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<sup>19</sup> Health Funding Authority and Ministry of Health contracted evaluations of National Demonstration Integrated Care Pilot Projects January 2001.

- innovative and flexible, to meet the diverse and changing health and support needs of older people and family, whānau and caregivers
- set up to have consistent access criteria and clear accountability for service delivery
- operating with a reflective feedback loop focused on ongoing improvements and achieving best value for money from decisions about what services to provide and when
- developed to include the following range of services:
  - information to assist older people and caregivers to access services and make informed decisions
  - health promotion and healthy living counselling to assist people to maintain or regain good health
  - assessment, reassessment and early intervention to address ill health and support needs
  - alternatives to hospitalisation, where feasible
  - rehabilitation to maximise good health, functional abilities and self efficacy
  - long-term care that recognises rehabilitation opportunities.

# Appendix 2: Draft Timeline for Implementing Health of Older People Strategy Actions

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The following tables set out an indicative timetable for work to be completed by 2003, 2006 and 2010. Priority for completing work with or by DHBs will be developed in collaboration with individual boards. Other actions will be developed as progress is reviewed and further work identified.

**Table A1: Actions for completion by July 2003**

Actions/steps	Objective
Work with 'early leader' DHBs will develop models of an integrated continuum of care (by 30.6.02, and ongoing)	1.1
Ministry of Health work programme to support implementation of the strategy (by 30.6.02 revised annually)	1.2
A conference held to promote changes needed to implement the strategy (by 30.6.03)	1.2
Publication of a statistical reference report on demographic change, health status and service utilisation of older people* (by 28.2.02)	1.3
Publication of preliminary statistics report on mental health service utilisation by older people (24.12.02, updated report by 24.12.04)	1.3
Comprehensive data available to model service demand* (by 30.6.03)	1.3
Advice on funding long-term care (links to analysis of overall level of funding for health services)* (by 1.8.02)	2.1
Implementation plan and guidelines for comprehensive needs assessment for older people and caregivers* (by 30.6.02 regular reviews)	2.2
Review of mental health services for older people (by 30.6.02)	2.3
Service development plan for older people with dementia (by 30.6.02) Implement plan (ongoing) (links with mental health service, review of specialist services for health of older people and quality standards work)	2.4
Collaborate with ACC on managing access to and transition between services (by 30.6.02 and ongoing)	2.6

\* work planned or under way

Actions/steps	Objective
A process for collaboration with local iwi and Māori to develop culturally appropriate public health programmes, primary and hospital health services and long-term care for older Māori (by 30.6.03 and ongoing)	3.1, 3.3
Access options for reducing cost barriers to primary health care starting with those most in need (includes older people with chronic conditions)* (by 30.6.02 and ongoing)	5.3
Facilitate development of a plan for implementation of the Primary Health Care Strategy in rural areas – will assist older people as well as others in rural areas* (by 30.6.02 and ongoing)	5.4
Review of specialist health services for older people (by 30.6.03)	6.1
Commenced development of specific residential care standards for dementia* (by 1.7.02)	7.2
Determined the need for further specific standards for consumer protection (by 30.6.03)	7.2

\* work planned or under way



**Table A2: Actions for completion by end of 2006**

Actions/steps	Objective
Plans for Pacific and mainstream health and support services to meet the needs of older Pacific peoples and their families	1.5
Plan for Māori workforce and provider development to meet the needs of increased numbers of older Māori from 2010	3.2
Initiate public health action on nutrition, physical activity and reducing depression, loneliness and falls	4.1, 4.2, 4.3, 4.4
Collaborate with key sectors impacting on health – housing and transport	4.5
Assess options for intermediate-level rehabilitation and convalescent care. Develop implementation plan as appropriate	6.4
Development of guidelines for service co-ordination for older people with complex health and support needs	7.1
Specification of the range of long-term care and support options to provide a flexible response to diverse need	7.1

\* work planned or under way

**Table A3: Actions with completion dates yet to be determined**

Actions/steps	Objective
DHB strategic plans outline the broad approach to implementing the Health of Older People Strategy	1.1
Health and support service workforce planning and training provide for the needs of an ageing population (links to Health Workforce Advisory Committee work, primary health care, nursing, and health aid workforce development projects*)	1.4
Public information on healthy living, access to services, and complaints procedures	2.5
Development of advocacy services for older Māori	3.4
Primary Health Care Strategy is implemented with a greater emphasis on population health, the role of the community, health promotion and preventive care and co-ordination across a range of professionals and services*	5.1
Assess and develop active care management initiatives in primary health and community care, such as early detection of disease/disability, service co-ordination and support for management of complex medical conditions (partially under way)	5.2
Develop systems for planning and co-ordinating care between community and hospital (including shared care plans)	6.2
Completion of best-practice guidelines to support clinical decision making and shared care plans (consolidates guidelines already developed)	6.2
Provision of age-appropriate care and treatment in acute hospitals for older people	6.3
Implement the Palliative Care Strategy (including older people receiving long-term care accessing palliative care as appropriate)	7.3
Strengthen provisions for protecting vulnerable older people, including: <ul style="list-style-type: none"> <li>• review of enduring power of attorney in PPPR Act (led by Ministry of Justice)</li> <li>• compliance with human rights legislation</li> <li>• support development of family violence protocols and provider training</li> </ul>	7.4
Long-term support providers build in opportunities for appropriate health promotion, disability prevention and rehabilitation	7.5

\* work planned or under way

# Appendix 3: Members of the Expert Advisory Group and the Sector Reviewers

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The Ministry of Health would like to thank the members of the Expert Advisory Group and sector reviewers for their invaluable contribution to developing the draft Health of Older People Strategy.

## Expert Advisory Group Members

Dr Jill Calveley	Programme Specialist, Auckland Healthcare
Lorna Dyall	Senior Lecturer, Māori and Pacific Health and Public Health, University of Auckland
Dr Keith Gibb	Retired GP, involved in Elder Care Canterbury
Pam Greenaway	Manager, Services for Older People and Disabled People, Pacific Health
Dr Margaret Guthrie	President, Age Concern; Consultant Gerontologist
Dr Carl Hanger	Geriatrician, Princess Margaret Hospital, Christchurch
Dr Sally Keeling	Social Scientist, Christchurch School of Medicine
Dr Pam Melding	Consultant in Old Age Psychiatry; Chair of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists
Dr Verna Schofield	Social Worker; Alzheimer's Disease International executive member
Margaret Southwick	Pacific Health Research Centre, Whitireia Polytechnic, Porirua

Special thanks are due to Matthew Parsons, Senior Lecturer in Gerontology, Medical and Health Sciences, Auckland University, who worked closely with the Ministry of Health on identifying evidence and examples of innovative practice.

## Sector reviewers

Garth Taylor	Age Concern New Zealand
Bruce Gollop	District Health Board NZ (CEO)
Nigel Millar	Elder Care Canterbury
Cheryl Hamilton	Health Promotion Forum
Barbara Disley	Mental Health Commission

Maree Todd	NZ Association of Gerontology
Shereen Maloney	NZ Home Health Association Inc
Lesley Clarke	NZ Private Hospitals Association
Stephen Neville	College of Nurses Aotearoa
Carol Cowan	NZ Physiotherapy Association
Linda Bryant	Pharmaceutical Society of NZ
Petrina Turner	Residential Care NZ Inc.
Claire Austin	Royal New Zealand College of General Practitioners
Susan Gee	NZ Institute for Research on Ageing, Victoria University of Wellington
Chris Cunningham	Department of Māori Studies, Massey University
Judith Byrne	New Zealand Council of Trade Unions health sector group

# Appendix 4: Relevant Government Strategies

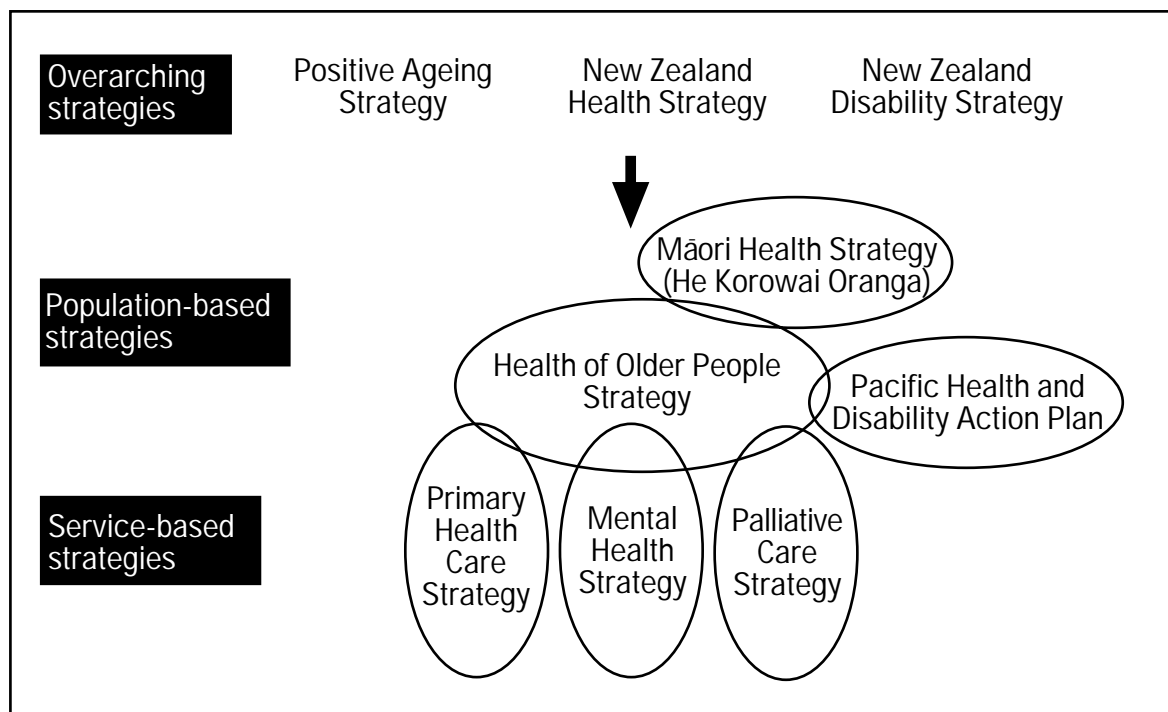
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## Health of Older People Strategy and other strategies

The New Zealand Positive Ageing Strategy, the New Zealand Health Strategy and the New Zealand Disability Strategy provide an overarching set of aims and principles within which the Health of Older People Strategy has been developed. The Health of Older People Strategy also links with a number of other health service specific strategies – the draft Māori Health Strategy (He Korowai Oranga), the Pacific Health and Disability Action Plan and the Primary Health Care, Palliative Care and Mental Health strategies (FigureA1).

The diagram below identifies the relationship between the Health of Older People Strategy and the Positive Ageing Strategy, the Disability Strategy and relevant health strategies.

**Figure A1: Relationship between strategies**



The key points from these strategies are summarised below.

## **New Zealand Positive Ageing Strategy**

The Positive Ageing Strategy outlines a vision for a society:

Where people can age positively, where people are highly valued and where they are recognised as an integral part of families and communities. New Zealand will be a positive place in which to age when older people can say that they live in a society that values them, acknowledges their contributions and encourages their participation (Minister for Senior Citizens 2001).

The vision is supported by 10 principles and the strategy identifies 10 goals that focus on the areas of income, health, housing, transport, ageing in place, cultural diversity, rural areas, attitudes, employment and opportunities. The recommended key actions to achieve the health goal of 'equitable, timely, affordable and accessible health services for older people' are to:

- promote holistic-based wellness throughout the life cycle
- develop health service options that allow integrated planning, funding and delivery of primary, secondary, residential care and community support services
- ensure the availability of multidisciplinary comprehensive geriatric needs assessment throughout New Zealand.

Each year government departments will identify work items for an action plan to achieve the Positive Ageing Strategy goals and report on progress in the previous year. The Health of Older People Strategy is one of the Health work items identified in the 1 July 2001 to 30 June 2002 Positive Ageing Strategy Action Plan.

## **New Zealand Health Strategy**

The New Zealand Health Strategy sets the platform for the Government's action on health. It identifies the Government's present priority areas and aims to ensure that health services are directed at those areas that will ensure the highest benefits for the population, focusing in particular on tackling inequalities in health.

The Strategy identifies seven fundamental principles for the health sector and, out of a total of 10 goals and 61 objectives the Strategy highlights 13 population health objectives and three priority objectives to reduce inequalities in health. The three priority objectives are to:

- ensure accessible and appropriate services for people from lower socioeconomic groups
- ensure accessible and appropriate services for Māori
- ensure accessible and appropriate services for Pacific peoples.

The strategy is a living document and will continue to be refined over time. Details of how specific priority areas will be addressed are either set out in more specific strategies and action plans (such as the Health of Older People Strategy) or are being worked through in the development of tool kits that will provide guidance for DHBs and identify performance indicators. While none of the tool kits are specific to older people, it is anticipated that the tool kits and the Health of Older People Strategy will reinforce consistent messages to funders and providers of health and support services for older people.

## **New Zealand Disability Strategy**

The New Zealand Disability Strategy presents a long-term plan for changing New Zealand from a disabling society to an inclusive society. New Zealand will be fully inclusive when people with impairments can say they live in 'a society that highly values our lives and continually enhances our full participation'.

The Strategy specifies 15 objectives (and associated actions) to underpin the vision. The objectives are to:

1. encourage and educate for a non-disabling society
2. ensure rights for disabled people
3. provide the best education for disabled people
4. provide opportunities in employment and economic development for disabled people
5. foster leadership by disabled people
6. foster an aware and responsive public service
7. create long-term support systems centred on the individual
8. support quality living in the community for disabled people
9. support lifestyle choices, recreation and culture
10. collect and use relevant information about disabled people and disability issues
11. promote participation of disabled Māori
12. promote participation of disabled Pacific people
13. enable disabled children and youth to lead full and active lives
14. promote participation of disabled women to improve their quality of life
15. value families, whānau and people providing ongoing support.

There will be annual work plans to implement the Strategy, beginning with key government departments for 2001/02 and rolling out to other departments in 2002/03. The Minister for Disability Issues will report annually to Parliament on progress, and full reviews of progress on implementing the strategy will be conducted after five and ten years.

## He Korowai Oranga Māori Health Strategy Discussion Document

The He Korowai Oranga Māori Health Strategy Discussion Document (Minister of Health 2001c) sets two broad directions that reflect the important roles both Māori and the Crown have in implementing health and disability strategies for Māori. These recognise that both Māori and the Crown have aspirations and roles in improving Māori health. Public consultation on the discussion document took place in May 2001 and a final strategy is due in December 2001.

The overall aim of *He Korowai Oranga* is whānau ora: healthy Māori families supported to achieve their maximum health and wellbeing. The strategy proposes four pathways to achieve the aim of whānau health:

- the Crown working collaboratively with whānau, hapū and iwi to identify what is needed to encourage health as well as prevent or treat disease
- active participation by Māori communities at all levels of the health and disability sector
- ensuring that whānau receive timely, high-quality, effective and culturally appropriate health and disability services
- the health and disability sector taking a leadership role across the whole of government and its agencies to address the broad determinants of health.

Each pathway has associated objectives with identified policies, processes and steps that will underpin more detailed action plans for DHBs. The action plans will include targets and performance measures, as well as guidelines and standards on how to achieve service effectiveness.

## Draft Pacific Health and Disability Action Plan

The draft Pacific Health and Disability Action Plan is aligned to the New Zealand Health Strategy, New Zealand Disability Strategy and Primary Health Care Strategy. The focus of the Action Plan is long term. It sets out approaches to improve the overall health of Pacific people as well as reduce the inequalities that contribute to poor health. Immediate priorities within the Action Plan are the continued implementation of provider and workforce development.

Information and research on issues for Pacific elderly in New Zealand is sparse, yet is important in informing the design and development of primary and preventive healthcare services.

The draft Pacific Health and Disability Action Plan supports the need for responsive health promotion programmes that progress healthy lifestyles for Pacific elderly and their families, development of a workforce specialising in the health and wellbeing of Pacific elderly, and development of integrated health promotion and primary health service delivery to the elderly.



## Primary Health Care Strategy

The Primary Health Care Strategy defines quality primary health care as essential health care that is based on practical, scientifically sound, culturally appropriate and socially acceptable methods and that is:

- universally accessible to people in their communities
- involves community participation
- integral to, and a central function of, New Zealand's health system
- the first level of contact with our health system.

Primary health care covers a broad range of services (although not all of them are government funded), including:

- participating in communities and working with community groups to improve the health of the people in the communities
- health improvement and preventive services, such as health education and counselling, disease prevention and screening
- generalist first-level services, such as general practice services, mobile nursing services, community health services, and pharmacy services that include advice as well as medications
- first-level services for certain conditions (such as maternity, family planning and sexual health services and dentistry), or those using particular therapies (such as physiotherapy, chiropractic, and osteopathy services, traditional healers and alternative healers).

The Primary Health Care Strategy aims for closer co-ordination across all of these services. Its vision is that over the next five to ten years:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

The six key directions for achieving this vision and moving to a system that is organised around the needs of a defined group of people are (Minister of Health 2001b: 6)

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people's health
- co-ordinate care across service areas
- develop the primary health care workforce
- continuously improve quality using good information.

Each direction has associated key actions that will form the basis of work to achieve the vision. All of these key directions are important for older people. Key directions 3 and 4 are of particular relevance to the direction of the Health of Older People Strategy.

## **New Zealand Palliative Care Strategy**

The New Zealand Palliative Care Strategy sets in place a systematic and informed approach to the future provision and funding of palliative care services. The Palliative Care Strategy was developed for the following reasons.

- Evidence shows that palliative care is effective in improving the quality of life for people who are dying.
- Palliative care needs to be better understood and accepted by health professionals.
- There is a demonstrable need for palliative care now, and increasingly into the future.
- Palliative care provision is complex, and a range of issues need to be addressed.

There are nine strategies identified for implementing the Palliative Care Strategy over the next five to ten years to achieve the vision:

All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a co-ordinated way.

Additional funding has been allocated to implement the first two priorities, ensuring that essential services are available for all dying people, and that at least one local palliative care service is available in each DHB. The other strategies will be implemented in line with other government priorities outlined in the New Zealand Health Strategy.

## **Looking Forward: Strategic Directions for the Mental Health Services**

This 1994 national strategy confirmed the fundamental change in direction from a hospital-based service to a community-based service. The strategy identified a number of priority areas and priority groups and set out five key strategic directions for service development.

Strategic direction 1, implementing community-based and comprehensive mental health services, identifies older people as one of the priority groups requiring research into their specific needs and the establishment of benchmarks before the most appropriate type of services can be developed. Targets for older people's access to specialist mental health services will be set by 30 June 2002, in line with Moving

Forward, the implementation plan for the strategy. Additional work being undertaken by the Ministry of Health on specialist mental health services for older people is identified in key step 2.3 of this strategy.

# Appendix 5: Demand for Health and Support Services

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Key factors that influence demand for health and support services are the size and age structure of the population, the health status of that population, technological advances, and people's expectations of health and support services. The following sections provide a brief overview of population ageing, service utilisation and health status.<sup>20</sup>

## Population ageing

The New Zealand population is ageing because of three key trends: the baby boomer generation growing older, the overall increase in life expectancy, and a decline in fertility (the number of children born per woman).

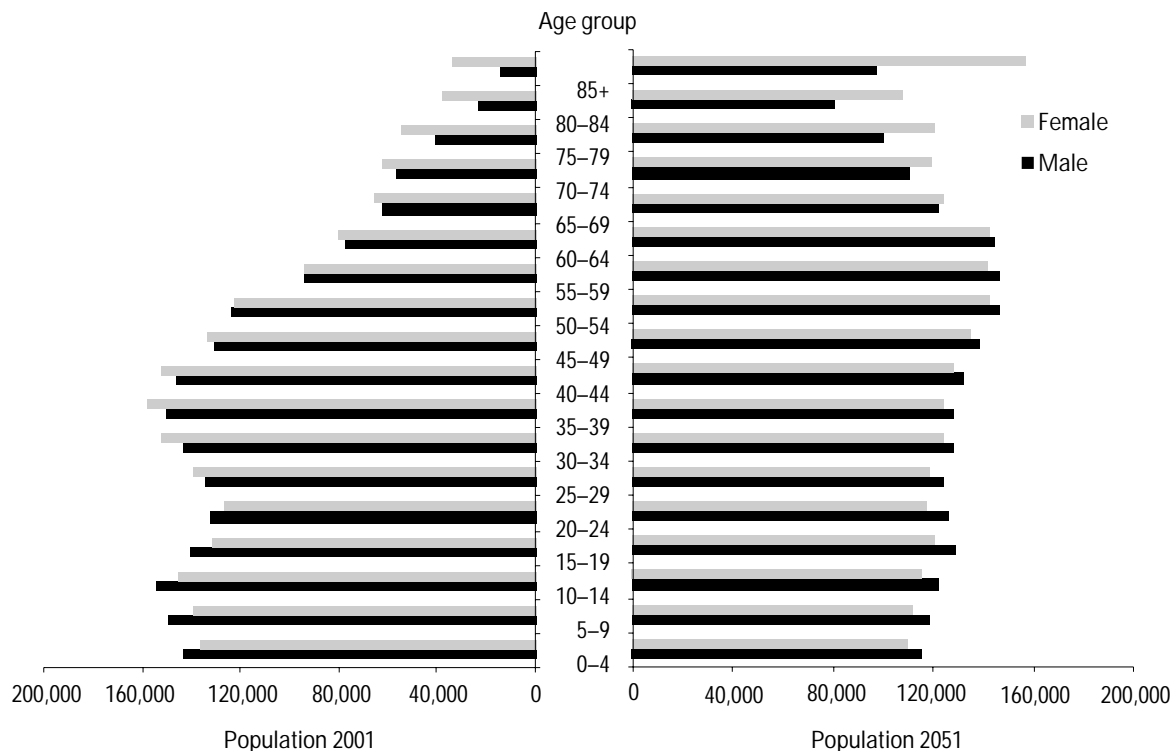
The growth in the proportion of older people in the population will be gradual for the next nine years, but from 2010 the increase will be noticeable (see Figure 1). Since 1996 the population aged 65 and over has grown at approximately 1 percent per annum. Currently 456,000 (11.5 percent) of people in New Zealand are aged 65 or over, 207,000 (5.2 percent) are aged 75 or over and 49,000 (1.2 percent) are aged 85 or older.

There are risks in projecting population numbers too far into the future, but it is anticipated that people aged 65 and over will increase to 13 percent of the total population by 2011, rising to 22 percent by 2031. By 2051 there will be 1.18 million people (25 percent) aged 65 and over, 680,000 (15 percent) aged 75 and over, and 258,000 (6 percent) aged 85 and over. Figure A2 illustrates the dramatic ageing of New Zealand's population over the next 50 years.

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<sup>20</sup> The final Health of Older People Strategy will be accompanied by a statistical report on older people's health and service utilisation.

**Figure A2: Projected population pyramids for New Zealand in 2001 and 2051, by five-year age groups**

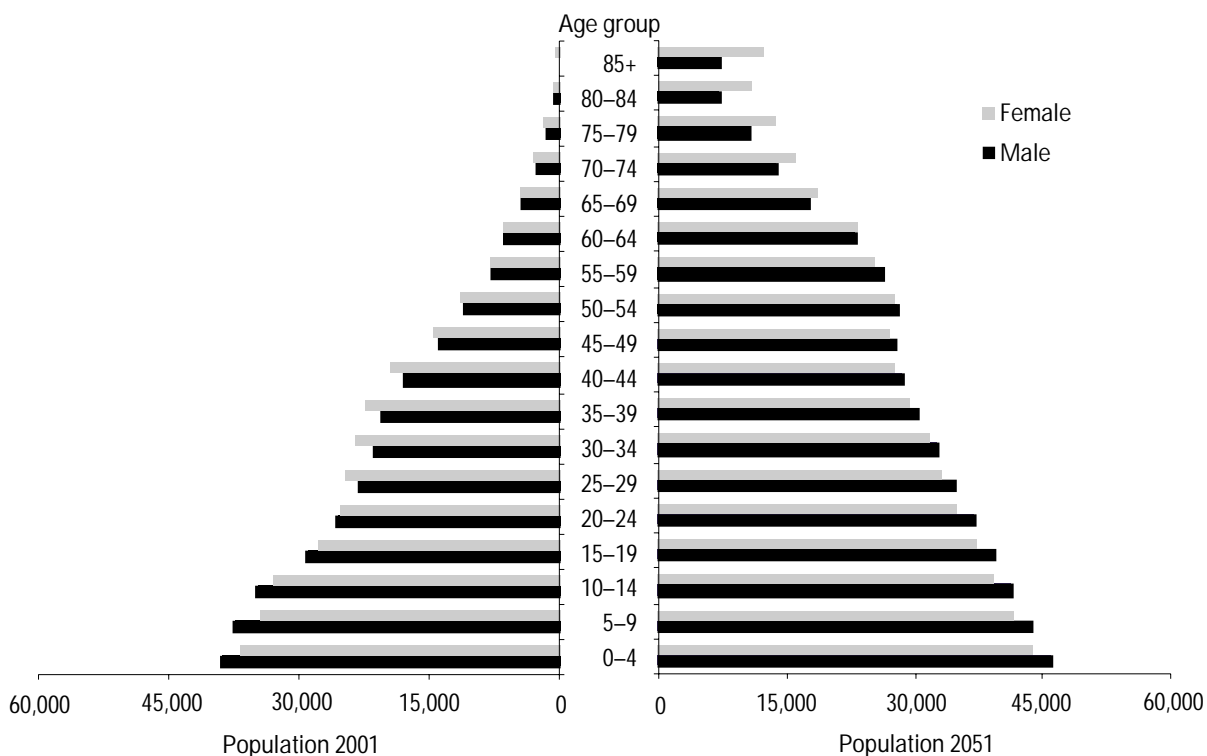


Source: Statistics New Zealand, Population Projections

A diversity of cultures and lifestyles within New Zealand means that older people are also becoming increasingly more heterogeneous. Although Māori and Pacific people still have a shorter life expectancy than the New Zealand average, this is improving. In the future, significant numbers of older people will be of other than European origin.

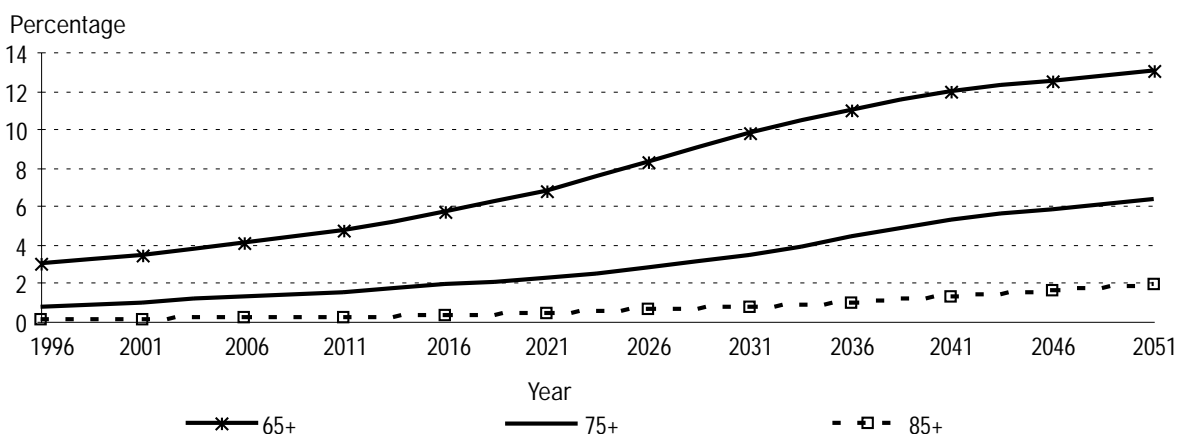
The Māori population is projected to grow to almost 1 million by 2051. Māori aged 65 or more will make up approximately 13 percent of the total Māori population by 2051 compared to 3.5 percent in 2001 – a 270 percent increase (Figures A3 and A4).

**Figure A3: Projected population pyramids for Māori in 2001 and 2051, by five-year age groups**



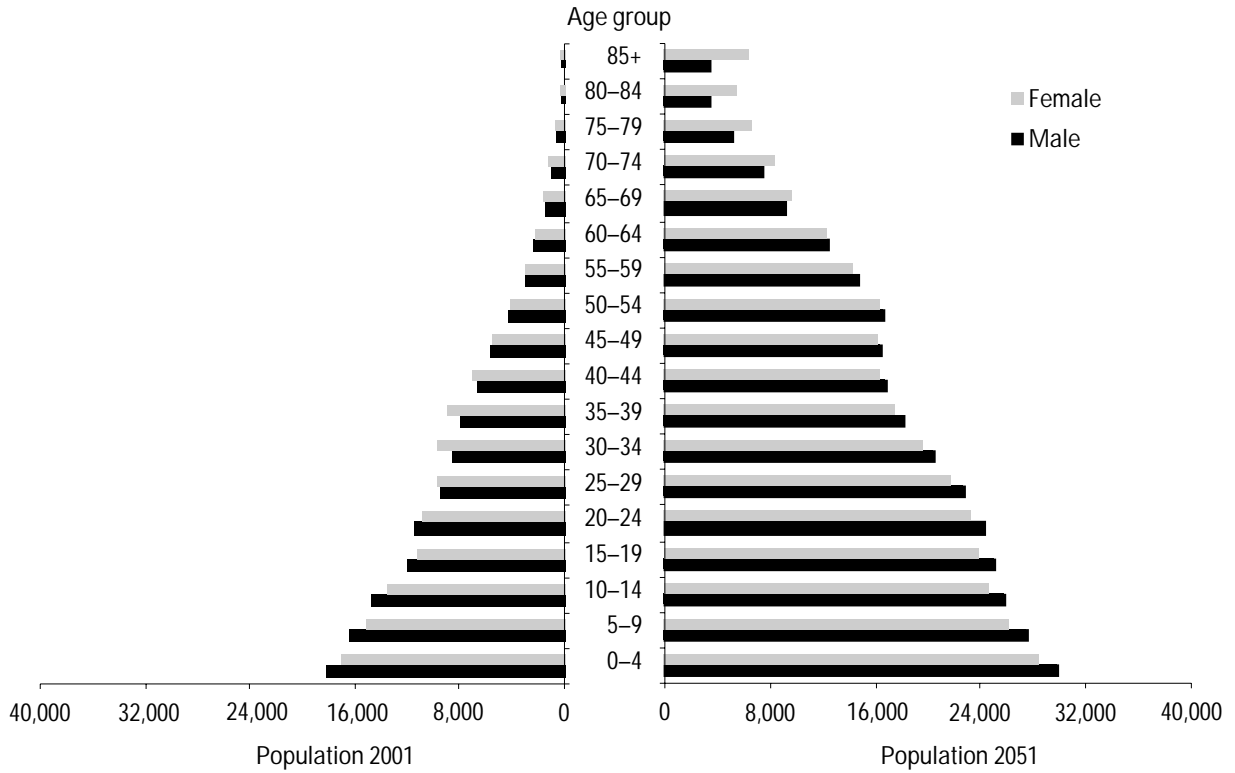
Source: Statistics New Zealand, Population Projections

**Figure A4: Projected Māori population 65+, 75+ and 85+ as a percentage of the total Māori population, 1996–2051**



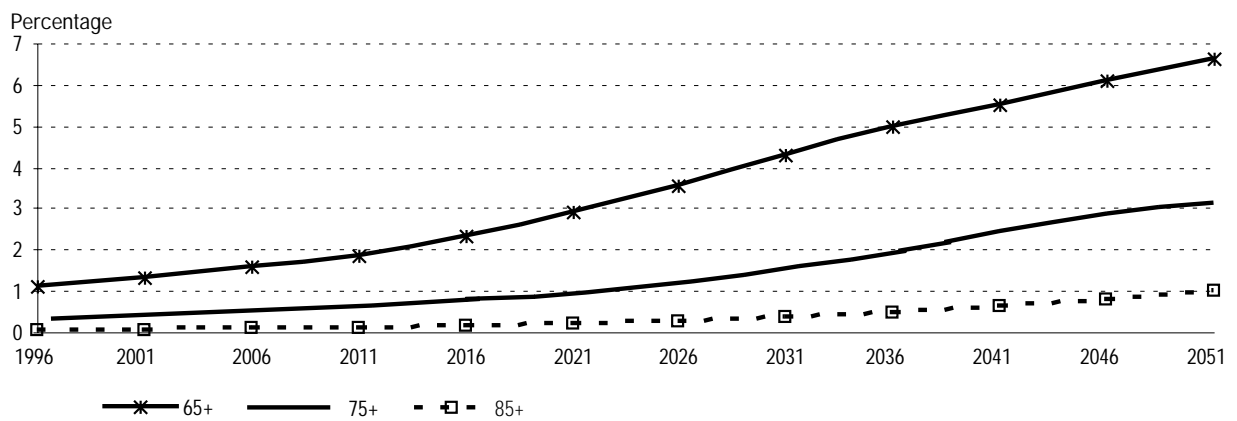
A high rate of growth is also projected for Pacific peoples, with those aged 65 and over expected to reach 6.6 percent of the total Pacific population by 2051 compared with 1.3 percent in 2001, an increase of over 400 percent (Figures A5 and A6).

**Figure A5: Projected population pyramids for Pacific peoples in 2001 and 2051, by five-year age groups**



Source: Statistics New Zealand, Population Projections

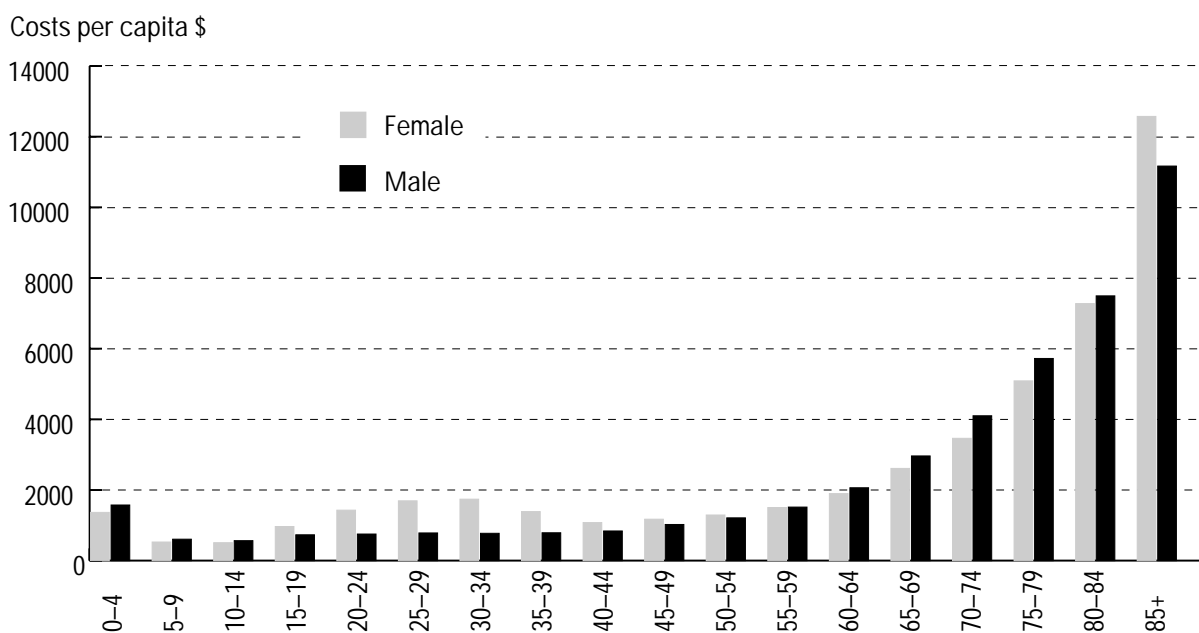
**Figure A6: Projected Pacific peoples population 65+, 75+ and 85+ as a percentage of the total Pacific peoples population, 1996-2051**



# Health care and disability support costs

Older people are high users of health and disability support services, with per capita expenditure increasing with advancing age (Figure A7). For example, estimated per capita costs of health and disability support services are \$849 for people under the age of 15 and \$1,190 for someone aged 15–64, compared with \$3,261 for people 65 to 74 years, \$6,144 for people aged 75–84 and \$12,105 for people aged 85 and over.

**Figure A7: Estimated per capita expenditure on health and disability support services, by age group and sex, 2001/02**



Source: Ministry of Health unpublished data, 2001

Note: cost per capita is GST exclusive.

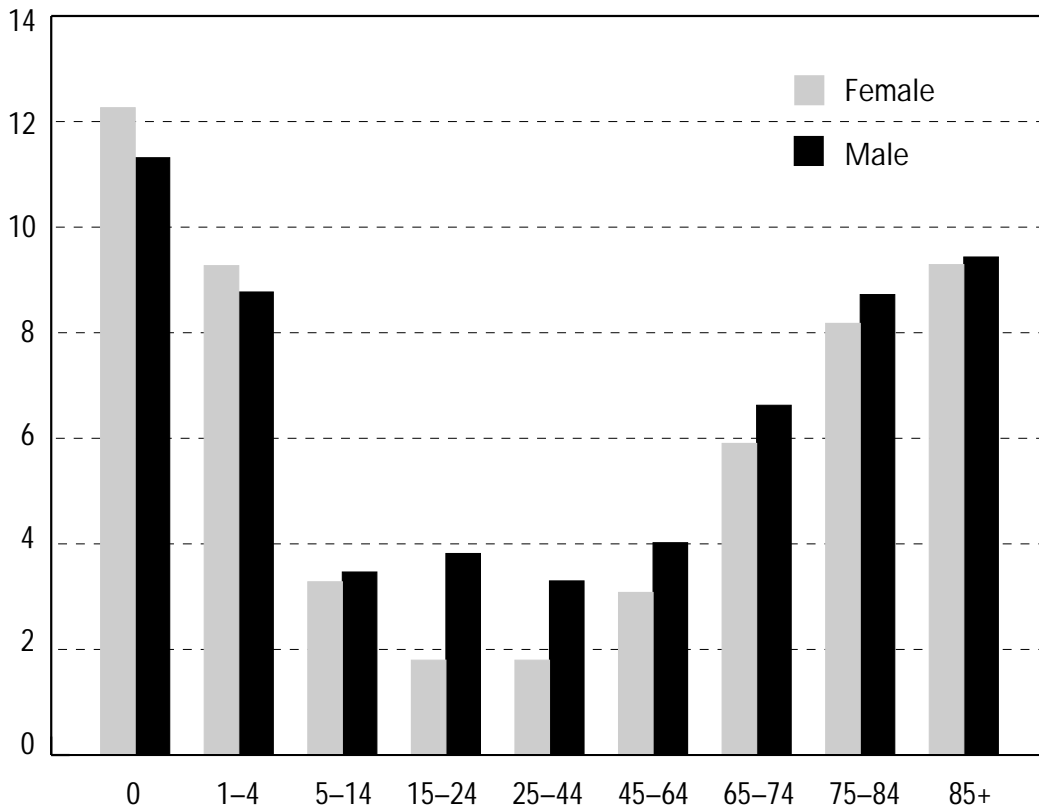
## Service utilisation

Usage of both primary care (Figure A8) and hospital care (Figure A9) is highest at younger and older ages. Within the older age groups usage of both services increases with advancing age. While GP visits averaged around three per year for people aged 5–64 years in 1998/99, they increase to around six per year for people aged 65–74 and around nine for people aged 85 and over.



**Figure A8: GP utilisation per capita, by age group and sex, 1998/99**

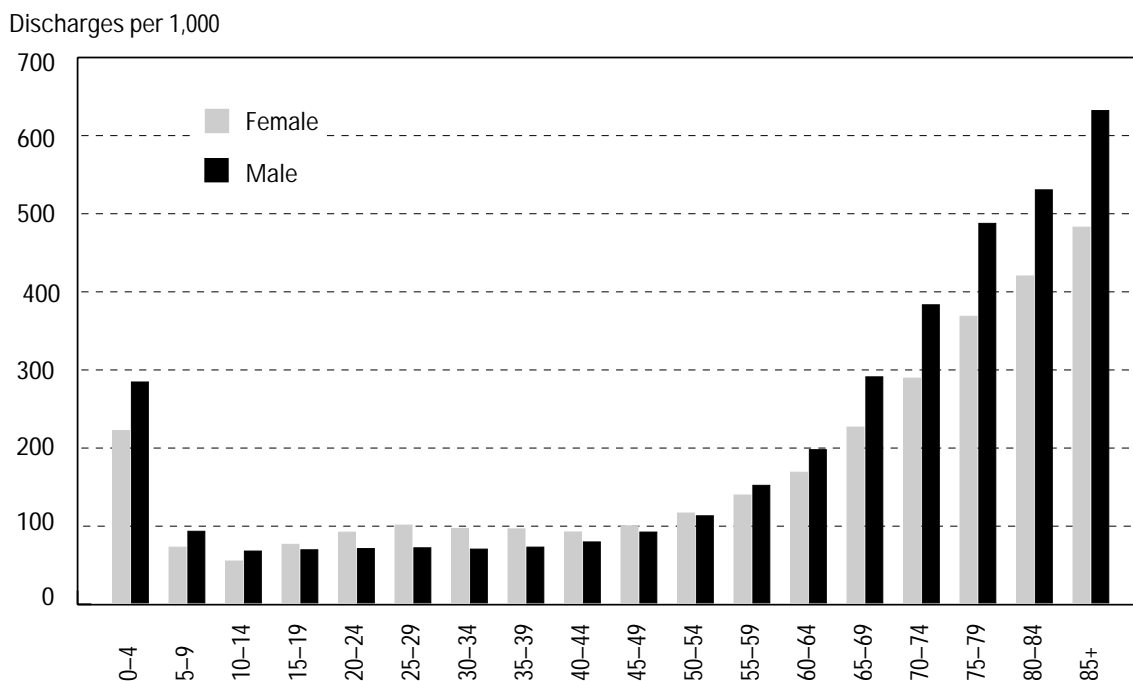
GP visits per capita



Source: Ministry of Health, unpublished data, 2001

There were approximately 520,000 publicly funded medical and surgical discharges from hospitals in 1999/00. This represents a rate of 135 per 1,000 people. However, the discharge rate for people aged 65 and over was 366 per 1,000, increasing to 456 for people aged 75 and over and 527 per 1,000 for people aged 85 and over.

**Figure A9: Medical and surgical hospital discharge rates per 1000, by age group and sex, 1999/00**

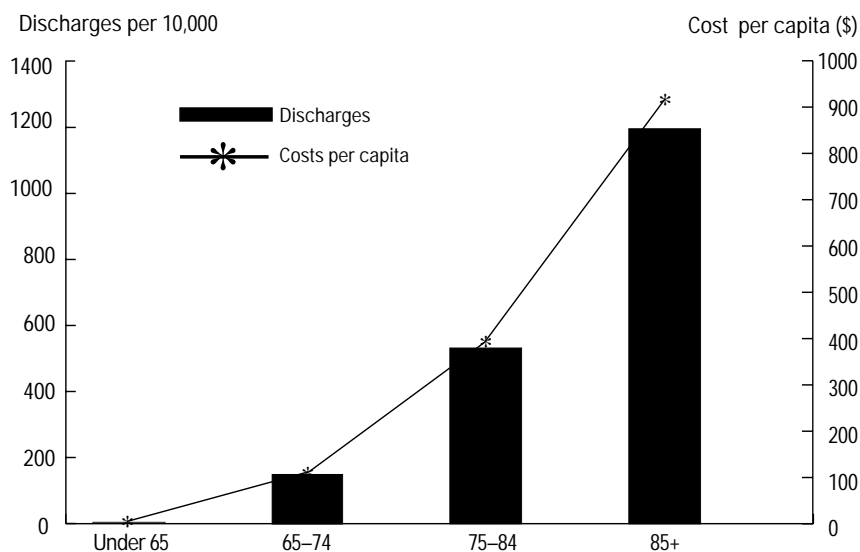


Source: Ministry of Health, unpublished data, 2001

People over 65 are spending less time in hospital than in the past. The average length of stay has decreased from 10 days in 1988/89 to five days in 1999/00. The steepest decrease occurred in the early 1900s, but has continued to trend downwards since then. At the same time the number of older people recorded as day cases has increased markedly. In 1989/90 day admissions for people aged 65 and over represented around 5 percent of all hospital admissions for this age group, but by 2000 this had risen to around 19 percent.

Older people are the almost exclusive users of assessment treatment and rehabilitation units, with utilisation rates and per capita costs increasing with age (Figure A10).

**Figure A10: Discharge rates and costs per capita for AT & R hospitalisations, by age group, 1999/00**

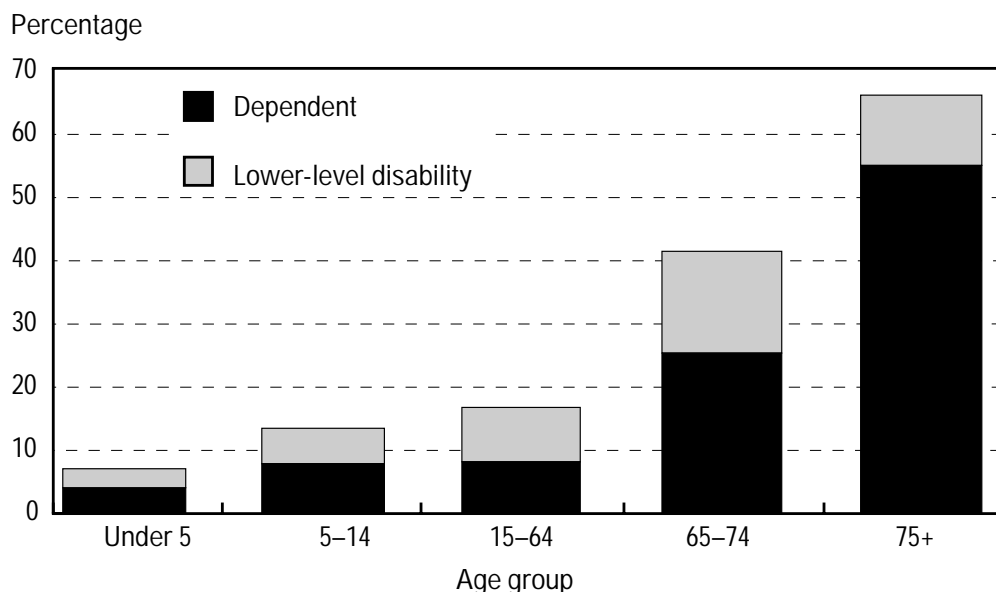


Source: Ministry of Health, unpublished data, 2001

## Level of disability

The 1996/97 disability survey (Health Funding Authority and Ministry of Health 1998) showed increasing rates of disability with advancing age. For example, while 17 percent of people aged 15–64 had some form of disability, 42 percent of people aged 65–74 and 66 percent of people aged 75 and over had some form of disability. Fifty-five percent of people aged 75 and over had a disability requiring assistance (Figure A11). The most common form of disability was restricted mobility or agility, followed by sensory impairment (hearing and sight).

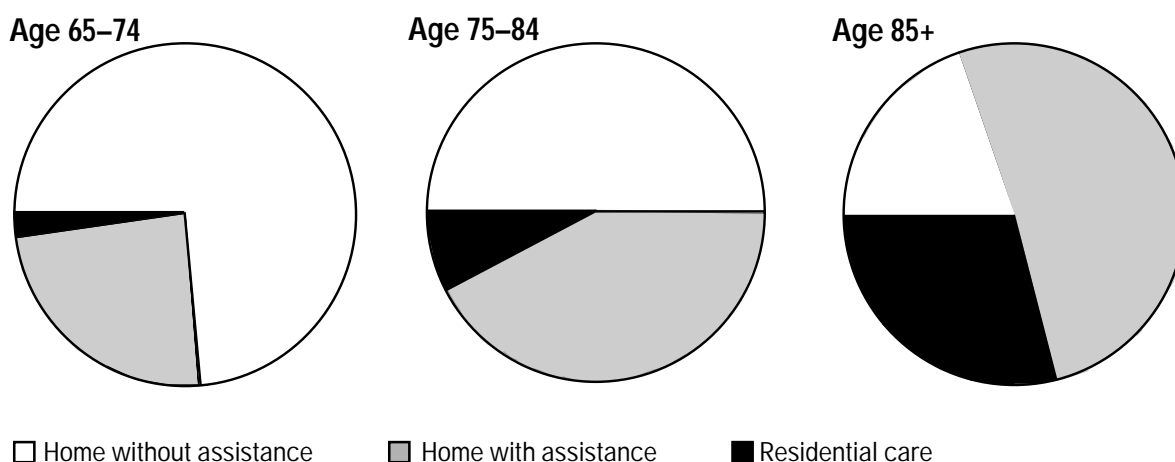
**Figure A11: Prevalence of disability, by age and severity level, 1996/97**



Source: Statistics New Zealand, New Zealand Disability Survey, 1997

One consequence of this is that older people may require additional support services to remain living at home, or may need to move into residential care (Figure A12). At the 1996 Census almost 75 percent of people aged 65–74 were living at home without assistance. However, only 50 percent of 75–84-year-olds were living at home without assistance, and only 20 percent of those aged 85 and over. Around 30 percent of those aged 85 and over were living in residential care.

**Figure A12: Residential distribution of people aged 65 and over, by disability status, 1997**



Source: Statistics New Zealand, Census of Populations and Dwellings, 1996, and New Zealand Disability Survey, 1997

Developing dementia is an increasing reason for an older person needing assistance or residential care. A study reported in 1983 estimated that 7.7 percent of people aged 65 and over would have dementia, with the prevalence increasing significantly with advancing age, doubling each 5.1 years between the ages of 60 and 90 years (3.8 percent of people aged 65–74 years and 40.4 percent for people aged 90 and over) (Campbell et al 1983). This exponential increase possibly does not continue over the age of 95 years (Sainsbury et al 1997).

It has been estimated that between 1992 and 2016, the prevalence of dementia will have increased in New Zealand by between 96 and 100 percent, compared with a rise in the general population of 18–26 percent (Jorm and Korten 1988). At present around 70 percent of people with dementia are cared for in their own homes, usually by one carer, often also elderly (Richards 2001).

## Health status

Life expectancy at birth is currently 75 years for men and 80 years for women. Life expectancy for Māori has improved significantly over the last 40 years, but is still lower at 68 years for Māori men and 72 years for Māori women (Table A4). Life expectancy at birth for Pacific peoples is slightly higher at 70 for males and 76 for females. Ethnic differences in life expectancy are less marked at older ages, because of higher death rates among Māori and Pacific peoples at earlier ages, but are still significant.

Shorter life expectancy for Māori is reflected in fewer years of independent life expectancy at age 65 years (7.4 years for Māori men compared with 9.9 for all men, and 7.5 for Māori women compared with 11.9 for all women).

**Table A4: Life expectancy at birth and at age 65**

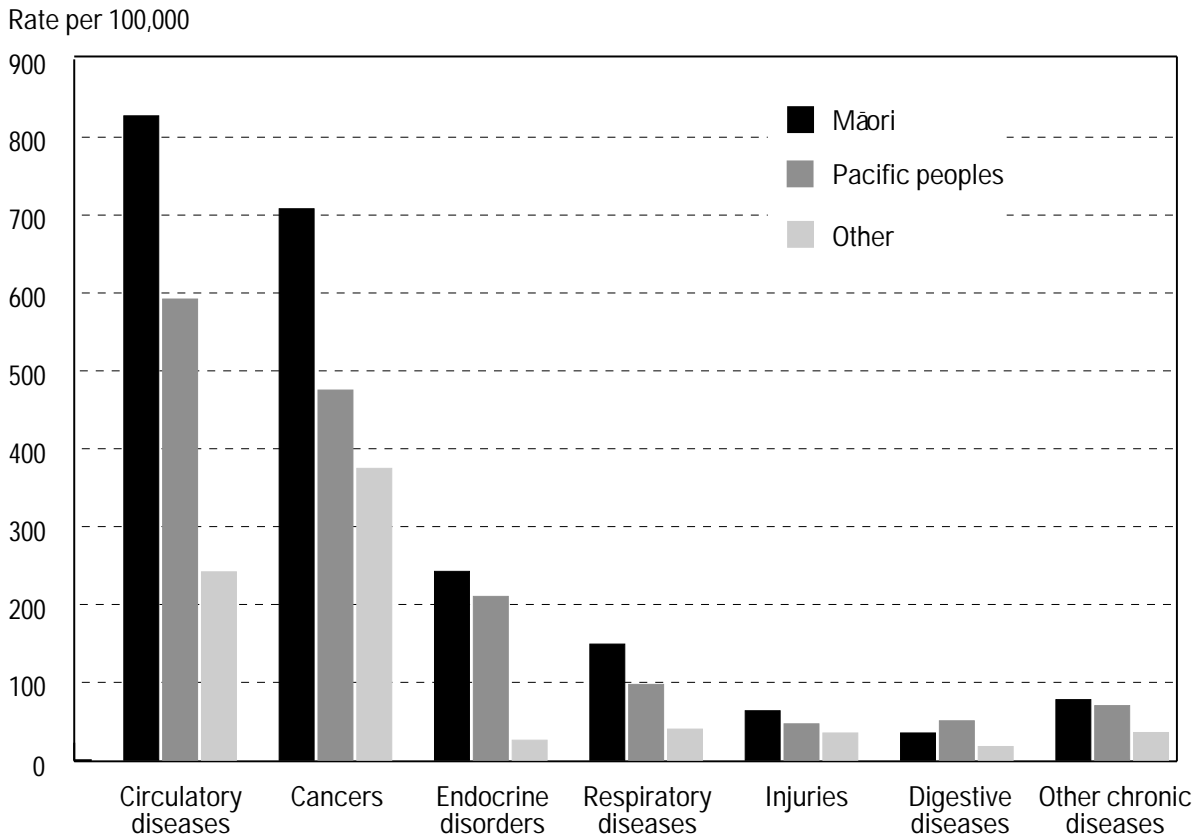
Life expectancy	All NZ	Male	Female	Māori male	Māori female	Pacific male	Pacific female
Life expectancy at birth	77.8	75.2	80.4	68.0	72.3	69.8	75.6
Life expectancy at age 65	17.8	16.1	19.5	12.6	15.0	13.4	16.6
Independent* life expectancy at age 65	10.9	9.9	11.9	7.4	7.5	NA	NA
Dependent life expectancy at age 65	6.9	6.2	7.6	5.2	7.5	NA	NA

\* Implies free of disability requiring assistance

## Mortality rates for Māori and Pacific peoples

The shorter life expectancy for Māori and Pacific peoples is due to higher mortality rates (particularly for circulatory diseases and cancers) at earlier ages. Endocrine disorders (principally diabetes) and respiratory diseases are also significant causes of death for Māori and Pacific peoples aged 55–64 (Figure A13). In this age group the Māori mortality rate is 9.4 times that of other New Zealanders and the Pacific peoples mortality rate is 8.2 times that of other New Zealanders.

**Figure A13: Mortality rates for people aged 55 to 64, by ethnicity and cause group, 1996–98**

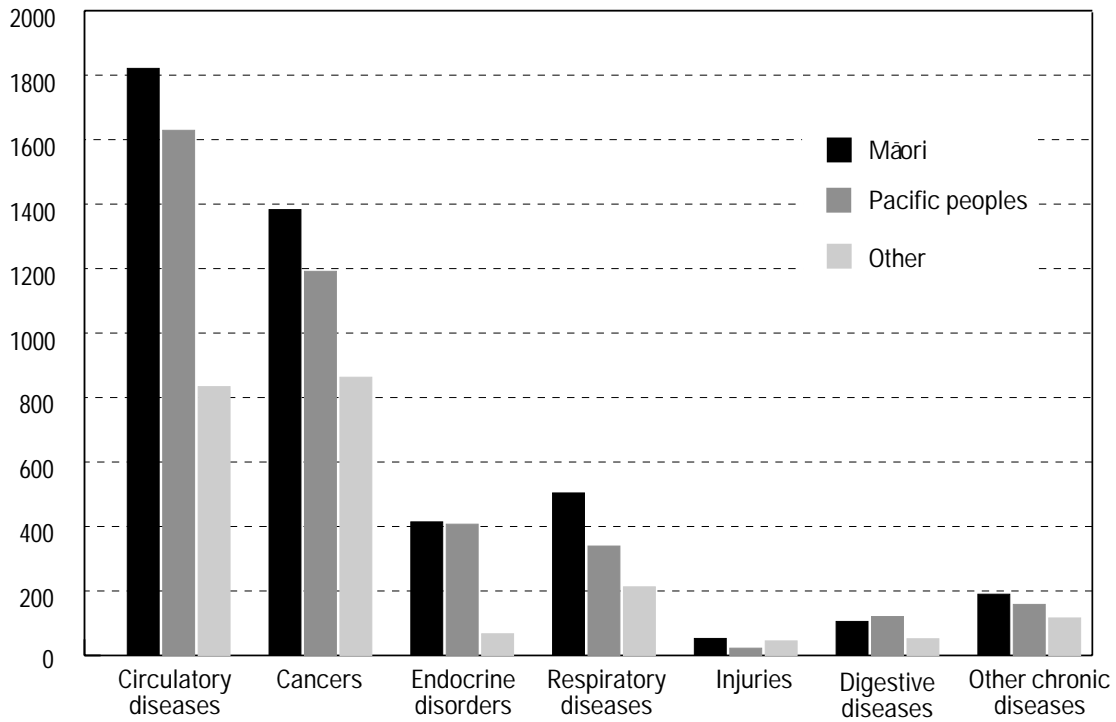


Source: Ministry of Health, unpublished data, 2001

The difference in mortality rates is still large in the 65–74 age group, with circulatory diseases and cancer remaining the two leading causes of death for all ethnic groups, followed by endocrine disorders and respiratory diseases (Figure A14). In the 75 and over age group respiratory diseases overtake endocrine disorders as a leading cause of death (Figure A15).

**Figure A14: Mortality rates for people aged 65 to 74, by ethnicity and cause group, 1996–98**

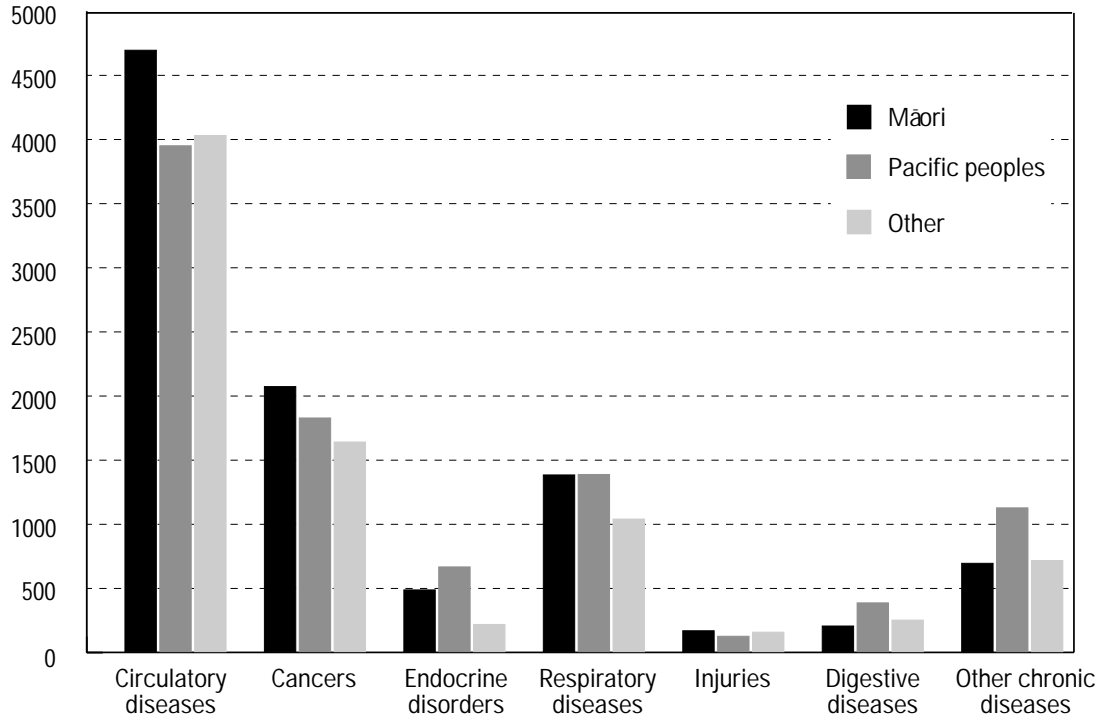
Rate per 100,000



Source: Ministry of Health, unpublished data, 2001

**Figure A15: Mortality rates for people aged 75+, 1996–98**

Rate per 100,000



Source: Ministry of Health, unpublished data, 2001

## Issues for women

While women consistently have a longer life expectancy than men, they also tend to have proportionately higher rates of chronic illness and disability in later life compared to older men, who typically suffer from acute conditions. As Table A4 shows, older women have, on average, 7.6 years with a disability and Māori women 7.5 years, compared to 6.2 years for all men and 5.2 years for Māori men. Since health care delivery is geared towards acute-care programmes, it generally ignores the needs of older women who require greater home care and not hospitalisation (UN Bulletin on Ageing 1999).

Women tend to have fewer resources than men and are more likely to:

- be widowed<sup>21</sup>
- live alone<sup>22</sup>
- have a lower income
- live in social and/or rural isolation
- be caring for a frail partner or elderly parents.

Older Māori women are particularly disadvantaged as they are more likely to have a combination of being widowed, living in a rural area and having a low income. Women who are aged over 85 are more than 50 percent more likely than men of the same age to be receiving residential care. This is an international trend. According to information from five countries (Australia, Austria, New Zealand, Sweden and the United States), the proportion of men aged 85 and over living in institutions ranged from 10.7 percent in Austria to 29.6 percent in Australia. The proportion of women aged 85 and over in the same countries who lived in institutions ranged from 20.8 to 44.6 percent respectively (OECD 1996).

## Socioeconomic inequality

Low socioeconomic groups experience poorer health outcomes. There is overwhelming evidence that socioeconomic inequalities affect health (National Health Committee 1998b). Socioeconomic inequalities have a cumulative health impact over time, and this is coupled in older age with the effect of lifetime deprivation (for example, in childhood nutrition) and disease.

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<sup>21</sup> At the 1996 Census 80.3 percent of women aged 85 and over were widowed, compared with only 45 percent of men in that age group (Statistics New Zealand 1998: 24).

<sup>22</sup> Older people who live on their own are most likely to be women in their 80s (three in five women in their 80s lived alone in 1996). Fewer people in their 90s live alone as the likelihood of disability and the need for care increase (Statistics New Zealand 1998: 42).



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