

# THE STRATEGY IN SUMMARY

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## The Vision

Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes.

## The Objectives

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

1. Older people, their families and whānau are able to make well-informed choices about options for healthy living, health care and/or disability support needs.
2. Policy and service planning will support quality health and disability support programmes integrated around the needs of older people.
3. Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whānau and carers.
4. The health and disability support needs of older Māori and their whānau will be met by appropriate, integrated health care and disability support services.
5. Population-based health initiatives and programmes will promote health and wellbeing in older age.



6. Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning.
7. Admission to general hospital services will be integrated with any community-based care and support that an older person requires.
8. Older people with high and complex health and disability support needs will have access to flexible, timely and co-ordinated services and living options that take account of family and whānau carer needs.

# INTRODUCTION

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## Overview

Most people aged 65 or over are fit and healthy. A minority are frail and vulnerable and require high levels of care and disability support. This is usually during the last few years of their lives, or as a result of chronic illness or disability that may have been present for many years.

Currently health and disability support programmes for older people tend to be planned, funded and provided in a piecemeal fashion that results in service gaps and overlaps in some areas and inconsistent access criteria. This is inefficient, and confusing for older people and carers trying to identify their health and disability support options. Opportunities for regaining health or improving quality of life are lost because of the lack of focus on promoting wellbeing in older age.

Particularly for frail older people, the way health and disability support services are provided is a key component of their quality of life. To recognise this, services need to develop to support ageing in place – offering people the opportunity to continue to live safely in their community. This includes appropriate treatment for acute episodes of ill health, rehabilitation to support recovery, and ongoing support for people who are disabled.

The primary aim of the strategy is to develop an integrated approach to health and disability support services that is responsive to older people's varied and changing needs. This approach, the integrated continuum of care, means that an older person is able to access needed services at the right time, in the right place and from the right provider. Providers work closely together, and, where appropriate, with



families, whānau and carers. Services and programmes in the continuum may include health promotion, preventive care, specialist medical and psychiatric care, hospital care, rehabilitation, community support services, equipment, respite care and residential care.

Key elements of the integrated approach are:

- services are older-person focused
- the wellness model is promoted
- services are co-ordinated and responsive to needs
- family, whānau and carer needs are also considered, where appropriate
- there is information sharing and a smooth transition between services
- planning and funding arrangements support integration.<sup>1</sup>

The strategy sets out a comprehensive framework for planning, funding and providing services. It includes a work programme for the Ministry of Health to provide the national framework for implementing the strategy and identifies the action steps for District Health Boards (DHBs) to develop an integrated approach to service provision in their own districts. Implementing the strategy will require the Ministry of Health and DHBs to systematically review and refocus services to better meet the needs of older people now and in the future. These changes will need to be made by reallocating available resources between services.

## The strategy in context

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 (Ministry of Social Policy 2001). Its development has also been

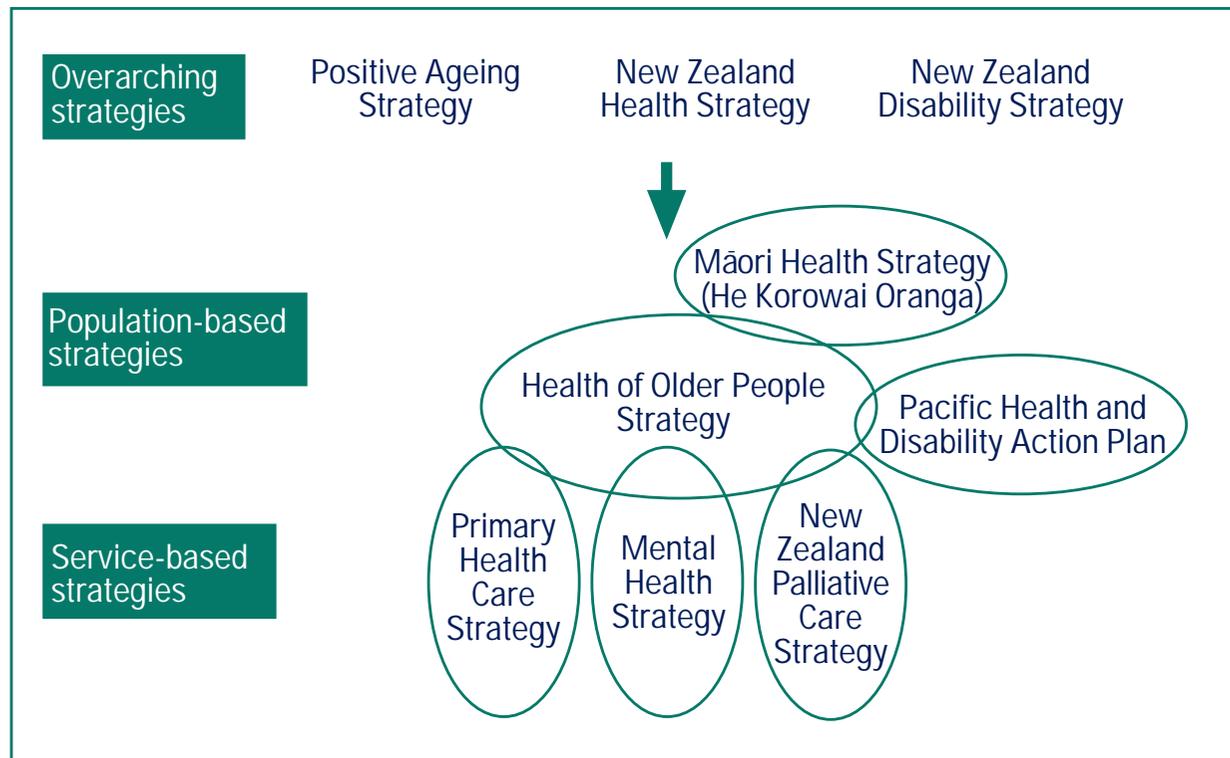
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<sup>1</sup> Appendix 1 provides more detail on key factors in successful integration.

guided by the aims and principles of the New Zealand Health Strategy (Minister of Health 2000), New Zealand Disability Strategy (Minister for Disability Issues 2001) and the draft Māori Health Strategy, He Korowai Oranga (Minister of Health 2001a).

The actions in the strategy draw on other health strategies, in particular the Primary Health Care, Palliative Care and Mental Health strategies (Minister of Health 2001c; 2001b, Ministry of Health 1994; 1997) and the Pacific Health and Disability Action Plan (Minister of Health 2002). The relationship between the various strategies is illustrated in Figure 1. This strategy will also inform the development of the New Zealand Injury Prevention Strategy being developed by the Accident Compensation Corporation and due for release later in 2002.

**Figure 1: Relationship between strategies**



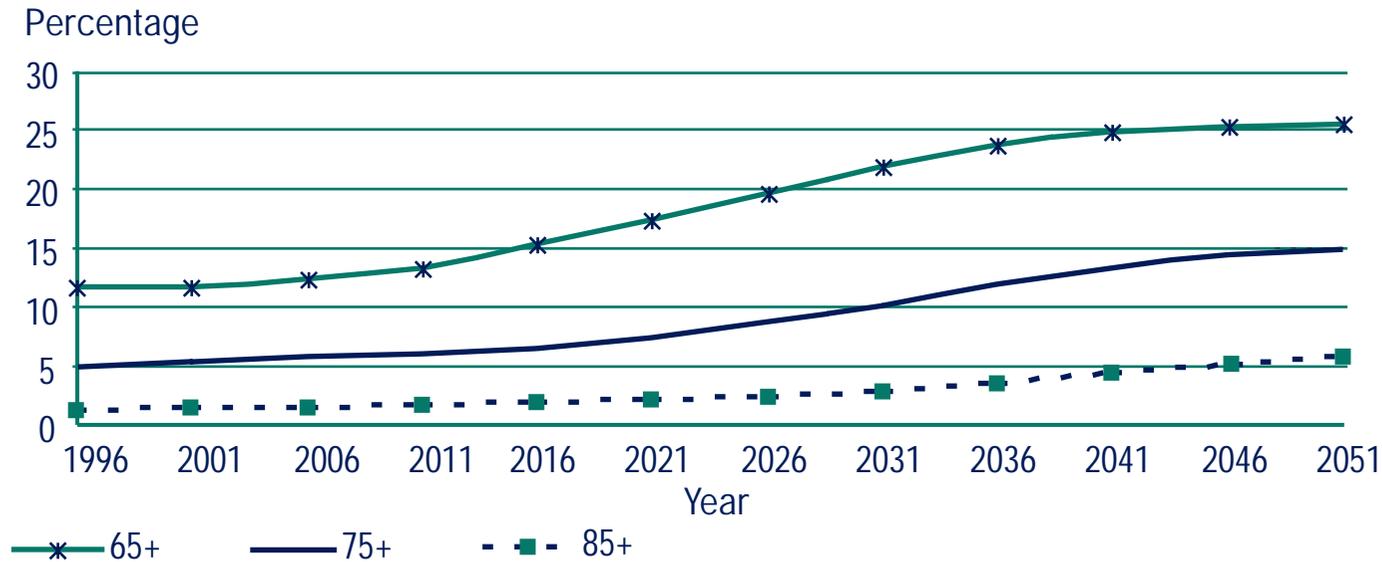
In line with the above strategies, the Health of Older People Strategy focuses on improving health status, promoting quality of life where health cannot be restored, reducing inequalities, and promoting participation – in social life and in decisions about health care and disability support provision. There is an emphasis on health promotion, disease and injury prevention and timely, equitable access to health and disability support services. The actions and key steps in the Health of Older People Strategy set out the implications of these strategies for older people and include the relevant actions from their work programmes.

The strategy has been developed in collaboration with an expert advisory group, comment from sector reviewers and public consultation. It has drawn on the *United Nations Principles for Older Persons* (United Nations 1991) and on overseas policies to meet the health care needs of ageing populations, particularly in the United Kingdom and Australia and to a lesser extent Canada. It has also been influenced by work undertaken by the World Health Organization (WHO 2001) and the Organization for Economic Co-operation and Development (OECD 1996).

## Planning for an ageing population

Compared to OECD countries New Zealand has a young population, with only 11.5 percent of people aged 65 and over. The proportion of older people in New Zealand is projected to grow steadily to about 13 percent by 2010 and then much more rapidly (to 22 percent by 2031 and 25 percent by 2051).

**Figure 2: Projected New Zealand population 65+, 75+ and 85+ to 2051 as a percentage of the total population**

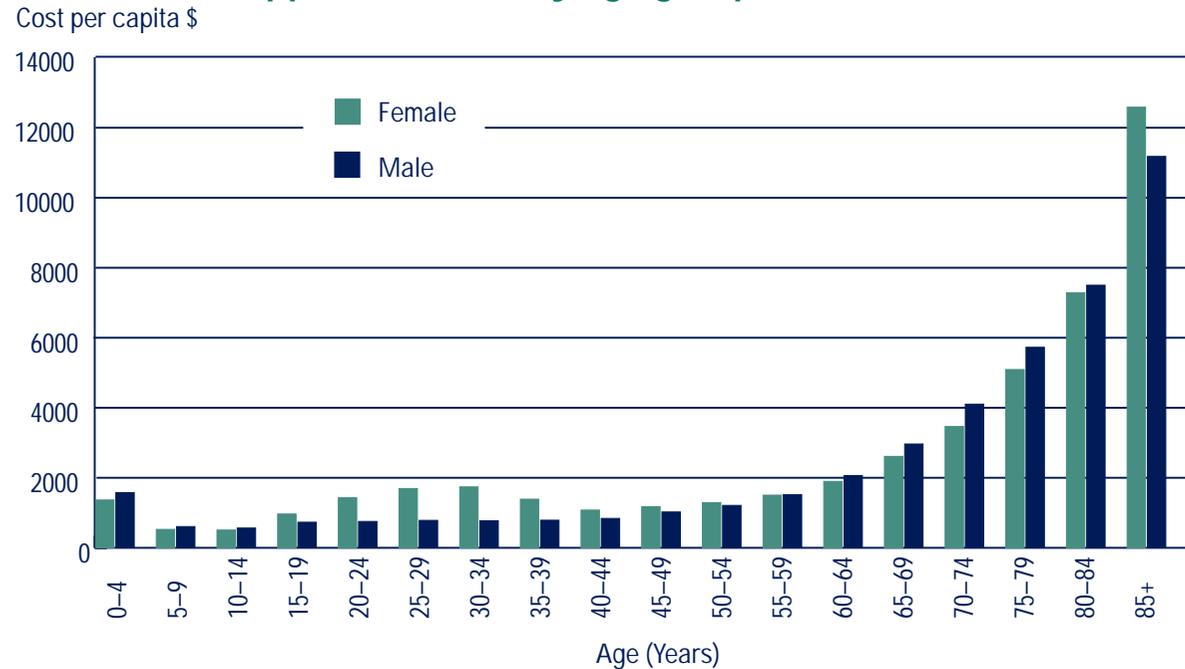


Source: Statistics New Zealand, Population Projections

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 more than a 400 percent increase in the proportion of Pacific peoples aged 65 and over. Other ethnic minority populations, while also relatively young, are also projected to increase significantly. A key theme underlying the actions and key steps under the objectives of the strategy is the provision of culturally appropriate services for an increasingly diverse older population.

Costs of health and disability support services increase significantly with age, as illustrated in Figure 3.

**Figure 3: 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: expenditure is GST exclusive.

While older people may be healthier for longer in the future, the rapid growth in the number and proportion of older people, particularly between 2010 and 2040, will inevitably increase pressure on health funding.

A Ministry of Health paper (Johnston and Teasdale 1999) has projected that, based on then-existing patterns, health expenditure would need to grow by an average of 3.6 percent per year over the next 50 years to meet increased demand for existing services arising from population growth and the greater proportion of older people. The actual rate of increase is difficult to predict, however, 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 carers, technological advances, rising expectations for more and better services, and changing rates of disability among older populations (Cutler 2001).

Policy decisions and health system design also have a major impact on health expenditure. An OECD study (Jacobzone et al 1998) noted the usefulness of an 'active' strategy towards ageing in relation to the need for long-term care services:

“[An] 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” (Jacobzone et al, p26).

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

## The life course approach

The Jacobzone et al study also highlighted the impact that lifestyle choices made for and by people at younger ages have on demand for health and disability support services in older ages. Interventions at both a population and individual level that create supportive environments, foster healthy choices throughout life and reduce health inequalities are needed to reduce the risk of functional decline in older age.

There is evidence that socioeconomic inequalities have a cumulative health impact over time (National Health Committee 1998b). In older age this may be coupled with the effects of lifetime deprivation and disease. Research on the living standards of older New Zealanders (Fergusson et al 2001) has found that people most at risk of poor living standards in older age (one of the determinants of poor health) were

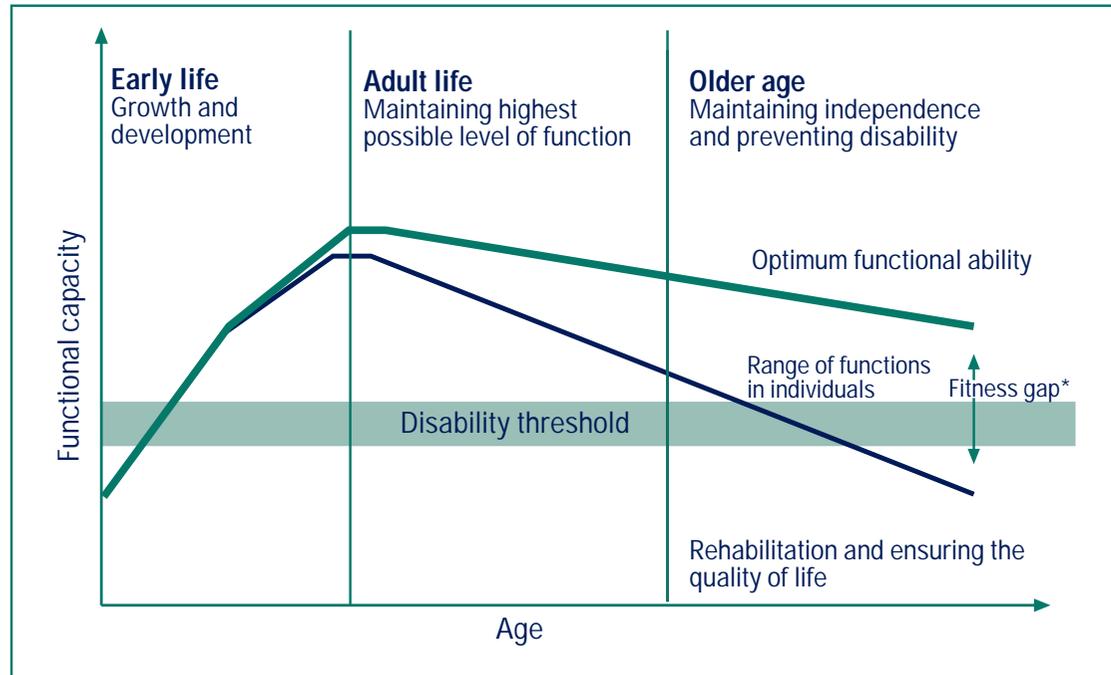
characterised by a mix of low income, a history of economic stress, no savings, high accommodation costs, poor housing, having held a low-status occupation, and being Māori or Pacific.

Older women are also at higher risk of poor health. 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.

The life course approach to positive ageing supports activities in earlier 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 4 illustrates the potential impact of an active approach to ageing throughout the life course. 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 4).

**Figure 4: 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, and diet and alcohol consumption), social support and external environmental factors can have on functional capacity.

## Who the strategy is for

This strategy focuses on people aged 65 and over. The integrated approach to service provision that it sets out will particularly benefit those older people who have high and complex needs that cross service boundaries.

This approach could also be effective for the relatively small number of people under the age of 65 who have health and disability support needs similar to those more commonly experienced in older age, notably Māori and Pacific peoples.

The Ministry of Health is separately advising the government on how best to manage services for people under age 65 years who could benefit from an integrated approach to services. The Ministry is also advising the government on options for disabled people who reach 65 to ensure continuity of service provision for this group.

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

One of the five principles underlying development of the New Zealand Health Strategy is an acknowledgement of the special relationship between Māori and the Crown (Minister of Health 2000). 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. In the health and disability sectors, this relationship has been based on three key principles:

- partnership in service delivery
- participation at all levels of the health sector
- protection and improvement of Māori health status and safeguarding Māori cultural concepts, values and practices.

These principles have guided development of the Health of Older People Strategy. Key elements of this are recognising and responding appropriately to the holistic view of health<sup>2</sup> held by many Māori, and the unique position of older Māori and kaumātua<sup>3</sup> in New Zealand.

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<sup>2</sup> There are several models that characterise a holistic Māori view of health. A frequently used framework is Te Whare Tapa Whā, which 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.

Ministry of Health advice to the government on issues for people under 65 who have health and disability support needs similar to those more commonly experienced in older age will include specific advice on issues for Māori.

## Implementing the strategy

Both the Ministry of Health and DHBs have responsibility for implementing the Health of Older People Strategy. Appendix 2 provides a summary of the actions and key steps under each of the eight objectives. The Ministry's timelines for completing the actions and key steps it is responsible for are set out in the strategy, where these are known. While DHBs will need to implement the strategy by 2010, milestone dates have not been given. Each DHB will determine how and when it will implement the strategy by 2010 and will signal this in its annual plans.

Some DHBs, predominantly those with high numbers or proportions of older people, have already established working groups to plan for and develop integrated services for older people. Canterbury and Northland DHBs are 'early leaders', working with the Ministry on the development of the integrated continuum of care approach. The process and outcomes of this work will provide guidance to other DHBs.

The strategy also poses challenges to service providers and health sector workers to change the way services are delivered to meet the needs of older people. The Ministry of Health and DHBs will work closely with these groups on ways they can contribute to a more integrated approach to health and disability support programmes for older people.

The Ministry of Health will monitor DHBs' progress on the implementation of the Health of Older People Strategy against their annual plans. The Ministry will also undertake three-yearly reviews of progress to coincide with Ministry of Social Development status reports on implementing the Positive Ageing Strategy (Minister for Senior Citizens 2001).

## THE VISION

Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes.



## THE PRINCIPLES

The vision will be a reality when health and disability support programmes are integrated around the needs of older people and operate in the following way. They:

- foster a positive attitude to growing older
- work within the framework of the Treaty of Waitangi to address issues for Māori
- use a holistic, person-centred approach that promotes wellness and participation
- provide information to enable older people, carers, family and/or whānau to make informed choices about their health and wellbeing
- support carers in ways that strengthen the older person's family, whānau and informal support networks
- work with other key sectors to reduce barriers to positive ageing and increase service integration for the benefit of older people
- recognise and respond to cultural and social diversity and health inequalities, among Pacific and other ethnic and social groups
- provide timely, equitable, needs-based access to comprehensive and integrated care that is good quality and responsive to changing needs

- provide appropriately for older people who are disadvantaged through ill health, difficulty accessing services, or socioeconomic circumstances
- encourage people to take responsibility for preserving their health through a healthy lifestyle
- respond to changing individual and community health needs in ways that are innovative, collaborative and flexible
- are based on best practice and supported by research
- are affordable to the individual as well as the state.

# Objective 1

**Older people, their families and whānau are able to make well-informed choices about options for healthy living, health care and/or disability support needs**

Ageing is a dynamic and ongoing process that is part of the normal life course. Responsive health and support services that respect and value older people are a key factor in enabling older people to continue active lives and contribute their skills and knowledge to their family and communities.



## Actions

## Key Steps

1.1 The Ministry of Health and DHBs will make appropriate information about health and support programmes and services easily available and accessible to older people, carers and service providers.

The former Health Funding Authority published various information packs on services it funded. This material needs to be reviewed and updated and made easily available in a range of formats suitable for those most in need of this information. Particular areas for development are approaches that provide information in a culturally appropriate format. This includes links to community networks as well as information about government-funded services. There is also a need for access to interpreter services (Holt et al 2001) and health promotion, education, counselling and information about how to improve health and prevent disease in older age (Richmond et al 1996).<sup>4</sup>

<sup>4</sup> A study by Richmond et al 1996 of 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.

- 1.1.1 DHBs and the Ministry of Health will work to improve information on service availability for older people; their family, whānau or caregivers; and service providers and health professionals who may be advising them.
- 1.1.2 The Ministry is working with disability support services information providers to explore ways of their sharing information to provide a more co-ordinated service to people, including a national information network linked to both a central information resource and to specialist information centres.

1.2 Service providers and health professionals will involve older people, and their family, whānau and carers where appropriate, in decisions about their care and support.

- 1.2.1 DHB/Ministry contracts with health and disability support service providers will require:
  - a holistic approach to care and support – including consideration of physical, mental health, social, emotional and spiritual needs of older people
  - older people having a key role in developing their own care plans (refer to actions 6.1 and 7.1)
  - carers being involved in decisions that affect them
  - older people or their delegated carer holding a copy of their care plan.
- 1.2.2 The Ministry of Health is planning to develop a framework around individualised funding that will provide options for individuals to manage their own support services.

## Actions

## Key Steps

1.3 The Ministry and DHBs will review and strengthen provisions for protecting vulnerable older people from abuse.

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

1.3.1 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).

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

1.3.3 The Ministry 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.

## Actions

## Key Steps

1.4 The Ministry, DHBs and service providers will foster and model positive attitudes to ageing and older people.

1.4.1 Ministry of Health and DHB planning and service provision will:

- promote positive attitudes towards older people
- place greater emphasis on skills needed to work alongside older people, their families, whānau and caregivers in community and home settings
- develop the health care and home support workforce to focus on home-based rehabilitation (home support) services (refer to actions 8.3.2 and 8.5.1)
- recognise the respected and honoured position accorded to older people in Māori, Pacific and other ethnic communities
- facilitate the development of advocacy services to improve access to services; for example, where English is a second language.

# Objective 2

**Policy and service planning will support quality health and disability support programmes integrated around the needs of older people**



Actions	Key Steps
<p>2.1 Each DHB will outline in its annual plan how it will develop an integrated continuum of care for older people and implement the Health of Older People Strategy.</p>	<p>DHBs have until 2010 to implement the Health of Older People Strategy and develop an integrated continuum of care approach to service planning, funding and provision for older people.</p> <p>2.1.1 From 2003/04 each DHB will include in its annual plan its broad approach to services for an ageing population and milestones for implementing the Health of Older People Strategy. Each plan will be informed by consultation with the DHB's community, aged-care providers and consumer groups, and an analysis of the district's health and support needs.</p> <p>2.1.2 'Early leader' DHBs (Canterbury and Northland), with assistance from the Ministry, will develop and test models for delivering an integrated continuum of care. Their experience, and that of others at similar stages of developing integrated service provision for older people, will inform development in other DHBs.</p>

2.1.3 DHBs, in collaboration with the Ministry, will progressively review priorities for services in anticipation of growth in older age groups and to support ageing in place. This will require DHBs to identify:

- barriers to implementing an integrated continuum of care in current planning and service practices
- changes necessary to transfer funding between services within their DHB to support an integrated continuum of care.

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2.2 The Ministry of Health will facilitate implementation of the Health of Older People Strategy.

2.2.1 The Ministry of Health will organise a workshop in 2002 for DHBs, service providers, health sector workers and older people's representatives, to support implementation of the Health of Older People Strategy.

2.2.2 The Ministry will establish a web page on its website by June 2002 providing access to information about health of older people, including information about statistical data on service utilisation and health status and best practice examples of integrated services.

2.2.3 The Ministry will work with DHBs to develop performance indicators to measure progress on implementing the Health of Older People Strategy.

## Actions

## Key Steps

2.3 The Ministry, in collaboration with DHBs, will establish a process for collecting reliable data to model current and projected demand for services.

2.3.1 By June 2003 the Ministry, in collaboration with DHBs, will have agreed a standard set of data to model current and projected demand for services for people aged 65 and over, and established a process for collecting and collating reliable data. Key components of the model will be demographic change, health status, and service utilisation trends and projections by age group, ethnicity, and geographical location.<sup>5</sup>

2.3.2 The Ministry will work with DHBs and relevant agencies to improve the quality and coverage of existing databases and targeted surveys to model demand.

2.3.3 The Ministry will work progressively to improve the quality and availability of disability support services data, including service utilisation by older people.

2.3.4 The Ministry 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>5</sup> Wherever possible the Ministry will make data available to the sector as well as DHBs and the government. Any action by the Ministry to improve the quality of data collection will take account of existing data demands on funders and providers.

## Actions

## Key Steps

2.4 The Ministry will implement a planned approach to strengthening the health workforce to meet the needs of an ageing population.

The health sector workforce consists of a broad range of workers contributing to the health of older people. These include hospital and community-based health professionals such as doctors, nurses, and therapists; social workers; health aid workers; <sup>6</sup> orderlies and kitchen staff. In addition, family, whānau, individuals and a range of voluntary and community agencies play a significant role in providing care and support for older people.

Developing a workforce that is able to meet the needs of an increasingly culturally diverse older population will require an education system that responds effectively to health sector needs.

Workforce development will draw, where appropriate, on work being undertaken within the Ministry of Health that includes: implementing the nurse practitioner role; developing regulations for nurse prescribing, including for nurse practitioners in aged care; developing a framework for primary health care nursing; and options for developing the health aid workforce.

2.4.1 The Ministry of Health will advise the Ministry of Education by June 2003 of the nature of the future health workforce required to meet the needs of the New Zealand Health and Disability Strategies. This will include a preliminary analysis of current workforce issues for health of older people services.

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<sup>6</sup> 'Health aid worker' 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.

2.4.2 By June 2004 the Ministry of Health will produce a report on the workforce needs of the ageing population. This will involve working with DHBs and consulting Māori and mainstream service providers, the Ministry of Pacific Affairs and Office of Ethnic Affairs, health sector workers, relevant community and voluntary agencies and older people. The plan 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)
- ensuring that mainstream services are culturally appropriate for the increasing ethnic diversity of older people
- ensuring continuing education for the existing health workforce includes older people's health issues and appropriate interventions
- developing the specialist professional workforce in older people's health
- promoting working conditions that support the development and retention of appropriately trained staff, particularly in rural areas.

## Actions

## Key Steps

- 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 objectives of the Employment Relations Act 2000
- the role of family and whānau carers and volunteers.

2.4.3 The Ministry will work with DHBs to monitor changes in the size, composition and competency levels of the workforce, including the contributions of family, whānau and volunteers, to feed back into policy and funding decisions.

2.5 The Ministry, in collaboration with relevant DHBs and the Ministry of Pacific Island Affairs, will plan for Pacific and mainstream health and disability support services to meet the needs of older Pacific peoples and their families.

DHBs with significant numbers of Pacific peoples in their regions will take particular responsibility for Pacific peoples' health issues. Key areas for development are building capacity in health promotion and primary health care. There is a need for trained ethnic promoters to deliver health and service information, as language is a major barrier for Pacific elders in accessing services. This work will be done in conjunction with implementing the Pacific Health and Disability Action Plan.

2.5.1 By 2006 the Ministry will have worked with DHBs 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

## Actions

## Key Steps

- 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.

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2.6 The Ministry will work with the Office of Ethnic Affairs to develop guidelines for DHBs on the health and disability support service needs of ethnic minority communities.

Although many of the ethnic communities in New Zealand are small in numbers, they are growing, as is the proportion of people in these communities who are aged 65 and over. The number and proportion of older people in ethnic communities are expected to increase significantly over the next two decades. Key current issues are the cultural appropriateness of services, particularly health promotion and primary care, and addressing language barriers.

2.6.1 By 2006 the Ministry will have worked with the Office of Ethnic Affairs to develop guidance for DHBs on health services for older people in ethnic minority communities.

## Objective 3

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### **Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whānau and carers**

Public funding for health and disability support services accessed by older people is currently channelled through a number of funders. These include DHB funding for personal health (community and hospital based) and targeted funding for mental health, Ministry of Health-administered funding for disability support services and for public health initiatives, and ACC funding for accident victims. Each funding stream has its own set of access criteria, service priorities and rules governing user charges.

These complex funding arrangements work against service providers collaborating to develop co-ordinated responses to health and disability support needs at either a population or an individual level. The Ministry for Social Development has identified the need to undertake work to develop a draft framework for providing coherent services and support on an equitable basis for people with disabilities, including, for example, consideration of issues relating to payment to caregivers.

Actions under this objective are designed to improve funding and service delivery to remove barriers to integration. The primary focus of the actions is to clarify funding responsibility, specify the scope and range of services to be provided, and facilitate the linkages between services to ensure that older people have access to services that are responsive to their needs.



## Actions

## Key Steps

3.1 The Ministry of Health will provide advice to the government on future funding for older people's health and disability support services.

3.1.1 The Ministry of Health will provide advice to the government on future funding for health and disability 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. The Ministry is currently undertaking three funding projects that will contribute to this work:

- separating out disability support services funding for older people to facilitate co-ordination of health and disability support services for older people with complex care and support needs. This work will also include providing policy advice on service provision and funding options for younger disabled people, including provision for when they reach the age of 65 (by September 2002)
- analysing policy options for funding long-term care – this will include advice on removal of asset testing for residential care
- removing cost barriers to accessing primary health care (refer to action 6.3).

Actions	Key Steps
<p>3.2 The Ministry, in collaboration with DHBs, will develop an implementation plan and guidelines for comprehensive integrated assessment for older people and their carers.</p>	<p>An integrated assessment system for accessing health and disability support services needs to cover physical, mental health, social, cultural and spiritual needs. It also needs to include assessment of whether functional limitations can be reversed by treatment and/or rehabilitation. The assessment process therefore needs to be integrated with treatment and rehabilitation services.</p> <p>3.2.1 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 guidelines for comprehensive, multidisciplinary needs assessment for older people by June 2003. The guidelines will be incorporated into the Nationwide Service Framework<sup>7</sup> and will:</p> <ul style="list-style-type: none"> <li>• include assessment of carer support needs, and culturally appropriate assessment for older Māori, Pacific people and other ethnic communities with increasing numbers of older people</li> <li>• 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.</li> </ul>

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<sup>7</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.

## Actions

## Key Steps

3.3 The Ministry will review specialist mental health services for older people within the framework of current mental health and disability strategies.

Older people with a physical illness or disability have a greater tendency than others to have or develop psychiatric symptoms such as depression or treatment-related psychoses (Aneshensel et al 1984; Arling 1987; Lindsay 1990). For example, up to 70 percent of people with dementia have behavioural and psychological symptoms that require psychiatric intervention.

3.3.1 By June 2002 the Ministry of Health will set targets for older people's access to specialist mental health services.

3.3.2 By June 2002 the Ministry, in collaboration with DHBs will develop a nationally consistent framework for specialist psychogeriatric<sup>8</sup> inpatient and outpatient services.

3.4 The Ministry will develop a service development plan for older people with dementia.

3.4.1 By July 2002 the Ministry of Health, in collaboration with a working group including DHBs, representatives of service providers, health sector workers, advocacy groups and older people, will produce 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 plans to address those issues
- identifying quality issues in residential care for people with dementia

<sup>8</sup> In this context psychogeriatric services means psychiatric services provided to older people with functional and organic mental disorders (including people with dementia).

## Actions

## Key Steps

- developing dementia-specific standards for residential care services by 2003. These will be developed within the framework established by the Health and Disability Services (Safety) Act 2001, and will provide greater specificity than the generic Health and Disability Sector Standards (Standards New Zealand 2001)
- involving trained psychogeriatric professionals in the appropriate management of people who have significant psychiatric or behavioural symptoms associated with dementia
- strengthening the audit process for all aged care services, including dementia services.

3.5 The Ministry of Health, in collaboration with DHBs, will undertake a service review of specialist health services for older people.

There are significant differences in the effects of disease and injury in older age compared to younger adults. The incidence of disease, particularly multiple disease conditions and combinations of physical and mental disability, is also significantly higher amongst older people than other age groups.

Because of this combination of factors, health professionals without specialist knowledge of older people's health may miss conditions or the interactions between multiple conditions or medication. Failure to accurately diagnose a condition or drug interaction in an older person can result in rapid physical and/or mental deterioration that is difficult or impossible to reverse.

Integrating mental health services for older people with physical health and disability support services will assist service providers in addressing cross-service needs simultaneously, where this is appropriate.

3.5.1 By June 2003 the Ministry of Health will, with DHBs and representatives of specialist service providers, complete a review of specialist services for older people. The review will cover the following functions:

- core multidisciplinary assessment, treatment and rehabilitation services, including physical and mental health
- co-ordinating care for people with highly complex health and support needs
- providing shared care with other clinical specialities, (for example, orthopaedics, cardiovascular, ophthalmology)
- specialist advice and resources available to primary and community care providers
- clinical support for disability support service providers of home support and residential care.

The review will include:

- findings from the work undertaken in the review of specialist mental health services and the service development plan for older people with dementia (refer to actions 3.3 and 3.4)
- a stocktake of existing specialist health services for older people
- developing service specifications for specialist services for older people for inclusion in the Nationwide Service Framework

- guidelines for specialist services that:
  - provide for a continuum across assessment, treatment and rehabilitation in community, hospital-based and residential care settings
  - clarify the respective roles of, and inter-linkages between, physical and psychiatric specialist services
  - identify how they will provide support for primary and community care services in working with older people
  - are culturally appropriate for older Māori, Pacific peoples and other ethnic communities
  - ensure access to specialist services, including issues for people in rural and remote areas (links with action 3.6).

3.6 The Ministry will develop a co-ordinated approach to rural health issues to facilitate access by rural people, including older people, to appropriate and sustainable services.

Accessible and appropriate health services for people living in rural areas is a key service priority identified in the New Zealand Health Strategy. Access to services to enable people to remain in their own communities is also an objective of the New Zealand Disability Strategy.

3.6.1 The Ministry of Health will improve co-ordination of policy on rural health issues and develop policy and funding mechanisms to facilitate access by rural people, including older people, to appropriate and sustainable services. Key components of this work will be:

- defining 'rural'

## Actions

## Key Steps

- assessing the linkages between the primary health care sector and the secondary sector
- identifying the implications for providing hospital services, community health and disability services in rural settings (refer to action 6.4.1).

3.7 The Ministry and DHBs will work with ACC to manage access to, and transition between, services they fund.

ACC has responsibility for injury prevention and for the rehabilitation of people injured in accidents in New Zealand.

3.7.1 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 for older people
- 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
- consistent standards for services that both sectors fund – starting with home-based support services
- provision of the above services in a way that is culturally appropriate for older Māori and Pacific people and other ethnic communities.

# Objective 4

**The health and disability support needs of older Māori and their whānau will be met by appropriate, integrated health care and disability support services**

Easily accessible primary, community and hospital-based health care that meets the needs of older Māori is a priority for the Ministry of Health and for DHBs.



## Actions

## Key Steps

4.1 DHBs will work with local iwi and Māori communities to establish culturally appropriate, integrated health and disability support services for older Māori.

4.1.1 DHBs have the primary responsibility for planning services and improving Māori health. DHBs will establish a process for involving local iwi and Māori communities in planning, purchasing, delivering and monitoring culturally appropriate services for older Māori and their whānau.

## Actions

## Key Steps

4.2 The Ministry and DHBs will fund a range of health and disability support service providers to give older Māori and their whānau a choice of culturally appropriate mainstream or Māori providers.

4.2.1 The Ministry of Health and DHBs will work towards all mainstream and Māori providers of services for older Māori being clinically sound, culturally appropriate and well co-ordinated to meet the health care and disability support needs of older Māori. This includes services that:

- provide options for older Māori to continue to participate in and contribute to whānau life
- support whānau caring for older people (this will include information on and basic training in caring for older people)
- offer long-term support for older Māori with high or complex care needs
- provide clear information to Māori about government-funded health services available in their communities
- provide appropriate needs assessment
- offer community and residential care, including respite care, that is acceptable to older Māori and takes account of the increasing numbers of older Māori and their social circumstances
- 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

Actions	Key Steps
	<ul style="list-style-type: none"> <li>actively promote Māori participation in provider activities, such as planning, service delivery, consultation and communication</li> <li>include consideration of marae-based programmes that focus on wellness, emphasise the role of kaumātua, involve community participation and encourage social contact</li> <li>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.</li> </ul>
<p>4.3 DHBs will facilitate the development of health advocacy structures for older Māori in their district.</p>	<p>4.3.1 DHBs will work with local iwi, Māori communities and existing older people’s advocacy groups to identify, strengthen, support, and, where necessary, facilitate the development of advocacy structures that promote issues for older Māori, including issues for older Māori in rural areas.</p>

These actions will be developed in conjunction with implementing the Māori Health Strategy, He Korowai Oranga, to be released in the next few months.

## Objective 5

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### Population-based 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, promote and protect the health of *populations*, and reduce inequalities in health. 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 underlying determinants of health and risk factors, 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. They therefore recognise ageing as a normal part of the life course and support action to promote the concept of positive ageing. The life course approach adopted by Public Health supports activities in earlier life designed to enhance growth and development, prevent disease and ensure that people reach their greatest potential.

The focus of this objective is on health promotion activities and interventions that benefit all ages but with a focus on key areas for improving wellbeing in older age. Many of the actions recognise a link with personal health interventions and the need for collaborative or partnership approaches with primary and community health providers (refer to action 6.1).

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



Key public health priorities for improving wellbeing in older age are: improve nutrition; increase physical activity; reduce depression, social isolation and loneliness; reduce falls; promote intersectoral collaboration on housing and transport; other areas for public health action.

To promote action in these areas the Ministry of Health, public health planners and funders and DHBs, in collaboration with public health providers,<sup>9</sup> will:

- assess service needs for older people generally, with a particular focus on populations with the worst health status
- encourage the development of appropriate public health services
- develop collaborative national and regional relationships over public health services.

Actions	Key Steps
5.1. Improve nutrition	<p data-bbox="725 778 1955 1114">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 a highly significant 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. 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 1996).</p> <p data-bbox="725 1161 1928 1283">5.1.1 The Ministry, in collaboration with DHBs and relevant agencies and in consultation with the community, will support the development of services that promote healthy eating and physical activity.</p>

<sup>9</sup> The Ministry of Health currently has responsibility for funding public health services and programmes, in collaboration with DHBs who are responsible for the health of their local populations. Public health services and programmes are provided by a range of providers including DHB public health providers, health promotion professionals, independent or community agencies, and territorial local authorities.

## Actions

## Key Steps

### 5.2. 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 and falls, 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 and health in later life.

The Ministry of Health has consulted on a draft strategy for physical activity, nutrition and obesity called Healthy Action – Healthy Eating: Oranga Pumau – Oranga Kai. Towards an integrated approach to physical activity, nutrition, and healthy weight for New Zealand. The draft focuses on broad environmental as well as individual lifestyle factors. Physical activity for older people should also emphasise resistance and strength training, which is beneficial for both older men and older women. The type and level of physical activity for older people needs to be tailored to the physical abilities of the person.

5.2.1 The Ministry and public health providers will support campaigns emphasising that it is never too late to start physical activity, and advocacy for secure/ comfortable environments for physical activity and walking (such as safe public places and footpaths).

5.2.2 The Ministry and DHBs (in partnership with other key organisations, such as Sport and Recreation New Zealand, formerly the Hillary Commission) will support programmes and development of resources that encourage safe physical activity, including walking and safe environments, such as well-lit footpaths, safe cycle tracks and community recreation facilities appropriate for older people.

## Actions

## Key Steps

5.2.3 The Ministry of Health and DHBs will support the Green Prescription scheme (where GPs prescribe physical activity) as an intervention closely linked to primary health care and therefore particularly relevant for older people.

5.3 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 (Ames 1993). Depression is often missed at the primary care level or misidentified as loneliness, ageing or dementia (NSW Health 1999). Some migrants and refugees may be especially vulnerable given the barriers to social interaction such as language (Abbott et al 2001; Altinkaya and Omundsen 1999). 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<sup>10</sup> (Cattan and White 1998). Home visiting, home calling and befriending programmes, often provided by volunteers, may also help to reduce depression.

5.3.1 The Ministry and DHBs will work with local communities and local authorities to support services to identify and address social isolation and loneliness among at-risk groups of older people.

<sup>10</sup> The study found that further evaluation of one-to-one interventions was needed and that appropriate evaluation and monitoring tools need to be developed to measure often subtle qualitative changes in wellbeing.

## Actions

## Key Steps

- 5.3.2 The Ministry and DHBs will 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, Age Concern Councils and Māori Women's Welfare League), are more cost-effective and self-sustaining over time. (Tang et al 1995; Alcohol & Public Health Research Unit 2001).
- 5.3.3 The Ministry and DHBs, in collaboration with local communities and local authorities, will support services to reduce depression.
- 5.3.4 The Ministry and DHBs will support approaches that raise community awareness of depression and suicide in older people and encourage them to seek help.

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### 5.4 Reduce falls

A third of older people living in private homes and about half of those in institutions will fall each year. Falls are the most common cause of injury and a major cause of hospitalisation in older people. Even if there are no injuries, falls may result in loss of confidence, and/or loss of independence and quality of life.

Although falls may appear to result from a single cause, they usually result from a combination of physical, lifestyle, environmental, and social risk factors (Robertson and Gardner 1997). Several of these risk factors can be reduced by appropriate interventions that link public health actions and personal interventions. These include addressing: reduced muscle strength, impaired balance and gait, overuse of psychotropic drugs, neurological disorders, impaired vision, foot problems, depression, lack of social support, home safety, and the effects of winter conditions and low temperatures.

## Actions

## Key Steps

Programmes that are individually tailored and delivered by trained instructors are more likely to be effective in preventing falls than standard or group-delivered programmes (Gillespie et al 2001). Falls and fall injuries can be significantly reduced, especially in people aged 80 years and older, through effective home exercise programmes (Campbell et al 1997; Robertson et al 2001a; Robertson et al 2001b; Robertson and Campbell 2001). The Ministry of Health and ACC have a joint role in falls prevention initiatives.

5.4.1 The Ministry and DHBs will support programmes that address environmental risk factors, such as advocacy for safe, supportive environments and programmes to reduce hazards.

5.4.2 The Ministry and DHBs will support community falls prevention programmes for older people that are based on clear evidence of acceptability, feasibility and effectiveness.

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5.5 Promote intersectoral collaboration on housing and transport

### Housing

Most older people continue to live independently or with relatives, but may need home care and/or 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 because of security concerns), 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).

## Actions

## Key Steps

5.5.1 The Ministry and DHBs will work with other agencies to advocate for low-cost housing options for older people on low incomes, subsidies for heating and insulation, and universal design of houses to suit all ages (refer to action 8.1.4).

### 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 selective 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. Older people account for around a third of pedestrian fatalities.

5.5.2 DHBs will work intersectorally to encourage:

- the provision of public transport and appropriate social servicing in under-serviced areas
- community development approaches to improve transport options.

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5.6 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 will include the specific needs of older people as part of population health programmes to address those priorities.

*Tobacco control*

5.6.1 Ensure older people have access to smoking cessation messages.

*Alcohol abuse*

There is little reliable data on alcohol use amongst older New Zealanders. Alcohol abuse generally decreases in older people however, recent overseas studies show that one-fifth of older people regularly exceed recommended alcohol consumption limits (Alcohol Advisory Council of NZ and Ministry of Health 2001).

5.6.2 Encourage the Alcohol Advisory Council (ALAC) and other health providers to make information available on possible effects of alcohol on older people.

## Objective 6

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

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 and 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, community and hospital-based health and disability support services. The key mechanism for achieving this expanded role is through the development of primary health organisations. The separation of disability support services funding and planning for people aged 65 and over from that for younger disabled people will also provide the opportunity for closer alignment between funding for health and disability support services for older people.

A greater emphasis on primary and community health care is a key component of supporting older people to age in place in the community. Improved primary and community health care will help minimise loss of functioning, assist older people to have a good quality of life and reduce the risk of avoidable hospitalisation or inappropriate entry to residential care.



## Actions

## Key Steps

Most of the key steps in these actions are part of implementing the Primary Health Care Strategy.

- 6.1 The Ministry of Health and DHBs will work with primary and community health providers to reinforce their roles in health improvement and collaboration with public 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; oral health; and foot care.
- 6.1.1 Service specifications for primary and community health services will include a requirement to improve health through:
- health promotion on a population basis, linking to public health programmes at a national, regional and local level
  - intersectoral action and advocacy to improve health, including linking with community agencies and voluntary groups providing information, education and advice to older people, their families and whānau about healthy living options.

6.2 The Ministry will facilitate work by DHBs and service providers to assess and develop active approaches to care management.

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

As part of implementing the Primary Health Care Strategy and the New Zealand Health Strategy, the Ministry of Health will facilitate work by DHBs with primary health care providers and community health care workers to evaluate the benefits of, and options for:

- identifying older people at risk of developing disease, disability or mental health problems, taking account of ethnic and gender differences in disease prevalence
- providing appropriate preventive care for people identified to be at risk. Initiatives will focus on ways to most effectively reach target groups, including responding to gender as well as ethnic cultural preferences for service delivery
- screening for vision and hearing loss (links to action 8.2.3)
- feeding into a more comprehensive assessment of mental, physical, and social needs where necessary (refer to action 3.3.1).

#### 6.2.2 Service co-ordination

Most older people do not need any assistance to access the health and/or support services they need. However, access becomes more difficult when multiple service providers are involved, needs span health and disability support services, 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 the community; for example, the Co-ordinator of Services for the Elderly (COSE) developed by the Elder Care Canterbury project, in a primary health organisation or a hospital.

- The Ministry of Health is working with DHBs, service providers and health sector workers to develop service specifications for essential primary health care services provided by primary health organisations. These include collaborating with other health and disability support service providers and non-health agencies to provide patient-centric, co-ordinated care. (primary health organisations will be required to provide this service as they become established).
- 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. It is anticipated that specialist health services for older people will co-ordinate care for people with the most complex health and disability support needs (refer to action 3.5.1).
- The Ministry of Health will work with the sector to develop a toolkit for care planning and co-ordination for people with high health and support needs (refer to action 7.1.2).

### 6.2.3 Support for management of medical conditions

The Ministry of Health has developed toolkits 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 toolkits are specific to older people, many are relevant, particularly those relating to obesity, physical exercise, cancer, cardiovascular disease, and diabetes.<sup>11</sup>

The Ministry has facilitated the development and implementation of nationally consistent referral guidelines to help ensure patients referred by primary care receive specialist attention in order of greatest priority. The Ministry has also facilitated the development of management guidelines for patients with common, often low-priority conditions whose care is more appropriately managed by their general practitioner.<sup>12</sup>

- The Ministry will work with DHBs to ensure continued development of best-practice guidelines for clinical decision-making.<sup>13</sup>
- The Ministry will collaborate with DHBs, service providers and professional bodies to 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.

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<sup>11</sup> The toolkits are available on [www.newhealth.govt.nz/toolkits.htm](http://www.newhealth.govt.nz/toolkits.htm)

<sup>12</sup> The guidelines are available on [www.nzgg.careplans.org.nz](http://www.nzgg.careplans.org.nz)

<sup>13</sup> The Ministry is currently working with the Independent Practitioners' Association Council (IPAC) to facilitate the implementation of management guidelines in primary health care. Some have already been developed and are available from the New Zealand Guidelines Group website: <http://www.nzgg.org.nz/library.cfm>

## Actions

## Key Steps

- DHBs will work with primary and community health care providers and specialist clinicians to develop procedures for specialist advice and coaching to support community-based management of medical conditions. Particular areas for development include access to specialist general and mental health assessment services, early identification and treatment of dementia, and development of specialist services for older people (refer to action 3.5).
- The Ministry will facilitate extension of the pharmaceutical review service for people with a chronic disease, taking multiple medications, or at risk of adverse pharmaceutical events.

6.3 The Ministry will assess options for reducing cost barriers for older people to primary health care as part of broader work to remove barriers to primary health care.

6.3.1 The Ministry of Health will work with DHBs to establish Primary Health Organisations. These will start to be established from 2002/03 and will be funded on a capitation basis to lower access barriers for high-need groups. The Government has signalled that the Community Services Card will be gradually phased out as the Primary Health Care Strategy is implemented over the next 8 to 10 years. In the meantime efforts will be made to improve take up of the Community Services Card amongst eligible groups.

6.3.2 The Government is committed to reducing cost barriers to accessing primary health care services. Over the next three years funding will be increased to improve access, starting with those with the greatest need. Change will occur incrementally by working with those providers who are willing to participate in new initiatives.

## Actions

## Key Steps

6.4 The Ministry will facilitate implementation of 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.

6.4.1 The Ministry of Health is facilitating the development of a plan, by June 2002, for implementing the Primary Health Care Strategy in rural areas. The plan will develop a coherent approach to rural primary health service provision, including attracting and retaining an appropriate workforce (refer to action 3.6).

# Objective 7

## Admission to general hospital services will be integrated with any community-based care and support that an older person requires

From time to time older people need to be admitted to general hospital services. This can be for acute or prearranged medical, surgical, or psychiatric treatment (including admission to a specialist psychiatric unit). Many older people recover quickly from a period of hospitalisation and can be discharged with minimal support. Others take longer to recover or do not fully recover, and need integrated support from a range of services to maximise their recovery potential. These could include intermediate rehabilitation and convalescent care that is focused on returning to the community with optimum quality of life. Some older people needing hospital services will already be receiving varying levels of ongoing care and support, including residential care.



Actions	Key Steps
7.1 The Ministry and DHBs, in discussion with health and disability support service providers, will develop systems for planning and co-ordinating care between hospital services, community-based health and disability support services and carers.	7.1.1 The Ministry of Health and DHBs will review services for older people to assess options for community-based care and disability support to avoid unnecessary hospitalisation or inappropriate long-term residential care.  7.1.2 DHBs will work with community-based health and disability support services, hospital service providers and older people to support the use of shared-care intervention plans for older people with ongoing health and support needs. It is a requirement under the government strategy for elective services that all patients assessed for non-acute surgery receive a plan of care that includes: the diagnosis, the agreed care plan, the next action planned and who to contact if there is a problem. Information on shared-care plans will form part of a toolkit

## Actions

## Key Steps

the Ministry of Health will develop to support care planning and co-ordination for people with high health and support needs (refer to action 6.2.2).

7.1.3 The Ministry of Health will build on existing information systems to develop an infrastructure that will enable health and disability support services to share information to improve the treatment and care of individuals (this work has already commenced and will continue over the next two to three years).

7.1.4 DHBs will develop proactive approaches to integrating hospital care with ongoing care, including arrangements for systematic monitoring and review focused on:

- discharge planning
- recovery and rehabilitation
- preventing unnecessary or premature admission, or readmission, to hospital or residential care – ensuring that early work is targeted at service users at highest risk.

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7.2 Hospitals will provide quality, age-appropriate care and treatment for older people.

7.2.1 DHBs will work with hospital providers and health sector workers on quality improvement measures to provide services that are appropriate to the needs of older people. Areas of work will include:

- planning for facilities and environments that are appropriate to the needs of older people and optimise their recovery

- developing and implementing clinical management tools such as clinical care pathways or guidelines to systematise clinical decision-making and co-ordinate care for people with multiple conditions and those needing palliative care, as well as for those with a single, well-defined condition
- co-ordination of medical and mental health assessment treatment and rehabilitation services for older people across hospital and community settings
- ensuring staff are properly trained and supported in care of older men and women, including care of people with cognitive impairment and those for whom English is a second language
- 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 early in the assessment and treatment process
- implementing the plan prior to discharge, including providing appropriate information to primary and community health and disability 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.

## Actions

## Key Steps

7.3 The Ministry, in collaboration with DHBs and in discussion with health and disability support service providers, will assess options for intermediate-level care to bridge the gap between hospital and home-based care.

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-term residential care. The *National Service Framework for Older People* released by the Department of Health in the United Kingdom has provision of intermediate care as one of its eight standards (Department of Health [London] 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 services of short duration, and ongoing home-based support.

7.3.1 The Ministry of Health and DHBs will commence work in 2002 with service providers and health professionals to assess and, if appropriate, develop guidelines for intermediate-level care and rehabilitation for older people. The focus will be on providing a continuum of quality care between general hospital or psychiatric unit-based treatment and home-based support.

Key elements of intermediate care are:

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

## Objective 8

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**Older people with high and complex health and disability support needs will have access to flexible, timely and co-ordinated services and living options that take account of family and whānau carer needs**

Development of a comprehensive range of service options and accommodation will enable older people with long-term health and support needs to age in place for as long as this is a feasible option. Research and expert opinion (Royal Commission on Long Term Care 1999) suggest a need for a more co-ordinated policy, planning and practice approach to housing for older people and there is a need for more collaborative work at the local and national levels.

A key component of community-based support is provision of supported living arrangements. These 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.

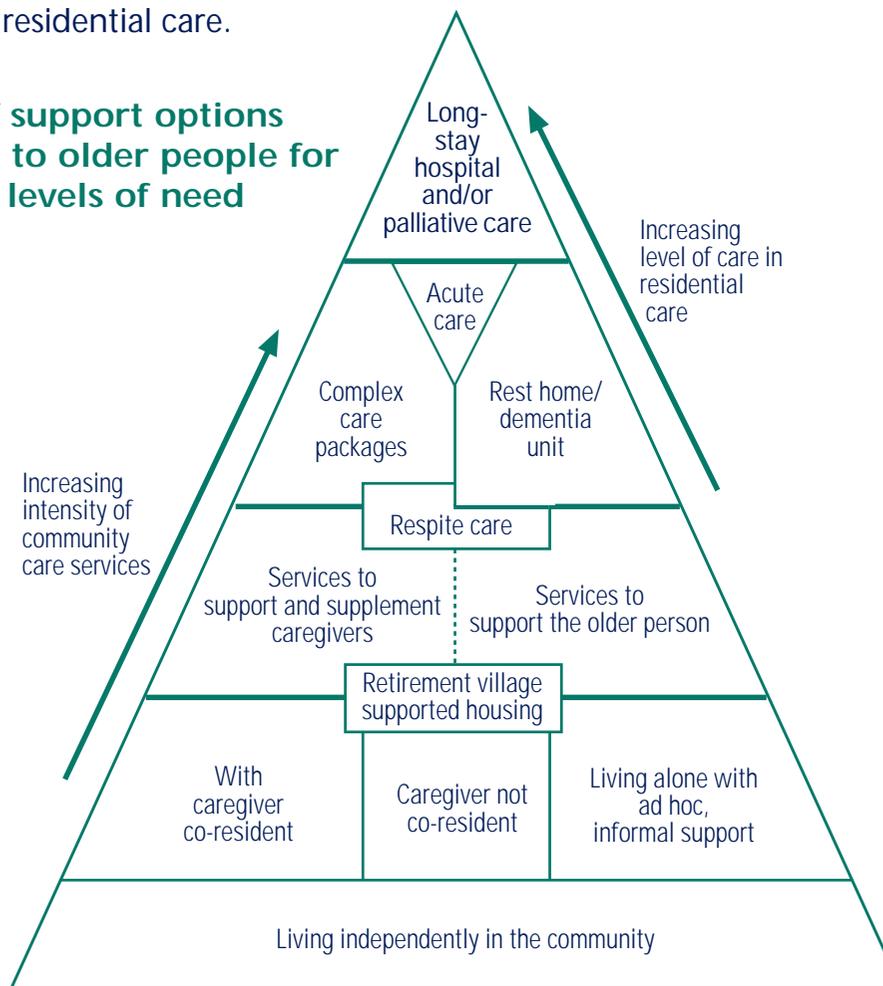
A second key component of services to support older people to age in place is support for family, whānau and other carers. This includes providing information, training and practical assistance to carers and liaising with organisations providing voluntary support.



8.1 The Ministry of Health<sup>14</sup> and DHBs will fund a range of health and disability support services to provide flexible, co-ordinated support for older people to age in place.

In figure 5 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 for residential care.

**Figure 5: Range of support options available to older people for different levels of need**



Source: Adapted from Howe 1996

<sup>14</sup> The Ministry of Health currently has responsibility for funding disability support services, some of which are provided by DHB-owned services.

A comprehensive assessment is needed before an older person moves between the support levels in the continuum of care depicted in Figure 5 (the levels are illustrated by solid lines).

- 8.1.1 By 2004 the Ministry of Health will have specified, in the Nationwide Service Framework, the core components of disability support services needed to respond in a timely way to the diverse needs of older people and their carers.
- 8.1.2 As part of its work to support DHBs in developing an integrated continuum of care (refer action 2.1.2), the Ministry will develop a resource manual of evidence-based practice. The manual will be available to DHBs from June 2003.
- 8.1.3 The Ministry will work with DHBs to develop and assess timely community-based options to support older people to age in place.
- 8.1.4 The Ministry of Health will collaborate with funders and providers of social housing (for example, Housing New Zealand Corporation, and representatives of local councils and community housing trusts) to promote the development of culturally appropriate supported living options for older people. This complements the work identified in action 5.5.1 on low-cost housing options and universal housing design to suit all ages.
- 8.1.5 The Ministry will investigate appropriate living options for older people with ongoing mental illness.

## Actions

## Key Steps

8.2 The Ministry, in collaboration with DHBs, will specify support services available to family, whānau and other carers.

8.2.1 The Ministry of Health and DHBs, in collaboration with older people, carers, service providers and health sector workers, will specify, in the Nationwide Service Framework, support services available and access criteria for family, whānau and others caring for older people. This will cover training and information needs, counselling, and timely assistance with care and respite services.

8.2.2 The Ministry is supporting development of an information network for carers. This will be launched in May 2002, with further development expected over the next two years and ongoing.

8.2.3 The Ministry of Health is planning work from November 2002 to move towards aligning access and eligibility criteria for equipment with the New Zealand Disability Strategy, the Health of Older People Strategy and human rights legislation. This will include revision of key targeting criteria for access to equipment services.

8.3 The Ministry, in collaboration with DHBs and where relevant, ACC, will develop standards for quality support services for older people.

The Health and Disability Services (Safety) Act 2001 provides, amongst other things, for the establishment of consistent and reasonable standards for providing safe health and disability services to the public (Health and Disability Services (Safety) Act 2001, Section 3). The Health and Disability Sector Standards (NZS 8134: 2001) were released in 2001 to provide the foundation for quality and safety standards for hospital and residential care. There is also a recognised need to develop similar standards for home-based services and to develop more specific standards for population groups with particular needs. People with dementia in residential care are one such group.

## Actions

## Key Steps

8.3.1 By July 2003 the Ministry of Health will have developed specific dementia standards for residential care services (refer to action 3.4.1).

8.3.2 By July 2003 the Ministry, in collaboration with ACC, will have developed standards for home-based rehabilitation / home support services (refer to action 3.7.1).

8.4 In line with the Palliative Care Strategy, the Ministry will work with DHBs to facilitate smooth access to palliative care for older people receiving long-term care.

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 2001b). 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.

8.4.1 The Ministry of Health and DHBs will undertake work to determine appropriate service provision to ensure that people receiving long-term care have access to the essential services set out in the Palliative Care Strategy when they need them. This requires that:

- staff in long-term care services have an understanding of the palliative care approach to alleviating pain and other distressing symptoms, and/or provide support during the last months of life
- there is a seamless transition for people who need palliative care services.

## Actions

## Key Steps

8.5 Long-term support providers (in the community and residential care) will build in opportunities for appropriate health promotion, disability prevention and rehabilitation.

Older people receiving long-term support can benefit from the public health actions identified in Objective 5, particularly from good nutrition, physical activity, a range of initiatives to reduce the risk of falls, and socialisation to reduce the risk of depression.

8.5.1 As resources allow, Ministry of Health and DHB contracts with providers of long-term home support and residential care will progressively 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 aid workers will include a focus on maintaining the older client's physical and mental 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.

# MONITORING AND SUPPORTING CHANGE

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## Facilitating change

Key to successfully implementing the Health of Older People Strategy is a process for monitoring and reviewing progress, learning from the insights gained, sharing information about what has worked well and modifying what is not working so well.

The Ministry of Health is working with leader DHBs to develop integrated models of care for older people and has established a wider network of DHBs to share ideas and experiences. As part of this process the Ministry will establish and maintain a web page providing access to information about health of older people, including statistical data on service utilisation and health status and best-practice examples of integrating services. The Ministry is also organising a workshop in late 2002 for DHBs, service providers, health workers and older people representatives to support implementation of the Health of Older People Strategy. The key focus of the workshop will be on actions to share information and experiences to support integrated planning, funding and provision of quality health and disability support services.



## Monitoring and reviewing progress

The Ministry of Health will establish a framework for monitoring and reviewing progress in implementing the Health of Older People Strategy. This includes annual monitoring reports and a three-yearly stocktake of progress. Both the monitoring and review processes will include specific consideration of implementation issues for groups experiencing health inequalities.

## Annual monitoring

There will be a phased approach to monitoring and reviewing progress in implementing the strategy. In the first two years the Ministry will focus on reporting on progress on:

- its own work programme set out in the strategy
- DHB commitments in their annual plans and performance measures in annual funding agreements.

As implementation proceeds the focus will move towards monitoring structural change in the funding and delivery of services and programmes and the impact on clients (older people and their family, whānau and carers).

Routine data will be used to monitor changes in service provision and utilisation. The Ministry will report on progress as part of its performance agreement with the Minister of Health and will also feed into annual reporting requirements against actions in the *New Zealand Positive Ageing Strategy Action Plan* (Ministry of Social Policy 2001).

The Ministry of Social Development is required to provide an annual progress report to Cabinet on projects listed in the *New Zealand Positive Ageing Strategy Action Plan*. 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.

## Three-yearly stocktake and review

Progress towards integrating services will be reviewed three yearly. This will form the basis for reporting to the Minister of Health and contribute to the health component of the Ministry of Social Development's status reports assessing progress towards implementing the New Zealand Positive Ageing Strategy.

## Research and information needed to support change

There is an extensive body of international literature on the impact of an ageing population on health and disability support programmes. 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.

Universities in New Zealand are gradually developing a body of graduate student research and a slowly emerging research workforce. These efforts need to be brought together to provide a focus for furthering research on ageing, for co-ordinating that research and disseminating research findings throughout New Zealand. The New Zealand Institute for Research on Ageing at Victoria University provides a vehicle for furthering research on ageing.

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; mental health; treatment; and home-based, residential and environmental<sup>15</sup> disability 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
- projecting future trends in caregiving to and by older people<sup>16</sup>

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<sup>15</sup> Includes equipment, appliances and modifications to home or vehicle.

<sup>16</sup> Work on the *Living Standards of Older New Zealanders* (Fergusson et al 2001) provides a good start in this area.

- 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 issues of staffing, 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 disability support services
- health status and service utilisation by ethnicity
- information on the size and composition of the health and disability workforce.

Service utilisation and workforce data collected should include ethnicity details consistent with the NZ Standard for ethnicity measurement.

Research is also needed in the following areas:

- affordability and access to health and disability support services<sup>17</sup>
- gender differences in health status, disability prevalence and demand for and utilisation of services
- international comparisons of health service provision and utilisation patterns and health status
- the reliability of assessment tools for determining eligibility for services

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<sup>17</sup> It is planned to update the work on *Living Standards of Older New Zealanders* at regular intervals.

- the extent of polypharmacy and its relationship to morbidity
- the effectiveness of family intervention, therapy and carer support programmes
- mechanisms for ensuring quality
- mechanisms for 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; OECD; government health and social welfare departments; universities and research foundations; and international professional, advocacy and support associations.

# 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>18</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 disability support services. This requires:
  - an inclusive approach to planning which accommodates a broad range of interests (including older people and carers)
  - 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

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<sup>18</sup> Nine evaluation reports to the Health Funding Authority and Ministry of Health on National Demonstration Integrated Care Pilot Projects summarised in the Health Services Research Centre and Te Rōpū Rangahau Hauora a Eru Pōmare Overview Report, March 2001.

- 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 carers
  - 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, carers and the community
  - innovative and flexible to meet the diverse and changing health and disability support needs of older people and family, whānau and carers
  - 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 carers 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 which recognises rehabilitation opportunities.

# Appendix 2: Summary of Objectives, Actions and Key Steps

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## Objective1

Older people, their families and whānau are able to make well-informed choices about options for healthy living, health care and/or disability support needs

Action/Step	Page
<b>1.1 Information on self-care, service availability, eligibility and cost</b>	<b>16</b>
1.1.1 Information for older people	17
1.1.2 A national information network	17
<b>1.2 Involving older people in decisions about their health care and support needs</b>	<b>17</b>
1.2.1 An inclusive approach in service contracts to older people and their family and whānau	17
1.2.2 Planning for individualised funding	17
<b>1.3 Protecting vulnerable older people from abuse</b>	<b>18</b>
1.3.1 Review of enduring power of attorney in PPPR Act	18
1.3.2 Family violence protocols and provider training	18
1.3.3 Collaboration with elder abuse and neglect prevention services	18
<b>1.4 Positive attitudes to ageing and older people</b>	<b>19</b>
1.4.1 Promotion of positive attitudes in planning and service delivery	19



## Objective 2

**Policy and service planning will support quality health and disability support programmes integrated around the needs of older people**

Action/Step	Page
<b>2.1 DHB plans to implement the Health of Older People Strategy and respond to population ageing</b>	<b>20</b>
2.1.1 Milestones for implementing the strategy in DHB annual plans	20
2.1.2 Models for delivering an integrated continuum of care	20
2.1.3 Review of services for an ageing population	21
<b>2.2 Ministry of Health facilitating implementation of the strategy</b>	<b>21</b>
2.2.1 Workshop to support implementation of the strategy	21
2.2.2 Health of Older People web page on the Ministry of Health website	21
2.2.3 Development of performance indicators	21
<b>2.3 Reliable data to model demand</b>	<b>22</b>
2.3.1 Data to model demand for services	22
2.3.2 Improving existing data	22
2.3.3 Improving the quality and availability of DSS data	22
2.3.4 Publication of statistics on mental health	22
<b>2.4 Development of the workforce for health of older people</b>	<b>23</b>
2.4.1 Analysis of health sector workforce needs	23
2.4.2 Report on workforce needs for the ageing population	24
2.4.3 Monitoring the workforce	25

<b>Action/Step</b>	<b>Page</b>
<b>2.5 Health and support services for older Pacific peoples and their families</b>	<b>25</b>
2.5.1 Planning for meeting the needs of older Pacific peoples and their families	25
<b>2.6 Health and support services for older people in other ethnic communities</b>	<b>26</b>
2.6.1 Guidance on health and support services for older people in ethnic minority communities	26

## **Objective 3**

**Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whānau and carers**

<b>Action/Step</b>	<b>Page</b>
<b>3.1 Funding for older people's health</b>	<b>28</b>
3.1.1 Advice on future funding for health and disability support services	28
<b>3.2 Integrated assessment</b>	<b>29</b>
3.2.1 Comprehensive multidisciplinary needs assessment for older people	29
<b>3.3 Review of specialist mental health services</b>	<b>30</b>
3.3.1 Targets for older people's access to specialist mental health services	30
3.3.2 Nationally consistent framework for specialist psychogeriatric services	30
<b>3.4 Service development plan for older people with dementia</b>	<b>30</b>
3.4.1 Service development plan for people with dementia	30

<b>Action/Step</b>	<b>Page</b>
<b>3.5 Review of specialist health services for older people</b>	<b>31</b>
3.5.1 Review of specialist services for older people	32
<b>3.6 Ministry of Health will develop a co-ordinated approach to rural health issues, including issues for older people</b>	<b>33</b>
3.6.1 Policy development for rural access to health services	33
<b>3.7 Collaboration with ACC</b>	<b>34</b>
3.7.1 Collaboration with ACC on service provision	34

## **Objective 4**

**The health and disability support needs of older Māori and their whānau will be met by appropriate, integrated health care and disability support services**

<b>Action/Step</b>	<b>Page</b>
<b>4.1 Working with local iwi and Māori communities</b>	<b>35</b>
4.1.1 Involving local iwi and Māori in services for older Māori	35
<b>4.2 Range of health and disability support services</b>	<b>36</b>
4.2.1 Service development for older Māori	36
<b>4.3 Development of advocacy structures</b>	<b>37</b>
4.3.1 Development of advocacy structures	37

## Objective 5

Population-based health initiatives and programmes will promote health and wellbeing in older age

Action/Step	Page
<b>5.1 Improve nutrition</b>	<b>39</b>
5.1.1 Healthy eating and physical activity	39
<b>5.2 Increase physical activity</b>	<b>40</b>
5.2.1 Promoting starting physical exercise	40
5.2.2 Safe physical activity	40
5.2.3 Green Prescription scheme	41
<b>5.3 Reduce depression, social isolation and loneliness</b>	<b>41</b>
5.3.1 Support identifying and addressing social isolation and loneliness	41
5.3.2 Support community development to improve social connection of older people and their self-care skills	42
5.3.3 Support services to reduce depression	42
5.3.4 Support raising community awareness of depression and suicide in older people	42
<b>5.4 Reduce falls</b>	<b>42</b>
5.4.1 Support programmes that address external risk factors for falls	43
5.4.2 Support community falls prevention programmes for older people	43
<b>5.5 Promote intersectoral collaboration on housing and transport</b>	<b>43</b>
5.5.1 Advocate for low-cost housing options for older people	44
5.5.2 Support transport /service access	44

<b>Action/Step</b>	<b>Page</b>
<b>5.6 Other areas for public health action</b>	<b>44</b>
5.6.1 Access to smoking cessation messages	45
5.6.2 Encourage provision of information on possible effects of alcohol on older people	45

## **Objective 6**

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

<b>Action/Step</b>	<b>Page</b>
<b>6.1 Health improvement and collaboration with health promotion programmes</b>	<b>47</b>
6.1.1 Health promotion and intersectoral action	47
<b>6.2 Active approaches to care management</b>	<b>48</b>
6.2.1 Early detection of disease and/or disability	48
6.2.2 Models for service co-ordination for older people accessing multiple services	48
6.2.3 Community-based management of medical conditions in older people	50
<b>6.3 Reducing cost barriers</b>	<b>51</b>
6.3.1 Development of Primary Health Organisations and Community Services Card take-up	51
6.3.2 Funding to improve access to primary health care services	51
<b>6.4 Implementing the Primary Health Care Strategy in rural areas</b>	<b>52</b>
6.4.1 Development plan for rural areas	52

## Objective 7

**Admission to general hospital services will be integrated with any community-based care and support that an older person requires**

<b>Action/Step</b>	<b>Page</b>
<b>7.1 Planning and co-ordination between hospital, community health and disability support services and caregivers</b>	<b>53</b>
7.1.1 Review of services for older people	53
7.1.2 Development of shared care plans	53
7.1.3 Infrastructure development	54
7.1.4 Development of proactive approaches to integrating hospital and community-based care	54
<b>7.2 Providing age-appropriate care and treatment in general hospitals and psychiatric units</b>	<b>54</b>
7.2.1 Service quality improvements, including development of clinical management tools; co-ordination of care; staff development and discharge planning	54
<b>7.3 Assessing options for intermediate-level care</b>	<b>56</b>
7.3.1 Assessment of options for intermediate-level care and rehabilitation	56

## Objective 8

**Older people with high and complex health and disability support needs will have access to flexible, timely and co-ordinated services and living options that take account of family and whānau carer needs**

Action/Step	Page
<b>8.1 Funding flexible options to support older people in an appropriate environment</b>	<b>58</b>
8.1.1 Specification of the core components of disability support services in the Nationwide Service Framework	59
8.1.2 Development of a resource manual to assist DHBs developing an integrated continuum of care	59
8.1.3 Development and assessment of community-based options for ageing in place	59
8.1.4 Collaboration to promote the development of culturally appropriate supported living options for older people	59
8.1.5 Appropriate living options for older people with ongoing mental illness	59
<b>8.2 Support for family, whānau and other carers</b>	<b>60</b>
8.2.1 Specification of services to support carers in the Nationwide Service Framework	60
8.2.2 Support for development of an information network for carers	60
8.2.3 Move towards amending equipment access and eligibility criteria	60
<b>8.3 Development of quality standards for support services for older people</b>	<b>60</b>
8.3.1 Development of specific dementia standards for residential services	61
8.3.2 Development of standards for home-based rehabilitation/home support services	61
<b>8.4 Implementing the Palliative Care Strategy</b>	<b>61</b>
8.4.1 Determining appropriate palliative care provision for people receiving long-term care	61
<b>8.5 Long-term support providers will promote clients' health and wellbeing and rehabilitation</b>	<b>62</b>
8.5.1 Contracts with providers of long-term home support and residential care to progressively include a focus on promoting health and wellbeing	62

# **GLOSSARY**

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## **Age in place**

The ability to make choices in later life about where to live and to receive the support needed to do so. A key component of implementing ageing in place is developing services that support older people to continue to live safely in the community.

## **Annual plans**

DHB operational plans covering a 12-month period.

## **Assessment treatment and rehabilitation services (AT&R)**

The aim of AT&R services is to:

- identify and treat potentially reversible conditions with the potential for rehabilitation
- manage symptoms
- restore the client to their maximum possible level of function.

## **Carer**

A carer or voluntary caregiver is a person, usually a family member, who looks after a person with a disability or health problem, and who is unpaid for providing this service.

## **Culturally appropriate services**

Service responsive to, and respectful of, the history, traditions and cultural values of the different ethnic groups in our society.

## **District Health Boards (DHBs)**

Organisations established to protect, promote and improve the health and independence of a geographically defined population. Each DHB 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**

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 DHBs, this will include the DHB annual plan, funding schedules and the DHB statement of intent.

**Health aid workers**

Health care and home support workers. Health care workers provide hands-on personal care, assisting clients with activities of daily living and personal hygiene. Home support workers perform household tasks. The same person may perform the two roles.

**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 independently prescribe medicine from a specified list of medicines approved for the particular scope of practice in which he or she will prescribe. The lists of medicines will be set out in regulations. The regulations define the aged care scope of practice in which nurses who attain registration as a nurse prescriber may prescribe.

**Integrated continuum of care**

An integrated approach to health and disability support services that is responsive to older people's varied and changing needs. Providers co-ordinate their services, working closely with the older person and, where appropriate, with their family, whānau and carers to provide services that appear seamless to the recipients. 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 either 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**

A way of living based on identifiable patterns of behaviour based on an individual's choice, influenced by the individual's personal characteristics, their social interactions, and socioeconomic and environmental factors.

**Long-term support**

Either community or residentially based 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**

Encompasses a diverse range of peoples from the South Pacific region living in New Zealand, who have migrated from the Pacific Islands or identify with them because of ancestry or heritage.

**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 includes 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 is a collective of health care providers and health practitioners that provide a set of essential primary health care services to an enrolled population. At a minimum these services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell.

### **Programme**

A group of activities directed towards achieving defined objectives and targets.

### **Psychogeriatric services**

Also called psychiatry of old age. Psychiatric services provided to older people with functional and organic mental disorders where there are associated significant psychiatric symptoms. Functional disorders include mood disorders and psychoses such as depression, anxiety, bipolar disorder, and schizophrenia. Organic mental disorders include dementia, delirium and personality change or delusional states induced by physical disorders.

**Respite care**

Care that may be provided in a residential care facility, day care, or in the person's own home to provide 'time out' for family, whānau and carers. This is a broader definition than one commonly used to refer only to residential care.

**Socioeconomic disadvantage**

A relative lack of financial and material means experienced by a group in society that may limit their access to opportunities and resources that are available to the wider society.

**Strategic plans**

Plans produced by DHBs and the Ministry of Health that will outline the strategic direction over a 5–10-year period.

**Supported living**

Accommodation for older people that provides:

- an explicit focus on privacy, autonomy and independence, including the ability to lock doors and use a separate bathroom
- an emphasis on apartment settings in which residents may choose to share living space
- the direct provision of, or arrangement for, home support, personal care and some nursing services, depending upon need.

**Wellbeing**

A dimension of health beyond the absence of disease or infirmity, including social, emotional and spiritual aspects of health

**Whānau**

Extended family including kaumātua, pakeke, rangitahi and tamariki. The whānau is recognised as the foundation of Māori society.

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