Update of the Health of Older People Strategy

Submission to the Ministry of Health

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces Te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to provide you with our comments and suggestions for the update of the Health of Older People Strategy 2002 ('the Strategy')

2. NZNO represents most registered nurses (RNs), enrolled nurses (ENs), nurse practitioners (NPs), clinical nurse specialists (CNSs) and health care assistants (HCAs) who work with older people in primary and hospital health settings and residential aged care (ARC) facilities.

3. NZNO has consulted its members and staff in the preparation of this submission, in particular members of College of Primary Health Care Nurses, the Gerontology Nurse Section, the College of Critical Care Nurses, the Aged Care Sector Group (ACSG), Te Rūnanga o Aotearoa, and NZNO's professional nursing, industrial, policy, legal, and research advisers.

4. NZNO will also be contributing to the strategy via the workshops the Ministry is organising, and has extended an invitation to the Ministry to attend the ACSG meeting with delegates, organisers and advisers during October 6th-7th, 2015.

5. Although much of the 2002 document is still relevant, we agree that there is a need for it to be updated, and systematically and accountably implemented. We believe the strategy needs to be broadly based, and consider the health of older people in the wider context of population health, health service delivery and equitable outcomes.

6. We recommend that Te Tiriti o Waitangi and the principles of social justice and equity - the bases of ethical relationships and actions in Aotearoa New Zealand – are acknowledged as fundamental *drivers* of the Strategy, rather than as 'objectives'.

7. The Strategy must affirm the intrinsic value of health equity and act to alleviate the significant health disparities within older populations that are the legacy of early disadvantage, structural discrimination and intergenerational inequality.

8. NZNO recommends you note the Public Health Association of New Zealand's *Policy on Reducing Health Inequalities,* adopted in 2002[1].

1. There is both the need and potential to improve the lives of older people more equitably and cost effectively through the adoption of a proactive and integrated, cross sector, interdisciplinary approach to health and wellbeing.

9. We suggest that contrary to current trends towards tailoring/targeting services to individuals, the whole community context needs to be considered for "aging in place" strategies i.e. what services and facilities are available and when, how easily are they accessed (transport), are they culturally appropriate/accessible etc.

10. We are not sanguine that individualised funding and 'investment' models are useful in the context of an aging population, which is geographically and culturally diverse, and when responsibility is shifted to individuals and families who may not be able to manage it successfully. Government stewardship of health and social services must be maintained to ensure quality, efficiency and equity.

11. Nurses supported by health care assistants (HCAs) or kaiāwhina[2], directly assess, manage, and provide personal and specialist health care to older people in all settings - home, hospital, and residential and community care facilities. The discussion below raises issues impacting the health of older people and suggestions for improving the quality and efficiency of health services.

12. Overall, we recommend that the Strategy focuses on:

    - simplifying services for older adults;

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[1] http://www.pha.org.nz/policies/phapolicyinequalities.pdf

[2] Health Workforce New Zealand (Ministry of Health) and Careerforce have recently introduced "Kaiāwhina" as a generic term for care and support workers in Aotearoa New Zealand as part of their joint plan to develop the non-regulated health and disability workforce http://www.careerforce.org.nz/kaiawhina/.

- incorporates the older person's point of view/perspective and goals;
- clearly identifying access points and pathways to health and medical care, and home and support services;
- engaging with and empowering communities to shape the way services are provided to match their needs;
- aligning health workforce planning and development with training, employment (including immigration), and regulation to ensure safety, quality and flexibility;
- using plain language to ensure that processes, entitlements and accountabilities are well understood;
- having measureable goals/indicators for actions with accountable consequences; and
- ensuring regular and robust evaluation of the strategy.

13. More specifically, the discussion below provides the context and rationale for the 'bottom line' actions NZNO recommends are prioritised in the updated Strategy, namely:

    - mandatory minimum standards for living and working conditions i.e. affordable healthy housing, transport and energy; a living wage, and safe, fair workplaces;
    - health impact assessments to be a mandatory part of the development of all new government strategies and public infrastructure (note the Ministry of Health has developed HIA and Māori HIA tools);
    - the removal of structural and funding barriers to coordinated primary healthcare and social services. Eg enabling alternative resource pathways, to primary healthcare and support for aging in place other than GP practice eg nurse-led clinics, community centres (eg Victory schools), NP models);
    - co-ordinated employment, education, and immigration policy and practice to support a high quality, self-sustainable and flexible workforce;
    - clear guidance on the role and professional boundaries between the regulated clinical workforce (health practitioners) and unregulated support and care workers to ensure safe, cost effective and appropriate health and support care for older people; and

- mandatory minimum standards, including staffing levels and skill mix, for safe aged and dementia care.

DISCUSSION

Te Tiriti o Waitangi and Health Equity

14. NZNO acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and acknowledges this formally through Te Runanga o Aotearoa which represents over 3000 of our 46 000 members.

15. Disparities between Māori and non-Māori on almost every socio-economic indicator of health and wellbeing are a bleak reminder of the gap between intention and delivery. The cumulative impact of lifelong health, education and economic disadvantage is evident in mortality and morbidity statistics which show not only that Māori do not live as long as non-Maori, they live in poorer health, and have fewer resources with which to meet their higher health needs (New Zealand Statistics, Social Indicators: Health[3]).

16. Structural discrimination in public services in Aotearoa New Zealand, including in the health system, contributes to and perpetuates health and other disparities (Human Rights Commission, 2012).

17. The Strategy presents an opportunity to recognise and alleviate entrenched health disparities between older Māori and non-Māori people, many of which are attributable to early disadvantage and structural discrimination (Dew & Matheson, 2008).

18. Separate agendas and specific objectives/funding for Māori (and other disadvantaged groups) have not delivered equity as intended, and in some cases have exacerbated disparities eg Māori health workforce strategies have not delivered equal participation and health professionals working for Māori and iwi providers, are paid up to 25 % less than their DHB counterparts[4]. Other targeted initiatives can reinforce negative stereotyping, while lack of cultural competence and safety has precluded vulnerable populations from benefiting from mainstream health initiatives and increased health disparities eg PHARMAC data show marked inequitable uptake by Māori for funded medications.

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[3] http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health.aspx

[4] Note NZNO's submission in support of its petition for pay parity for the Māori and iwi provider primary health workforce Te Rau Kōkiri (2008) http://www.parliament.nz/resource/0000170291

19. A radically different approach to community engagement and the development of specific community-based healthcare is needed, where the principles of Te Tiriti - **participation, partnership and active protection** – are genuinely embedded in the development of the Strategy and inform and direct *all* the strategic goals and actions.

20. We believe this approach, of unique relevance to Aotearoa New Zealand, fundamentally affirms the value of health equity, self determination and fairness for all New Zealanders. It is an inclusive and useful approach to ascertaining and meeting widely differing individual and community needs, including intergenerational needs.

21. We suggest there is a risk that in the current discourse and focus on investment in child health, the intrinsic value of health equity for older New Zealanders is in danger of being overlooked (Mary Breheny, *Focusing on child poverty – what does it mean for older people*, PHA conference, 2015), or minimised, including by older people themselves who are just as susceptible to negative messages about older people eg "the *onslaught* of baby boomers, the *tsunami* of dementia, the *burden* of caring for older people".

22. In fact, Aotearoa New Zealand is fortunate in having a younger age profile and more scope for immigration than many comparable OECD countries to help mitigate the impact of a rapidly aging population and workforce.

23. It is also likely that people will remain healthier for longer and that the costs associated with an increasing proportion of older people may be mitigated by the extended contribution that they are able to make as volunteers, workers, carers etc. to their families, communities and industry.

24. However, despite human rights legislation, prejudicial, negative images, stereotypes and language about older people abound in both public and professional fora - "acopia", "granny dumping", the "grey tsunami" for example, and the impact is telling.

> **It is clear from an audit done in my area that simply being an older adult means you wait longer in ED and are much more likely to breach the 6 hours. When you get to an acute ward and are difficult to discharge (because of complexity, multiple morbidity and system failure) you become a 'bed blocker' and, if it's winter, a quick exit via a residential care facility. That may seem like a good support mechanism but we would never suggest to a 45 year old that they go to residential care if they needed ongoing nursing!** ***Registered Nurses***

25. Like other forms of discrimination, ageism needs to be addressed systemically. We need to need to actively reverse the "burden"

message about older people and promote the "valuable resource, untapped potential" message" not only with the language and images in the Strategy, but throughout all government policy and publications.

26. All local and government agencies should be alert to the value of programmes which promote intergenerational and local connections; voluntary reading in schools, helping refugees, time banks, community gardens etc. are a low cost, practical way of providing the experiences needed to counter prejudice and increase social cohesion.

27. Programmes facilitating intergenerational relationships could be a requirement for health and education policymakers and providers.

28. A comprehensive approach to health equity that encompasses participation, partnership and active protection is given by The Public Health Association's *Policy on Reducing Health Inequalities* (2002). "Policies and interventions are likely to be more successful in reducing inequalities in health if they:

    - Have an explicit commitment to implementing the principles of the Treaty of Waitangi - participation, partnership and active protection
    - Acknowledge Māori perspectives of health such as te whare tapu whā
    - Are systems-level interventions that address multiple risk factors
    - Actively involve primary care providers and the district health boards
    - Favour the least advantaged
    - Ensure the participation of the least advantaged
    - Foster social inclusion and minimise stigmatisation
    - Take a population approach
    - Are focused on early rather than late interventions
    - Impact, where possible, on the short, medium and long term
    - Are responsive to changes over time in the social and economic circumstances of populations
    - Increase people's competence and control over their life circumstances
    - Support and build the capacity of local organisations."

A population health focus across all services

29. The greatest potential to improve the lives of all older people more equitably and costs effectively is through the adoption of a proactive lifelong and integrated approach to health and wellbeing, with regulatory support for ensuring the determinants of health are met i.e. universal access to affordable healthy housing, energy, food, health information and care, transport, and to support healthy lifestyles (Marmot, 2008).

30. A Health Impact Assessment should be a mandatory requirement for all government policy and strategic actions. The Ministry of Health has developed internationally recognised HIA tools, but there is little information as to where and when they have been used.

31. Treasury's Living Standards Framework, The NZ General Social Survey, Statistics New Zealand's official survey of well-being, and the National Health IT Plan are indicative of progress towards integrated government policy and action needed to support population health. However, there is less policy coherence with regard to the determinants of health and supporting healthy lifestyles.

32. Energy poverty, for example, is a significant problem in Aotearoa (Lawson & Williams, 2012), responsible for increased health demand and costs, and is a potential barrier to the health strategy for older people: 'aging in place'. While the government has acted to increase housing insulation, which has largely benefited individual homeowners, this has not been aligned with other 'universal' actions eg energy price reductions or increased superannuation, to improve energy affordability; or increased funding for pneumococcal vaccinations, which, unlike influenza vaccinations, are not free for over-65yrs to reduce hospital admissions.

33. Still less is there any coordination between, for example, Energy, Climate Change and Health policy and strategic action, as indicated in our submission to the Ministry for the Environment on the Consultation on Setting New Zealand's Post 2020 Climate Change Target (June, 2015)[5].

34. In this context we also note the need to strengthen elder abuse processes. A proactive, integrated approach is necessary to this form of domestic and family violence, with formalised processes between police, health and social services, including routine screening, consistent workforce education, and public awareness raising.

35. The Strategy should have clear and consistent policy links to other strategies and older people should be specifically considered in the development of building and planning regulations (eg. bathrooms that

[5] http://www.nzno.org.nz/get_involved/submissions

have room to a wheelchair or doors that open both ways, to reduce the need to later "enable" funded bathroom renovations for basic mobility issues; road signs that are large enough to read; well lit junctions; pedestrian crossings that give people enough time to cross the road; mobility scooter lanes/dropped curbs for wheeled vehicles (walkers, wheelchairs, scooters and to enable safe cycling for older people with balance issues); transport (eg accessible, subsidised local buses/taxis; 3 wheeled bike lanes); and access to recreational facilities especially those that promote exercise like national walk and cycle ways for people with disability or mobility/balance limitations.

36. In this context, we note the huge contribution that the free travel afforded by the Gold Card has made to the health of older people.

> **The gold card has been instrumental in enabling and encouraging older people to be active and independent, and maintain relationships, and interests. Being able to participate in normal, new, and community activities, without the burden of transport costs, is not only helping people to keep physically active and mentally stimulated, it is also reducing the isolation and loneliness that can lead to depression, poor nutrition and low activity. It has been an outstanding public health initiative. *Registered Nurse* (Mental Health)**

37. At a more structural level, intergenerational connections can be promoted through more flexible approaches to housing, including state and community housing, and the provision of health, social and recreational services.

38. Residential facilities for older people (which increasingly include retirement, rest home and acute/dementia care in one place), for example, often have excellent facilities and programmes for residents – swimming pools, gymnasiums, bowling and croquet lawns, homecare, healthcare, etc. -which provide a continuum of care and accessible services that many people, not just older people, need.

39. This is a model that could and should be adapted to meet diverse community needs, particularly as housing patterns of ownership, size, location etc. are changing in response to other factors as well as the increasing proportion of older people. the Australian Abbeyfield Model has been developed along these lines[6].

40. There is a significant risk that the large scale development of age and income restricted facilities, particularly when concentrated in one area (as is the case in Waikanae, for example) could lead to the problems of

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6 http://www.abbeyfield.org.au/(S(ml013d45tdtczd45p2gbxh55))/downloads/123%20The%20Abbeyfield%20Model.pdf

'ghettoization' and increasing inequity amongst the older population. The concentration of particular groups of people in one location eg young families in housing estates, those with mental illness or disability in institutions, has generally not led to the best social outcomes.

41. Flexible use of public funding for eg child care, housing support, aged care, recreation, healthcare etc. that could be aggregated, would enable *communities* to develop the facilities they need. Community empowerment is a key to democratic powersharing and redistribution of resources.

42. The Productivity Commission's recent report *More Effective Social Services* (2015) identifies the need to 'empower the client' i.e. empower individuals. However, there are several reasons why empowering communities is a more useful and sustainable model for improving, maintaining and managing the health of older people, including palliative and end-of-life care.

43. Aging affects everyone and thus requires a population health approach and universal access to services.

44. The policy requirement is for clarity around current and anticipated needs, and the development of appropriate health information/ promotion, effective models of care, and good data to facilitate continuous service evaluation and quality improvement. The Productivity Commission has correctly identified that "*the stewardship of this system is the government's responsibility, as it is the major funder of social services and has statutory and regulatory powers that other participants do not*".

45. In turn, consumers need to be able to understand health messages and information, and should know what services they're entitled to, how to access them and any costs involved. i.e. simplify services and use plain language (including in multilingual, multimedia formats) to ensure that processes, entitlements and accountabilities are well understood.

46. Universal services that are developed with, and in response to, the needs of both discrete and culturally connected communities are more likely to be cost effective and equitable, compared with those developed in response to individuals contracting for specific services in an open and contestable market.

47. The latter contributes to escalating inequity because of the huge variation between individual circumstances, resources and health literacy; individualised funding works very well for some people, in some circumstances, but population-wide health improvement requires a public health approach and service models that support health and wellbeing.

48. University of Sydney academics have also noted perverse funding incentives for private providers in aged care where higher dependency attracts more funding and there is little incentive for rehabilitative care[7].

Workforce

49. Regardless of resources, organisational structure or setting, all health and social services are delivered by and to people, and the quality of their interactions and health outcomes reflect their training, education, experience and conditions of work.

50. Public safety is protected by the regulation of health practitioners under the Health Practitioners Competence Assurance Act 2003 (HPCA Act), which sets stringent requirements for the registration and annual certification of practitioners by the relevant Responsible Authorities regulating them (eg the Nursing Council, Medical Council etc.). It assures the lifelong fitness and competence of health practitioners to practice within an autonomous scope of practice.

51. Critically, the HPCA Act is 'futureproofed' in that it allows for ongoing workforce innovation and professional development in response to advancing knowledge and practice new knowledge, models of care.

52. The regulated health and disability workforce is supported by a wide range of unregulated care and support workers, kaiāwhina; nationally consistent qualifications are being developed by the industry training organisation, Careerforce, as part of a joint action plan[8] with HWNZ to develop the non-regulated health and disability workforce.

53. Nurses, including ENs, RNs, NPs, have a critical role in the assessment, management, supervision and delivery of health care for older people in all health settings (hospital, community, and home, residential) and are the key clinical interface between people and the medical profession. Nurses work closely with patients, families, health and social services agencies such as ACC, Ministry of Social Development, and local Councils, as well with private service providers, including private hospitals and residential aged care facilities. They are also professionally accountable, for the direction, delegation and supervision of HCAs.

54. Health service costs are largely dominated workforce costs, so it is essential that workforce skills are fully and appropriately utilised.

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[7] https://theconversation.com/aged-care-funding-creates-dependency-and-lowers-well-being-of-residents-45157

[8] http://www.careerforce.org.nz/kaiawhina/.

55. In practice there are barriers to efficiency and safety, with the substitution and duplication of unregulated roles for nursing/health professional roles, and structural impediments to utilising the multidisciplinary skills of the regulated workforce. Both impact heavily on aged care services and the Strategy has an important role in addressing them.

56. Services supporting the health of older people have changed dramatically in the past thirty years from public provision of hospital based acute, rehabilitation, dementia and rest home care to contracted provision of privately-owned residential (and, increasingly hospital level and dementia) aged care, and a wide array of in-home care and support services.

57. The workforce has also changed in response to advances in medical science, education, technology, and employment patterns. There are more women, and more ethnic diversity, more workforce mobility or churn, more internationally qualified health practitioners (25 percent of nurses) and more unregulated workers.

58. However, regulation has not kept up with changes in service provision and there are no mandatory minimum standards for staffing and skill-mix in aged and dementia care, and the clinical and employment boundaries between clinical care, personal care and home support care have been blurred. This has compromised safety, efficiency, and fairness in all aged care settings (New Zealand Human Rights Commission, 2012).

I am aware of one business, [name withheld], who offered in-home care, as well as running a Bureau providing RN and HCA cover for the local age care facilities. My neighbour engaged their services to care for his father with early stage Alzheimer's. What a disaster! The carer sent had no previous experience of dementia care of any kind and ended up arguing with the client. She was employed to give 24 hour in home care and I have since found out the terms and conditions of their employment. They are required to be in the home 22 of the 24 hour period! For this they receive $100 in payment. They are contracted to […] and therefore pay their own taxes, ACC levies and transport costs, ending up with around $4.17 per hour before tax, while those who work through the Bureau are paid around $18 per hour. *Registered Nurse*

In residential aged care facilities the major issue for me is staffing levels. In 2003 I left rest home level aged care to work at the hospital level of care. There was one caregiver to five residents, or, occasionally, one to six. This meant every

resident was toileted 3 times per morning and afternoon shift, was showered every day, and mobilised to their maximum potential. The same hospital facility is now working as a rule one to eight and often when I visit it can be as high as one to ten or eleven! There is no way, no matter how good the nurse or caregiver is, for residents to achieve the level of care we used to be able to give. *Health Care Assistant*

The business providing care very often only has one or two RNs employed and they will be expected to undertake all the assessments, complex dressings if any, monitoring etc. This is a professional risk for them, as they are unsupported. I.e. they are working in isolation, without access to professional development, peer support, mentorship, training etc. Often those running the business are not aware of the risks they are asking these employees to run. *Registered Nurse*

59. The "bottom line" actions for the Strategy must be:

    - to develop and enforce mandatory standards for safe aged and dementia care for older New Zealanders (the voluntary New Zealand Standards *Indicators for safe aged and dementia care for consumers* (2005) are not implemented or freely available, and are outdated and unsafe);

    - to ensure that education and employment differentiate unregulated career pathways in community care and support from regulated career pathways in health; and

    - ensure that qualitative distinctions between clinical and care support work are understood by employers (including individual employers) and employees, so that both health and employment outcomes can be optimised.

60. Addressing structural impediments to utilising the multidisciplinary skills of the regulated workforce has belatedly begun, notably with some extension to prescribing and other authorities to non-medical professions eg pharmacy, midwifery and nursing. However, regulatory progress has been frustratingly slow (the long awaited Health Practitioners (Statutory Reference to Medical Practitioners) Amendment Bill currently under consideration addresses a small fraction of the legislative barriers), and traditional funding models based on a medically focused system remain a significant barrier to better care delivery.

61. Workforce ageing also has significant implications for the health sector with the average age of health practitioners around 50 years. Careful planning is needed to ensure:

    - career pathways to safely and seamlessly transition younger practitioners into leadership roles; and
    - the retention of workforce skills and knowledge through mentorship and flexible employment opportunities.

62. We draw your attention to NZNO's extensive research on nursing employment and the ageing nursing workforce in Aotearoa New Zealand [9], which you are welcome to discuss with NZNO's Principal Researcher, Dr Léonie Walker, and Nursing Researcher, Dr Jill Clendon.

Funding Models

63. Fundamentally, there needs to be more flexibility within the public health system to deliver *primary health care*[10] i.e. ensuring access to the necessary information, education and clinical care to manage good health to complement the delivery of primary (medical) care.

64. Currently both primary health care and primary care are largely delivered through capitation-based subsidies to private GP practices. Alternative public health purchasing models are needed to *drive* not just *demonstrate* innovation that optimises the use of funding and workforce resources.

65. HWNZ for instance has successfully demonstrated new models of care with:

    - a nurse practitioner working with aged care facilities in areas with GP shortages (2011)[11] ;
    - a gerontology clinical nurse specialist identifying at-risk older adults in a GP practice or practices; and, currently,
    - a palliative care managed clinical network[12]; and

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[9] http://www.nzno.org.nz/resources/research
[10] Primary health care services encompass not only a broad range of professional health care received in the community, including health education, counselling, screening, disease prevention and management, but also services that contribute to health, such as those centred on home support, community development, environmental protection, voluntary work. Primary health care ensures access to the necessary information, education and clinical care to manage good health.
[11] http://www.health.govt.nz/publication/evaluation-nurse-practitioner-aged-care
[12] http://www.health.govt.nz/our-work/health-workforce/new-roles-and-initiatives/current-projects/palliative-care-managed-clinical-network

- a rural health interprofessional immersion programme[13].

66. Unfortunately, despite claims to the contrary, new workforce roles and initiatives have *not* generally been adopted across the health sector, unless it is to substitute new cheaper roles, mainly because of lack of funding and a gap in leadership. The NP in aged care model is still rare (there are currently only about 5 NPs working in aged care and there is a critical need for more NPs working in aged care facilities, as per the model above, especially with current GP shortages.

67. The sustained reduction in health funding in over the past few years - estimated at $1billion (Rosenberg & Keene, 2015) – has constrained DHBs capacity to innovate or be proactive.

68. While each has its own policy for older people, all subscribe to a similar model which emphasises ageing in place, shorter bed stays, reducing re-admission, hospital-at-home etc, and devolving more responsibility, but fewer resources, to community-based care (GPs, PHOs, and NGOs) and families.

69. Essentially, rather than the range support options for older people's different levels of need, illustrated in the pyramid on page 58 of the current Strategy, people receive what their DHB can fund, what is available at the time, and what they and/or their health provider know what is available and how it can be accessed. Consequently there is significant variability in access to, and the quality of services, and little guidance for consumers in the selection of services.

Models of Care

70. With more people experiencing a significantly longer, healthier, post-retirement period, most older people will fit between the extremes of "fit and healthy" and "frail and vulnerable" and are likely to be "living with a chronic illness/es" and intermittently requiring specialist and hospital care as they move up and down the wellness ladder. I.e. their health and support needs will not be fixed, or necessarily move in one direction from independence to complete dependence.

71. Health promotion/disease prevention messages need to be tailored to older people. eg: currently healthy eating messages tend to be about weight loss, which is not ideal for older people, and the anticancer message 'slip/slap/slop' may be less important than ensuring they get enough vitamin D. Weight bearing exercise, however, is important for older people, as is staying healthy mentally and avoiding depression and social isolation.

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[13] http://www.health.govt.nz/our-work/health-workforce/new-roles-and-initiatives/current-projects/rural-health-interprofessional-immersion-programme

72. Funding for vaccine preventable /reducible disease –eg Pneumococcal vaccinations; shingles vaccines that reduce post hepatic neuralgia; bone density treatment (tablets, infusions); dental care and continuing standard screening and testing, such as cardiovascular risk assessment, to older ages or in response to *physiological* rather than chronological age, will be increasingly necessary and cost effective as the population ages.

73. Medical, technological and workforce innovation will also affect the way health is managed and services provided. While there will certainly be an increased demand for critical care services, there will also be a need for:

    - coordinated health and social services eg Fit for Frailty[14], British Geriatric Society;
    - models of care that responsive to the escalation and de-escalation of needs (eg Phase 2 Report: Palliative Care Capacity and Capability palliative Care and (Cancer Control New Zealand, 2013, p4);
    - improved health literacy, as opportunities for self management increase;
    - regular evaluation.

74. The Strategy should encompass the concept of advanced care planning and the process of engagement between family and health care professionals to ensure that older people are able to make decisions, based on what matters to them, about provision for their health care needs.

With the Government strategy of keeping people in their homes longer, some serious issues arise. A common situation is an elderly couple, where one is developing dementia and the other is managing, but showing some signs of age. Usually the partner needing care is assessed, and will get a few hours assistance, which is not enough to relieve the burden on the other partner providing round the clock care. While capable of living a relatively active normal life, this partner often becomes dissocialised, as they will not leave their spouse alone for fear of something going wrong - a fall, turning on an element and leaving it, for example. The mobility of both parties becomes very quickly lost as they often will just sit and watch TV or the like. Nutrition is compromised, as other than a meal that the carer may prepare in the hours allocated, they will snack and

[14] http://www.bgs.org.uk/index.php/fitforfrailty-2m

hydration is not as it should be. By the time the unwell spouse is assessed to go into care, the remaining partner has lost much as well. *Enrolled Nurse*

75. Dementia raises a number of complex clinical and ethical concerns besides those raised above. Many members are concerned that while secure units provide safe, clean environments, they can still be frightening, depressing and dehumanising.

Imagine losing your ability to rationalise. You lose your life partner - you can't remember him/her and cant find him/her, often you feel abandoned; you lose your home; and you even lose your freedom all because you have a disease. *Gerontology nurse specialist*

76. Many see IT innovation as a potential solution to secure dementia units to keep people safe, to afford some partners/families some respite from 24 hour care, and to enable timely communication with health care providers.

77. Indeed the potential for IT to positively affect the health of older people and their ability to remain in their own homes is of such significance that the Strategy should identify how IT will be incorporated into health services for older people, and should support investment in developing and trialling IT.

78. Rural areas pose particular challenges to aging in place strategies because of the isolation, smaller available workforce, and distances involved. While IT can help, there are still logistical problems that challenge safety, and very limited choices in terms of alternative accommodation.

79. However, the challenges of isolation and limited choices apply in other areas too. It is now more common for older people to have no family living nearby and to rely on informal neighbour and community support, as well as formal health and social services, and these are not always available or accessible.

80. Income inequalities affect the housing, nutrition and activity choices that impact most heavily on health. Current trends towards reducing home ownership and increasing inequity, much of which is structural (eg women are less able to save for retirement, as are those who with chronic illness, disability, long term unemployment etc.), indicate the urgent need for actions that will enable the redistribution of public resources to ensure equitable outcomes for all New Zealanders.

81. Finally, it is important to remember that aging in place is not appropriate in all circumstances, - loneliness can be a by-product of

ageing in place - and alternative housing/living arrangement need to be available and affordable to all.

CONCLUSION

82. NZNO has taken this opportunity to advocate for a broad-based Strategy that considers the older people in the wider context of:

    - population health;
    - safe, efficient health services focused on a primary health care model of, enhancing wellness and disease prevention/management; and
    - equitable health outcomes that will alleviate the significant health disparities within older populations that are the legacy of early disadvantage, structural discrimination and intergenerational inequality.

83. We recommend that you note and are guided by the Public Health Association of New Zealand's *Policy on Reducing Health Inequalities (*2002) which affirms the centrality of Te Tiriti o Waitangi and the principles of social justice to Aotearoa New Zealand.

84. We also recommend that the Strategy facilitates uses a community engagement and empowerment empowers and includes:

    - mandatory minimum standards for living and working conditions i.e. affordable healthy housing, transport and energy; a living wage, and safe, fair workplaces;
    - mandatory health impact assessments in developing all new government strategies and public infrastructure;
    - enables alternative resource pathways to primary healthcare and support for aging in place;
    - co-ordinated employment, education, and immigration policy and practice to support a high quality, self-sustainable and flexible workforce;
    - clear guidance on the role and professional boundaries between the regulated clinical workforce (health practitioners) and unregulated support and care workers to ensure safe, cost effective and appropriate health and support care for older people; and
    - mandatory minimum standards, including staffing levels and skill mix, for safe aged and dementia care.

85. We repeat our invitation to attend the aged care sector groups meetings on October 6 and 7th, 2015 and look forward to further discussion.

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