A report to
The National Advisory Committee on Core Health and Disability Support Services
by
David Richmond
Jonathan Baskett
Ruth Bonita
Pam Melding
Foreword from the Core Services Committee

This report to the National Advisory Committee on Core Health and Disability Support Services provides a basis for comment on care for older people in New Zealand.

The Committee has a legislative mandate to advise on the content and terms of access for publicly funded health and disability support services. It commissioned this report on Care for Older People to receive expert advice on these issues.

In commissioning the report, the Core Services Committee was particularly interested in:

- identifying the population groups covered by the project, including family and caregivers
- identifying the circumstances that produce needs for care in older people
- an assessment, in general terms, of the extent to which there are current gaps or excesses in meeting these needs
- defining the priorities and recommended terms of access and indications for these services using the Core Services framework of: What are the benefits? Is it fair? Is it value for money? Is it in line with the communities' values?

In developing advice for the Minister of Health, the Committee is required to consult with relevant professionals, lay experts, consumers and members of the general public. As part of consultation, this report is being distributed to stimulate discussion and to give the public an opportunity to comment on the advice it contains. The Committee will be considering this report and comments from interested parties before developing its own advice for the Minister of Health.

Our population is ageing, and the provision of care to meet the needs and growth of the very old, those aged 80 years and over, is important. Research has indicated that most older people prefer to be cared for in their own homes, and the concept of "ageing in place"—maintaining older people in their home environment is accepted world wide. Has New Zealand got the appropriate mix of services to meet the needs of a growing older population in their homes, and the communities in which they live, and in long term care facilities—rest homes and hospitals? What support systems should we be providing to and for carers in the home? What are older people's needs, how can we best meet them? These are the fundamental questions that the authors examine in the report.

The authors have developed a framework for strategies in action, a comprehensive
framework for services that should be provided to meet the needs of older people into the
next century. The strategies aim to address equity, health promotion, the strengthening
of primary health care, participation and community action, healthy public policy and
intersectorial and international co-operation.

A major goal is to “develop a national set of policies relating to the health of older
people, recognising different ethnic needs, which will be the basis for purchasing
decisions by RHAs and planning by public, religious and welfare sector providers”. As
one of the strategies to develop this goal, the authors have suggested that a unit be set up
to formulate and monitor national health goals and policies for older people. This unit
would include representation from the Ministry of Health, the Department of Social
Welfare, the Senior Citizens Unit and the ACC.

The report highlights the need for a comprehensive health care service for older people
to be available and accessible in all major urban and provincial areas and sets out the
characteristics of such a service. It also identifies a number of public health initiatives that
the authors see as of increasing importance to our ageing population.

The importance of examining the long term needs of increasing numbers of Maori and
Pacific Island communities has also been identified in the report. The authors comment
on the lack of data on the social and health needs of older Maori and Pacific Island people.
There is a need to ensure that health care and rehabilitation take place in a culturally
sensitive and environmentally friendly atmosphere. Of particular importance is an
understanding of cultural perceptions of disease and healing and of the nature of the body.
The role of the extended family in the long term care of elders should not be taken for
granted. In the urban setting particularly, the authors have identified that there are similar
pressures on Maori and Pacific Islands families to Pakeha families.

In all the areas addressed in the report the authors have stressed the need for
consultation with government departments and organisations, with RHAs, with other
groups and most importantly with the consumer.

Further copies of the report are available from the Core Services Committee telephone
04 496 2296 or fax 04 496 2341. Comments on the report should be sent to the Core
Services Comittee, Ministry of Health, PO Box 5013, Wellington

Authors

David Richmond
Professor, Academic Sub Dean, Auckland School of Medicine

Jonathan Baskett
Head of Department, Academic Section of Health and Mental Health Services for Older People, North Shore Hospital

Ruth Bonita
Masonic Senior Lecturer, Academic Section of Health and Mental Health Services for Older People, North Shore Hospital

Pam Melding
Senior Lecturer, Old Age Psychiatry, Academic Section of Health and Mental Health Services for Older People, North Shore Hospital
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Executive Summary

The most common reason why older people need care is because physical and/or mental disease causes failing health and increasing disability. Older people most at risk are those living alone, the ‘old old’, those recently bereaved, those recently discharged from hospital, those on multiple medications or with cognitive impairment and those of lower socioeconomic status.

New Zealand population projections show increasing proportions of people over the age of 65 in future years. The most vulnerable group—those over 80, will increase significantly over the next two decades. Only with effective health promotion and education programmes can we hope that illness and death will become compressed within a narrow band at the end of life, since research shows that it is possible to reduce, postpone or prevent disability and handicap in older people by promoting healthy lifestyles.

The concept of ‘ageing in place’, that is, maintaining frail older people in their own homes, is accepted world-wide. Research has demonstrated that this is the choice of most older people. The ageing of our population challenges Government strategists and health professionals to review current care programmes for older people and to plan for the future.

Much has been accomplished over the last quarter century. Well trained and dedicated health professionals are employed in hospitals and the community, special departments for older people (AT & R units) are attached to most district general hospitals, new models of service delivery have been implemented or are being trialled, the private, religious and welfare sectors have taken considerable responsibility for some aspects of care delivery, and voluntary organisations assist with advocacy and special support programmes.

Despite this, there are deficiencies. There is uneven distribution of health services for older people throughout the country with smaller centres and rural areas being especially disadvantaged. Old age psychiatry (psychogeriatrics) and support for confused older people and their families is generally under-resourced. There are no national health goals for older people, or comprehensive plans for the future, and central leadership is lacking.

There is a need for improved consultation with regard to the health requirements of older people in each of the major cultural groups in our community: Maori, Pakeha, and Pacific Islands people, and also in the smaller ethnic groups.

There is a good record of epidemiological and clinical research concerning older people in New Zealand but little health service development research. There has been
little or no attempt to evaluate the effects of a new service with regard to cost or consumer satisfaction. This needs to be addressed.

If voluntary organisations are to function effectively and efficiently, co-ordinating and supporting large groups of volunteers, some financial support is required for their small salaried administration and field officer services.

This report suggests six goals together with strategies for their accomplishment which, if achieved, would significantly impact on health care for older people. These goals are:

- the development of a national set of policies relating to the health of older people, recognising different ethnic needs, to be the basis of purchasing decisions by RHAs and planning by public, religious and welfare, and private sector providers
- agreement on a national framework for comprehensive care services for older people in various settings both geographical (urban and rural) and cultural, which will be regarded as authoritative by all parties involved in the planning, purchasing and provision of health care including government departments and ministries
- that all staff involved in the provision of health care for older people be trained to the work level skills appropriate to their contribution to the service
- that decision-making in health care services for older people be based as far as possible on researched information
- that networks between the government, community and professional organisations concerned with the health and welfare of older people be strengthened and formalised, to improve the flow of information to government decision-makers
- that every older person will have readily available information about wellness strategies for living, and about different types of support and their means of access to them, should ill-health strike.

Three major suggested strategies should be highlighted:

- formation of a new national body to formulate health goals and policies for older people. This body would span all government departments/ministries making policies which impact on older people. Such a strategy is essential to achieve the six goals set out above
- there should be national consultation about a framework of support for frail older people in various settings, both geographic and cultural. This strategy would require community, health care professional, administrative and cultural input
- the formation of an inter RHA Research Purchasing Agency, along similar lines to PHARMAC, to commission and purchase research on health service policy and development for older people. This strategy is based on the view that there is a need
for researched information which is common to all RHAs.

These goals and the strategies to achieve them are by no means all that are possible, or indeed all that are included in this report; however, they do represent a significant and important set of objectives which, if implemented, would enable a wide range of policy initiatives and planning strategies to unfold. New Zealand could have a platform of policies going into the 21st century which would be a world-class model for the care of an ageing population.
### Glossary of Abbreviations used in this Document

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Rehabilitation, Compensation, and Insurance Corporation</td>
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<tr>
<td>ADARDS</td>
<td>Alzheimer's Disease and Related Disorders</td>
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<tr>
<td>AHB</td>
<td>Area Health Board</td>
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<tr>
<td>AT &amp; R</td>
<td>Assessment Treatment and Rehabilitation</td>
</tr>
<tr>
<td>CHE</td>
<td>Crown Health Enterprise</td>
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<tr>
<td>DRG</td>
<td>Diagnostic Related Groups</td>
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<tr>
<td>EDH</td>
<td>Elderly, Disabled and Handicapped (Programme)</td>
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<tr>
<td>EEO</td>
<td>Equal Employment Opportunity</td>
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<tr>
<td>ESHEL</td>
<td>The Association for Planning and Development of Services for the Elderly (Israel)</td>
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<td>GHSAS</td>
<td>Geriatric Hospital Special Assistance Scheme</td>
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<td>GPs</td>
<td>General Practitioners</td>
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<tr>
<td>HEP</td>
<td>Health and Education Programme</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>PHC</td>
<td>Public Health Commission</td>
</tr>
<tr>
<td>PPP&amp;R Act</td>
<td>Protection of Personal and Property Rights Act</td>
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<tr>
<td>QRT</td>
<td>Quick Response Team</td>
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<tr>
<td>QALY</td>
<td>Quality Adjusted Life Years</td>
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<tr>
<td>RACP</td>
<td>Royal Australasian College of Physicians</td>
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<tr>
<td>RANZCP</td>
<td>Royal Australian and New Zealand College of Psychiatrists</td>
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<tr>
<td>RHA</td>
<td>Regional Health Authority</td>
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<tr>
<td>SNAP</td>
<td>Support Needs Assessment Protocol</td>
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Life expectancy in developed societies has increased by more than 30 years during the 20th century. The prospects for long life, even beyond 100 years and for living those years in good health, are constantly improving for the middle-aged and younger people of today.

Yet this apparent advance brings with it some troublesome social problems. Not all are health-related, but the ones that are will be ignored at great cost to the country's health and social services. There is a need to initiate long term planning now to prepare for future pressures on the health system as the population ages.

This paper has been commissioned by the Core Services Committee (see Appendix A for project specifications). The issues it seeks to explore are generated by the knowledge that while the majority of people in their 60s and 70s are in good health and largely independent, by the time they are in their 70s and 80s, increasing numbers of them are suffering from chronic illness and disability, supported by fewer members of their family, and are consequently increasingly dependent on the State for assistance. It is not yet clear whether the increase in life expectancy will bring the hoped for compression of illness and disability to the period at the end of life. Most health care systems for older people have been developed as unrelated initiatives, many beginning regionally and spreading, instead of being developed as part of an overall strategy. This is not to impugn the effectiveness of much that has been done; many service initiatives are based on overseas models and the New Zealand versions have worked well. However, New Zealanders should shape their own health care service for their older residents, building a service which is equitable, comprehensive, effective, flexible, integrated and affordable; a service which draws on the best from overseas and local developments.

This paper is about health care. It does not deal comprehensively with every issue which might be deemed to impinge on the health of older people; this was not our mandate. Some assumptions have been necessary: the fact that the State has a commitment to enhancing the welfare of older people is assumed. The New Zealand Superannuation programme, the health care subsidy systems and the existence of a Minister for Senior Citizens are all examples of Government initiatives over the years which support this assumption. Other assumptions relate to the relative roles and responsibilities of the State and the family regarding the care of older people. These matters have long been debated both in New Zealand and overseas: where should the balance of responsibility lie for the care of our older citizens? With the State or with the family? Does State assistance reduce the sense of responsibility of the family to be first-line carers? Or does it enhance the ability of the family to cope?
This paper takes the view that, in general, New Zealand families remain committed to their older members but that their ability to care is often limited by social factors. Further, it will accept the view argued elsewhere\(^2\) that State assistance, properly designed and applied, enhances rather than detracts from the ability of families to care. Where that balance should lie is part of the debate which this paper addresses. Other assumptions will be apparent in the body of the paper.

The focus of this paper is predominantly on older people who are physically or psychologically frail and who require help or advice from other people in order to optimise their safety, their physical and psychological wellbeing and to be able to stay in their place of choice. A health service for older people is unique among hospital based health services for its holistic view of the individual patient in the context of the family (whanau), the home and the community. Hence, a comprehensive health service for older people requires facilities for the support of the individual in the home, for support of family and carers and for long term residential care when the home option is no longer possible. This perspective is developed further in the paper.

In preparing the paper, the authors have tried to tap into the experience and opinions of a wide range of health care professionals, members of the public, and voluntary organisations concerned with the health of older people. The tight timeframe for the report means it is likely that there are innovative policy and service initiatives taking place in New Zealand which we have been unable to consider. Nevertheless, we are confident that the report provides the basis for informed and constructive discussion and that it can be a powerful catalyst for the future development of the care of older people in New Zealand.
1 Historical Background

1.1 The development of health care for older people in New Zealand

This section briefly reviews the major trends which have characterised health services for older people in New Zealand since the end of World War II.

1.2 The post war years 1945-1970

The major trend was to institutionalise disabled and handicapped older people who could not be cared for by their family. While the concept of the family’s responsibility to care for its older members in the community remained strong, where this could not be fulfilled, the need to provide beds for elderly care was answered in the form of large institutions like Cornwall Hospital in Auckland, and Parkside Hospital in Dunedin. These hospitals were characterised by their rather primitive conditions: large open dormitory wards; little in the way of comfort; virtually no special equipment; minimum of privacy; and low priority for resources in the local Hospital Board’s budget. Nevertheless, it was from these institutions that a small number of dedicated doctors developed the medical sub-specialty of Geriatric Medicine in New Zealand.

In 1960 the Government introduced a Capital Subsidy Scheme to assist religious and welfare organisations to establish homes and hospitals for older people in need of residential care. (This scheme was withdrawn in 1989 when residents of these rest homes became eligible for the then Rest Home Subsidy Scheme.) A subsidy for rest home care was introduced by the Social Welfare Department in 1961 for patients in Auckland Hospitals who were occupying beds but did not require hospital level care. It was available only to residents of privately owned rest homes. This scheme was extended in March 1966 to cover frail elderly pensioners discharged from psychiatric hospitals in Auckland and in May 1975, it was extended again to cover selected ex-psychiatric patients from Tokanui Hospital, who were former Auckland residents and who had strong family links there. The Rest Home Subsidy Scheme was eventually extended to cover the whole country. Licensing of Old Peoples Homes Regulations were introduced in 1965, and have been revised several times since.

1.3 Expansion of institutional care 1970-1984

The trend to institutionalisation continued with the advent of rest homes and long-stay hospitals in the religious and welfare sector to accommodate overflows from the large
public institutions. This development became part of a trend to decentralisation which, in Auckland, was perhaps most graphically demonstrated by the closure of Cornwall Hospital in 1972 and the opening of specialised public geriatric units on the North Shore and in Waitakere City. The trend to decentralisation has been slower to develop in other major centres.

In 1975 the Minister of Health wrote to Chairmen of Hospital Boards encouraging them to recruit geriatric physicians and develop Assessment and Rehabilitation (A & R) Units. This initiative was sparked by a position paper authored by Dr R A Barker, arguing the case for specialised A & R Units.

The Geriatric Hospital Special Assistance Scheme (GHSAS) was introduced in Auckland in 1975 to assist with the payment of fees for individuals who needed long term nursing care, but could not be accommodated in the public long-stay hospital system. Patients were required to contribute to the costs if their income and liquid assets were greater than $600. The scheme was eventually extended to the remainder of the country. The following year saw the introduction of what would later become more formalised assessment procedures, with the hospital boards' geriatricians being required to certify that patients required hospital level care. Between 1978 and 1982 the GHSAS was extended to include private hospital facilities owned and operated by commercial organisations. In 1980 limits were set on the number of beds available for long term hospitalisation in public and private facilities (18/1,000 aged 65 and over).

These years also saw the growth and diversification of public hospital based community services, a growth in the range of services provided by voluntary agencies such as the Age Concern Councils and a spectacular growth in the rest home sector. The trend for care for older people clearly moved in favour of institutionalisation of those who were unable to remain independently at home and indeed many regarded entry to a rest home as a retirement option. A lack of home support services encouraged this trend.

1.4 The last decade 1985-1995

This decade has been characterised by several important trends:

1.4.1 Publication of Service Guidelines

Planning Guidelines for Services for the Elderly were published by the Department of Health in 1986. They provided a framework for the elements of a health service for older people, guidance about categories and numbers of trained staff needed for such a service and advice about facilities required per 1,000 people aged 65 years and over. These Guidelines were never enforced by the Government and were eventually discarded.
1.4.2 A trend to devolution of service provision

This trend has seen the closure of public hospital long-stay beds and their devolution to the private sector, resulting in the further decentralisation of care. It has also tended to isolate older people in long term residential care from the geriatricians who had been responsible for their care in the public long-stay units, and placed greater responsibility on general practitioners many of whom have no special training in the care of older people.

1.4.3 A change of emphasis in the balance of care from institutions to the private home

Community surveys tell us that people prefer to remain at home for as long as possible and, from the point of view of Area Health Boards (AHBs) and more recently RHAs, the service cost is likely to be less if care can be provided in the home. However, the cost to the community is likely to be quite high when the costs of ‘hidden services’, eg those provided by family members without charge, are taken into account, and home based care may be more expensive than institutional care when intensive support services are required.

1.4.4 Service innovation to assist elderly people to remain at home

Home help schemes have been introduced (originally piloted in Auckland, Whakatane and the Horowhenua), case management pilots have been undertaken in Auckland, Wellington and Horowhenua, Quick Response Teams (QRTs) have been piloted in Christchurch and respite care schemes have been developed in both the private and public sectors throughout New Zealand. In Auckland, the respite care schemes have been devolved almost totally to the private sector.

1.4.5 Introduction of the ‘Purchaser-Provider Split’

The replacement of AHBs with RHAs placed responsibility on the latter to monitor the need for health and disability services in the community and to purchase appropriate services (Health and Disability Services Act 1993 Section 33). These services include those for older people. The devolution to RHAs of funding for a range of subsidies previously the responsibility of the Departments of Health and Social Welfare, including Rest Home subsidies, the GHSAS and later this year the Aids to Families Relief subsidy, carries with it the responsibility to contract with suitable providers.

1.4.6 An increasing emphasis on assessment procedures

An attempt to ensure that appropriate levels of service are provided for those who are assessed as needing them saw the piloting of the Support Needs Assessment Protocol (SNAP) in 1993. Although it was not a complete success, it was a genuine attempt to
standardise assessment throughout the country to ensure that it was multidisciplinary and took into account the wishes of those being assessed. It led to confusion about the relationship between support needs levels and levels of residential care needed by people. In some regions this has been addressed by adding another form to the assessment process. Less complex, more refined instruments for measurement are being developed.

1.4.7 Greater bureaucracy and higher administrative costs

An increased number of forms to be returned and guidelines to be followed has been justified in terms of fairness and accountability, but there is concern that this trend might sap resources which would otherwise be allocated to health care. Decentralisation of service delivery has undoubtedly increased administrative costs as each organisation acquires its own data base and arrangement systems. Generally speaking, health care services for older people have not been adequately resourced for the increasing administrative load they have been required to carry. In addition, the complex administrative arrangements between CHEs, the Income Assessment Service of the Department of Social Welfare and RHAs is a source of frustration to staff and patients.

1.4.8 Health services research

Research initiatives aimed at health services for older people have mainly occurred during the decade in academic geriatric units. This has been due to the lack of Government interest in appropriate pilot studies of new projects and concepts of service delivery over many years. (The SNAP pilot was a notable change in policy in this respect.)

1.4.9 Increased interest in the costs of services both in the public and private sector

The introduction of service budgets and contracts have been attempts both to unravel the costs of services and keep them to a minimum through increased competition between service providers. There is, however, the fear that the introduction of short term contracts for service will discourage service innovation and development and fragment service delivery.

1.4.10 The introduction of specialised health services

Specialised Assessment Treatment and Rehabilitation (AT& R) units have been introduced in most provincial centres in New Zealand. The number of health care workers in the field has grown considerably. Specialised psychogeriatric units have been set up in all the main centres, although not in each CHE.
1.5 Recent administrative changes affecting the health care of older people

In 1986 the Elderly, Disabled and Handicapped Programme (EDH) was established within the Department of Health. Its functions were to provide the Department and the Minister of Health with advice on policies relating to the health of older and disabled people and to co-ordinate programmes. Because the need for health promotion and education was seen to be a neglected area, the manager, Dr Margaret Guthrie initiated a nationwide programme which, between 1985 and 1990, produced a range of excellent multimedia material including 'Health Facts' sheets, radio programmes and videos. The EDH Programme was disestablished at the time of the second restructuring of the Department in 1989, although the Lifespan radio programme continued until the end of 1992 with Departmental funding, when it was terminated by Radio New Zealand. The Health Education Section of the Ministry of Health was disestablished in 1993. A proposal had been put to Government in 1991 for a network of eight specialist health educators to be appointed to work through area health boards. This was never implemented and the proposal was eventually overtaken by the advent of the purchase/provider split and the formation of the four RHAs and the Public Health Commission (PHC).

Some of the functions of the old unit were devolved to the Public Health Commission (eg the responsibility for health promotion and education) and others were taken up by the newly formed Disability Support Services Section of the new Ministry of Health. The latter, however, perceiving that the health of younger people with disabilities was neglected, has to date largely concentrated on them. While it is fair to say that many of the issues it has focused on cross boundaries, eg the assessment of disability (a process which the Section has been seeking to standardise on a national basis) and service co-ordination, issues relating to the health of older people have been neglected in recent years. There are, for example no national goals for the health of older people, there is no central support for health promotion, no policies on the elements of a comprehensive health service for older people have been developed, decisions about subsidies for long term residential care appear to have been made on an ad hoc basis and little guidance has been given to the long term care sector on planning of appropriate residential care facilities.

A further complication to effective administration of health services for older people was caused by the division of health care into personal health services and disability support services in 1992. The artificial split was an attempt to rationalise funding of programmes. However, it contributed to confusion over which Government agencies should have responsibility for aspects of health care for older people, exemplified by the rivalry between Health and Social Welfare.
The Public Health Commission's major focus during its brief existence was mostly on the younger community. As a result the needs of older people were not strongly addressed and the Commission was disbanded shortly after publishing its strategic policy advice to the Minister of Health on services to promote and protect the health of older people. The disappearance in the restructuring of the national Health Promotion and Education Programme, which had focused on older people, is of special concern. Attempts to devolve it to the Regional Health Authorities have not been successful and Age Concern New Zealand is attempting to fill the gap. The Ministry of Health has contracts with the Alzheimer's Society of New Zealand, the New Zealand Council of Christian Social Services and the New Zealand Council of Social Services for policy advice on matters pertaining to older people.

A third government agency concerned with older peoples' welfare is the Senior Citizens Unit based in the Social Planning Agency of the Department of Social Welfare. The Unit maintains an overview of policy and legislation affecting older people and provides the Minister for Senior Citizens with policy advice. The Minister has an advocacy role and represents the views of older people at Government decision-making forums. However, the Minister has a lesser status in Cabinet than the Ministers of Health and Social Welfare. (Currently the portfolios of Social Welfare and Senior Citizens are both held by the Hon Peter Gresham.)

The Senior Citizens Unit works closely with agencies such as Age Concern, the Hillary Commission for Sport, Fitness and Leisure and with government departments such as the Ministry of Health which are formulating policies that may affect older people. Concern for the health of older people is not central to its mandate; nevertheless the Unit has done useful work in elder abuse, in collaboration with Age Concern New Zealand, and in 'positive ageing', in collaboration with the Hillary Commission.

The Minister for Senior Citizens also has an Advisory Council which provides independent advice on matters relating to older people. Members of the Council are appointed for their knowledge of older people's issues and their community involvement.

Responsibility for the health services for psychiatrically disabled older people lies with the Mental Health Section of the Ministry of Health. There is a general perception among psychogeriatricians that older psychiatrically disabled people are not a priority of that Section at the present time.

1.6 Conclusions

The numerous re-organisations of the Ministry of Health since 1986 have fragmented the responsibility for the development of policy and programmes affecting older people in New Zealand. No one unit has an overall mandate for older people and therefore
policies and programmes which could have been effective and should have been further
developed have been lost.

The World Health Organisation (WHO) constitution states that 'health is a state of
complete physical, mental and social well-being and not merely the absence of disease
or infirmity'. It furthermore states that 'governments have a responsibility for the health
of their peoples which can be fulfilled only by the provision of adequate health and social
measures'. In its recent publication New Horizons in Health, the Regional Office for the
Western Pacific of WHO proposes that countries should formulate policies and imple-
ment programmes focusing on the concerns of the elderly. In particular, the strengthening
of social and community support systems is encouraged. The Report advises that tools
be developed to assess the quality, effectiveness, and success of national policies for the
elderly. These would include measurements of health as well as other socioeconomic
indicators such as the number of self-reliant senior age groups. In New Zealand at the
present time, the fragmentation of responsibility for health care of older people at a
ministerial level has resulted in a lack of a comprehensive national policy.

The authors believe that New Zealand requires an inter-ministerial organisation along
the lines of ESHEL (The Association for Planning and Development of Services for the
Elderly) in Israel, to plan and co-ordinate health and social services for older people. The
organisation should span the Ministries of Health and Senior Citizens, the Department of
Social Welfare and the Accident Rehabilitation, Compensation and Insurance Corpora-
tion (ACC), with a management Board drawn from representatives of those organisa-
tions. The Unit (as we shall call it) would employ a small staff whose responsibilities draw
together the functions of existing groups such as the Senior Citizens Unit of the
Department of Social Welfare, the Advisory Council of the Minister for Senior Citizens,
the former Elderly, Disabled and Handicapped Programme of the old Department of
Health and the health promotion and education functions for older people devolved to the
former Public Health Commission.

The Unit staff would consult widely on a range of issues including health goals, health
services, housing and hospice facilities for older people and bring recommendations to
Government for action. The Unit would work closely with RHAs providing advice on
priorities for purchasing health care services and give advice to the public, private,
religious and welfare and voluntary sectors on health care and social programmes. It
would encourage health services research and assist Government agencies to interpret
and apply research results in policy development.

We believe that the advisory, co-ordinating and advocacy roles of such a Unit would
be of significant benefit to the future health and welfare of all older people in New
Zealand.
The changing age structure of New Zealand's population has prompted many of the responses to health services needs during the last few decades. Although New Zealand's ageing population does require a response in the form of aged care policies and programmes, demographic trends alone should not set directions; social and economic considerations are also of paramount importance.

Population ageing in New Zealand is far less pronounced than in many developed countries. However, our great diversity in patterns of handicap, living arrangements, housing and availability of carers, all affect the need for care of older people. Taking these aspects into consideration together with the anticipated demographic trends, a number of implications emerge regarding policy development and service needs into the next century.

### 2.1 Growth of the aged population

#### 2.1.1 Short term and long term trends

The growth of New Zealand's aged population (defined for the purposes of this Report as people 65 years and over) from 1991 to 2031 is shown in Table 1 for five year periods coinciding with census dates. The total population aged 65 years and over has increased

<table>
<thead>
<tr>
<th>Year</th>
<th>65+ '000</th>
<th>% incr.</th>
<th>% total</th>
<th>80+ '000</th>
<th>% incr.</th>
<th>% total</th>
<th>% over 65s aged 80+</th>
<th>Total popn '000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>316</td>
<td>-</td>
<td>10.0</td>
<td>54</td>
<td>-</td>
<td>1.7</td>
<td>17.0</td>
<td>3176</td>
</tr>
<tr>
<td>1986</td>
<td>350</td>
<td>11.6</td>
<td>10.6</td>
<td>65</td>
<td>21.0</td>
<td>2.0</td>
<td>18.6</td>
<td>3307</td>
</tr>
<tr>
<td>1991</td>
<td>385</td>
<td>11.3</td>
<td>11.3</td>
<td>78</td>
<td>20.0</td>
<td>2.3</td>
<td>20.3</td>
<td>3418</td>
</tr>
<tr>
<td>1996</td>
<td>427</td>
<td>11.8</td>
<td>11.8</td>
<td>97</td>
<td>25.0</td>
<td>2.7</td>
<td>22.8</td>
<td>3623</td>
</tr>
<tr>
<td>2001</td>
<td>455</td>
<td>11.9</td>
<td>11.9</td>
<td>115</td>
<td>18.0</td>
<td>3.0</td>
<td>25.2</td>
<td>3820</td>
</tr>
<tr>
<td>2006</td>
<td>492</td>
<td>12.3</td>
<td>12.3</td>
<td>135</td>
<td>17.0</td>
<td>3.4</td>
<td>27.4</td>
<td>3985</td>
</tr>
<tr>
<td>2011</td>
<td>543</td>
<td>13.2</td>
<td>13.2</td>
<td>151</td>
<td>12.0</td>
<td>3.7</td>
<td>27.8</td>
<td>4120</td>
</tr>
<tr>
<td>2016</td>
<td>628</td>
<td>14.8</td>
<td>14.8</td>
<td>159</td>
<td>5.0</td>
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<tr>
<td>2021</td>
<td>711</td>
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<td>16.3</td>
<td>175</td>
<td>11.0</td>
<td>4.0</td>
<td>24.6</td>
<td>4364</td>
</tr>
<tr>
<td>2026</td>
<td>805</td>
<td>18.0</td>
<td>18.0</td>
<td>202</td>
<td>15.0</td>
<td>4.5</td>
<td>25.0</td>
<td>4483</td>
</tr>
<tr>
<td>2031</td>
<td>892</td>
<td>19.5</td>
<td>19.5</td>
<td>246</td>
<td>22.0</td>
<td>5.4</td>
<td>27.6</td>
<td>4584</td>
</tr>
</tbody>
</table>

Note: 1996-2031 projections based on 1991 data, medium fertility, medium mortality and migration of 5,000.
since the 1980s, but with the smaller birth cohorts of the 1930s reaching 60 years of age, this growth has now abated significantly. In 1991, 11.3% of the population were 65 years and over. The postwar generation will reach age 65 around 2006 (accounting for 12.3% of the population) but the 'baby boomers' will not be elderly until around 2021, at which stage, 16.3% of the population will be aged 65 years and over.

Significant shifts in the Maori age structure will occur in coming years. Low birth rates, increasing life expectancy, and the ageing of children born during the 'high' fertility years of the 1950s and 1960s, mean that the Maori population will become older (median age in 2031 of 28 years compared with 20.5 years in 1991) although this ageing is less pronounced than for the total New Zealand population (projected median age 39 years by 2031 compared with 31.4 years in 1991). The number of Maori people 65 years and over is projected to increase rapidly from 11,000 in 1991 to 59,000 in 2031, an increase of 48,000, ie over 400%, representing 9% of the total Maori population compared with 3% in 1991.

The Pacific Islands population will also age significantly over the next 40 years (the median age will increase from 22 years in 1991 to 27.9 years in 2031). According to current projections, Pacific Islands people aged 65 years and over will number 27,000 by the year 2031, or almost seven times the number in the 1991 Census, making up 8% of the total Pacific Island population compared with only 3% in 1991.

It is the growth of the very old population, those aged 80 years and over, that has most relevance for the care of older people. The growth of the 'old old' age group is expected to increase 25% from 1991 to 1996 and a further 18% from 1996-2001. Although only one in five elderly people (aged 65 years and over) was 80 years or more in 1991, this figure will reach one in four by 2001 and this high growth of the "old old" population will mean sustained pressure on services in the immediate future. Even so, by the year 2031, persons aged 80 years and over will comprise only 5.4% of the total population, while countries like Canada will have over twice that proportion in this age group.

While the rate of increase in the very old declines somewhat after 1996, the growing absolute numbers and the higher proportion that they comprise of the total aged population means that care of older people will have to be sustained on a larger scale. (Figure 1).

Another consideration in the planning of health service needs for older people is the variation of the population projections. Figure 2 shows the actual and projected population 1961-1991 and the range of different projections (using the assumptions of medium fertility growth and migration) according to the base year used in making the projection. For example, predictions based on 1986 census population figures suggest a much faster increase in the proportion of the population 65 years and over, than projections based on
the 1991 census (Figure 2). According to the projections based on 1986 census information, the population 65 years and over would reach 12.8% of the total population by the year 2011, compared with only 12.1% based on the 1991 projections. Depending on the 'correct' projection, there is either an overestimate or underestimate of approximately 15,000 people. Conversely, predictions made on the basis of the 1976 census would have seriously underestimated the growth of the older population. The disparity in projections is even more pronounced the further into the future we move.
CARE FOR OLDER PEOPLE IN NEW ZEALAND: a prescription for a world-class system of care for the 21st century

Life expectancy in developed societies has increased by more than 30 years during the 20th century. The prospects for living a long life - even beyond 100 years - and for living those years in good health, are constantly improving for the middle-aged and younger people of today.

In New Zealand, people are living longer and more of them are doing so. Population projections show increasing proportions of people over the age of 65 in future years. In 2021 when the 'baby boomers' are New Zealand's older population, 16.3% of the population will be aged 65 years and over, and by 2031, 19.5% of the population will be.

In the decade 1991-2001 numbers of the 'old old' - those over 80 - will increase by 43%.

This report to the Core Services Committee says that such advances bring with them some troublesome social problems which will be ignored at great cost to the country's health and social services. The report says there is a need to initiate long term planning now to prepare for future pressures on the health system as our population ages.

The report calls on New Zealanders to shape their own health care service for their older population. It says it is essential to build a service which is fair, comprehensive, effective, flexible, integrated and affordable; a service which draws on the best from overseas and local developments and provides a platform of policies going into the 21st century which would be a world-class model for the care of an ageing population; a service which must be affordable and sustainable for New Zealand.

The Core Services Committee commissioned the report on Care for Older People in New Zealand with the purpose of exploring the issues generated by the knowledge that while the majority of people in the 60s and 70s are in good health and largely independent, by the time they are in their 70s and 80s, increasing numbers of them are suffering from chronic illness and disability, supported by fewer members of their family and consequently increasingly dependent on the State for assistance.

The fact that the State has a commitment to enhancing the welfare of older people is assumed in the report. In 1994/95 the Government provided $1.4 billion for disability support services. 63% of this was spent on older people with disabilities, the majority of it (90%) on long stay residential rest home care.
The report says that the concept of "ageing in place", maintaining frail older people in their own homes is accepted world-wide - research has shown this to be the choice of most older people. It says that New Zealand's ageing population challenges health care planners and health care professionals to review current care programmes for older people and to plan for the future.

Some of the fundamental questions the report examines are:

- has New Zealand got the appropriate mix of services to meet the needs of a growing older population in their homes and communities in which they live and in long term care facilities - rest homes and hospitals?
- what support systems should we be providing to and for carers in the home?
- what are older people's needs and how can we best meet them?

The report says that while much has been accomplished in the last 25 years, there are deficiencies. The report suggests a framework of six goals together with strategies to achieve them to meet the needs of older people into the next century. The framework addresses the issues of equity, health promotion, the strengthening of primary care, research, information and consultation, healthy public policy and intersectoral and international co-operation.

A major goal is the development of a national set of policies relating to the health of older people, recognising different ethnic needs, to be the basis of purchasing decisions by RHAs and planning by public, religious and welfare, and private sector providers. One of the strategies suggested to achieve this goal is the setting up of a single unit to formulate and monitor national health goals and policies for older people. The unit would consist of people from the Ministry of Health, the Department of Social Welfare, the Senior Citizens Unit and the ACC.

The importance of examining the long term needs of increasing numbers of Maori and Pacific Islands people is identified. The report comments on the lack of information on the social and health needs of these New Zealanders saying there is a need to ensure that health care and rehabilitation take place in a culturally sensitive and environmentally friendly atmosphere. Of particular importance is an understanding of cultural perceptions of disease and healing and of the nature of the body.

The report has been written for the Core Services Committee by David Richmond of the Auckland School of Medicine and by Jonathan Baskett, Ruth Bonita and Pam Melding of the Academic Section of the Health and Mental Health Services for Older People, North Shore Hospital, Auckland.

The Core Services Committee is pleased to receive this report. A large sum of public money is spent on the care of our older people each year. It is appropriate given the committee's brief to recommend on the content, quality and terms of access to publicly funded health and disability support services that we examine this area of care within our public health system.
The authors have provided the Core Services Committee and the public of New Zealand with an extremely comprehensive and thought provoking report. This is a report of relevance not only for older people; the issues the report addresses directly affect New Zealand's post-war and baby-boom generations - most of us in fact.

The report's authors are confident their work offers a prescription for a world-class model for the care of older people in New Zealand. The committee hopes the report will stimulate widespread and well considered debate for us to consider before we make recommendations to the Minister of Health on the content, quality and terms of access for the Care for Older People in New Zealand.

The committee's consultations on the report begin with an official launch at a meeting of the Wellington branch of the Gerontology Association and the Wellington branch of Age Concern in Lower Hutt on the evening of Tuesday 8 August. The report will be mailed to members of the public, the media, interested groups, consumers and carers, government departments and ministries, RHAs, health care providers and professionals. The committee will be making its recommendations to the Minister of Health early in 1996.

for further information or copies of the report contact:

The Core Services Committee
PO Box 5013
Wellington
Tel: 04 496 2296 fax: 04 496 2341
2.1.2 Life expectancy

Much of the inaccuracy of the earlier predictions results from the inability to predict the extent of declining death rates and the resulting improvements in longevity. Improvements in life expectancy at age 65 years and at 80 years for men and women since the 1950s is shown in Table 2. At age 65, life expectancy increased 2.0 years for men and 3.7 years for women between 1950-2 and 1990-2. Even at age 80, improvements in life expectancy occurred during this period: 1.1 years for men and 2.2 years for women.

Table 2: Life expectancy (years) at age 65 and at age 80 for men and women, 1950-2, 1990-2

<table>
<thead>
<tr>
<th></th>
<th>At age 65</th>
<th></th>
<th>At age 80</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>1950-2</td>
<td>12.8</td>
<td>14.8</td>
<td>5.5</td>
<td>6.2</td>
</tr>
<tr>
<td>1990-2</td>
<td>14.8</td>
<td>18.5</td>
<td>6.6</td>
<td>8.4</td>
</tr>
</tbody>
</table>

2.1.3 Gender differences

Women considerably outnumber men at older ages. In 1951, the ratio of women to men (65 years and over) was 109:100. By 1991, this figure had increased to 134:100. However, the ratio now appears to have peaked and is projected to fall slightly to 122:100 by the year 2011 as the number of elderly men rises more quickly than the number of elderly women.

In 1991, among those aged 60-69 years, women outnumbered men by 7%, among those aged 75-79 years by 28%. However, among the ‘old old’ (85 years and over), women outnumbered men by 63%. The excess of women over men in the elderly population is projected to decrease until 2016 with the changes more prominent at ages 75 years and over.

2.1.4 Dependency ratios

The ageing of the population brings changes in the relationships between the population of working age and those who are either young or aged dependents. These relationships are commonly expressed in terms of dependency ratios which compare the proportions of the total population in the relevant age groups.

Ageing in New Zealand is not necessarily associated with a substantial increase in the dependency ratio. This stability is due to the working age groups being maintained by the baby boom cohorts reaching middle age, as well as increased immigration. There is, however, a change from younger to older age dependency: the ratio of the population aged 15 years or under to the population aged 60 years and over falls from 1.51 in 1991 to 1.10 in 2011, 0.83 in 2021, and 0.70 in 2031⁶. Demographic dependency ratios provide only
one view of the implications of population ageing. Other information such as the relative
costs of different age groups is required to interpret the policy consequences of changes
in the age structure. Government spending per capita on older people has historically been
much higher than on the young.

2.2 The population in need of care

2.2.1 Ageing and disability

The 1992-93 Household Health Survey provides information on patterns of handicap
in the New Zealand population. Several different measures of disability are used, 'self-
identified' measures, 'diagnosed' measures, and measures of mobility. Unfortunately,
there is lack of overlap between these measures and it is difficult to interpret the results.
For example, more than 85% of people 75 years and over reported a mobility problem,
but only 60% reported a long term illness or disability.

Regrettably, there are no routine measures of disability and well-being in the older
population which monitor changes over time. The Household Health Survey is not
designed as a comprehensive survey of disability in the population, either with respect
to the measures used or the sample selected. Diagnosed long term illness or disability and
self reported loss of function, disability and long term illness from the Household Health
Survey are shown in Table 3 for two age groups, 60-74 years and 75 years and over, men
and women combined.

| Table 3: Diagnosed long term illness or disability and self reported loss of function,
disability and long term illness, 1992-93 |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of age group reporting condition</td>
</tr>
<tr>
<td>One condition only</td>
</tr>
<tr>
<td>More than one condition</td>
</tr>
<tr>
<td>No conditions reported</td>
</tr>
</tbody>
</table>

These results suggest that 59% of people 60-74 years of age, and 60% of people aged
75 years and over have some diagnosed long term illness or disability or self reported loss
of function. This includes 20% of those aged 60-74 years, and 34% of those aged 75 years
and over reporting hearing loss, with 15% and 20% in the respective age groups reporting
physical disability. It is difficult, if not impossible, to interpret this material, nor does this
published data reflect the differences between men and women for different age groups.

The size of the very old population is not the only determinant of the need for care;
trends in the level of disability among this population also need to be considered in
estimating the level and need for care.
2.2.2 Living arrangements

In the absence of more detailed information, the need for care within the population can be assessed by whether older people requiring care live in the community or in residential care, and if living in the community, whether alone or with others. While the majority of the older people with disabilities living in the community live with others, the difficulties faced in maintaining very old people with disabilities in the community on their own are substantial. While co-resident carers provide most personal care and support, the contribution of carers who do not live with the elderly person is also important. In addition, whereas spouses are most likely to be carers for those aged under 70, the increasing probability of widowhood means that younger family members become more involved as carers for the oldest old individuals. The kinds of support required by carers will be influenced by whether they are spouses or other relatives and by family decision-making about responsibilities for care.

The great majority of the older disabled population live in the community; less than one in twelve are cared for in institutions or aged care facilities. The significance of residential care increases markedly with increasing age: in the age group 65-69 years, less than 2% are cared for in long term care institutions compared with 33% of those aged 80 years and over. These gradients become more pronounced at the oldest age groups and for those with severe disability compared to moderate disability; in the oldest age groups women are twice as likely to be in aged care facilities than are men. (Table 4).

Table 4: Age-specific rates (per 1000 population) for men and women in aged-care institutions, Auckland, 1993

<table>
<thead>
<tr>
<th>Age group</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>70-74</td>
<td>26</td>
<td>23</td>
</tr>
<tr>
<td>75-79</td>
<td>48</td>
<td>64</td>
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<tr>
<td>80-84</td>
<td>103</td>
<td>158</td>
</tr>
<tr>
<td>85-89</td>
<td>203</td>
<td>354</td>
</tr>
<tr>
<td>90+</td>
<td>397</td>
<td>636</td>
</tr>
</tbody>
</table>

2.2.3 Housing arrangements

Housing has a major bearing on the ability of an older person to deal with disability or handicap, when it occurs. However, the onset of disability is one of many factors including retirement, widowhood or other changes in the family structure, which may lead to a change in housing during old age. Choices are influenced by the range of available options, the mix of support services provided and costs.

2.2.4 Diversity of groups in need of care

As the factors above show, there is considerable diversity in the demographic and social characteristics of groups within the handicapped older population and in their need.
for care. This diversity is evident when the size of the groups with different care needs is estimated as a proportion of the total handicapped aged population. It has been estimated from Australian data that about 100 of the 360 people who are handicapped per 1,000 people aged 70 years and over are provided for in residential care. The care needs of the remaining 260 are met in the community, of these, about 90 live alone and about 170 with others.

2.3 Implications of an ageing population

A number of implications for policy and programme development emerge as a result of the continuing growth of the older population and the great diversity of needs within that population. There is still a breathing space until the large cohorts of the “baby boomers” reach old age. Detailed demographic measures of disability and handicap in the older population are urgently required to plan future needs and to monitor the success of programmes and policy. Greater attention needs to be applied to the special needs of older Maori and Pacific Islands people, as well as to older people in rural areas. The socio-demographic context of New Zealand differs markedly from that of overseas demographic changes. The differences need to be fully taken into account when interpreting the relevance and applicability of overseas developments to the New Zealand setting.
The concept 'need for care' implies that an older person has lost the ability to remain independent in the community. This loss of independence may be the result of any one of a number of unfortunate circumstances or to a combination of circumstances. The World Health Organisation (WHO) has attempted to define three major concepts:

- impairment (a defect in organ function or whole body systems which may be temporary or permanent)
- disability (a defect in performing a normal activity or action)
- handicap (the social consequences of these defects).\(^{10}\)

Impairments may lead to disabilities and handicaps so that people cannot live their usual and expected lives. While medical intervention may be appropriate for diseases causing impairments, other types of intervention are more appropriate in coping with disability and handicap. This is why health care services for older people must be multidisciplinary in nature.

### 3.1 Circumstances causing a need for care

#### 3.1.1 Failing health

Failing health is the most common reason why older people need care. The level of disability and handicap in the population rises with age, although there is great variability between individuals and there is a sub-set of older people who have lived with disability all their lives\(^{11,12}\). Disability and handicap may be the result of either physical or mental disease. Common causes are cardiovascular disease (cerebrovascular accident and myocardial ischaemia), diseases of the chest, the end results of falls and accidents, diseases of the locomotor system (muscles, joints, skeleton), chronic anxiety and depression and degenerative central nervous system disorders such as the dementias.

It is entirely conceivable that the mix of physical and mental disorders responsible for ill health and disability in the older community will change with the passage of time. For example, if current trends towards a reduction in smoking continue, we may see less chronic obstructive respiratory disease, fewer strokes and a reduced incidence of myocardial and peripheral vascular disease. On the other hand greater numbers of
depressed and demented older people may need care.

A variety of circumstances may cause older people to need care. The 'disablement process'\textsuperscript{13} may be any one of a variety of chronic, slowly progressive disorders of which dementia, Parkinson's disease, arthritis, and the end results of smoking such as emphysema and lung cancer, and poor nutrition are examples. Under these circumstances loss of independence occurs slowly, the need for care does not have a discrete beginning and there is time for both the individual and any care providers to compensate. However older people also suffer from acute injury due to falls and from acute diseases such as stroke or myocardial infarction, situations in which the loss of independence may be very sudden, the sense of loss by the individual and his or her family much greater and the strain on community resources more acute.

Even if an older person does not suffer a debilitating mental or physical disease, loss of confidence as a result of a fall, the loss of a companion, or becoming the victim of violence or burglary may precipitate the need for care in a person who is apparently otherwise well. Loneliness is another hazard for older people living alone which may lead to a desire for care. For some older people, the mental and physical burdens of day to day living, such as meal preparation, can become so great that they do not wish to continue living independently. The debilitating effects of alcohol or drug abuse, eg addiction to benzodiazepines (tranquillisers and sleeping pills) may precipitate loss of independence\textsuperscript{12}.

3.1.2 Delays in appropriate treatment

Older people may require care if reversible medical conditions go untreated leading to unnecessary ill health. This may occur if people feel they cannot afford to see a doctor, or if there are gaps in available health services, or where there are long waiting lists. Examples include lengthy waiting lists for cataract surgery, transurethral resection and joint replacement.

The risk of requiring care may be increased if suitable rehabilitation facilities are unavailable, if access to them is delayed when an older person suffers a potentially incapacitating disability, or they are not available for sufficient time. Although assessment facilities are available in most provincial centres and all major cities, referral to a rehabilitation unit may be delayed by the individual's family practitioner, be impractical because of distance, be socially unacceptable to some cultural groups, or be delayed because of inadequately resourced assessment facilities.

3.1.3 Unavailability of a carer

It is well recognised\textsuperscript{14} that the presence or absence of a live-in carer is vitally important in determining whether an older person with a disability can remain at home or must enter
long term residential care. This has been called the 'carer dividend'. The provision of care may depend on the availability of a spouse or partner, or other family and friends. There remains a high level of commitment, as far as we can judge, by spouses and family, to the care of older disabled relatives. However, often the family of many older citizens is geographically distant, or there may be no family, so that no support is available from this source. Some families are unwilling or incapable of assisting their older relatives with a disability to remain at home. Some families who have struggled to assist for months or years may reach the limits of their ability to cope, in which case community resources will be required. Nevertheless, because of the input of family and friends, the actual level of need for care in the community is unclear. At present, statistical data on care provided by family members is not collected and this potentially valuable indicator of needs is therefore unmeasured.

There are times when older people do not wish their families to provide care and circumstances, such as abusive families, where it would be inappropriate for them to do so.

3.1.4 Lack of appropriate accommodation

Inappropriate accommodation leads to the need for care. Where older people are living in inappropriate or sub-standard accommodation eg in caravans, garages or crowded houses with other family members, there is the potential for self neglect or elder abuse. The need for care may only become apparent when there is a sudden breaking down of a social situation which the individual cannot remedy alone. Elder abuse, physical or psychological, is one form of social breakdown involving elderly people. It is often an indication of carer stress. Residential care may be an alternative, but it may be possible to find some other form of sheltered housing.

3.1.5 Gap between personal capability and the environment

Disability and handicap may be viewed as disfunctional relationships between people and their environment. They can be alleviated either by increasing personal capability (the medico/therapy strategy) and/or by reducing demand. The latter may include personal accommodation more suited to circumstances, modifying the environment and providing external supports. A person may enter into care when these options are insufficient or unavailable.

3.2 Relationships between care options

If the concept of care is defined widely to include: care in the home; short term respite care; acute hospital care; and long term residential care; it is evident that an older person suffering from a disability may or may not require care at any of these levels, depending
on the severity of the disability, the speed with which it is resolved and/or the degree to
which rehabilitation is successful.

Although the major care alternatives in the community tend to cluster around care in
the home, care in the acute hospital system, or short term respite care and long term
residential care, (Figure 3) there is no particular progression through the system. Many
people being cared for in the home would require hospital level long term care if the carer
were unable to continue; residents from all levels may require short term acute admission
to a public or private hospital to deal with sudden emergencies. There is evidence that in
some areas of the country, shortages of acute hospital beds lead to a tendency to resist the
admission of older people from rest homes to general hospitals. Such a policy has a high
risk of rendering these patients more dependent than they were previously.

3.2.1 Care in the Home

There are many varieties of home care. Some is ‘substitutional’ in character in that it
replaces the need for acute hospital admission or residential care. Or it may provide
ambulatory care in conjunction with specialist outpatient or day ward visits. Sometimes
it may be very highly resourced to provide terminal care or high tech care such as chronic
ambulatory peritoneal dialysis.

Figure 3: Major care alternatives for older people

Short term
respite care

“Sheltered” care
options

Family
home

General hospital
admission

Long term residential
or hospital care

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3.2.2 Short term Respite Care (sporadic or programmed)

The circumstances leading to the need for short term respite care may relate to both the carer and the person being cared for. The former may need ‘time out’ to perform important tasks, or to have a rest, or holiday, while the latter may need social interaction not possible in the home, a ‘change of scenery’, different activities or assessment. Or, they may require short term nursing or medical attention. Older people living alone with a chronic illness or disability may also benefit from respite care or convalescence care.

3.2.3 General hospital care

Admission to a general hospital may be required for health problems which cannot be managed in the community because they require major surgical intervention, intensive monitoring, intensive therapy or intensive rehabilitation. Not all admissions requiring major surgical intervention are emergencies but major operations such as elective hip replacement require general hospital admission. Where community resources are lacking, or proper assessment and rehabilitation facilities are not available or are under-resourced, the sudden breakdown of a social situation with insufficient time to organise alternatives may result in an acute hospital admission, the so-called ‘social admission’. This is poor utilisation of acute hospital resources.

3.2.4 Long term residential care

The need for long term residential care is usually the result of a combination of circumstances. These may include deteriorating health, increasing disability, the unavailability of family care or appropriate community resources such as meals on wheels, and home help; or the inability of the person to cope despite appropriate service provision. The level of care required depends upon the level of disability. In the past, residential care was seen by some as a retirement option and it was not uncommon to have lengthy waiting lists for entry to certain facilities. This was especially true of some of the religious and welfare sector homes. The high level of individual home ownership in New Zealand and the availability of superannuation allowed individuals to realise funds for such a retirement option. In more recent times with the development of retirement villages and the insistence by Regional Health Authorities on appropriate assessment prior to entry to a rest home, this particular cause of entry has become much less frequent. Also, it seems that older people increasingly see their home as the appropriate place in which to live and in which to die.
Access to health services in New Zealand is a human right, legally guaranteed by Acts of Parliament and accepted as morally just by society. However, it is generally recognised that the right to health care is not open-ended; there are resource constraints in the health system, as indeed there are in all health systems worldwide. Accepting this fact however, raises important ethical issues relating to the distribution of health services among various groups in the community.

4.1 Distributive justice

Ethical considerations about the distribution of health resources are concerned largely with justice, 'giving to each person his or her due'. The problem is to define what is due or fair to each member of society. This is not just a theoretical consideration, there are divergent views in society over what access to health care resources the oldest and disabled should be entitled. There are those who consider older people to be a burden on society, consuming resources which are then denied to others considered more deserving. Then there are those who consider older people to be a valuable resource to society, a group which warrants respect and care at a high level.

There are many interpretations of distributive justice in relation to health care resourcing, and a wealth of literature on the subject. We will not discuss them in depth, but instead refer interested readers to the Core Services Committee report on the subject. However, the main ethical themes which are appealed to to provide guidance on resource distribution can be characterised as:

4.1.1 The ‘egalitarian’ model

All people are equal, therefore all should have the same sized share. This concept, while appearing adequate at first sight, does not take account of the fact that all people are not in fact equal in their need for health care: some are fit and well; others are not. To set aside a certain share for the fit and healthy would mean that some would have funds they would never use, while the needs of others would be underfund. On the other hand if the level of the individual health care allocation is set low to avoid ‘wastage’, it would prevent those who needed more from purchasing a higher level of health care. Individual differences in health status may result in inequality of resources provided: for example, if equality of life-span was to be targeted as the aim of the health system, younger people could justly claim preferential resource allocation over older people who have lived out
most of their lives.

4.1.2 The 'meritocratic' or 'employment contracts' model

This says that some people are more valuable than others to society by reason of their contribution to the good of all; therefore greater efforts should be made to preserve these people by awarding them access to a proportionately greater share of health care resources. This model is unsatisfactory because of the problem of deciding who is making greater (or lesser) contributions to society, who makes those decisions and using what criteria. It could easily discriminate against the oldest. It also fails on the grounds that many are hindered from contributing to society through no fault of their own, and hence it intuitively seems unfair. It also allows the punishment of people for blameworthy behaviour (eg withholding treatment from a life-long smoker with lung cancer).

4.1.3 The social welfare model

Most people become sick or disabled because of circumstances over which they have no control and these imbalances can be remedied by devoting more resources to the more underprivileged, to each according to need.

This model, while superficially more acceptable than the others, can also be criticised. It seems manifestly impossible to meet all the needs of all the people; it would be more expensive than society could afford.

4.1.4 Rawlsian model

All people are to be equally valued by society, recognising that some are less favoured by circumstances. However, although people are not equally privileged, they should all have the same opportunity. The intent is to distribute resources equally, recognising that the disadvantaged have a special call on resources, and therefore arranging distribution in favour of the least well-off. While the model has a special place for the individual, it has been criticised on the grounds that it might be difficult for society to agree to distribute resources to the greatest benefit for the least advantaged. It may also require high levels of resourcing to provide the less healthy with an adequate level of health.

4.1.5 'Utilitarian' model

Resources should be distributed to benefit the greatest number of people. Although this theory would seek to maximise the benefit to society as a whole by expenditure on health care, it suffers from difficulties in application. Attempts to quantify the maximising of benefit, include the use of Quality Adjusted Life Years (QALYS) and cost-benefit analysis. Even so, it is extremely difficult to balance it against the benefit to the individual. Indeed, in Utilitarian theory, the individual is always likely to be discriminated against for the sake of the greater social good.
This list by no means exhausts all the theories of distributive justice. However, we believe it is reasonable to say that no single theory currently advanced provides all embracing guidance as to the way in which health-care resources should be divided up to ensure universal fairness. Rawls' theory perhaps comes closest to society's ideas of equity. It is instructive that when the State of Oregon in the USA set priorities for the delivery of State-funded health care, the method chosen was not based on ethical theory but public opinion reflecting what R M Hare would characterise as intuitive thinking. However, the outcome was adjusted by the members of the priority-setting Health Services Commission to ensure 'proper' placement of items in the list of priorities.

It is acknowledged that setting criteria for a just distribution of resources is not an easy task. The Core Services Committee has struggled with it for several years. Nevertheless, it does seem important that our society should endeavour to agree on a way or ways of defining the limits of publicly-funded health care while continuing to avow the value of all people in society to society.

### 4.2 Economic theory-based methods of distributing resources

Efforts have been made in recent years to make the health care dollar go further. Worldwide, attention has been focused on the cost of pharmaceuticals, on evaluating the relative cost benefits of different approaches to health care, on setting limits to what purchasers of health care are willing to pay for episodes of health care and on managing access to health care.

It is not within the scope of this paper to discuss these issues at length. With regard to the cost of pharmaceuticals, it is acknowledged that the oldest groups in the community consume a high proportion of all medication prescribed. However, recent policy changes aimed at reducing the purchase price of drugs in New Zealand are achieving their ends. Further, it is widely recognised by geriatricians that many older people are over-medicated, with up to 12% of admissions to acute hospitals caused by a reaction to medication. Health services for older people are playing a major role in rationalising and reducing drug regimens and are thus contributing to a reduction in the national drug bill.

Evaluating the cost-effectiveness and cost-benefit of therapeutic approaches has become increasingly important as the spotlight has focused on health care costs in recent years.

#### 4.2.1 Cost-effectiveness analysis

Cost-effectiveness analysis is designed to compare the costs of different approaches to a problem. An example would be the costs of stroke rehabilitation in inpatient, day
hospital or home settings. Cost-effectiveness analysis is helpful in discovering the least costly solution to achieving a particular goal of a health system, once it has been defined. It does not help to define the goals, nor does it take into account any benefit to the patient. There is some limited research being done on such issues in the health care of older people in New Zealand, but more is needed.

Cost-effectiveness analysis does not enable us to compare different treatments for different diseases. For example, it does not enable us to compare the relative benefits of treating constipation in older people with lactulose (a high cost item in terms of inpatient drug bills) and treating dyspepsia with ranitidine (another high cost item). An attempt to compare different treatments for different diseases in order to allow them to be prioritized for funding is found in the methodology of cost-benefit analysis.

4.2.2 Cost-benefit analysis

In this process a formula is derived which factors the costs of a procedure or treatment by the value of the net benefits gained. Costs include the cost of the intervention less the costs of treatment foregone by its implementation. Benefits include a value assigned to a positive outcome multiplied by a factor for the chance of such an outcome occurring, less a value for harm multiplied by a factor for the probability of harm occurring.

The most widely used form of cost-benefit analysis involves the use of Quality Adjusted Life Years (QALYs). In essence the cost of a health care intervention is factored by the quality of the life-years it generates. The value of 1 is assigned to a year of healthy life expectancy, the value of 0 to being dead. The worse the quality of life generated, the lower the score (including scores less than 0 in cases where the quality of life is considered to be worse than being dead). A beneficial health care activity is one that generates a positive amount of QALYs, an efficient health care activity is one where the cost per QALY is as low as possible. Efficient health care activities should be given high priority, but activities where the cost per QALY is high should be given low priority.

There are ethical problems if QALYs are to be used to decide who has access to health care in that they discriminate against older people. One reason for this is that the longer the period over which benefit is enjoyed, the higher the value of the QALYs associated with it. For example, if two people one aged 60 and the other 75, each require hip-joint replacement, the QALY value of the operation will be much higher for the former than for the latter simply because of the difference in their ages.

Justifying the withholding of ‘high-tech’ interventions from older people on the grounds that increasing age reduces the likelihood of benefit is flawed on several grounds. In the first place, the cost to society of doing nothing for an older person may in the long run be higher than the cost of the intervention, especially if the nature of the disability is
such that the individual then requires long term care, either in the home, or in an institution. Secondly, the notion that age *per se* determines a person’s physiological function is based on generalisations which are not necessarily true for the individual. The Boston Longitudinal Study for example\(^\text{22}\) has shown that physiological functions of people as they age differ widely: some improve with age. Thirdly, the widely held view that older people benefit less from health care interventions than do younger people, has been shown to be based on outcome studies biased against the older subjects because the researchers failed to provide them with the same intensity of treatment as the younger subjects received on the assumption that the older people would benefit less\(^\text{23}\).

### 4.3 Defining priorities within a service for older people

Given that there are finite resources in budgets for health of older people, how shall priorities within a service for older people be agreed?

There is already in existence a reasonably well agreed ‘core’ of services for older people, a ‘core’ which is similar in its elements to those available in countries similar to New Zealand. It includes primary and secondary health services, assessment and rehabilitation services, home support and long term residential care at various levels. Assessment and rehabilitation services have been shown to be cost-effective (see Chapter 6). This core of services has been developed in response to perceived needs. If it were to be changed, it would need to be clear that the changes were in keeping with the public’s wishes (based on consultation) and identified health needs and that changes were not being made purely to reduce costs. The move away from early residential care to supported home care is a case in point. It meets public expectations and needs but it is not yet clear whether, in the New Zealand setting, it will be a cheaper option.

The main debate about priorities within a service ranges around the applicability of so-called ‘high tech’ interventions to older people. At the present time, the fairest way to make decisions about the use of ‘high tech’ treatment interventions is by individualised assessments based on the clinical indications using the same criteria as for younger patients, but modified by knowledge of the effects of the burden of chronic illness which the individual is already carrying. It is acknowledged that some older people will not respond to treatment as well as younger people. This is not because of their chronological age but because they are suffering from a variety of chronic, long term incurable disorders such as chronic obstructive lung disease, the residue of previous cerebrovascular disease, heart failure and renal failure.
4.4 Budgeting for health services: case-mix models

Efforts to manage budgets for health care services in many countries have increasingly been based on the concept of 'case-mix'. This is a term describing any system which groups patients by predetermined factors into clinically meaningful and resource-homogeneous groups. The most commonly used system is Diagnosis Related Groups (DRGs). Each DRG groups diagnoses which are similar from a clinical perspective and should therefore have a similar pattern of resource use. Such a system simplifies the description and analysis of the activities of a hospital, including the costs of treating different groups, allows more meaningful comparisons between institutions and assists with the allocation of budgets. While DRGs have been shown to be useful in characterising acute inpatient care, they are not applicable in their original form to rehabilitation, to community care, to long term residential care or to psychiatric care. The Australian States of Victoria, New South Wales and Queensland have put considerable resources into developing case-mix models which are relevant to these non-acute aspects of health care. It is clear that DRG-based funding for health care will be adopted in New Zealand in the near future. We believe that, in the case of services to older people, the funding bodies should look to Australia for models of appropriate casemix formulas which might be adapted to New Zealand conditions.
5 Services Required to Meet the Health Needs of Older People

It is relatively easy to list a series of service possibilities or options which could be offered to meet the health needs of older people. In reality the issues are more complex than that. New Zealand cannot afford ‘wish lists’ and we would clearly prefer to offer services of proven value.

Any discussion of a health service should begin with the question:—what is the definition of this ‘health service’. What does it include? what does it exclude? It could be argued for example that income maintenance and social support provided by the Department of Social Welfare, housing assistance provided by Housing New Zealand, social and community services, recreational activities and venues including libraries, community houses and swimming pools provided by Local Bodies, the Accident Rehabilitation, Compensation and Insurance Scheme and so on, all contribute to the quality of life and therefore the health of older people. However, for the purposes of this paper, only services provided by the Ministry of Health and its affiliates will be discussed. It should not be forgotten that services provided by other government agencies affect the quality of life of older people. The authors are not unaware, for example, of considerable public disquiet about Government housing policies. Moreover, in terms of our understanding of disability and handicap, environment is just as important as personal capability, in enabling older people to live satisfying lives. While this paper focuses on the sorts of service which a Regional Health Authority might be expected to fund, the authors believe that this would be an appropriate time for a national review of social policies and support for older people.

5.1 Factors influencing availability of services

The provision of health care services for older people is unevenly distributed throughout New Zealand. In some areas, desirable services are non-existent. In any discussion about the services required to meet the health needs of older people, problems of availability and delivery must be kept in view. The unavailability of certain services may be due to multiple factors:

5.1.1 A failure to realise that a need exists

This may be due to lack of community consultation or to the fact that all of those
involved—purchasers, providers and community—are prepared to put up with the status quo.

5.1.2 Insufficient resources

Insufficient resources affect the availability of a range of services from too few beds to too few health workers, including volunteers, or lack of equipment and aids.

5.1.3 Arbitrary decisions about who should or should not receive services

Such decisions may be due to ‘ageist’ attitudes on the part of health providers or funding agencies, lack of research-based information about the value of certain interventions, or failure to be informed about research-based information.

5.1.4 Inability of groups or organisations to capitalise on available opportunities

This may be because the rewards are perceived as being inadequate, eg when RHAs screw the value of contracts down to an uneconomic level, or potential staff are offered poor levels of remuneration.

5.1.5 Gaps in the availability of general health services.

Older people utilise a wide variety of health services and it may be that they suffer along with the general population from gaps in the availability of general health services, especially specialty services. Those which impinge particularly on older people include ophthalmology and optometry, audiology, dental services, podiatry, dermatology, urology and orthopaedics.

5.2 Factors influencing accessibility of services

Services may be available but not easily accessible, for a variety of reasons:

5.2.1 Lack of information

There may be a lack of knowledge on the part of the public and general practitioners about the services available in a particular area and how to gain access to them.

5.2.2 Inefficient organisation of services

The organisation of services may not be particularly efficient with fragmentation due to poor co-ordination of the range of providers including general practitioners and lack of integration of the public, private and voluntary sectors, resulting in confusion and overlap.

5.2.3 Devolution of services

Services currently provided by CHEs may come to be regarded as ‘non-core’ business
and be devolved to other providers. This would add considerably to the fragmentation of service delivery and have an adverse effect on access.

5.2.4 Difficult access to services

The location of services may not be the best, especially where services tend to be centralised and transport is difficult. Although this is often thought of as a rural problem, it is also a problem in large cities with poorly developed public transport systems and high fare structures.

5.3 Factors influencing appropriateness of services

Services may be available and accessible, but not particularly appropriate, for a variety of reasons:

5.3.1 Model of service delivery

There is currently some debate about whether the model of long term residential care which has developed in New Zealand is appropriate for meeting the needs of its users. There is also debate about whether the best model for the delivery of home services should be by multiple small contractors, or by large groups; and whether it should be entirely in the private sector, or whether there should be public sector involvement. Dependence on multiple providers for home service delivery in the absence of case management is, in our view, a recipe for disruption and unnecessary intrusion into the subject’s life.

5.3.2 Inappropriate services

Some services appear to have been developed with the needs of the provider rather than the recipient primarily in view. This is particularly so where services are poorly located because of centralisation or where services are not sufficiently flexible to meet individual needs.

5.3.3 A lack of options, choices and flexibility of services

Health services often appear to have been developed without discussion with the groups they seek to serve.

5.3.4 Perceived high costs of services

Some health services are perceived to be excessively expensive despite the fact that a range of subsidies is available, eg dental services, optometry services, hearing aid services, and medication. Subsidies for the Aid to Families Scheme have also failed to keep pace with the institutional care costs (although the way the funds are used can be quite flexible).
5.3.5 The organisation of services may not be culturally appropriate

This is a particular problem when the bulk of administration, service design and delivery are by pakeha.

5.4 Principles of health service provision and delivery

In light of the above and before we begin to list services which might be useful, it is necessary to develop some principles of health service provision for older people. The following principles are suggested:

5.4.1 Fostering independence and self help—empowering older people

Strategies to encourage independence and self help include the availability of health promotion and education, encouraging voluntary agencies working with older people, and the provision of information about service availability. Adequate income support, housing and transport are also vital for the maintenance of independence.

5.4.2 Adequate consultation with the community

Involvement of older people in the strategic planning process for health services for older people is imperative. Communities differ in their needs and requirements and decisions about the range of services a community needs can be assisted by community consultation. Such consultation will also help to define the options and choices which should be available. Services provided for individuals should also be subject to participative discussion. Moreover, the older community and informal care givers need to be included in discussions about the funding of their health services. Nor should the knowledge of health care workers working with older people be overlooked in strategic planning discussions. Their expertise can be of considerable value. Some RHAs have overlooked this.

5.4.3 Supporting ‘ageing in place’

In recent years there has been a shift in the balance of long term care away from institutions to the home. Older people are being encouraged to remain in their own homes and communities for as long as possible (“ageing in place”) and consequently, the proportion of them receiving long term institutional care is decreased to the essential minimum.

Strategies to achieve this include;

- the provision of appropriate community-based support services
- the ability to individualise the mix of support services
• the availability of adequate assessment and rehabilitation services
• the availability of subsidies for home care
• the provision of local health services including adequate primary health care through local GP’s

When making decisions about the health care of older people, not only the older person concerned, but their family and friends need to be considered in choosing between home care and residential care alternatives.

Sudden changes in policy direction should be avoided since time is needed to develop home care provider services and to minimise disruption to institutional services which may affect the quality of care.

5.4.4 Improving co-ordination, integration and funding of services

Health services for older people have been developed by diverse groups with different target populations, methods of administration, sources of funding and service guidelines. Integration and co-ordination require strategies both from ‘above’ and ‘below’. By “above” we mean the system of administration of health services particularly through the RHAs and by “below” we mean that older people are helped to ensure they receive a particular mix of services appropriate to their needs. RHAs must be prepared to recognise excellence in health care provision and reward it appropriately. Current trends in contracting appear to encourage mediocrity. CHEs must be prepared to develop new integrating approaches including care co-ordination. We suggest that in New Zealand, the imperative should be to develop effective mechanisms for matching a more varied range of resources to the complexity of individual disability and for doing this in a co-ordinated fashion. Case management is one model for achieving this.

Poor discharge planning for older people, particularly those in general hospital beds, is a problem which impedes co-ordination with community services. This is a matter which individual CHEs must address. Above all a new perspective on the Health Care Services for older people on the part of all stake holders is required so that it is seen as one service, unified in purpose and direction, despite the fact that provision may be divided between public, private and voluntary sectors in various mixes.

5.4.5 Initiating appropriate health services development research

Recent decisions to devolve funding for health care services from a variety of government departments to the RHAs have started an important trend. RHAs must now be prepared to fund research into health development and policy for older people.
5.4.6 Matching services to community needs

In this context, appropriate includes ‘sufficient’ and raises the issues of resource allocation and agreement on the range of services to be available. There may be particular problems for rural areas and particular difficulties for certain groups within the community, for example, individuals with dementia and their carers. Strategies to accommodate this principle will include community consultation, discussion with special interest groups eg voluntary agencies supporting people with certain types of chronic disease process, application of the Core Services Committee’s existing guidelines and development of new ones.

5.4.7 Evaluating services provided as an ongoing process

The quality of existing services, both public and private, must be evaluated using appropriate methodology; as must any proposed new initiatives. To date the private sector has shown much greater interest in the quality accreditation of services for older people using the protocols of ISO 9000 or the Council for Health Care Standards. The public sector can no longer avoid accreditation of its services.

5.4.8 Identifying elements of service quality

Quality of service must mean more than just the efficient and effective provision of service. The service must be provided in a caring manner and in a way that maintains the dignity and self determination of the recipient as much as possible.

5.4.9 Assessment for services

The assessment of an older person’s eligibility for a service should be as streamlined as possible and, because of the physical, mental, social and economic considerations which must be taken into account, it should be undertaken by a trained multidisciplinary team. The team approach is preferred because time delays between medical and financial assessments make it more difficult for older people to receive the services they need. Because it is not possible to separate the assessment and treatment process from rehabilitation of disability and handicap, it makes sense to base the multidisciplinary teams with the local Crown Health Enterprises. Meta-analysis research into service delivery for older people has shown clearly that to be effective, assessment teams must have control over service delivery. This contradicts the notion being promulgated by the Ministry of Health that assessment can be a totally separate entity from health service delivery. Care is required so that the assessment process does not become a bureaucratic nightmare for either the agency performing it or for the person undergoing it; and that it is not too rigid in its application. Flexible service provision based on assessment is highly desirable.
The authors support the use of a nationally consistent assessment procedure to encourage the effective use of resources and fairness. Training in assessment procedures for all involved should ensure uniformity of process and outcome.

5.5 Range of services

The following is a suggested range of services to meet the needs of older people. The list is based on our own experience, the input from community consultations held in recent years and comments from experienced health care workers.

5.5.1 Personal Health Care

- General practitioner services
- acute hospital inpatient care
- access to specialist outpatient clinics and services
- district nursing
- continence service.

5.5.2 Rehabilitation Services

- assessment for rehabilitation in the community, residential care institutions, day hospitals, AT & R units, acute hospitals
- rehabilitation services for physically disabled by AT & R units in public hospitals, in day hospitals and community centres
- access to dedicated assessment and treatment inpatient psychogeriatric units
- provision of orthotic and prosthetic appliances
- equipment loan services
- social work, community therapy, dietary services
- activity centres with a non-institutional focus.

5.5.3 Other health services

- assessment for eligibility and level of long term residential care, day care etc
- hospice facilities, palliative and terminal care
- podiatry and chiropody services
- quick response teams
- case management /care-co-ordination.
5.5.4 Personal care

- attendant care (24 hours)
- support provided by voluntary organisations
- informal or formal assistance with washing/bathing/dressing/feeding/toileting etc in the home
- long term residential care accommodation, pensioner flats, hostels, boarding houses, rest homes, geriatric hospitals.

5.5.5 Domestic care and maintenance

- meals on wheels
- home help schemes /cooking /cleaning /laundering
- assistance with shopping, household repairs and maintenance
- assistance with gardening etc.

5.5.6 Social support

- counselling services/grief support
- subsidy support for long term residential care, and for carer relief
- subsidy support for short term convalescence in residential care, for convalescence following accident and for short term contingency admissions to appropriate facilities
- advocacy services and complaints services
- assistance in dealing with authorities, handling of finances etc
- activity centres with a non-institutional focus
- companionship
- carer respite services: public/private sector “flexibeds” including overnight and weekend only stays, day care centres, home assistance, sitting services and hire-in services.

5.5.7 Information and education services

- information about the range of services available and methods of accessing them, about health and social welfare benefits and subsidy entitlements, about legal and financial affairs eg. PPP & R Act, Wills, Enduring Power of Attorney
- telephone/fax consultation and referral systems to health services for older people by GPs
• specialised health education and promotion professionals
• support for community organisations such as Age Concern and voluntary agencies providing support for the older people and their carers.

5.5.8 Training and research facilities

• training for people working in domestic care and other home support settings
• postgraduate training for general practitioners and other health professionals working with older people
• training in research for health professionals
• training for administrators and managers.

Appropriate versions of the above services need to be developed for the various ethnic groups in the community, in consultation with the major groups. Many of these services would also be applicable to older people living in residential care.
6 Issues in the Care of Older People

This section reviews in greater detail the salient features of the development of health care services for older people in New Zealand. Because care services have mostly evolved regionally rather than nationally, there are many local variations. However, there are enough common features to discuss in this review.

6.1 Care in the community

World wide there is a move to enable older people to live in their own homes for as long as possible. "Ageing in place" is supported widely by health and social policy makers in New Zealand. However, consensus on how it should be achieved has not been reached nor reflected in uniform policies. The initiatives in this paper reflect comparable trends in other countries expressed in papers from the OECD meeting on Care for Frail Elderly People: Policies for the Future, held in Paris in July 1994, and in the Australian Policy on Aged Care.

Some of these commentators express concern that the balance of care is now swinging too much towards home care and that protagonists are over emphasising its advantages. Community care planners must give proper recognition to the place of institutional care, acknowledging that there are some circumstances when home support services cannot adequately support caregivers or the older person concerned. Nevertheless the authors support the principle of "ageing in place", as do older people themselves. Research in New Zealand shows that older people generally prefer to remain in their own homes.

6.1.1 Informal Care

A single main carer is usually the most important support for a frail older person, and 75% of the time this person will be a family member living in the same household. This carer is likely to be elderly and in some cases almost as frail as the person they are caring for. There is no indication in the literature or from experience that this population of informal care givers, or those requiring care, make unnecessary demands on services. It is far more likely that they will be reluctant to ask for help, and that they are likely to

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Results of an analysis of a questionnaire sent to Health Services for Older People in each Crown Health Enterprise, and another sent to voluntary and private organisations, are shown in footnotes. The questionnaires are found in the appendices. Twenty-four Crown Health Enterprises, and 32 voluntary agencies have responded to the questionnaires. Discrepancies are due to the fact that not all respondents answered all questions. The questionnaires were designed to identify the range of services provided across New Zealand, and to identify area of perceived deficit or oversupply.
require encouragement to accept counselling to recognise the difficulties they are having and to accept outside assistance.

It is well recognised that certain groups of older people are more at risk than others. They include:

- those living alone
- the ‘old old’ (80+ years old)
- those recently bereaved
- those recently discharged from hospital
- those on multiple medications
- those with cognitive impairment
- Maori and Pacific Islands people
- those on low incomes.

It would make good sense for these people to be targeted for evaluation for assistance as a preventive measure.

While an enormous contribution to care of older people is made by families, and largely by women—spouses and daughters—informal care comes from a variety of other sources. Undervalued and under-rated is the role of the ‘good neighbour’. Not all older people have family members on whom they can call for assistance. Informal assistance of any kind can be at considerable personal cost to those who give it, a cost burden not only in monetary terms, but in disruption of normal family life, lost employment opportunities, and personal stress. With a higher proportion of women in the workforce, and the prospect of lower unemployment, the expectation of policy makers that informal care giving is primarily the responsibility of families will simply not be met. There is an increasing need to find policies which acknowledge a proper balance between the ability of family and other informal carers to provide care, and the role of funded services. Part of this policy should be to preempt stress developing, or at least to recognise stress in caregivers and provide appropriate support where stress is recognised. Two reasons highly likely to cause caregivers to withdraw their care resulting in the placement of the cared for person in an institution, are frequent disruptions of the caregiver’s sleep and persistent urinary incontinence in the person cared for.

6.1.2 Services to assist caregivers

There are many services which provide essential support for caregivers. These include:

- personal services: counselling, support groups, advisory services and training
• practical assistance: home help, home maintenance etc
• carer relief: day care, respite care
• care packages which are flexible, affordable and acceptable will offer the greatest assistance.

Analysis of the questionnaire circulated to 32 voluntary and religious and welfare organisations evoked the following responses. Options for the financial recognition of the work of spouse and family in caring are discussed in Section 6.5.

6.1.3 Aids for Older People

A wide range of aids for older people with disabilities is available. A major criticism is that doctors, the usual contact for those with disabilities, fail to tell their patients about the aids, appliances, adaptations and agencies which are available to them. By not advising their patients of these facilities they deny them important opportunities to minimise their problems. Aids exist to assist older people with specific impairment such as low vision or impaired hearing, and with more general impairments such as difficulty with mobility outside or inside the home. Even simple advice, such as on the appropriate length of a walking stick or the provision of a suitable walking frame, may do much to optimise independence and improve safety. If doctors do not feel comfortable advising on such matters, referral to occupational therapists, orthotists or other appropriate health professionals should be considered.

Of concern too is the difficulty some older people, particularly those on low incomes, have meeting the cost of simple aids such as dentures, glasses and hearing aids. Such problems lead to attempts to do without such aids, or to make do with cheaper versions not suitable to their needs. This can lead to further health problems and create unnecessary communication difficulties.

II Over half believe that they have to give support which should be provided by professional groups. A wide range of professional services for older people were valued. Prominent in the responses were AT & R Units, respite care, Home Care services, Community Health Services (district nursing, social workers, therapy etc), Meals on Wheels, Day Centres. Examples of voluntary care valued were the accredited visitors scheme, the Stroke Foundation, Arthritis Foundation, Alzheimer’s Society, Parkinson’s Society, St John Ambulance, Day Centres. Most valued care provided by private organisations included general practitioners (medical centres), residential homes, day care. Age Concern groups around the country commented widely on lack of support for confused elderly people in the community. Unfulfilled need was identified as flexibility of services, funding for home support, mental health services, transport problems for older people particularly those in rural areas, specialist clinics in rural areas, lack of planning by hospitals with regard to discharge back into the community, provision of weekend support eg. Meals on Wheels, Home Care. It was believed that voluntary organisations have roles in providing information and education, advocacy, care and support within their areas of interest, and providing transport. Very few could give examples of oversupply.
More work is needed in New Zealand to ensure that older people are advised about, receive and use aids. It would also be helpful if there were some means of sharing information about new aids and their correct use and effectiveness.

6.1.4 Professional Care

The range of services required to meet health needs of older people was identified in the previous section (pg. 42). Many of these services are able to be delivered more cost effectively in main centres than in rural areas, although the questionnaire returned from CHEs suggest that in most areas a wide range of services is available in the community. In New Zealand, as overseas, there is a move towards pluralism, a commitment to free enterprise, and market competition. Flexibility and ‘consumer choice’ are clearly desirable provided the choice is informed choice.

In many situations fundholding case managers should be the most effective way to ensure delivery of essential services, and ensure cost effectiveness for recipients and funders of services. It has been argued in some quarters that service allocation has too often been ‘provider-led’ rather than ‘needs-led’, that services are not responsive to consumer preferences, nor subject to quality assessment. These alleged deficits are blamed on the fact that the public sector has a monopoly on assessment, treatment and rehabilitation services. We are not convinced that the public sector is either more or less responsive to patient needs than the private sector.

However, if such criticism is true, it highlights the need for policy development, the setting of goals and strategies and the constant monitoring of health service delivery. It is undeniable that community based services for older people in New Zealand would benefit from better overall management, communication between service providers, and

iii Six non governmental organisations are well represented throughout the surveyed CHE areas: ADARDS/Alzheimer’s Society, Hospice New Zealand, Cancer Society, Parkinson’s Society, Stroke Foundation, and the Motor Neurone Disease Society.

All respondents indicated that Respite and Intermittent Care using the Carer Support Schemes provided by private and religious and welfare organisations are available in their areas. Nineteen of 23 indicated that respite care is also provided in public (CHE) beds. Only 8/24 have a respite care scheme provided by a dedicated professional.

Twenty-three of 24 respondents indicated that ‘day care’ is provided by the private religious and welfare sector although 7/23 indicated that this was also provided by the CHE.

Twenty-four of 24 AT & R units and 15/23 mental health services for older people provide a consultation service to the private sector.

CHEs appear to be the primary provider of community rehabilitation services (24/24) although 3/20 indicated that rehabilitation services are also provided by the private sector on contract. Only 6/20 respondents believed that community rehabilitation services are adequate, the main reasons for inadequate service being ‘not enough staff to cover a large geographical area’.

Home help services are provided by CHE staff (19/20) and by private organisations on contract (15/22).

Twenty-two of 23 had a meals on wheels service, 21/23 continence service, 23/23 ostomy service, 18/22 prosthetic limb service.
understanding by service providers of their roles. In order to upgrade these services efficiently, a comprehensive review of the organisation of local and national community-based rehabilitation services will be required and should become part of a national strategic plan.

Pluralism brings with it the possibility of uninformed choice for older people with the financial means to stay outside the public system for their health care. Poor choices may severely compromise independence, dignity, and quality of life. They may not seek specialist advice or be referred to a specialist service. In this way subtle and potentially reversible conditions, the hallmark of old age medicine, may go untreated. Undetected disease is frequently accepted as an inevitable ageing process, eg an older person buys expensive continence aids without first being referred to see if her incontinence is reversible. Of huge concern to specialist services for the elderly for many years, and one which RHAs are having to come to terms with, is entry into residential homes without specialist consultation. Without specialist assessment, older people are often admitted too early, before other options are explored. An associated issue is whether or not older people in residential homes should receive a subsidy on entry unless they have been assessed by a specialist.

6.1.5 The role of voluntary organisations

Voluntary organisations are largely set up because of a perception that a specific group is not being catered for adequately by any other service. Examples of voluntary organisations in New Zealand which have a large component of older people in their membership are Age Concern, the Stroke Foundation, the Alzheimer's Society, Parkinson's Society, and the Continence Society. Most of these organisations have a small salaried management and service group which co-ordinates a much larger group of volunteers. They also serve the valuable role of advocacy for the group they represent and act as 'watchdogs' on policy developments.

Religious and welfare organisations provide a diverse range of services in the community, and although the pattern of delivery may differ among districts, the types of services remain the same. Examples include social clubs, information services, day care, home visiting, meals services.

6.2 Care in Institutions: General hospitals and rehabilitation units

6.2.1 Interface between community and hospitals (CHEs)

It is well recognised that older people, especially those over 80 years of age, are high users of hospital services, particularly acute hospital services. About 50% of admissions
to residential homes and long term care are decided during such a hospital admission. The majority are discharged back into the community, often frail and still recovering from their illnesses. General practitioners frequently express concern about delays in obtaining information from hospitals about the care of the patients they have referred, and hospital doctors express concern at the poor referral information they receive from general practitioners. In the interests of ‘efficiency’, but in many cases of cost shifting, lengths of stay are reducing and patients are returned home earlier and earlier, risking a resulting increase in unplanned readmissions. Carers, and voluntary agencies complain that they are not consulted, and are unsupported, unprepared and untrained for what is expected of them when looking after the discharged sick older person. It is commonly discovered that appropriate support services have not been organised prior to discharge. Even if they have been arranged, poorly resourced services may not be able to provide care immediately the patient arrives at home. Unplanned readmissions may therefore occur creating further problems and put the older person at further risk from the complications of a hospital admission.

There is clearly a need to review discharge procedures and to subject them to regular quality assessment. Because of communication difficulties experienced between hospital and community services, there is a need to question the reasons for their separation. The concept of ‘integrated’ or ‘seamless’ care is clearly attractive, but would require lateral thinking to achieve. Case management and quick response teams which are part of the health services for older people are examples of initiatives which can transcend the traditional hospital/community boundary.

6.2.2 Interface between geriatric medicine and general medicine

Older people require access to acute medical and surgical services and to the technology available in district general hospitals (CHEs). This also implies access to specialists in the various disciplines of medical care. It is encouraging to see the development throughout New Zealand of services specialising in the management of disease in old age (geriatric medicine) and old age psychiatry (psychogeriatrics). However this has raised questions about the interface between geriatric and general medicine. Such questions are not unique to New Zealand. The interface between the specialties of geriatric medicine and general medicine is usually at the point where older patients admitted to acute medical wards for the care of acute illness require a rehabilitation programme and/or discharge planning. Only geriatricians have the authority to approve subsidies which may be appropriate for patients who are likely to require sheltered (residential) care, or long term nursing (hospital) care.

iv Only three of 21 CHE respondents provide a Quick Response Team service. Case Management services however are more commonly provided by CHEs, 21/23 as opposed to 3/22 provided by private organisation on contract to the CHE.
While general physicians have argued that they too have the expertise to approve such placements this is not borne out by published research in New Zealand. In a recent study, almost half of patients judged to require residential or long term nursing care by acute physicians or general practitioners were able to be discharged back to the community with support after being assessed by a geriatric service and most were still there six months later\textsuperscript{39}. These outcomes reflect the lack of specialist training in assessment and rehabilitation on the part of general physicians and general practitioners.

Where both geriatric and general medical services exist in general hospitals, three main models of care for older people have evolved: the traditional, age defined, and integrated. In the traditional model a decision whether an older patient is admitted to a geriatric or general service from the community is made largely by general practitioners in consultation, but at times by emergency departments or other physicians. In the age defined model all medical patients above a certain age are admitted to the geriatric service, the age being determined largely on the basis of resources available. The integrated model combines both services with geriatricians and general physicians taking equal responsibility for the full case mix of patients admitted. A refinement of this model allocates patients in line with the speciality interest of the physicians involved.

There are claimed advantages and disadvantages of each of these systems, but none appear to be so compelling as to substantially advance the cause of one model over another. Geriatric services in New Zealand largely follow the traditional model although there are examples of each of the others operating. In smaller centres the integrated model may be the most practical.

Decisions on transfer of patients between specialties, or timing of discharge, are often not easy and not only require detailed knowledge of the patient’s needs but, just as important, intimate knowledge of the availability and quality of the health service resources in the community into which the person will be transferred. Good communication between general medical and geriatric services are therefore essential for the care of older people. Training of junior doctors in both specialties is essential and it should be noted that the Royal College of Physicians, United Kingdom, emphasises the desirability of experience in geriatric medicine in the training of general physicians at both general professional and higher medical training levels. The Royal Australasian College of Physicians has not yet issued such a policy statement.

The interface of geriatric medicine with specialties other than general medicine within the hospital can also be effective. Examples include ortho-geriatric services where in Christchurch,\textsuperscript{31} there is liaison with emergency departments, and close working relationships with Mental Health services for older people. Resources for geriatric services within general hospitals should allow them to take on a wide responsibility for older
people admitted under other specialist services.

6.2.3 The role of assessment, treatment and rehabilitation units (AT&R Units)

AT&R Units in New Zealand are largely run on the traditional model of care for older people. Most services admit directly from the community on request from general practitioners or after assessment in the community by one of the team. In addition significant numbers of patients are transferred from acute medical, surgical or orthopaedic wards in general hospitals. In rehabilitation, emphasis is placed on a multidisciplinary approach. Other characteristics of rehabilitation units which distinguish them from general medical units include: an emphasis on 'wellness' rather than 'illness' (gets patients up and dressed), an emphasis on goal-setting including the patient and relevant others, close liaison with community services, both CHE based and private sector, the use of standard assessment protocols, and comprehensive discharge planning involving carers and family members. Most AT&R Units have Day Hospital facilities where older people come up to the hospital for assessment, treatment and rehabilitation on an outpatient basis. Day Hospitals are increasingly including as part of their services specialty clinics such as bone, memory, continence, and Parkinson's and Stroke follow-up clinics.

The value and effectiveness of multidisciplinary rehabilitation services for the elderly is now unequivocally proven. Many studies show that such an approach significantly reduces day stay in hospital, morbidity and mortality. However, therapy and social work have proved to be easy targets for cost-cutting hospital administrators and it is likely that many AT&R units are below maximum efficiency because of staff shortages. There is a need in New Zealand to determine what the optimal ratios of the various therapy disciplines are for maximum efficiency to be achieved. No guidelines exist at present which are accepted by RHAs.

Rehabilitation units need to review their methods and approaches on an ongoing basis to be able to quickly incorporate new approaches of greater efficacy. Multidisciplinary research on rehabilitation methods is to be encouraged, including research into the value of rehabilitation in the community versus rehabilitation on an inpatient basis.
The efficacy of AT&R units is not dependent solely upon the efficiency of the care occurring with their walls. It is heavily dependent on there being adequate facilities in the community for ongoing rehabilitation support of patients and carers, and long term residential care. Poor resolution of any of these will materially affect length of stay in AT&R units.

6.3 Care in institutions: Long term Residential Care

6.3.1 Options in ‘sheltered’ care

Institutional or ‘sheltered care’ can provide a wide range of options for an older person. Ideally, various ‘levels’ of sheltered care should be available in the community, each incorporating a more intensive component of supervision. A first level model is the warden controlled flats where older people live independently in a small number of flats on a local campus supervised by a warden who is available to give residents some assistance, but whose main responsibility is to note any problems that they may be having. These are successful overseas but uncommon in New Zealand.

At a slightly higher level is the Abbeyfield house concept, now well developed in the United Kingdom but only recently introduced to New Zealand in Nelson. Abbeyfield housing provides boarding facilities for fit, older people who do not wish to live alone. They live in en-suite rooms with a cook/housekeeper providing all meals and are supported by volunteers and the executive of the Abbeyfield organisation.

At a still higher level are cottage-type units on the campuses of some of the larger residential care institutions. These may be rented, or in some cases purchased. The residents have access to the facilities of the larger institution including, if needed, meal services, laundry services and so on. There is regular supervision by staff.

On a more ‘upmarket’ scale, retirement villages fulfil an important role, some providing a large range of facilities including independent units, serviced apartments, residential homes and private geriatric hospital level beds on the same campus. Religious and welfare organisations and the Masonic Order have experimented with the development of lower cost retirement-type villages with some success. It has become evident that some retirement village complexes which promised a full range of services ultimately failed to do so.

6.3.2 Long term care in rest homes and geriatric hospitals

Rest homes for frail older people are the predominant model of sheltered care in New Zealand with long term hospital beds, frequently in the private sector, available for people requiring nursing care. These institutions are expensive to operate well.
A survey of people in residential care (rest homes and long-stay public and private hospital beds) in Auckland has shown a clear increase in dependency levels in both sectors between 1988 and 1993. Over a five year period there was a significant fall in the number of physically independent people in rest homes and an increase in dependent people. Dependency levels in the long-stay hospital sector were found to have risen in parallel. One reason for this change in dependency in Auckland institutions is thought to be the increasing emphasis on 'ageing in place', and the success of services designed to keep people at home longer. It is also clear that greater insistence on assessment before entry to rest homes has reduced the tendency for many physically non-able older people to use them as a retirement option. These changes are indicative of more effective use of these expensive resources.

However this increase in dependency levels has been accompanied by discord in the industry about responsibility for the care of Support Needs Level (SNL) category 4 and SNL category 5 people. Rest homes have found it increasingly difficult to cope with higher ratios of more dependent people, given the staffing levels possible with the funding levels offered. We are aware that there is a group of quite severely dependent residents who have not moved out of rest home care because they and/or their relatives have been unwilling to accept transfer to a geriatric hospital. It is likely that some rest home proprietors attempt to manage severely disabled residents without seeking re-categorisation to private hospital level (SNL 5), in order to keep their beds full. On the other hand, many geriatric hospitals having developed their facilities to cope with the devolution of public long-stay beds to the private sector in the late 1980s, now find their facilities underutilised. The reasons for this are complex and include the provision of Stage III beds in the rest home sector, organisation of better respite care schemes and other measures to enable older people to remain at home longer, and market forces which, despite limits previously imposed on the numbers of beds have nevertheless seen a growth in the industry. We can find no substance to support the complaint advanced by some in the private hospital sector that assessment teams have been pressured by RHAs to categorise heavily dependent residents as SNL 4 rather than SNL 5 in order to save RHAs money. However, we are convinced that there is a problem with the current configuration of the SNL 4—SNL 5 interface. We believe that it should be reviewed. A possible way forward would be through the introduction of additional categories at the interface, as has been done in Australia, to recognise variability in the dependency of these high-dependency people. This would allow geriatric hospitals to offer a range of fees appropriate to the SNL categories. A second strategy would be to review the pros and cons of encouraging the development of multi-level homes and hospitals so that residents who become more dependent would not have to move from one institution to another. Such a policy was first advocated by the Committee on the Care of the Elderly of the Board of Health in 1987.
In recent years many long term care institutions have moved to become accredited according to the ISO 9000 or the New Zealand Council of Health Care Standards criteria. This process has been accelerated in the Northern Region by the financial advantage which North Health is offering in their contracts to accredited institutions. It seems likely that in future all institutions, both public and private, will be required to be accredited and have appropriate quality assurance/quality of care programmes in place according to government policy. Although quality of care and quality of life are not totally synonymous, the former impacts on the latter.

In response to the survey, the private hospital sector, concerned with long term care for older people, warns of the danger of the balance of services being distorted in the direction of home care because of perceptions of too much funding support for rest home hospital services. Private hospitals believe they could do more in the area of respite care, day care/night care and also convalescent or rehabilitation type care following acute incidences such as joint replacement surgery.

- Concern is expressed by the private sector that the Support Needs Assessment Protocol (SNAP) requires national monitoring and there is considerable variation in assessment outcome from AT & R Unit to AT & R Unit. A major inadequacy in the assessment process is identified in that no formal mechanism for follow-up monitoring and reassessment is in place and it is left to the older person or their care giver to re-initiate it. New service co-ordination requirements are suggested, in particular, the introduction of service co-ordinators to monitor the changing care needs of their clients.

- Purchasing policies of RHAs are also questioned. There is concern that RHAs’ prime concern is cost reduction and that there is inadequate recognition of the cost of maintaining quality.

- The questionnaire revealed that the majority of rest home care is provided by the private sector throughout New Zealand. Most respondents perceive the total number of rest home beds to be at an adequate level (20/22). The majority have hospital care provided by the private and religious organisations (21 of 22), and many also provide hospital care in public beds (15/22). Just over half (12/19) of the respondents believe that long term hospital beds are adequate in their areas, but 7 of 19 reported levels to be inadequate.

A detailed discussion on 'quality of institutional life' is included in the references. Such a policy was first advocated by the Committee on the Care of the Elderly of the then Board of Health in 1987.
6.4 Community expectations of institutional care

While it is established that home care is a successful substitute for long term institutional care for many elderly people, the evidence that it is a lower cost alternative when all factors are taken into account is problematic. This is particularly true of the most dependent group living at home who, in many cases, require a wide range of resources and intensive input in order to remain at home. Evidence from research overseas is conflicting on the economics of alternatives to residential care. It is argued that concentrating resources for home care on the most severely disabled is not cost-effective and that it syphons off resources which the less disabled might utilise more effectively.

It is commonly found that relatives under stress from a deteriorating condition in a frail elderly relative, increase the amount of care provided, rather than use stress as an excuse to hand over care to an institution. Mental confusion, particularly where agitated or disruptive behaviour occurs, or frequent nocturnal disturbance, together with urinary and faecal incontinence, are the most common reasons that relatives relinquish care to institutions. In such situations, it is important that all those involved, including the general practitioner and social worker, do not capitulate immediately to long term institutional care without first exploring options to enable the older person to remain in the community. Frequently, after a period of assessment in a specialised geriatric service, ways can be found to minimise the problem and refreshed relatives be introduced to channels of communication, surveillance, and respite care which will ensure that similar problems can be dealt with much more efficiently in the future.

6.4.1 Benefits of a comprehensive health service

- Frail older people do not remain in acute medical and surgical beds longer than necessary. Once the acute episode is resolved prompt consultation with old age services leads to transfer to a more appropriate facility, or to discharge home with support as necessary

- More frail older people are discharged home with appropriate discharge planning and care services, rather than to long term care facilities

- Greater consumer satisfaction is demonstrated not only because more frail older people are discharged home, but because co-ordinated support is arranged for that person and their carers

- General practitioners benefit from community-based consultation services, and from appropriate communication with regard to admissions and discharges

- General practitioners, and staff in the private sector such as rest homes and private hospitals, have increased awareness of needs of elderly people as a result of focused educational and training programmes
• More efficient use is made of the health dollar, with fewer extra costs due to inefficient use of services and/or unplanned readmissions due to poor discharge planning.

Reference has already been made to the difficulty in estimating value for dollars spent on care for older people. Little attempt has been made in the past to identify benefits from new programmes introduced, either in more efficient use of the dollar or in real benefit to frail older persons and their carers. Currently a Case Management Programme is being evaluated in Auckland. This study is examining the costs and benefits of home care for frail older people under case management, compared with costs and benefits of rest home care in a comparable group of people. The study has been funded by North Health and the results should be available towards the end of 1995.

6.5 Financing of Care for Older People

Six principles governing the funding of care for older people have been proposed by the OECD which can be used to evaluate the extent to which existing systems are appropriate or to evaluate new proposals. We endorse these principles in considering funding of care for older New Zealanders:

• The provision of funding should be related to an assessment which takes an holistic view of the needs of the older person, rather than focusing on the need for a single service

• The funding provided should be accessible for expenditure on a range of care services, broadly defined, which will sustain a good quality of life in old age

• There should be a built-in bias towards home care solutions, but funding should be available for care in sheltered settings

• Access to these sheltered care settings should be decided on the basis of need and should not be impeded by inability to pay

• Conditions governing the receipt of public funding should enhance rather than reduce the degree of choice which the older person has over their conditions of life

• Private provision of care should be encouraged and supported, but older people should not feel obliged, or required, to run down their assets in the purchase of care to such an extent that their quality of life or their independence is impaired.

There are a growing number of schemes in OECD countries for paying cash benefits to family carers, sometimes with the intention of replacing lost earnings, and sometimes as a compensation for caring which is not pitched at an income replacement level. An interesting scheme in Japan allows volunteers to have a credit payment for hours worked
which goes into a special bank account under their name. Volunteers can use this accumulated fund to pay for care for themselves or other designated people in the future. Other options include tax rebates in recognition of the costs of caring and/or more generous income support benefits than currently exist.

Another way of supporting volunteers is by assisting voluntary organisations to fund key positions and training programmes for volunteers. Voluntary service organisations in the health sector join home carers as the ‘hidden welfare state’ within the welfare state. While voluntary organisations, by definition, harness a huge amount of unpaid labour it is necessary to pay for quality management, field officers, and key co-ordinator positions. It is extremely difficult for voluntary organisations to find key people who are willing to commit themselves to between 12-40 hours per week unpaid. Without these funded positions, voluntary organisations have much more difficulty in providing high quality, consistent support services. As well, the much larger unpaid voluntary workforce providing the ‘hands on’ support may not be effectively managed and indeed may become discouraged through lack of leadership and organisationvi.

A review of the funding of voluntary health sector organisations with established track records is urgently required in order to facilitate their organisational capacities.

In New Zealand a system of subsidies for long term residential care has existed for many years. In 1993 moves were made to consolidate responsibility for these with the RHAs, and the final devolution of rest home subsidies is to occur in 1995. Moves were also made towards a uniform means and asset testing formula for rest home and hospital level subsidies. Currently, people who are assessed as requiring institutional care, but who fail to meet the requirements for provision of subsidised care, are required to pay the first $636 of the fee. This approach has been criticised as being unfair on individuals who have saved up for their old age, but have been unable to accumulate sufficient funds to be able to meet the fee out of income without eating into capital. Furthermore, since no other group in New Zealand is expected to pay for publicly funded health care, this suggests apparent discrimination against older people. A fair way of resolving this issue is to require everyone to contribute to an agreed cost of living or ‘hotel’ component of the institutional fee with Government funding of the remaining ‘health care’ component. A detailed discussion on these issues has recently been published38.

6.6 Health promotion and education

While most older adults are not significantly disabled39 and most appear to view their health largely in positive terms40, those 60 years and over suffer more from health

vi Our questionnaire identified that problems with financing administrative staff are currently experienced by organisations such as Age Concern, the Stroke Foundation, the Alzheimer’s Society, and the Parkinson’s Society all of which cater predominantly to the needs of elderly people.

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problems than do younger adults, and these problems tend to be more chronic. The decline in health contributes to a loss of independence which impacts on both health and social services.

The link between lifestyle and health in older age has been well documented. Commentators such as Manton have made the point that the functional loss associated with ageing is due to the accumulated effects of exogenous damage on the physiology of the individual. There is increasing evidence, that even at older ages, risk factors can be identified which are associated with an increased probability of morbidity and premature mortality. These risk factors include both exogenous variables such as smoking, nutrition and alcohol consumption and physiological variables such as blood pressure, serum lipids, bodyweight and blood sugar. A growing body of evidence also suggests that strong social support systems may be critical for health maintenance and disease prevention in older age. Increasingly it is being shown that controlling risk factors among the elderly has the capability of improving or reversing the pathological effects of the risk factors. Examples include stopping smoking, encouraging regular exercise in order to prevent bone loss and osteoporosis, maintaining cardiovascular fitness, conserving general health and mobility, and maintaining adequate nutrition to improve disease prevention and recuperation from illness. In short, reducing the impact of risk factors through lifestyle change has the potential to significantly reduce the costs of health and social services.

Under the HEP programme of the Department of Health, the beginnings of an effective nationwide health promotion and education initiative directed at older people was established. Resources including printed material, video programmes and self help kits were developed and widely distributed. Attention was addressed to combatting ‘ageist’ attitudes, and community and voluntary sector groups were encouraged and, where necessary, trained to develop their own local health education programmes.

Research into effective health promotion strategies in New Zealand was begun.

There is, however, now no national focus for health promotion and education for older people in New Zealand. This deficiency needs to be redressed.
Interest in the mental health care of older people as a service activity is less than twenty-five years old worldwide and perhaps less than fifteen years old in New Zealand. Until the 1960s, interest in the mental disorders of old age was largely confined to research with very few actual services provided. According to Arie, recognition that mental health care is a necessary part of health care for older people has been largely brought about by:

- an increase in numbers of aged and with that, an increase in numbers of mental health disorders in older people
- marked improvement in psychiatry’s ability to treat conditions previously described as hopeless
- the proven effectiveness of geriatrics in medicine
- the de-institutionalisation movement in psychiatry
- the influence and teachings of Roth (Cambridge), Robinson (Edinburgh), Kay (Newcastle), Post (London) and Corsellis (Runwell), Arie (Nottingham) also deserve to be added to this list.

7.1 History of mental health care for older people in New Zealand

In the past, there has been a large under-treated population of older people who failed to access appropriate diagnostic and treatment services. Older people with mental health problems, particularly those with depression or anxiety disorders, were unlikely to be referred to specialist services. Or if they were referred to adult psychiatric services, they often failed to receive the same level of support or treatment strategies offered to younger people. Substantial barriers existed, and still do for patients attempting to access adult services. For example, services are often not adapted to the special needs of older people, long waiting lists hinder timely intervention, and difficulties with mobility and transport inhibit access. Consequently, the actual incidence of mental health problems in older people has been unrecognised and under-represented in health care data.

People with the more serious of the functional disorders, such as chronic schizophrenia, long standing treatment resistant depression or severe anxiety, disorders that capture
community attention because of abnormal behaviours or severe distress, tended to be institutionalised in psychiatric hospitals, often for many years. In addition, older people with organic mental disorders such as dementia, with or without behavioural disturbances, were also institutionalised in psychiatric hospital ‘back wards’. These wards were poorly staffed with little in the way of psychiatrist oversight. Incarceration in these hospitals and psychotropic drugs were the main methods of managing socially unacceptable behaviour in mentally and functionally impaired elderly people. In particular, psychotropic antipsychotic drugs have been inappropriately used, considerably overused, and sometimes frankly abused, as methods of chemical restraint rather than as therapeutic agents in behaviourally disturbed older people. Similar conditions for mentally unwell elderly people have been described in both the USA and the UK, up to the present day.

In the United Kingdom the first dedicated psychogeriatric services began to emerge in the late 1960’s with Sir Martin Roth, Professors Robinson, Arie, Kay and Post pioneering these services. In New Zealand, the first changes occurred in the mid 1970s and early 1980s when Dr Kingsley Mortimer, a former professor of anatomy with a diploma in psychiatry, took charge of the elderly wards at Carrington Hospital in Auckland. In several articles written for the public press, Dr Mortimer highlighted issues of inadequate care, poor facilities and lack of treatment options for this group of people. Dr. Mortimer set about de-institutionalising the psychogeriatric wards at Carrington, first by placing patients in suitable rest homes whenever possible and second, by providing an outreach assessment and follow-up service to those rest homes. His small team consisted of himself, a senior nurse and a social worker and together they markedly reduced the long stay psychogeriatric beds at Carrington. The trend continued after his retirement and further reductions in long stay beds in Auckland were enabled by growth in the private rest home sector. A similar de-institutionalisation process occurred at the other psychiatric hospitals but not to the same extent as at Carrington. At the current time only Porirua Psychiatric Hospital in Wellington has a substantial number of psychogeriatric long stay beds. Even these have been halved in the last seven years and there are plans to reduce these further over the next two years.

The Geriatric Hospital Assistance Scheme discriminated against elderly people with psychiatric diagnoses being placed in private hospitals along with patients with physical diagnoses; and this policy continued to foster institutionalisation in psychiatric hospitals until very recently. Older people with psychiatric disorders were not eligible within the guidelines for the GHSAS subsidy which was capped at 18/1000 elderly for physical disorders only. As many of the disorders of old age have both physical, organic and psychiatric manifestations, this policy insisted on artificial divisions that were often impossible to determine. Decisions regarding the granting of subsidies were not always
made on 'need for care' grounds but sometimes on the medical specialty of the physician signing the forms.

The transfer of responsibility for funding and licensing, plus the ability to determine local policies to Regional Health Authorities, has the potential to address this problem so that the major criterion for subsidy consideration can indeed be 'need for care'. Some Regional Health Authorities have gone some way towards this by streamlining all residential care subsidies into one, based on need, for either rest home or geriatric hospital care. In 1993 the government introduced the special Stage III scheme for patients with dementia and other related neuropsychiatric disorders to address the special needs of this particular patient group. However, despite the needs of patients with dementia and those who require rest home care being more appropriately met, de-institutionalisation of the psychiatric hospitals has created an unfulfilled need for appropriate residential care for the elderly person who is neither demented nor physically frail, but who requires ongoing supervision in a specialised facility which does not need to be a psychiatric hospital.

Dedicated acute beds for inpatient assessment and treatment of older people with mental health problems have always been in relatively short supply in New Zealand, but in contrast to the attrition of long stay beds, acute bed provision has increased. Despite this, overall New Zealand still has less than UK recommended numbers for acute assessment beds for older people with mental health problems (Table 5). The recommended acute bed levels according to UK figures are 1.5 per 1000 people over 65 years of age.

| Table 5: Dedicated bed numbers for psychogeriatric patients in the major centres in 1995 |
|----------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                                  | Auckland        | Christchurch    | Dunedin         | Palmerston North| Waikato         | Wellington       |
| Acute beds (numbers)            | 47              | 45              | 38              | 24              | 8               | 20              |
| Acute beds/1000                 | 0.43            | 1.15            | 2.53            | 1.26            | 0.8             | 0.72            |

In most regions of New Zealand, current mental health policy is to establish equivalent facilities for treatment and residential care for older people with mental health problems as for those with general medical disabilities. Many regions are working towards closer association of mental health services of old age with medical services for older people and towards establishing community based (non public hospital) residential care.

### 7.2 Mental health disorders of old age

Psychiatry of Old Age deals with the broad range of mental health disorders occurring in late life. These include the functional psychiatric diseases such as affective (mood) disorders, psychotic and somatoform disorders as well as the organic cognitive disorders. Some of the more common or important are listed below.
7.2.1 Affective disorders

Depression is the commonest disorder presenting to old age mental health services with an incidence of 1% to 1.5% in people 65-74 years. The disorder steadily increases to between 4% and 10% at ages 75 years and over. In addition, it has been estimated that between 15% and 30% of the older population have minor levels of depression. Major risk factors for the development of depression in late life are concurrent physical illness, reduced mobility and dependency together with organic biological changes in the ageing brain. Other major risk factors include the high number of life events and stressors, particularly loss events, to which older people are more subject. The loss of life partners, friends and family members reduces resilience and multiple bereavements and grief can precipitate depression. Social withdrawal and complaints of loneliness may disguise depression, which is often not recognised as such by families, general practitioners or even the sufferer themselves and erroneously put down to 'ageing'.

It is important to remember that older people, especially males, have a higher incidence of successfully completed suicide and depressed older people, living alone, with poor access to support networks, who have complicating physical pathology are particularly at risk.

Bipolar affective disorder is also common and, in old age, episodes tend to cycle more rapidly and be more difficult to treat, often because of complicating physical pathology.

7.2.2 Anxiety disorders and stress

Some increase in anxiety is expected as people grow older, as ageing brings frailty and lack of mobility which can make an older person feel more vulnerable and they often have exaggerated fears of being assaulted, their homes violated or robbed. While such fears may be understandable and increase stress, for most older people, they do not usually interfere with normal functioning. However, older people also have a higher incidence of the anxiety disorders that do significantly interfere with functioning. Older people may be also at risk for adjustment disorders when they find themselves with unaccustomed leisure and reduced income after retirement and not uncommonly, marital relationships that have endured during the working life, may come under some strain. Stress may be experienced by older people in response to the multiple losses of old age such as decline in health and physical status, decreased mobility and loss of independence.

In New Zealand European cultures, retirement often brings social losses in status, income, friends and family roles. In contrast, in other cultures, for example Maori, retirement can bring additional status but greater responsibilities. Both negative and positive psychosocial changes can be associated with increased stress and anxieties for elderly people.
7.2.3 Alcohol and drug use

There is little reliable data on drug and alcohol use in elderly people in New Zealand, but according to recent UK studies, one fifth of the elderly residents studied were regularly exceeding sensible limits for alcohol. In addition, many older people are dependent on benzodiazepines that have been legitimately prescribed for many years. Benzodiazepine dependency can occur quickly and prolonged use can cause or increase cognitive impairment such as memory deficits and facilitate delirium or a tendency to falls.

7.2.4 Organic mental disorders

The organic mental disorders are a heterogeneous group and include various dementias and reversible organic disorders such as delirium. The incidence of the dementias is about 3-5% up to age eighty and approximately 20%-30% thereafter. The commonest dementia, Alzheimer type, is more common in women at advanced ages (presumably because the life expectancy of women is greater giving them a greater chance of developing the disorder, rather than the disease itself having a gender predilection). On the other hand, vascular dementias are commoner in men and tend to occur at a younger age than dementia of the Alzheimer Type. Dementia of all types can be complicated by other disorders such as delirium, anxiety and depression or have behavioural complications which cause difficulties in caregivers coping.

7.2.5 Functional psychoses

The major psychoses are all represented in Old Age Psychiatry. Patients with chronic disorders who have been treated for many years with antipsychotic medication can develop tardive dyskinesia and/or tardive dystonia. These distressing conditions commonly increase in severity with ageing and cause complications with eating, dressing and mobility.

7.3 Social issues in mental health

7.3.1 Stigma

Mental illness may affect an older person for the first time in late life. Some older people find the concept of being mentally unwell particularly troubling and feel very stigmatised as a result.

7.3.2 Elder Abuse

Mental fragility also opens up the possibility of abuse. 'Elder Abuse' teams now exist in many areas as elder abuse is more common than is generally realised. Abuse is more
than physical or sexual mistreatment and can exist in many guises. Several papers at a recent Age Concern national conference on ‘Elder Abuse’ highlighted that the commonest form of abuse appears to be financial abuse. The assets or property of a mentally impaired person may be inappropriately used to the benefit of relatives rather than the person themselves, rationalised on the grounds that the assets would be ‘coming to them’ eventually. Some relatives do not allow an older person to have appropriate levels of care when needed, to preserve assets for inheritances. In addition to financial or property misuse, other abuses include neglect, failure to render proper care and attention and actual physical harm by caregivers or others.

7.3.3 Caregiver stress

A recent publication on Dementia from the Alzheimer Society New Zealand includes a cartoon captioned, ‘She has dementia, but they all suffer from it’. This neatly encapsulates how families and caregivers suffer immense stress as the result of an elderly loved one developing dementia. The burden of caring for a demented relative can be so arduous that caregivers may break down with anxiety, depression and failure to contend with difficulties. Even if the main caregiving stress is relieved by a person going into care, the loss of the caregiving role can induce guilt, depression and grief in relatives. Many of these caregivers are elderly themselves, with their own attendant ageing problems, which can increase stress and reduce resilience.

7.4 Mental health needs of older people

Because of the above mental health disorders and social issues pertaining to older people which put them at risk, there are a number of principles in determining the mental health needs of older people:

- early, accurate diagnosis and treatment by personnel trained and skilled in the assessment, diagnosis, treatment and complications of mental health disorders in later life
- support for patients and carers through psychiatric illness, grief, and stressful adjustments to changing circumstances
- prevention of patient and carer stress that can progress into more severe psychiatric disorders, difficulties in coping and poor quality of life
- respite care to allow caregivers to continue caring
- dedicated special care for the patient with moderate to severe dementia and behavioural problems who is unable to be managed at home
- attention to the special needs of the elderly patient with long standing psychiatric
disability who falls outside all other 'categories'.

- training and education of providers and clinicians so that the mental health disorders of old age are better recognised, are addressed before they become chronic or treatment resistant and are treated more appropriately
- education of the elderly public in mental health maintenance, stress management, communication about facilities and organisations concerned with aged welfare
- research and evaluation of epidemiology of mental disorders, assessment methodologies, suitable treatments and service delivery methods for mental health disorders.

7.5 Philosophical issues in provision of Old Age Psychiatry services

7.5.1 The Specialty of 'Old Age Psychiatry'

Psychiatry of old age deals with two broad populations of disorders, the organic disorders and the functional disorders. The principle that general adult psychiatry should deal with functional disorders at any age including elderly people and that only organic disorders are the province of 'psychogeriatrics' has not served old people with mental health problems well. There are several reasons why a specialised old age psychiatry service should deal with the full range of mental health problems in later life.

In most cases it is impossible to separate the functional from the organic and dementia can complicate other psychiatric disorders. Depression, anxiety and psychosis may herald, precede or complicate cognitive deficits. For example, without the diagnostic expertise to delineate symptoms, patients can be inappropriately treated, with depression (a reversible condition) being treated as dementia (an irreversible condition) or vice versa.

Functional disorders of old age may arise for the first time in late life, usually precipitated by loss or stress of illness. They are better treated in a developmental framework by health professionals who have a deep understanding of the particular issues of ageing. While this principle of care is not impossible for adult psychiatry services to achieve, most adult services are not focused on the particular issues of old age.

In contrast to younger people, older people's psychiatric disorders are commonly complicated or precipitated by physical illness. Treatment can be specially challenging if drug incompatibilities and complications are to be avoided. Special expertise is required in managing the complexities of psychopharmacological agents and the pathophysiological changes of ageing.
Older people have problems with access to hospital based assessment services and consequently community based home assessment services reduce stress for the individual and in addition, enable assessment of the environmental situation. Such a community focus is more likely found within an old age rather than an adult psychiatry service.

Mixed units containing frail elderly and young active psychotic adults can be countertherapeutic for older people. They require programmes specifically directed and paced for the elderly who often have a different set of cultural and cohort norms of behaviour to younger adults. Nursing staff, in particular, often find it difficult to meet the needs of young and old simultaneously.

7.5.2 Psychiatric versus general hospital services

Secondary services vary in style and philosophy and this can limit access to 'appropriate' care. In the UK, old age psychiatry services are more plentiful and developed than in Australasia. Despite this, only 40% of services are based on the preferred District General Hospital model, the rest are still in Psychiatric Hospitals. Until very recently, virtually all New Zealand old age psychiatry units were located in psychiatric institutions and had limited access to Geriatric medicine. Currently both Wellington and Christchurch still have their services based at Porirua and Sunnyside psychiatric hospitals respectively although access to geriatric services has improved for both institutions. Christchurch's service is administratively configured with the Department of Health Care For the Elderly and shortly all their services will be concentrated on the same site.

A few services are within Geriatrics and have limited access to psychiatry. Others have fully integrated departments of Health Care for the Elderly, e.g., Palmerston North or have conjoint services such as Waitemata Health. Full integration or conjoint services are considered to be the ideal, as patients often have simultaneous mental and physical disease.

7.5.3 Alignment with Geriatric Services

Philosophical variation occurs over the treatment of old people with functional disorders (depression, paranoia and anxiety disorders) as opposed to those with dementia. Recently the New South Wales Department of Health issued a policy of 'mainstreaming' old age psychiatry services into general adult psychiatry wards (1992). This policy goes against strong recommendations from old age psychiatry and geriatrics to align old age psychiatry services with geriatric services rather than with adult psychiatry wherever possible.

The Section of Old Age Psychiatry of the Royal Australian and New Zealand College of Psychiatrists and the Australian Society For Geriatric Medicine have recently ratified
a joint policy statement recommending functional alignment of Geriatric and Old Age Psychiatry services to improve quality of service delivery. This document (RANZCP Position paper No 31, revised 1995) outlines four important principles:

- wherever possible, it is desirable that conjoint geriatric and psychogeriatric services be operated
- when services are conjoint, external referring persons or agencies must have the option of referring explicitly either to the geriatric or psychogeriatric service
- where referrals to a combined service are made without the requirement for either geriatric or psychogeriatric assessment having been specified, then triage to either geriatric or psychogeriatric services should be conducted by representatives of both services
- mechanisms of cross-referral between services should be freely available.

7.5.4 Liaison with geriatric medicine

It is desirable that old age psychiatry services are associated geographically and functionally with geriatric services. The reasons for this include the following:

- there is a high proportion of medical disorders in patients presenting with psychiatric problems in old age. The incidence of such complicating disorders varies from 43-52%9. The presence of illness can lead to diagnostic difficulties and complications in treatment, as drugs used in physical disorders may cause complications when combined with those used to treat psychiatric disorders
- psychiatric symptoms complicate physical disorders in medically ill patients presenting to geriatric and general medical and surgical wards. The close proximity of psychiatric care and treatment in assessing psychiatric complications can shorten general hospital admissions and enhance rehabilitation
- patients presenting for the first time with new disorders can be difficult to diagnose. Access to the full range of diagnostic services associated with general hospital medicine is desirable and maximises efficiency of aged care services. Both geriatricians and psychiatrists have a professional interest in the treatment of dementia. The shared expertise of the two specialties can improve assessment and treatment. Examples of such sharing can be in a joint triage process and amalgamation of resources in specialised assessment clinics such as memory clinics.

7.5.5 Changing styles of service delivery

The preferred typical service in the UK consists of an admission unit based at a District General Hospital with access to medical resources, some long stay and respite beds and a day hospital. Most New Zealand services would now add community assessment and treatment services to this configuration.
7.5.6 Community based services

Most Australasian old age psychiatry is still based at psychiatric institutions. A few areas have set up community services for the assessment of dementia. Even fewer have set up services that are community based for the assessment and treatment of the full gamut of old age psychiatry disorders. One exception is in Auckland where such a model has been successfully operational for five years. This is based on a model of case management. Such a model is highly acceptable to older people themselves for whom their case manager, usually a district nurse, is available for consultation and advice not only to the patient themselves but also to their caregiver.

Provided the community resources are adequate, such a model has the potential to reduce reliance on inpatient beds for assessment and treatment, as disorders can be assessed earlier and often treated at home. Support provided to caregivers may itself be sufficient to prevent the need for admission. Careful monitoring of mental health disorders in the community also increases the level of awareness for potential problems that caregivers and providers might encounter. Community focused teams probably also have an educative, liaison and normalising effect on the population served. However such a model is not yet the norm and its effectiveness has to be formally evaluated.

7.5.7 Day hospitals

Day hospitals are considered pivotal in service delivery but the hope that they would prevent either acute or long stay admissions has been shown to be unfounded. They do provide assessment, support and treatment. There is a difference between daycare and day hospitals for old age psychiatric services and sometimes the two types of programme are mistaken for one another. Day care is often provided by non medical providers with the aim of providing companionship, oversight and activities for the older person but these programmes are without a specific therapeutic goal. On the other hand, old age psychiatry day assessment and treatment programs specifically target symptoms such as depression or anxiety or memory loss, have specific therapeutic goals in mind and direct treatment toward rehabilitation. Day treatment need not be centred on specific premises. Some units have improved access to day treatment by the novel innovation of mobile day hospitals. In one large extensive rural area in southern England, a travelling day hospital service was set up to access older people living in outlying areas who otherwise would not have received either assessment or treatment. In New Zealand day treatment services are in short supply and unevenly spread throughout the country with few places being reported as available.

vii Only seven out of 22 respondents indicated that they provided such a day treatment facility. The number of places provided ranged from 10-20 with a median of 15. Total number of places in New Zealand reported by the respondents was only 75.
Patients with dementia can be managed at home in the early stages but as they reach the middle stages of dementia the disorder may be complicated by challenging behaviours that cause difficulties for the caregiver. These patients need access to higher levels of supervision than can be provided in their own home. Dementia can cause challenging behaviours such as aggression, wandering, faecal smearing and incontinence, making home care difficult even with support. In the past many of these patients needed hospital level of care.

Incarceration in unstimulating institutions has been thought to be detrimental to patient functioning and to test this hypothesis the British Department of Health funded three experimental units to cater for patients with dementia and behavioural disturbances, Redcourt in Liverpool, Seward Lodge in Hertford and Highgrove House in Hampshire. These homely units provide care for seventeen to twenty-three patients, previously resident in psychogeriatric wards of public hospitals. The units have high staffing ratios, of about 1.5:1 and the majority of care staff are non-health professional aides trained and supervised by professional nurses and occupational therapists. The units are very non-institutional and flexible in their approach to patients and have been closely monitored on a variety of parameters by the Institute Of Human Ageing in Liverpool. They have been shown to enhance quality of life for patients as evidenced by falling medication levels, improvement in difficult behaviours and reduced use of physical restraints. Other innovations in this respect have been the Homes for the Elderly Confused in Exeter. These again are specialised institutions catering for small numbers of patients who would otherwise be hospitalised in high care dependency units. Provision of such units is variable across the UK, the USA and Australia. The high staffing ratios makes them expensive options but perhaps no more so than public hospital level of care. Quality of life for the residents is much improved. Although similar high care units to these can be identified in New Zealand, specific services have not been evaluated to the rigorous extent of these overseas units and thus it is difficult to establish whether New Zealand facilities currently attain equivalent outcomes.

Not all health professionals agree that specialised segregated homes for the demented are preferable. Some health professionals have argued strongly on ideological grounds that segregated units reduce any possibility for improvement because all residents have low functioning. However, this view does appear to be a minority one with most workers in the field agreeing that it is more detrimental to mix behaviourally disturbed older people with dementia with their more functional peers.

What is clear is that behaviourally disturbed patients require higher levels of care and supervision. The Stage III subsidy scheme was a government response to an ADARDS
(Alzheimer's Disease And Related Disorders Society, now Alzheimer's Society New Zealand) initiative that provided extra funding in recognition of the increased level of care required to manage patients with behavioural complications of dementia.

The policy set guidelines, through the RHAs, for standards required by providers of services to be eligible for the scheme. However, despite the good intentions, the Stage III concept has not been developed to its full potential in New Zealand. The initial policy had problems for several reasons. The time frame for application prevented many suitable providers from applying for a Stage III licence, environmental regulations took precedence over regulations concerning standards of provision of care and the licensing regulations meant that the funding was tied to physical buildings rather than patients, as with the hospital subsidy. The total number of places was capped at 720 for the whole of New Zealand and available places were quickly occupied. Dementia is a progressive disease and complicating behavioural disturbances usually diminish in the later stages. Whereas initial assessment of patients was required to gain the subsidy, no review process was set up to assess ongoing need for this type of care for the individual. This lack of review together with limited total Stage III places has caused a bottleneck for newly presenting patients requiring Stage III places.

7.5.9 Patients with psychiatric disability

The de-institutionalisation process has highlighted a gap in service provision for a small but important group of patients with longstanding psychiatric disability which cannot be regarded as age related. These patients were previously cared for in psychiatric hospitals, but with increasing closure of psychiatric institution beds, there are few suitable facilities for these patients, many of whom have spent much of their life in care. In addition, this client group does not meet current criteria for special residential funding for either private hospital subsidy or Stage III, which represent the appropriate level of funding for the care required. At least one private hospital is now providing care for such patients funded and supported by public mental health services. At the present time this novel provision of care has not been fully evaluated.

7.6 Requirements for integrated care

7.6.1 Access to dedicated assessment and treatment inpatient psychiatry units

Ideally separate facilities should be available for patients with dementia and for those with functional disorders, as this allows for the development of more focused programmes for different disorders. Inpatient assessment units should be in close geographical and functional proximity to geriatric, medical and diagnostic services to facilitate efficiency of aged care services.
7.6.2 Multidisciplinary community assessment, treatment and assertive follow up

Such teams can prevent inpatient admissions and treat less serious functional and cognitive disorders in the patient’s own setting, which is less stressful for families. An Australian survey of hospital admissions for psychiatric disorders in old age found that readmission within 30 days of discharge was usually due to compliance failures with medications and side effects of drugs, all of which can be prevented by close follow-up\(^5\).}

7.6.3 Access to specialised facilities

Provision of day programmes that deal with specific goals of treatment can provide support and treatment for patients with depression, anxiety, grief, difficulty in coping and memory difficulties. In addition, access to respite care for caregivers enables them to continue to care for relatives at home as long as possible with appropriate supports.

Access to special facilities would include those which provide specialised care for behaviorally disturbed demented people as well as specialised long stay care facilities for medically well patients with psychiatric disabilities who require supervision.

7.6.4 Access to community based services.

This includes access to other aged care services in order to provided integrated care, Meals On Wheels, Home Care 60s plus and Day Care facilities.

7.6.5 Mental Health promotion and early intervention

Considering that stress and loss are well known to be contributing factors to the development of mental health problems in late life it is perhaps surprising that mental health promotion and early intervention have not had greater prominence. While some excellent programmes already exist to help older people psychologically adjust to retirement, bereavement, changing social roles, loneliness and illness, these could profitably be extended to reach more people at risk. Such programmes\(^6\) have been shown to be effective in preventing the development of more serious depression and anxiety disorders which can have profound effects on quality of living at best and may lead to premature or unnecessary institutionalisation.

Prompt diagnosis, early intervention and plentiful education for caregivers have important places in the care of older people with dementia. Many challenging behaviours are the result of anxiety and fear in a patient who cannot understand the meaning of environmental stimuli. These behaviours may often be avoided by quite simple environmental interventions that can be easily taught to caregivers. The provision of adequate information, practical guidance and support networks builds confidence and coping skills in caregivers, which in turn can reduce anxiety and difficult behaviours in patients.
8 Cultural and Bicultural Perspectives

Although the life expectancy of Maori has improved this century, it remains well behind that of Pakeha. A 1989 report\textsuperscript{64} cites the differences as minus 7 years for men and 8.5 years for women. This has raised questions as to whether the legal definition of ‘elderly’ for Maori, on which eligibility for national superannuation is determined, should be set at a lower age than for Pakeha\textsuperscript{66}.

In New Zealand there seems to be little data on the social and health needs of older Maori and Pacific Islands people. Information on, for example, comparative rates of disability in the community and use of health care facilities by the older members of the various cultural groups represented would be helpful for planning purposes. Research in these areas by representatives of the various ethnic groups is needed.

Although the mix of illness and disability may vary from one cultural group to another, the types of disability and their causes are similar. All cultural groups have the same needs for access to personal health care and to rehabilitation. For many Maori, as indeed for members of all minority ethnic groups in New Zealand, there is a need to ensure that health care and rehabilitation take place in a culturally sensitive and environmentally friendly atmosphere. Of particular importance is an understanding of cultural perceptions of disease and healing and of the nature of the body. For example, to Maori certain parts of the body, the head, the breast and the pelvis, are considered to be tapu (sacred) and some routes of drug administration, rectal and vaginal, may be considered to be inappropriate\textsuperscript{66}.

As discussed in Section 2, the number of Maori aged 65 and over is projected to increase significantly over the next 35 years, creating a demand for culturally appropriate community and residential services.

8.1 Strategies for providing more effective health care

If health care is to be effective for all cultural groups, it will be necessary to:

- provide health services staffed by Maori or Pacific Islands people
- train greater numbers of Maori and Pacific Islands people to staff health care services for older Maori and Pacific Islanders
- train health care workers of European descent in cross-cultural skills so that they can care for older people of other cultures in a sensitive manner.
• appoint Maori and Pacific Islands people to managerial positions in the service
• consult with Maori and Pacific Islands leaders when planning new service development
• provide qualified interpreters, and have translations of health care documents and information sheets readily available for people who are not comfortable with English language.

8.2 Long term care for Maori and Pacific Islands people

For some members of all cultural groups, rehabilitation will not restore independence, and the individuals concerned will require residential care or home support. The role of the extended family in the long term care of elders, while of considerably greater cultural importance to Maori and Pacific Islands families than European families, should not be taken for granted. In the urban setting especially, these families have similar pressures on them to pakeha families: married women in the work force, smaller families to share the burden of caring, geographic separation because of the locality of work, less contact with the Maori or Pacific Islands communities and so on. When under these circumstances the old people end up in long term residential care, it should not be seen as a negation of cultural values.

Rural Maori are, in addition, more likely to be economically disadvantaged than pakeha, be housed in circumstances which are not so favourable to the presence of additional disabled family members and be distanced from support services. There is on the positive side though, often good support from the local community. Nevertheless, such families require special consideration and innovative approaches to support: for example it may be appropriate to pay a family member to act as full-time carer.

Some iwi have sought to meet the challenge of their older people by developing ‘kaumatua flats’ on local maraes. Foster-care of older Maori is also practised. These approaches are indicative of the innovations in long term care which are possible and which preserve contact with the cultural and spiritual life of the community.

However, for the reasons outlined above, the use of rest home and hospital level care by Maori and Pacific Islanders is relatively high in urban areas. In the long term residential care studies in Auckland of 1988 and 1993, Maori and pakeha were occupying residential care beds at the same rate of 69/1000. Pacific Islands people were using beds at approximately half this rate67.

Contracts for the provision of home help have, in some urban areas with high densities
of Maori and Pacific Island residents, been let by RHAs to pan-tribal and pan-island community groups to manage; and in Northland (and possibly elsewhere) to a group representative of the predominant iwi. Such initiatives are to be applauded but they are not without problems which will require careful negotiation. The desire of each iwi or island group to have its own organisation for the sake of local identity has to be balanced against possible service fragmentation and loss of economies of scale.

8.3 Improving understanding of health care options

The extent to which older Maori and Pacific Islands people have recourse to use of traditional remedies and traditional healers instead of, or in addition to, Western health care is unclear. There is a need for health professionals to develop greater understanding of the personal use and value of traditional remedies to people of different cultures and respect for their use. There is also a need for educational programmes among the various ethnic groups to explain what is available by way of publicly funded health and disability care. Such programmes would be best undertaken by trained people from the ethnic groups concerned.

8.4 People for whom English is not their first language

There is already in New Zealand a significant minority of immigrant people from a wide range of ethnic backgrounds including Pacific Islanders, Chinese, Japanese, Dutch, Yugoslavs and Indians for whom English is not their first language. A minority of these may not be able to converse with any fluency in English. Even when fluency has been achieved it is a common experience to find that after a severe illness, typically a stroke, an older person may lose fluency in English and be able to communicate only in their original tongue. This creates difficulties for health service and home care providers and highlights the need to use qualified interpreters and translations of health care documents. It is suggested that research into the viability of single-language residential care facilities in the main centres for at least the larger cultural groups represented is required.
9 Research and Training

Research and training are likely to be forgotten in any discussion of health care for elderly people which focuses exclusively on service provision. We wish to emphasise that research and training must be considered to be priorities.

9.1 Research

At several points throughout this paper reference has been made to the need for research-based information. Of specific concern from the viewpoint of this paper is an apparent lack of recognition by health administrators that new service initiatives require careful scientific evaluation as to their overall impact. We believe that RHAs should not fund new programmes without the implications first being evaluated in properly designed pilot studies. In the UK there is a strong tradition of academic evaluation of health services and there is enormous scope for contract research in this country. There are major difficulties in running such pilot studies: a range of research methodologies and complex statistical analyses are required, but in our view they are essential and should be planned with advice from competent statisticians. Many of the research priorities recommended by Koopman-Boyden in 1975 remain pertinent.

The question is often raised as to why research on health care issues should be undertaken in New Zealand. The implication is that it would be preferable (and cheaper) to use research data obtained from overseas studies. We believe that such a short sighted attitude can only be detrimental to health care in New Zealand. The justification for undertaking research in New Zealand can be summarised as follows:

- Information is needed on health trends and disability levels in the New Zealand context. The population in New Zealand is not the same as in any other country including Australia. There is a different ethnic mix, different age structure, different local trends in rural and urban areas and different risk factors.
- The mix of health care services developed in New Zealand is unique to New Zealand and therefore needs to be evaluated in New Zealand.
- Solutions to uniquely New Zealand problems are likely only to be found in New Zealand.
- Research ensures ongoing evaluation of programmes and methods. It is a way of learning and of bringing discipline to the provision of health care.
- Careers in health care for older people should be attractive as a vocational option to highly skilled and motivated health professionals and scientists who can...
contribute much to its effectiveness. Such people need the intellectual stimulation of research opportunities. They have open and enquiring minds and are constantly wanting to search for better ways of doing things.

It is our belief that at the present time too little funding is earmarked for research into health care of the elderly, the needs of carers and the effect of a person's environment on the quality of their life. There is intense competition for the research dollar in New Zealand. We acknowledge and commend those RHAs which have begun to fund contract research into health service delivery for older people. We believe that this is the beginning of what should become an important trend.

Academic and large hospital units and the Centres for Health Services Research at Victoria and Auckland Universities have the expertise to mount health services research, as do departments of Social Sciences and Economics and Management in the Universities. Some types of research would be enriched by linkages with the private and/or voluntary sectors.

The authors believe that there are many research questions relating to service development and the evaluation of existing services which are of national interest. Because of this we believe that it is time to consider the formation of an inter-RHA Research Purchasing Agency along similar co-operative and administrative lines to PHARMAC to commission and purchase research on health services policy and development for older people. Examples of research investigations which are urgently needed are:

- current levels of disability among the older population
- trends in disability over time
- improved ways of delivering services to older people
- improving the effectiveness of rehabilitation methods
- health service needs of older Maori and Pacific Islands people
- sickness and disability prevention (e.g., fall prevention)
- effective methods of health promotion and education of older people

A multidisciplinary approach to research is highly recommended.

9.2 Audit

A strong case has been made in this report for a unified approach to health care for older people notwithstanding the fact that services are provided by a mix of public, private and trust-based organisations. It has also been noted that the devolution of long term
residential care from the public to the private sector has placed greater responsibilities on general practitioners and restricted the access of geriatricians to this group of older people. Also highlighted is the interest shown by providers of long term residential accommodation in accreditation of their facilities.

These interests could all be facilitated by a greater involvement of CHE-based geriatricians in educational and audit support for the residential care sector. There are in fact several examples of such co-operation already in existence. They include the involvement of the Academic Department of Geriatric Medicine in Christchurch in independent audits of standards of care in local private hospitals, the provision under contract of staff education and audit for several private hospitals on Auckland’s North Shore by the Academic Department of Geriatric Medicine of the University of Auckland and periodic ward rounds and teaching sessions by geriatricians from other Auckland CHEs in local residential care facilities. This is a trend that demonstrates a commitment to improving standards of care and communication between services and it should be encouraged. The major barrier to wider employment of such initiatives is the availability of personnel and financial resources.

9.3 Training

There is at present little co-ordination in the training of people working with the elderly, whether they be health professionals, administrators, providers of home help, members of voluntary organisations or family members. We believe that specific training programmes must be developed at varying levels of intensity for all these groups. Some of the major cities have postgraduate gerontological courses for nurses and the Royal Australasian College of Physicians has a specific training programme for doctors wishing to specialise in geriatric medicine. It is of special concern that many general practitioners work with ageing practices and/or in providing medical services to rest homes and private long-stay hospitals but have had no formal training in geriatric medicine themselves. A Diploma in Geriatric Medicine is planned for 1996 in the University of Auckland but it failed to attract sufficient interest to start in 1995. We believe that the management of all residential care institutions should require that their medical practitioners have undertaken specialised study in geriatric medicine. We are concerned also that there are ad hoc programmes only for the training of researchers in the health care of the elderly. Funding needs to be set aside for this. In the late 1980s several supernumerary positions were funded by the Health Department under the Shortage Specialty Scheme. These positions enabled not only additional specialists to be trained but also enabled them to obtain training in research methodology. Funding for the programme was withdrawn in the early 1990s.
Several academic institutions in the United Kingdom provide diploma courses in health care of older people for lay and professional people whose work is in this field. Such courses do not require a University degree as a prerequisite. There is clearly room in New Zealand for the development of similar courses.

It is of concern that innovative programmes for community care may be developed by RHAs without appropriate training for those running them. Examples are case management and quick response team initiatives. There is, in New Zealand, a small core of people who have experience in these areas. Their expertise in training others should be made available on a nationwide basis.
A framework for setting goals and strategies for service development is suggested by the Ottawa Charter which, although focusing on strategies that address the determinants of health at a population level rather than the consequences of ill health at an individual level, does call for the setting of goals and the development of action strategies. The strategies aim to address equity, health promotion, the strengthening of primary health care, participation and community action, healthy public policy, and intersectorial and international co-operation. These are all issues which we believe are of fundamental importance to this project.

In proposing the following goals and strategies we acknowledge that some of them have already been met by some health authorities. Our concern is however, for an even spread of health care policies and services for older people throughout the country. For example, the fact that RHAs are obliged under the Health and Disability Services Act to consult does not mean that they are all doing it appropriately.

10.1 Policies and programmes

Goal: The development of a national set of policies relating to the health of older people, recognising different ethnic needs, which will be the basis for purchasing decisions by RHAs and planning by public, religious and welfare and private sector providers.

Strategies:

- the formation of a Unit or other administrative grouping representative of the Ministries of Health and Senior Citizens, the Department of Social Welfare and the Accident Rehabilitation, Compensation Insurance Corporation, to formulate and monitor national health goals and policies for older people and integrate across all government sectors, policies which may impact on the health of older people
- the development of national health goals and policies for older Maori and Pacific Islands people in partnership with these respective communities
- the commitment of RHAs, CHEs and private providers to real consultation with the older public and with health professionals when planning new services or changes to services. The establishment of formal consultative groups could be a
way of achieving this

• the commitment of RHAs and CHEs to a policy of partnership with Maori, and with other ethnic groups such as Pacific Islands, Asian, Indian and Dutch communities when planning new services or changes to services. The appointment of administrative staff capable of liaising with these communities in a culturally appropriate fashion could be a way of achieving this

• the commitment of health services for older people to policies of appointing Maori and Pacific Islands people who are suitably qualified to administrative and service positions. This implies more than an EEO policy: it implies a strategy of actively seeking to encourage suitably qualified people to apply for such positions

• the commitment of RHAs to developing policies and programmes consistent with the concept of ‘ageing in place’. This will require that they are prepared to commission and purchase pilot programmes designed to facilitate this policy and ensure that these programmes are evaluated in a scientific manner

• identification by RHAs of special groups within the older population who have specific needs and commitment to developing purchasing policies to meet those needs. Such groups will include ethnic minorities, carers and the geographically isolated

• active promotion of multidisciplinary health promotion and education programmes for older people, supported by a national programme developing appropriate resources. Programmes designed for Maori and Pacific Islands people will need to employ representatives of these communities in their development

• agreement on sickness and disability prevention programmes for older people which are to be actioned nationally and locally. The following priorities are suggested for such programmes: anti-influenza immunisation, fall prevention, anti-smoking, early detection of cervical, breast and prostate cancer, physical fitness, psychological and emotional health and bone protection.

10.2 Services and Providers.

Goal: Agreement on a national framework for comprehensive health care services for older people in various settings both geographical (urban and rural) and cultural, which will be regarded as authoritative by all parties involved in the planning, purchasing and provision of health care including government departments and ministries.

Strategies:

• national consultations on guidelines for health services for older urban and rural people and for older Maori and Pacific Islands people
• national consultations about models of residential care best suited to meet the future needs of New Zealand's ageing population

• the adoption of appropriate case-mix models for funding health care services for older people which can be standardised nationally, in recognition of the inappropriate nature of classical DRG-based models

• a review of the SNL4—SNL5 interface with a view to developing guidelines and if necessary regulations for determining responsibility for the care of residents with deteriorating health in residential care

• a review by the RHAs, of the contribution of voluntary agencies working with older people with a view to resourcing their administration

• CHE-based health services for older people in each health district to be united under a single administration covering both hospital and community services, geriatric medicine and psychogeriatrics

• careful development of quality of service monitoring so as to focus on key outcomes, that it be service-centred, supported administratively, and strategic in the sense of having an impact on service development both locally and nationally. Indicators chosen should be agreed in discussion with service managers and clinicians.

10.3 Training

Goal: That all staff involved in the provision of health care for older people be trained to the work skills level appropriate to their contribution to the service.

Strategies:

• employment contracts with staff members (including administrative staff) should include requirements for in-service training and continuing education. Funding should be built into health service contracts to allow such training and opportunities for educational conference leave for health professionals. Staff of voluntary organisations should also receive appropriate training

• all staff should be trained in cross-cultural skills with Maori and Pacific Islands language acquisition encouraged.

10.4 Research

Goal: That decision-making in health care services for older people be based as far as possible on researched information.
Strategies:

- the formation of an inter-RHA Research Purchasing Agency to commission research on health service policy and development for older people
- agreement that all new service initiatives whether sponsored by the Ministry of Health, RHAs, CHEs or the private sector be subjected to scientifically designed pilot studies prior to formal adoption.

10.5 Advocacy

Goal: That networks between the organs of government and community and professional organisations concerned with the health and welfare of older people be strengthened and formalised in order to improve the flow of information to government decision-makers.

Strategies:

- appropriate funding of organisations such as Age Concern which advocate for older people in the community
- consultations between the Advisory Council to the Minister for Senior Citizens, the Ministry of Health, the Senior Citizens Unit of the Department of Social Welfare and community and professional groups as to how this goal might be achieved.

10.6 Information

Goal: That every older person will have readily available information about wellness strategies for living and types of support and means of access to it, should ill-health strike.

Strategies:

- establishment of a national programme for the preparation and dissemination of information on normal ageing and wellness strategies for living
- RHAs to be responsible for ensuring that information about health services, professional assistance, sources of informal support and other relevant information about services provided by CHEs, private sector, religious and welfare organisations, and voluntary organisations be available to older people at regional and local levels
- health care professionals should be encouraged by their professional organisations to disseminate information about models of service delivery and other treatment and rehabilitation initiatives which have been shown to be effective through their conferences and by publications in local journals.
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The authors wish to record their thanks to the following who commented on the draft of this document. As a result of their help many additions have been made to the final draft which have considerably added to the depth of information and wisdom of the final product.

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Physician, Health Services for the Elderly, Auckland Healthcare

Dr Margaret Guthrie  
Chairperson Advisory Council for Senior Citizens

Dr Margaret W Guthrie  
Consultant Gerontologist, President, New Zealand Association of Gerontology

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Jane Yoong  
National Director, Age Concern New Zealand
We gratefully acknowledge responses made by the following groups and individuals.

*Questionnaire for voluntary and private organisations involved with older people*

The questionnaire was sent to the central organisation where possible, with an invitation to consult more widely if thought appropriate. Not all have responded

Age Concern Ashburton	 (Jennifer Audeau)
Age Concern Canterbury	 (Mike Harvey)
Age Concern Hamilton	 (Karen Berisman)
Age Concern Kaitaia and District	 (D M Archer)
Age Concern Mid North	 (Jill Williams)
Age Concern Mt Maunganui	 (J R Laybourn)
Age Concern North Shore	 (Janferie Bryce-Chapman)
Age Concern Otago	 (Don Herd)
Age Concern Southland Old People's Welfare Council	 (Peter Ide)
Age Concern Taranaki	 (Jo Rodrigues)
Age Concern Tairawhite	 (Janice Petty)
Age Concern Tauranga	 (Rob Chalmers)
Age Concern Wairoa	 (Julie Turner)
Age Concern Wanganui	 (Lys Noble)
Age Concern Wellington	 (Norman Wright)
Age Concern Whangarei	 (Beryl Wilkinson)
Aged Care Complex	 (Margaret Brazier)
Auckland City Mission	 (Rev. Jeny Terrell)
Doubtless Bay Retire and Live Group	 (Committee)
Presbyterian Support	 (Helene Willis)
Elder Care Presbyterian Support Services	 (J Blackler)
Presbyterian Support Home Care Services	 (Sue Caiger)
Elmwood Village, Manurewa	 (Jan Stokes)
Auckland Home Support Services, PSS	 (Ann Robertson)
Presbyterian Support Services Melrose
Presbyterian Support Services (Northern)
Home Support Services Tauranga, PSS
Multiple Sclerosis Society of Auckland
Parkinson’s Society
Stroke Foundation NZ
The Selwyn Foundation
Trevellyn Home and Hospital

Responses on behalf of Crown Health Enterprises

Alan Davis, Northland
Jonathan Baskett and Pam Melding, North Shore, Auckland
Roger Harris and Lynn Leadley, Auckland Central
Jeff Okpala and John Strachan, Auckland South
Paul Freidman Waikato
David Spriggs and Chris Perkins, Auckland West
Pam Greenaway, Whakatane
Murray McDonald, Lakeland, Rotorua
Michael Kingston, Gisborne
F B Atcheson, Taupo
L M Taylor, Taranaki
J Fisher, Hawkes Bay
John Rivers and J Cantillon, Wanganui
Fred Hirst, Palmerston North
Karen Palmer, Wellington
Yogu Pasupati, Hutt Valley
S K Jayathiara, Masterton
Rob Blackbeard, Nelson
Lynda Scott, Marlborough (Blenheim)
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Rosalind Allen-Parker, Health South Canterbury
Prof. A J Campbell, Dunedin
Frank Tyree, Southland

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Joanna Broad and Adrian Collier

Typing Services
Pam Andrew
Jill Roberts
References


3 The WHO definitions of disability, impairment and handicap are included as Appendix B


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Appendix A

Purpose of Contract

The Core Services Committee requires advice on priorities for the range, quality and terms of access for services that should be publicly provided to meet the needs of older people.

Services to be provided by the Contractor

A paper is to be prepared by Professor David Richmond, Dr Jonathan Baskett and Dr Ruth Bonita on services to meet the need of older people. The paper should address the following:

- Identify the population groups including family and caregivers.
- Identify the circumstances that produce needs for care for older people.
- Assess, in general terms, the extent to which there are current gaps or excesses in meeting these needs. Home Care Services, Long-term residential care and psychogeriatric care should be included.
- Identify the range of services that might meet the needs of older people.
- Define the priorities and recommend terms of access and indications for these services using the following framework:
  - what are the benefits
  - is the service value for money
  - is it fair
  - is it consistent with communities’ values

Performance measures

Draft paper to be completed by 13 May 1995.

Paper to be submitted for peer review to agreed individuals and groups.

Final paper incorporating comments from peer review to be completed by 30 June 1995.
Appendix B

Definitions of Impairment, Disability and Handicap

World Health Organisation definitions

*Impairment*

"Any loss or abnormality of psychological, or anatomical structure or function".

Impairments are disturbances at the level of the organ which include defects or loss of limb, organ or other body structure, as well as defects or loss of mental function.

*Disability*

A "restriction or lack of (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being".

It describes a functional limitation or activity restriction caused by an impairment. Disabilities are descriptions of disturbances in function at the level of the person.

*Handicap*

A "disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual”

Handicap describes the social and economic roles of impaired or disabled people that place them at a disadvantage compared to other people. These disadvantages are brought about through the interaction of the person with specific environments and cultures.
CARE FOR OLDER PEOPLE IN NEW ZEALAND

(This questionnaire is part of a survey being conducted by the University Geriatric Unit, North Shore Hospital, on behalf of the Core Services Committee, queries to Dr J J Baskett, Ph: 09 486-1491 ext 2830).

QUESTIONNAIRE (LOCATION

Name of person completing this questionnaire Phone

(Please complete this so that we can acknowledge your contribution in the report).

A. COMMUNITY SERVICES AND LONG-TERM CARE Which of the following services are available in your health district?

Please tick the boxes if available, leave blank if not available. You may wish to complete this section in conjunction with representatives of your Community Services.

1.0 Long term Care (Residential (Rest Home) and Nursing Hospital)

1.1 Residential Care in your area:

   a) is provided by private or religious and welfare organisations
   b) is provided by public (CHE) sector
   c) Stage III beds are available

1.2 Hospital Care in your area:

   a) is provided by private/religious and welfare organisations
   b) is provided by public (CHE) sector

1.3 What is the approximate balance between private/R & W (combined) and public (CHE) provision of these services? (eg 50:50, 75:25)

   Rest home level
   Hospital level

1.4 Do you consider the total number of residential care (Rest Home) care beds available to be adequate in your area?

   Comment

1.5 Do you consider that the total number of long term care nursing/hospital beds available to be adequate in your area.

   Comment

2. Respite Care/Intermittent Care (by short-term admission) in your area

   (Tick box if available in your area)

   a) is provided by private/R & W organisations
   b) is provided by public (CHE) sector (using CHE beds)
c) has provision for respite care over and above the 28 day to Families Scheme.  

☐ ☐

d) has dedicated beds co-ordinated by dedicated employee (eg nurse practitioner)  

☐ ☐

e) has dedicated beds co-ordinated by Health Services for Elderly (HSE staff)  

☐ ☐

f) Uses 28 day relief to families scheme only  

☐ ☐

Other comment

3. Day Care (NB Not Day Hospital or Day Ward) is:  

Yes No

a) Provided by private/R & W sector  

☐ ☐

b) Provided by CHE  

☐ ☐

3.1 Is Day Care provision adequate for your area?  

☐ ☐

Comment

4. Hospice/Palliative Care (beds) Does your area have hospice beds  

Yes No

If yes please answer below:

a) Provided by private/R & W sector on contract to CHE.  

☐ ☐

b) Provided by private/R & W sector but not on contract.  

☐ ☐

c) Provided by Hospice Foundation or similar.  

☐ ☐

d) Public hospital beds used (CHE).  

☐ ☐

4.2 Are hospice services adequate for your area?  

Yes No

☐ ☐

Comment

5. Community Consultations (for GPs, RHs etc)

5.1 For assessment of health status are provided  

Yes No

a) By private organisations on contract (specify)  

☐ ☐

b) By teams from the public sector  

i) Health Services for Elderly (medical)  

☐ ☐

ii) Mental Health Services for Older People  

☐ ☐

5.2 For assessment of support needs level (SNL) are provided:

a) By private organisations on contract  

☐ ☐
b) By teams from the public sector

i) Health Services for the Elderly (medical)

ii) Mental Health Services for Older People

6. Community Rehabilitation (Physio/OT/SW/ST etc) provided

   a) By private organisations on contract
   b) By the Community Health Service of the CHE

   6.1 Are these services adequate?

   if “no”, please explain

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

7. Meals on Wheels (readily available)

8. Continence Service (readily available)

9. Ostomy Service (readily available)

10. Prosthetic Limb Service (readily available)

11. Quick Response Teams (QRT) (Community services team who can provide short term care in the home at short notice available 365 days/yr)

   Comment __________________________________________________________________

12. Home Help Services provided by:

   a) Private organisations on contract to CHE
   b) CHE staff

13. Case Management/Client Service Coordination provided by:

   (manage a flexible budget to organise and monitor extra services to support frail older people at home)

   a) Private organisations on contract to CHE
   b) CHE staff

14. District Nursing Type Services

   a) By private organisations on contract to CHE
   b) By CHE staff
15. **Health Promotion and Education**
   a) By CHE staff
      ☐ ☐
   b) By other organisations
      ☐ ☐

16. **Is Age Concern active in your area?**
    ☐ ☐

17. **Please list any other services you have available not mentioned above**

   __________________________________________
   __________________________________________
   __________________________________________

18. **Which of the following organisations are active in your area?**

   ADARDS/Alzheimer Foundation ☐ Parkinson's Society ☐
   Hospice Foundation ☐ Stroke Foundation ☐
   Cancer Society ☐ Motor Neurone Disease ☐
   Other

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

19. **What other community-based services not listed by us, are available in your area?**

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
20. What community-based services would you like to see established in your area?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

22. Are there any needs of older people that are overserviced in your area? Yes No

If "yes", what are they?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

B. PUBLIC HOSPITAL SERVICES

Which of the following services are available in your hospital? Please tick the boxes if available, leave blank if not available.

1. Inpatient Assessment and Rehabilitation (Medical)

If "yes" please answer below:

(a) Number of beds ____________________________
(b) Number of physiotherapists ____________________________
(c) Number of occupational therapists ____________________________
(d) No. of speech therapists ____________________________
(e) Number of house physicians ____________________________
(f) Number of registrars ____________________________
(g) Number of consultant geriatricians/physicians for elderly (as FTEs) ____________________________
(h) Number of community nurse practitioners attached to your unit. ______
(i) Number of social workers. ____________________________
2. **Day/Hospital (Ward) Rehabilitation service**

   If “yes” please answer below

   (a) Number of places ____________________________

2.1 Is this number of places adequate for your catchment?

3. **Outpatient Clinics (run by your service).**

3.1 Follow-up clinics

3.2 Specialty clinics eg osteoporosis memory etc (list by name)

5. **Clinical Psychology Service**

6. **Specialist Consulting Services**

   (a) On site: Urology

   Gynaecology

   Dermatology

   Ophthalmology

   Audiology

   Neurology

   Oncology

   Cardiology

   Respiratory

   Gastro/Endoscopy

   Rheumatology

   Orthopaedic

   Haematology

   Psychogeriatric Service

   Other (list)
### (b) Off Site: (Patients must travel to another site to access service)

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Urology</td>
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<tr>
<td>Gynaecology</td>
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<td>Dermatology</td>
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<td>Ophthalmology</td>
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<td>Audiology</td>
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<td>Respiratory</td>
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<td>Gastro/Endoscopy</td>
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<td>Rheumatology</td>
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<td>Orthopaedic</td>
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<td>Haematology</td>
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<tr>
<td>Psychogeriatric Service</td>
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<tr>
<td>Other (list)</td>
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</table>

### (c) Other sources available not listed above

____________________________

____________________________

7. **Adequacy of the Inpatient/Day Patient Service Provision**

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Ad</th>
<th>Inad</th>
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<tbody>
<tr>
<td>Junior medical staff (H/P and registrar)</td>
<td></td>
<td></td>
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<tr>
<td>Senior medical staff (geriatricians)</td>
<td></td>
<td></td>
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<tr>
<td>Therapy staff</td>
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<tr>
<td>Nursing staff</td>
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</tbody>
</table>

7.1 On what basis do you judge adequacy? (eg guidelines/waitingtimes/comparison with outside, or FTE)
8. Do you have access to:
   Cultural advisors? □ Yes □ No
   Interpretation Services? □ Yes □ No
   Patient Advocacy Services? □ Yes □ No

9. Is there a satisfactory Complaints Service? □ Yes □ No

10. Do you have adequate ancillary services? □ Yes □ No
    (a) Laboratory □ Yes □ No
    (b) General radiology □ Yes □ No
    (c) CT scanning □ Yes □ No
    (d) MRI □ Yes □ No
    (e) Endoscopy □ Yes □ No
    (f) EEG □ Yes □ No

Any comments about your service?
______________________________________________
______________________________________________
______________________________________________

C. OLD AGE PSYCHIATRY (MENTAL HEALTH SERVICES FOR ELDERLY PEOPLE)

1. Inpatient Facilities □ Yes □ No

If “yes” please answer below (give FTEs where appropriate)

a) Number of beds ____________________________
b) Number of dedicated therapists __________________
c) Number of house physicians __________________
d) Number of registrars _________________________
e) Number of old age psychiatrists ________________
f) Number of social workers ______________________
g) Access to special medical physician
2. **Community-based Facilities**

If “yes” please answer below (in FTE)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Number of community psychiatric nurses</td>
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</tr>
<tr>
<td>Old Age psychiatrists</td>
<td></td>
<td></td>
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<tr>
<td>Social workers</td>
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</tbody>
</table>

Other (please specify):

3. **Day Hospital Facilities (Dedicated to Old Age Psychiatry)**

If “yes” please answer below:

<table>
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<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Number of places available/day.</td>
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<tr>
<td>Number of places dedicated to assessment and treatment.</td>
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<tr>
<td>Number of places dedicated to day care only.</td>
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</tbody>
</table>

Other (please specify)

4. **Community-based care facilities:**

If “yes” please answer below

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<thead>
<tr>
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<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Number of dedicated day care facilities.</td>
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<tr>
<td>Number of Stage III residential beds.</td>
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<tr>
<td>Number of dedicated psychiatric long-term care hospital beds.</td>
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<tr>
<td>Number of dedicated respite care beds for psychiatric patients.</td>
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D. **DEMOGRAPHIC AND OTHER INFORMATION**

1. What is the size of the elderly population (65+) served by your health district?
2. Is your Unit served by an effective transport system e.g. bus/train? Yes □ No □

3. What (approximately) is the furthest distance a person in your Health District must travel to obtain A & R Services? ______________________

4. Have you or your CHE ever held community forums to gather opinions about the nature of services deemed suitable for older people? Y N DK
   (a) If “yes” when was the last such forum held? / / DK

   DD MM YY

5. What is your opinion about:
   (a) the access to A & R Services
   (b) the comprehensiveness of A & R Services
   (c) the funding/resourcing of A & R Services
   in your health district? Please answer below
   (all replies will be treated with strictest confidentiality)

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

16 What is your opinion about:
   (a) the distribution of/access to Community Services
   (b) the comprehensiveness of Community Services
   (c) the funding/resourcing of Community Services
   In your health district? Please answer below. (all replies confidential)

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

Please Return this questionnaire in the enclosed envelope to:

Dr Jonathan J Baskett
Care for Older People Project
Health Services for Older People
University Geriatric Unit
North Shore Hospital
Private Bag 93 503
NORTH SHORE CITY 9
CARE OF OLDER PEOPLE PROJECT
Questionnaire for Voluntary and Private Organisations involved with Older People

(This questionnaire is part of a survey being conducted by the University Geriatric Unit, North Shore Hospital, on behalf of the Core Health Services Committee)

This response is made on behalf of ___________________________ (organisation)

by ________________________________________ (please give your name so that we can acknowledge your contribution in the report).

(Please address any queries to Dr Jonathan Baskett, Dr Ruth Bonita, or Professor David Richmond Phone 09 486-1491 ext 2830)

1. Please describe briefly the main objectives of your organisation:

2. Approximately how many people over 65 yrs are registered with you? ______

3. How many of those people over 65 years is your organisation actively helping each week (approximate figures)?

4. Are you having to give support to some people who you think should be catered for by a professional (RHA funded) group? Yes No

4.1 If “yes” to above please specify:

5. In your opinion what are the BEST examples of care provided at present by professional RHA/CHE funded groups for older people in your area?

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6. In your opinion what are the BEST examples of care provided in your area of expertise by:

6.1 Voluntary organisations?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6.2 Private organisations

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

7. Please can you identify areas of UNFULFILLED NEED which should be provided for by RHA/CHE services:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

8. Are there unfulfilled areas of need in your area which would be BEST PROVIDED BY YOUR ORGANISATION? (Please specify).

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
9. Do you know any services for older people in your area of expertise which are OVERSUPPLIED OR OVERSERVICED?


Thank you for your help!

Please send this questionnaire back in the enclosed prepaid envelope to:

Dr J J Baskett
Care for Older People Project
University Geriatric Unit
North Shore Hospital
Private Bag 93-503
NORTH SHORE CITY 9