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7 September 2016

S16.18

Submission to the Ministry of Health on the Health of Older People Strategy: Consultation Draft

The National Council of Women of New Zealand, Te Kaunihera Wahine O Aotearoa (NCWNZ) is an umbrella group representing 288 organisations affiliated at either the national level or to one of our 20 branches. In addition to our organisational membership, about 260 women are individual members of branches. NCWNZ's function is to represent and promote the interests of New Zealand women through research, discussion and action

NCWNZ welcomes the opportunity to participate in this consultation process. Our submission has been prepared by the NCWNZ Health Standing Committee. We have sought information from members of the Health Standing Committee, from NCWNZ branches and from individual members.

Healthy aging

1a. The draft Strategy sets out a vision for the goal of healthy ageing. Do you have any comments or suggestions regarding this vision?

Men's life expectancy is shorter than women, however, in New Zealand, the combination of various health and social factors result often in a lower quality of life for women in later life. As widowers, older men tend to be more isolated than women due to perceived lack of male skills in developing social and familial ties. On the other hand, the persistence of gender stereotypes which, compounded by discrimination faced by older people in the labour market, particularly reduce the employment opportunities of older women; women's greater vulnerability in the labour market, due also to the impact of career breaks or taking time out of employment to engage in caring responsibilities on women's savings, which, together with the persisting gender pay gap, exposes women to a higher risk of violence, abuse and poverty in old age as compared with men. The Ministry of Health 2013/14 Health Survey26 found that women had a greater unmet need for primary health care than men (33 per cent of women versus 22 per cent of men).

A gender analysis should be applied no matter the issue being considered, for example, abuse, emergencies, health promotion, primary health care, supportive environments and income security.

We are generally in agreement with this vision although we are concerned that healthy and dignified ageing must involve a gender dimension, taking into account the specific needs of both women and men as well as the transition period given the nature of society at the moment and attitudes towards older people.

Resilience and equity are focuses we applaud. Resilience needs to be supported not only by family/whānau, but must also include support from friends, a positive community, church and organisations which provide information, stimulation and interaction. We all need to feel a sense of self worth, value and belonging. A lot of research has been done on the benefits of exercise in mature/elderly adults. It has shown that regular physical exercise improves circulation, mobility, appetite, digestion, movement, confidence, mood and social connectedness. Easy access to services that support independence and wellbeing is essential. Greater encouragement of people making social connections in ways that incorporate good health, diet, exercise and intellectual stimulation is important. At the same time encouraging people to make a positive contribution within their community (volunteering for example) is a positive step towards achieving the goal of healthy living.

Prevention of illness must be the emphasis going forward.

Having confidence in a positive future.

Regular health assessments must be encouraged where minor ailments such as hearing, eyesight, joint function, diabetes, cognitive capability, pathology, can be picked up before they become major problems and ensure appropriate and timely treatments/surgery.

Dementia education, awareness, support services and access to information is essential.

Abuse and neglect services easily accessed, awareness raising of signs and symptoms.

Housing that is age appropriate, affordable, supported, supervised and accessible.

Financial security is imperative. Education and planning for retirement must be available for the general population.

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing. Do you have any comments or suggestions regarding these actions?

Transport is a vital means for reducing social isolation. Access to public transport is as important for people living in retirement villages as it is for individuals living in their own homes.

Resourcing is essential on a needs basis. Professional health groups must work as leaders in partnership with other community groups/interested parties to get messages disseminated.

Education. Assist **older people** to become "Health Smart". Use various media options to improve people's knowledge and understanding of what to expect, the signs of change/symptoms of illness and degeneration, pathways and agencies that can assist and support and answer their questions. A strong focus on **younger people** to encourage planning of their individual health futures.

Educate the community on the worth and value of the older person. Focus on respect and acknowledgement of the worth of older people and highlight the skills they have acquired and their ability to contribute; for example – men's sheds, craft workshops, heritage research.

Educate medical and health support agencies of the need to **listen** with eyes and ears and wait patiently while older people articulate their concerns/worries. **Explain** treatments, medications and dietary changes. **Refer** to appropriate agencies. Many do this very well but there are still glaring gaps.

Ensure education and training opportunities are available to enable older people to become familiar with and skilled with up-to-date technology - Promote the use of Healthline and other on-line services such as on-line banking and encourage the use of Skype facilities so that aged and family can remain connected.

Educate older people not to answer the question "How are you today" with "I'm alright", when often they are presenting with serious concerns. Older people need time to gather their thoughts. They should be encouraged to write down concerns before the appointment.

Promote volunteering, networking and opportunities for older people to continue in paid employment. Maintaining skills, dexterity, cognitive stimulation, self management, self worth and community interaction are all beneficial for maintaining good health.

Support Green Prescription programmes – Move it or Lose it.

Plan for the later life infirmity/disability in the areas of housing and funded long term care.

Provide choices that enhance not diminish the twilight years.

Dental care is an area overlooked too often in older people. It is critical for health, wellbeing and independence. There must be education, information, treatment and provision available for on-going and affordable dental care.

Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care. Do you have any comments or suggestions regarding this vision?

Whilst we believe objectives are good, the strategy is light on detail regarding the crossover with long term conditions.

Communication is imperative. Communication is the best tool for ensuring that an older person is given/receives the optimum care and treatment for recovery and long term wellness. It is a combination of well trained clinicians, support staff and agencies in *combination* with family/whānau and community who are given/can give accurate, timely and understandable information to assist in reaching the goal of *recovery*. This is even more critical when the older person suffers from cognitive impairment, dementia, brain injury or inability to vocalise their personal needs/goals.

We acknowledge the increasing costs of hospital care and are aware older people are high users, *but* discharge from hospital before family and support services are put in place, jeopardises recovery of the old and frail. Far too often older people are put at serious risk and doomed to re-admittance.

We agree that family and whānau *must* be involved. We adamantly believe that the home-care/ District Nursing Service must be maintained at a high level of care.

We have heard very positive feedback on the "extended care paramedic model", please extend it.

Yes to streamlining assessments for home based services/shared care to enable reduction in duplication, or worse, not meeting needs because of delays or gaps.

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care. Do you have any comments or suggestions regarding these actions?

Discharge planning should be a priority and should start while the person is still in hospital and should support family/whānau and other support people, together with all relevant professionals to achieve good, long term results whether the person returns to their own home, a rest home or retirement village. All communications must be clear and simple. Consistency across regions is important because of the mobility of some people.

Paramedic roles. We support extending the role of paramedics for after hours triage, acute geriatric care pathways and applying technological solutions where practical.

Long term conditions. Commendable goals. The desire to provide the best possible living conditions, tools, support, information, home and care support, connected agency resources, structures and training must be developed into an accessible reality for all older people living with long term conditions *and* that they are equitable with outcomes for the population as a whole is commendable.

Respite care for the family/whānau must also be given much more consideration for long term cases.

There is a critical need for health, community and social sector agencies to identify and support older people with mental, alcohol or drug problems earlier, *before* situations become critical and long term harm is done/suffered. The need for inter-service sharing of information and flagging "at risk" people in our communities has become increasingly urgent as has the notification of older people abuse.

Encourage and support health professionals, social services and communities to become more dementia friendly.

Living well with long term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions. Do you have any comments or suggestions regarding this vision?

While the goals are good, we consider there is a great need for them to be well resourced for the long term.

Long term health conditions are the "Challenge of this Century". Currently 1 in 6 New Zealanders live with 3 or more long- term conditions and that is expected to increase. It was interesting to note that most of the long term conditions referred to mental health and drug and alcohol related conditions, with Alzheimer's and related dementia receiving little/or no mention.

We agree that the early detection and prevention of long term conditions *must* strive to implement improvement.

Training. Comprehensive training for all parties is particularly important. Training of health workers, carers and support agencies must be a priority. The better the information at every level of care the better the long term results. More real support and training must be provided for home carers, family and whānau members. This includes the group less likely to receive training for whom English is often only their second or third language. Accurate information must be circulated to ensure they do not become, or are made to feel isolated and/or inadequate.

Ongoing training and education is essential and must be part of the retention package for staff. At present, once recruited, there is very little opportunity for ongoing education for carers.

Improved links to support agencies is another avenue that must have better funding and connectivity. We are witnessing frail carers caring for frail, ill, long term older partners or parents being made to feel there is little, or more often, minimal help for them. Have you ever considered how very frightening that is? **It is not fair. It is not equitable.** We must, however, respect that there are some people who will reject any offers of help; whose pride prevents them from accepting help.

It is an unquestionable priority to deliver support systems that are focused and well delivered.

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions. Do you have any comments or suggestions regarding these actions?

Buy in from all sectors will be essential. Care will need to be taken to avoid further inequity with other groups in society, a factor which has probably contributed to these people suffering conditions in the first place.

Commendable goals. For older people to successfully and actively self-manage, many will need to learn how to be "Health Smart". The medical and health professionals are striving to improve information distribution, encouraging physical and mental stimulation and community connectedness. Government can contribute to this through funding education opportunities, providing well researched information and encouraging co-operation with Health Agencies. An excellent example is the ACC Falls Prevention Programme. With the right supports, the development of personal alarms and new computer technology, older people can be confident of maintaining independent living. This is an excellent goal.

Can older people afford the new technologies as proposed such as health apps, tele-monitoring and assistive technology? This sounds like a solution for urban communities for what is likely to be a

bigger problem in rural areas. There are at present large areas of the country where there are dead spots for phones and technological devices.

Support for People with High and Complex Needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs. Do you have any comments or suggestions regarding this vision?

Labelling people as "frail" was an expressed concern. Would this definition include emotional as well as physical frailty?

Respite care should be extended. The current 3 weeks allocation is not enough for those caring for a person with a long-term condition and/or complex needs. Whilst the goal to encourage people care for themselves and live in their own home for as long as possible is laudable, the onus on the caregiver can be huge.

People with high and complex needs are very vulnerable and too often exposed to negative attitudes that are both intimidating and frightening. The older person with complex needs requires time and patience to find pathways of resolution for treatments, together with co-operation and awareness of personal responsibility. Although they are unwell, frail and with complex needs, their access to medical services and treatments must not be compromised. Well prepared and co-ordinated service provision, linked to accurate information channels e.g. medical, surgical, pathology, X-ray and imaging would contribute greatly to reducing wasted time, repeated testing, delays in treatments and resolution of problems arising because of communication break down or conflict.

The introduction of InterRAI was a good step forward and an improvement, but it does take an enormous amount of professional time to input the information for each client and then to keep updated. For other professionals (e.g. doctor), it takes considerable time to read and absorb the case history of the individual client.

Integrated care must be improved and present barriers removed. New Zealand has become an ethnically diverse country and health service providers must be appropriately educated to give best care to everyone.

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs. Do you have any comments or suggestions regarding these actions?

How will help get to people who do not know they need help, or even if they do, choose to refuse consent for treatment?

A frailty identification tool will need to be an assessment tool that is qualitative and quantitative and supports best practice. It must be transparent and consistent across all regions. How will the right people be targeted and how will cost influence this?

Flagging frail older people at primary healthcare level is fundamental, as is including family/whānau when assessing and reviewing the complex needs required for successful care. Too often an older person will answer the question “How are you?” with “I'm fine”, when they very obviously are not. They do not want to “bother” the health professional. This is an attitude that has to change. Patients presenting must be able to explain what is wrong. Older people must be educated to understand and communicate their concerns, symptoms and confidently ask questions about their health and wellbeing.

Regular review of medications of people with higher and complex needs should also be required and adjusted, with the person’s changing health outcomes.

Accessibility for wheelchairs and affordable adaptations in homes may require educating of the building sector.

Providing continuity of care for people transitioning from their home to residential care and between regions must be multidiscipline, apolitical and well resourced. Intergenerational care programmes must also be supported.

Respectful End of Life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life. Do you have any comments or suggestions regarding this vision?

People talking comfortably about dying and preparing for death should be the most important aspect of this section. The Ministry of Health should be working across all sectors including volunteer groups, to encourage this.

There exists **a prevailing hesitancy** that causes many New Zealander's to defer discussing end of life care and death. This can lead to conflict and disagreement. Hospices throughout the country have worked very hard to improve information about the services they offer and have achieved some public awareness, but there are still big gaps in many people’s understanding about palliative and end of life care which needs to be addressed. This is an opportunity to discuss what will be required, clarifies and stipulates the who, what and when. Having an advanced care plan prepares for a smoother transition at end of life provided the document accompanies the frail person. Cultural requirements are considered and respected.

Palliative care, whether administered from a Hospice, public institution, rest home or home, should be government funded. Hospices should not have to fundraise for the shortfall of the DHB funding they receive.

Advanced care plans gives clear indication of a person’s wishes and who is responsible for ensuring those wishes are carried out.

Preparing and completing Individualised Care Plans, Enduring Power of Attorney and Advance Care Plans must be encouraged to enable carers to know the wishes and requirements of the older person.

Discussion with family/whānau enables fuller understanding of the needs/requirements of a loved one preparing for death. It also gives opportunities to tell our family/whānau stories.

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life. Do you have any comments or suggestions regarding these actions?

There needs to be training, resources, use of media etc to encourage discussion about the development of future care plans and the promotion of an exit list of how people wish to be treated at the end of their lives – not just medical care.

Care plans gives opportunity for discussing treatments, medications, personal requirements and personal needs. It clarifies for all involved the progression of end of life and gives opportunity to have questions answered

Staff members preparing the person and their family/whānau, travels this journey with them and it is imperative they are well trained, well supervised and well supported.

Funding of Palliative Care Services, training of providers and development of more Hospices must be a priority.

6. Implementation, measurement and review

Proposals for implementing, measuring and reviewing proposed actions must be well resourced, not only in terms of dollars, but also in people. Current data should be used to assess priorities e.g. more staff in dementia care. Good qualitative and quantitative measurements which can inform planning and implementation of interventions are essential.

Other Comments

Generally the heading “Lead” on pages 31-42 should read as “Partnerships”.

The challenge for this document will be the cost of implementation, with burgeoning numbers of baby boomers and resultant increase in the ageing population, along with the many social needs which must be dealt with now if this strategy is to be succeeded.

Resourcing according to needs is essential, with services moving from service-centred to people-centred and provided in a collaborative and integrated approach across all sectors including volunteers.

Age-friendly communities will require a mind-set change both with the population in general and with local governing agencies which control funding and must balance the numerous and various needs of the community as a whole.

Conclusion

NCWNZ's main goals regarding gender equality and the health of older people are that:

- Societies are free from any kind of age or gender-based discrimination.
- Healthy and dignified ageing must involve a gender dimension, taking into account the specific needs of both women and men.
- Older women and men are both included in their communities and their contributions are recognised.
- Older women and men receive equitable access to health and social services.

We are aware of the increasing expectations on the health dollar and the increasing expectations of New Zealanders for a readily available and accessible Health Service. The pressure on existing health services will continue to build with the increasing number of frail elderly needing access to services and support. The role of older women as both major providers and users of care services, and their reliance on health care and long-term care provisions are crucial gender issues.

We support the establishment of an outcomes & measurement framework and the planning & review process.

The draft Strategy is comprehensive and sets out a laudable pathway but gender discrimination must be taken into account. Thank you for the opportunity to make a submission on the Health of Older People Strategy: Consultation Draft 2016.

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