



FOREWORD

As part of Government's contribution to the International Year of Older Persons in 1999, the Minister for Senior Citizens allocated funding for a research project investigating factors that enable older people to maintain their independence.

I am very pleased to introduce this research to you.

With New Zealand's ageing population, it is crucial we continue to extend our understanding of the changes that we as a country need to make so we can best adapt to and benefit from this change.

The Government has a commitment to promote positive ageing. We know that many people express a preference to maintain their independence as long as possible.

This research has provided an opportunity for older people, and those who work with them, to suggest ways that Government, communities and individuals can contribute towards the Government's goal of maximising the independence of older New Zealanders.

I am sure that this research will make a useful contribution to future policy advice in this area.

I would like to thank the authors for their contribution to a very successful International Year of Older Persons.

A handwritten signature in dark ink, appearing to read 'Margaret Bazley'.

Dame Margaret Bazley, DNZM
Chief Executive
Ministry of Social Policy



PART I: INTRODUCTION

Introduction

This research was undertaken as part of the national observance of the International Year of Older Persons. The purpose of the research was to identify and investigate factors that allow older people to remain independent. The project was undertaken by Gray Matter Research and was jointly managed by the Senior Citizens Unit and the Research Unit of the Ministry of Social Policy. The findings of the research will be useful in the development of policy to meet the needs of an ageing population.

The context

As in other western countries, older people are growing as a proportion of the New Zealand population. In 1996, just under 12% of the population was aged 65 or over. This proportion is expected to peak at around 25% of the population in 2050. The most rapid increase will be in the “old old”. By 2031, people aged 80 and over are expected to make up 27% of the population of those aged 65 and over. The ethnic composition of this population will become more diverse as the proportion of older Maori and Pacific people increases. Maori are now 3% of older people, and are expected to be 5% of the older population in 2011. Pacific people are 1% of the older population now and expected to rise to 2% by 2011¹.

Ageing can involve not just superficial

changes but decreased mobility and dexterity, decreased strength and stamina, and reduced sensory acuity. Statistically, the probability of morbidity or illness and some disabilities increases with age. Older age is associated with an increase in the prevalence of chronic diseases including heart attack, stroke, arthritis, osteoporosis, cancer and dementia. Older people are also likely to suffer more severe non-fatal injuries from falling². Older people are often more affected by, and take longer to recover from sicknesses, such as influenza.

On the social side, ageing can involve isolation from family and friends, including the loss of peers. The composition of neighbourhoods may change as older people die or move out and younger families move in. To “age in place” successfully requires planning and often support from health and disability support services, as well as family, and physical changes to one’s home.

One of the key challenges facing government is to find appropriate, cost-effective and fiscally affordable ways to assist people to live independently.

The relationship between age, level of disability and living independently

Ageing does not occur at a uniform age or rate. There are different views on whether the expected average duration of disability and illness will increase, decrease or stay the same as life expectancy increases, with most seeing

¹ Statistics New Zealand, 1998, *New Zealand Now 65 plus*

² Smith, R., 1998, “The cost effectiveness of home assessment and modification to reduce falls in the elderly” in *Australia and New Zealand Journal of Public Health*, Vol.22 No.4, 436-440



the long-term links between longevity and the health of older people as unclear. One view is that medical advances and changes in lifestyle will compress the onset of mortality and disability into a shorter period. Another view is that the current experience, where improvements in health are not quite keeping up with increases in life expectancy, will continue. That is, on average, disability or illness will occur at older ages, but the period of disability or illness will be longer. A recent report on long-term care concluded that, for the United Kingdom, the best evidence suggests that factors that are causing people to live longer are also resulting in extra years of life being free of severe disability³.

Most older people do live independently. At the 1996 census, 92% of people 65 and over, and 87% of people 75 and over lived in private dwellings. That is, they lived at home, with or without family care or other health or welfare services. There are degrees of independence or interdependence amongst those living in a domestic setting. Most disabled older people, including those with severe disabilities and high dependency on others, presently live in private households.

On average, levels of disability and need for support increase with age. However, many older people with a disability⁴ or who are ill do not access formal support

services at all. In 1996/97, the disability rate for adults aged 65 -74 was 414 per 1000. More than half of these (384 per 1,000) had a disability requiring assistance. Adults aged 75 and over had a disability rate of 661 per 1000; with over half the people in this age group (550 per 1000) having a disability requiring assistance⁵. In 1996, 75% of adults over 75 with a disability, including those with a Level 2 or Level 3⁶ disability held a Community Services Card. Around 17% of New Zealand Superannuation recipients also receive a Disability Allowance, an income-tested and capped payment to cover regular, additional costs that arise as a result of a disability or ongoing illness.

As expected, older people receiving institutional care have a greater average level of disability than those who are living independently. There is, however, no unambiguous point of transition, and some people living independently have higher levels of disability than others who are in institutional care.

The research project

The New Zealand Government has a commitment to Positive Ageing. Government supports the principle that older people should be encouraged to remain independent and self-reliant as long as possible. At the time this research was commissioned, the Ministry of Social Policy, for example, contributed to

³ Royal Commission on Long Term Care, 1999

⁴ A disability is defined as any limitation in activity resulting from a long-term condition or health problem. Status is self-ascribed.

⁵ Health Funding Authority and Ministry of Health, 1998, *Disability in New Zealand: Overview of the 1996/97 Surveys*, p.73, also Appendix Table 3.10, p158

⁶ Level 2 represents those who require assistance to live independently, but do not require this assistance on a daily basis; Level 3 represents those who require intensive assistance on a daily basis.



government strategic result areas through the following key result goal: “Positive attitudes to ageing encourage and support older people to remain self reliant. Through this they can participate in their own well-being and that of their families.”

One of the goals of Disability Support Services⁷, funded through Vote Health, is to maximise independence⁸. This goal states that: “The Government remains firmly committed to the concept of providing a range of services for people with disabilities, designed to support their ability to live independently within the community. The basic prerequisites of living independently include access to information, equipment and environmental support services, income, appropriate housing and personal support services. The Government remains committed to assisting with the provision of independent living settings in the community and in people’s own homes, rather than institutions, wherever possible.”

A 1995 report of the National Advisory Committee for Core Health and Disability Support Services⁹ recommended that ‘ageing in place should be supported, as most people prefer to remain independent in their own homes for as long as possible rather than move to rest home or residential care’. In addition, older people have the

skills, experience and knowledge to contribute to society, and continued productivity in older age has benefits for the individual concerned, the community and the state¹⁰.

While there have been a number of government initiatives to support these principles, the government identified a need for further information and research on the factors that determine the ability of older people to maintain their independence and contribute to society. The information will fill a knowledge gap and assist government to make decisions on policy priorities that may reduce the fiscal risk of an ageing population.

1999 was the International Year for Older Persons, which made it particularly appropriate for government to commission research in this area. The study was undertaken in three stages.

Literature review

The first stage was a review of New Zealand and international literature on factors that contribute towards older people maintaining their independence. It reviewed the literature under four main headings:

1. Factors that maintain the health of older people.
2. Environmental factors that help older people maintain their independence.

⁷ Ministry of Health and Health Funding Authority, 1998, *Disability Support Services Strategic Work Programme: Building on the New Deal* Ministry of Health pp14-15

⁸ Under the present funding arrangements, older people requiring support are defined as having disabilities.

⁹ Richmond, D. et al., 1995, *Care for older people in New Zealand* A report to The National Advisory Committee for Core Health and Disability Support Services

¹⁰ Senior Citizens Unit, 1996, *Issues Papers for the Minister for Senior Citizens*, p7-1



3. Factors which make it more probable that an older person who is ill or has a disability can live independently.
4. Personal services and other initiatives that enable people to stay living independently.

The review also highlighted barriers that restrict older people's independence and examined literature on the incentives older people have to invest in independent living.

The review used census data to identify significant trends in the proportion of people living at home. It compared the circumstances of men and women, and people in different ethnic, income and age groups. It also discussed data on health expenditure on institutional and home-based care of older people.

The main points of the literature review are summarised in Part II of this publication.

Empirical research

The second stage of the research used key informant interviews, focus group discussions and letters to identify significant factors that contribute towards the maintenance of independence of older people. The research explored the experiences of a range of older people in New Zealand and the views of informants working with older people or having expertise in this area. It was designed to complement the findings of the literature review. Because of the relatively small scale of the research, its findings are necessarily indicative rather than conclusive. The research report is included as Part III of this publication.

Suggestions for change

The third stage was to draw together suggestions for change arising from both the literature review and the empirical research. These are included as Part IV of this report.



PART II: SUMMARY OF RELEVANT LITERATURE

Factors that maintain the health of older people

Policy makers and service providers are interested in the extent to which high proportions of older people can live independently in the future. However, it is clear from the literature that living independently does not simply mean living at home.

Living independently means having a quality of life which involves remaining active and contributing to the community, while living either in a separate dwelling, owned or rented, alone or with friends, relatives or carers, or in a retirement village. Internationally, higher levels of formal care are being provided outside institutions, with the growth of assisted and group living situations being an important part of this trend. According to Kane (1995) this suggests that the distinction between independent living and institutional care is likely to be blurred in the future. This review considers factors that promote or hinder independent living.

As noted previously, the probability of morbidity or illness, and some disabilities, increases with age. The probability of having Alzheimer's Disease or related dementia, for example, is 1 in 10 over age 65 and 1 in 5 over 80 (Prime Ministerial Task Force on Positive Ageing, 1997a). There are differences in the morbidity patterns of women and men.

The 1992/93 New Zealand Health survey showed that 86% of people 75 and over

have some type of disability or long term impairment. One third have some hearing loss. Thirty-six percent of men and 42% of women have partial mobility limitation, with 21% of men and 31% of women having severe limitation (Triggs et al., 1994, cited in Davey, 1998). The 1996 Household Disability Survey recorded 66% of women and men aged 75 and over, as identifying as having a disability (Health Funding Authority and Ministry of Health, 1998).

Healthy lifestyles

The link between lifestyle and health in older age is well documented. According to a National Health Committee report (National Health Committee, 1998), much of the physical decline associated with old age can be attributed to inactivity rather than the ageing process. The report concludes that between one sixth and one fifth of the 7,800 deaths in New Zealand each year from coronary heart disease, colon cancer and diabetes are attributable to physical inactivity. Physical activity can also reduce other risk factors including obesity, high blood pressure and feelings of depression and anxiety. Moderate exercise also helps build and maintain healthy bones, muscles and joints thereby reducing the risk of falling and also improves older people's ability to perform daily tasks.

A large number of reports and publications, including the New Zealand report *Active for Life* (1998), suggest suitable activities for older people. These range from gardening, swimming and using a wheelchair to walking.

Social, emotional and mental health

Good social, emotional and mental



health is a critical ingredient in successful ageing.

There is a general consensus that later life sickness and suffering can be partially alleviated by a frame of mind that affirms and embraces life. When people are 'health conscious' they tend to believe they can manage their own health. Mott and Riggs (1992), for example, found that many older people with multiple disabilities had a positive health perception due largely to a feeling of independence and a sense of control over their own lives. Similar findings emerged from a study on the health and well being of older Maori people (Te Pumanawa Hauora, 1997).

An extensive review of gerontological research shows quite conclusively that regular engagement in meaningful activities contributes to the overall health and welfare of older people (Seedsman, 1991). Overseas studies have demonstrated that older people at highest risk of mental illness are those recently discharged from hospital, the recently widowed, living alone and the poor and socially disadvantaged. Men are more at risk of mental illness than women (Melding, 1997). Suicide risks amongst older men in New Zealand are second only to the rate of suicide in younger men (Ellis and Collings, 1997, cited in Age Concern, 1999).

Income

Income is a predictor of health status. The links are two-way. Lower incomes limit options for purchasing health care,

health insurance, appropriate housing and other goods and services that can assist in the maintenance of health. In addition, poor health tends to limit income-earning opportunities.

Older people have lower incomes than average. In 1996, the median annual income for someone aged 65 or over was \$12,040, compared with the median income for all New Zealand adults of \$15,600. The main income source for people aged over 65 is New Zealand Superannuation (NZS). The 1996 census recorded a lower proportion of older Maori (78.4%) receiving NZS than the proportion of the whole over 65 population (90.7%). It is not clear why this discrepancy exists. Older Maori also had a lower than average annual income (\$10,380). Income levels for older Pacific and Asian people were lower with average incomes of \$8,900 and \$8,440 respectively. Part of this difference relates to access to NZS, which is subject to residency criteria¹¹. Only 38% of older Asian people and 46% of older Pacific people received NZS (Statistics New Zealand, 1998d).

One possible source of additional income for older people is paid work. Labour force participation rates for New Zealand men between 55 and 64 were generally dropping in the late 1980s when NZS was available from age 60, but are now starting to increase¹². The shifts have been more pronounced for 60-64 year olds. For women in their late fifties, labour force participation has trended upwards over the last ten years and for

¹¹ Living in New Zealand a total of ten years since age 20, and five years since age 50.

¹² The labour force includes those in full-time and part-time employment and people who are unemployed and seeking work.



women in their early sixties, labour force participation has increased significantly over the last four years. Women's labour force participation is still substantially lower than men's for the latter age group.

A potential source of income is the release of equity in housing that older people own. This may occur through 'trading down', that is selling larger family homes and moving to smaller units. There is little research into how often this occurs or how successful it is.

Equity release schemes are another option but take-up of these in New Zealand is low (Davey, 1998; Kennedy and Mackay, 1996). Despite the resistance to such schemes, Davey and Kennedy and Mackay believe that the prospects for commercial equity release schemes are good and they stress the need for government endorsement and a Code of Practice.

Environmental factors that help older people maintain their independence

Attitudes and perceptions

The diversity of older people means there is no general experience of living as an older person. Nevertheless, in a range of surveys, older people have identified common factors that determine quality of life. A New Zealand survey, involving face to face interviews with 1000 people over 60, found that three factors, an adequate income, good health and social contacts, were determinants of each individual's quality of life (Colmar Brunton, 1990). After reviewing a range of surveys, Day (1996) added three additional factors: a sense of security,

self-management, and having a respected place in the community. These factors are closely related with self-esteem, a healthy mental state, and the ability to maintain a positive outlook. Moreover, a common theme in both pieces of research is that older people with disabilities commonly perceive themselves as "well and healthy".

A survey of 397 kaumatua who lived in non-institutional settings had findings consistent with those noted above. For that group, higher standards of health were significantly associated with active marae participation and cultural affiliation, home ownership and higher incomes. Among the kaumatua surveyed, impaired vision or hearing was common, but mental health problems were not (Te Pumanawa Hauora, 1997). Maori who are involved in the Maori community benefit from the respect and status accorded older people, and especially kaumatua. According to Maaka (1993), older Maori who are alienated from their culture can suffer from a strong sense of isolation.

Housing

Having appropriate housing can enhance people's ability to adjust to disability and illness and make it more likely that they can continue to live independently. The literature, both in New Zealand and overseas, suggests that older people generally want to live in their own homes, whether owned or rented, as long as possible.

More than 9 in 10 older people live in private dwellings, a proportion that has remained fairly constant over the ten years 1986-1996, despite the ageing of



the older population. In 1996, 84% of older people in private dwellings were owner-occupiers. The proportion of older people living on their own has increased in the last 30 years. In 1966, 1 in 5 older people lived on their own, compared with almost 1 in 3 in 1996. Three in five women in their eighties lived alone (Statistics New Zealand, 1998e). While the proportion of older Maori people living alone is currently lower than for the population as a whole, the numbers living alone are likely to increase (Te Pumanawa Hauora, 1996). A similar trend is predicted among Pacific people.

Research suggests that tenants, in particular, fear that they will be forced into smaller accommodation as they get older (Rushmoor, 1998). Bed-sitting rooms or one-bedroom flats can restrict social contact with families and the ability to engage in hobbies or recreational activities. Lack of facilities for caregivers can lead to unnecessary entry into hospital/residential care, either in the short or long-term.

Thorns (1993) notes that retired owner-occupiers in New Zealand may have a high asset base but a low annual income, which can impose hardship. Some are able to take advantage of rates rebates from their local authority and the Senior Citizens Unit (1996) reports that 33% of those receiving a rates rebate were single superannuitants living alone.

Home maintenance is a concern for older owner-occupiers, and the literature identifies the value of and need for home

maintenance and related support services for older people (Taylor et al., 1981; Hereford, 1989; Rushmoor Borough Council, 1998).

Hereford (1989) reported on the Supportive Services Program for Older Persons in America. This tested the feasibility of requiring older people (and/or their caregivers) to pay for services themselves, and found a strong demand for handyman, minor home repair and housekeeping services, particularly from women living alone. Another American study investigated why older people do not make modifications to their homes even when they agree that these are a high priority (Steinfeld and Shea, 1998). The authors found that while economic constraints were important, so were older people's perceptions both of themselves and of the problem. Some things were perceived as 'too much trouble' despite their obvious value. In other cases, individuals either denied a change in their status or blamed their own limitations as the cause of the problem.

Research on migration trends confirms that older people who move tend to do so first for amenity or retirement reasons. Widowhood or moderate disability may lead to a second move to be closer to family or medical services (Silverstone and Horowitz, 1992). This trend is also evident among Housing New Zealand tenants¹³ and raises the question of how much accommodation should be modified to meet the needs of particular tenants or residents.

¹³ Personal communication, Sherry Carne, Housing New Zealand



Transport

Many studies, including one by Mott and Rigg (1994) have found that geographical isolation and lack of public transport limit older people's ability to be involved in social life, confining many to activities in their own, or at most, an adjacent suburb. Older people do not wish to be seen as too demanding and limit their requests to 'really important errands' such as doctor's appointments, minimising requests for shopping and not asking for transport for reasons such as visits to friends (Legge and Cant, 1995).

The proportion of older people who hold current driver licences decreases significantly with age. In August 1996, approximately 65% of New Zealanders aged 71 or over held driver licences. For people aged 81 and over, less than thirty percent held driver licences. The Land Transport Safety Authority has recently reviewed driver licensing for older drivers. A 1996 discussion paper reports that compared to other age groups, drivers aged 71 and over are involved in fewer crashes per year but have a higher accident rate per kilometre travelled (LTSA, 1996). In addition, older drivers tend to be more fragile and will suffer more severe injuries than younger casualties in the same crash do.

Changes effective on 3 May 1999 relaxed the driver retesting provisions for older drivers. A medical test is now first required at age 75 and the first practical re-test at age 80. Both medical and practical tests are required every two years thereafter. The new policy retains provisions to restrict licences for particular conditions, such as time of the day or a specific location.

The availability and affordability of public transport in New Zealand varies across the country and is the responsibility of Territorial Local Authorities. At present, Transfund subsidises public bus, ferry and rail transport. It also helps fund social service transport programmes but this may change in the future.

Friendship and community participation

The support of family and friends is an important component of independent living. Research indicates that there may be gender differences in both the need for, and ability to maintain social networks. A 1990 Colmar Brunton study found the norm for women living alone was frequent contact with family members. Several studies have found a greater openness among women to maintaining and establishing new friendships in older age (Armstrong, 1991; Bonita, 1993). However, Riggs (1997) found that friendships played a significant role and helped men adapt when their spouse had died.

Factors which make it more probable that an older person who is ill or has a disability can live independently

Family support and care

There is a consensus within research that the presence or absence of family support is a prime factor in determining whether or not an older person continues to live independently (Tilson and Fahey, 1990; Richmond et al., 1995; Kendig and Brooke, 1997).



Different cultures regard institutional care differently. It has sometimes been assumed that Maori and Pacific extended families will provide care for older family members. However, a Ministry of Health report (1997a) notes that ‘the role of the extended family in the long-term care of elders should not be taken for granted, particularly as 80% of Pacific income earners have an income less than \$20,000 per annum. This compares with 64% of income earners in the total population.’

The key factor influencing family care is agreed to be not family size but having a spouse or a daughter (Prime Ministerial Task Force on Positive Ageing, 1997, p.30). From a national sample of 3000, Abbott and Koopman-Boyden (1994) found that over one-third of the total adult population is providing regular informal care to older people, with people who are retired, unemployed and homemakers providing the largest amounts of care.

The breakdown of care can occur due to the poor mental health of the older person and/or of the carer. Carer stress has become of increasing concern and can be linked to elder abuse and neglect. Keys and Brown (1993) support a multi-agency approach to dealing with elder abuse, which is in effect the approach adopted in New Zealand. There are currently 22 elder abuse and neglect services in operation, of which 14 are provided by Age Concern. The Department of Child, Youth and Family funds these services.

Issues for women

Women live longer than men, and are more likely than men to live alone in old age. Living alone and having lower average incomes are factors that lead women into institutional care at higher rates than men at older ages.

Comparative statistics from the 1996 census are shown in Table One below. Some older people are also resident in other institutions, such as public hospitals, but these figures are small and declining.

Table 1: Percentages of men and women in rest homes: 1996 census¹⁴

Age group	80-84	85-89	90-94	95+
Men	6.3%	12.8%	24%	33.1%
Women	10.1%	22.0%	38.3%	50.6%

Steinburg (1997) identified transport, perceptions of safety and security, poor body image, poor self esteem, lack of confidence, stereotypes of women’s inability to make informed medical decisions or choices, and society’s devaluing of older lives as barriers to self help or correlates to dependence for women. Older women placed particular emphasis on functional environments and communities.

The interaction between doctors and older women is a common theme in the literature on the loss of women’s independence. Steinburg (1997) noted that older women considered that GPs did not relate well to them and neglected important issues such as incontinence, oral health, polypharmacy and

¹⁴ This category includes non-private dwellings providing supportive accommodation for the aged or retired. The provision of meals is a minimum requirement for supportive accommodation. This category may therefore include living arrangements such as Abbeyfield houses and some serviced apartments in Retirement Villages.



alcoholism. The failure to manage incontinence, in particular, is often a major factor in determining admission of an older person into a rest home.

Personal services, and other initiatives that enable people to stay living independently

While most of the costs associated with living independently are met by individuals, and most of the care older people need is provided by families, government has a key role in enabling independent living, particularly in the area of health and home-based services.

Public Health approaches

Preventive programmes can reduce illness and accident rates for older people, and thereby reduce the flow through to institutional care. However, as yet there is not much evidence of the cost-effectiveness of comprehensive approaches to reduce the possibilities of injury at home. An Accident Compensation Corporation initiative, the *Community-Based Fall Prevention Demonstration Projects for Non-Institutionalised Older Persons*, was established in 1997 to reduce the incidence of injuries, their severity and their costs in people over 65 years of age who live independently. While it is too soon yet to say whether it has been effective, early indications are positive.

The provision of home-based services

Much of the literature on the provision of home-based services has focused on their cost effectiveness compared with institutional care. There has been

relatively little evaluation of the range of other supports that arguably contribute to independent living, particularly in the New Zealand context.

In 1996, Waitemata Health carried out the most substantial New Zealand study to date of home-based services as an alternative to institutional care (Richmond and Moor, 1997). The study found no difference in death rates and no statistical difference in activities of daily living, morale, mental status or support needs between those receiving care at home and those in institutions. Those in the home care group were more satisfied with their living arrangements. When the cost of secondary health care was included, the weekly cost of the home care programme was substantially less than residential care - \$353.95 compared with \$508.47 per week. No costs were imputed for family carers.

The picture for family carers was less satisfactory. Two-thirds of the carers of those at home admitted feeling at some point that their relative would be better off in institutional care. The stress levels of home care carers remained higher than those of rest home carers, and their morale was lower. The study concluded that case-managed home care has the potential to reduce the costs of community care. Challenges remain to find ways to better alleviate carer stress through case management (Richmond and Moor, 1997).

In a review of the literature, Fine and Thompson (1995) concluded that it is possible to support people at extremely



high levels of disability in their own homes. As in the Waitemata Health study discussed above, many studies have found some advantages for consumers in remaining at home. In some studies, carers were also better off. However the costs of caring for people with high levels of need were often higher than alternative provision in residential care.

Kane (OECD, 1996) sees a need to shift away from the institutional care/home care dichotomy, towards trying to identify optimum transition points to favour one type of care over another. She argues that specialised residential complexes and the growing phenomenon in the United States of Naturally Occurring Retirement Communities (NORCs) are resulting in favourable economies of scale by bringing services to where people live.

The evidence on the value of providing low intensity services to people who are not at risk of institutionalisation is inconclusive and seems to depend on what outcomes are included in the assessment of benefits. Fine and Thompson caution against reducing services to people not at risk of institutionalisation, because of the positive impact of services on quality of life, and the evidence that some relatively low cost services, such as delivered meals, community transport and social day care, assist in maintaining independence.

Approaches to assessing need

The literature consistently argues that providing people who have complex or high levels of need with low levels of standardised services is relatively ineffective.

Bebbington and Davies (1993) note that policies targeted at those most in need cannot pick out even a majority of those at very high risk well in advance, given the random nature of many events which precipitate the need for admission to institutions for long-term care. With formula approaches, field staff (assessors) tend to make their decision on need first, then try to work their way through the forms to yield the required score. The authors argue that few systems have depended only on allocations determined by simplistic formulae, and where they have, there have been some dire results. They see a much stronger case for using tools rather than formulae to assess whether people need a service or not.

Age Concern, the National Health and Disability Committee (1995) and the Richmond study assert that the value and effectiveness of multidisciplinary assessment, treatment and rehabilitation (A,T and R.) services for older people are unequivocally proven. Richmond references studies that show this approach significantly reducing day stay in hospital, morbidity and mortality.

Accessibility and appropriateness of services

A number of studies have considered the philosophies underlying service delivery for older people. Russell and Oxley (1990), for example, argue that 'it is vitally important to see in cultural context the meaning of domiciliary services as experienced by recipients and adapt service delivery accordingly'.

A number of studies in New Zealand and overseas have identified problems in



service delivery. Te Pumanawa Hauora (1997) reports that while kaumatua make a strong contribution to whanau life, they face barriers to accessing services for themselves. These include cost, lack of culturally appropriate services, lack of appropriate information and the need for integrated services.

A Ministry of Health report (1997) identifies similar accessibility problems for older Pacific people.

Lack of publicity about existing services can lead to what Gilmour (1998) calls 'rationing by ignorance'. She discusses this in the context of respite care for older people with dementia, of whom at least 80% are living in the community. Respite services are not widely publicised or understood, leading to lower demand.

Richmond et al (1995) also identified a number of concerns about the limited skills of doctors in meeting the age-related needs of older people. This included the failure of doctors to advise on aids and refer people to specialists, and the failure of the two-way information flow between hospitals and GPs. In their view, GPs are not able to judge whether or not a person really needs residential care. The Older People's Health Forum also raised the issue of doctors' tendency to prescribe high levels of drugs for older people. The Forum advocates prescribing the lowest possible dose of a drug and the consideration of alternative non-drug therapy as a principle of elder care (p21).

The more institutional care an individual receives, whether short-term or long-term, the greater the likelihood of their entry into residential care. Hennessy

(1996) noted that entry into residential care frequently occurs not after a long period of decline but rather as a result of a sudden loss of faculty with injury or illness, followed by a spell in hospital receiving acute care. Many residential care placements are therefore from hospital rather than directly from the community. He saw this as pointing to a need to focus on post-acute care and rehabilitation.

The Health Funding Authority has recognised this issue and is currently funding the Canterbury Elder Care pilot project, which aims to integrate and improve health services for older people. As part of the pilot, a number of projects have been instigated including the Stroke project, the Broken Hip project and the Simplified Funding project. Project teams have also been established to develop new models for discharge planning and for ongoing care in the community.



PART III: RESEARCH REPORT

This part of the report is in five sections:

- I. Introduction
- II. Personal factors that affect the independence of older people
- III. Environmental factors that affect the independence of older people
- IV. Services that help maintain the independence of older people
- V. Summarising the issues for Maori.

Introduction

As part of its contribution to the “International Year of Older Persons 1999”, the Government commissioned this research into the factors that help older people¹⁵ maintain their independence.

In this study, “independent” has been defined as remaining active and contributing to the community, while living either in a private residence alone, or with a partner, friends, relatives or carers, or in a retirement village. “Living independently” specifically excludes living in any form of residential care, but does include those who receive in-home assistance such as personal care and meals on wheels.

The aim of the research

The aim of the research was to identify the factors that contribute to the maintenance of independence of older people and their continuing community contribution. Most people prefer to remain living independently rather than move prematurely into residential or rest

home care. The Government also wants to encourage older people to remain at home, independent and self-reliant, for as long as possible. Older people have skills, experience and knowledge to contribute to society. They are, and should be, valued and valuable members of the community.

Information sources

Information for the research was collected through key informant interviews, focus group discussions and letters. The main findings of the literature review completed as part of this project are summarised in relevant sections of this report.

The key informants were people who are knowledgeable about and/or who work actively with older people. They included service providers, local authority workers, health professionals, members of community groups, researchers and academics. They were chosen in consultation with the Senior Citizens Unit to provide a range of expert opinion and to canvass the views of the major advocacy groups for older people. Where possible, key informants were interviewed in the areas where focus groups were held, for example, in Taihape and Kapiti. The researchers also sought the views of informants in the South Island. The full list of informants is included in Appendix II and the interview guide used for most of the interviews is in Appendix III.

Focus group discussions were held with older people themselves. They were invited to discuss both the factors that

¹⁵ People aged 65 and over unless otherwise stated.



help older people maintain their independence and any barriers to achieving this. They were also asked to make suggestions for improving both policy and service delivery and, in particular, to identify interventions that they consider would be cost effective. The groups comprised 51 people from Wellington, the Kapiti Coast, Taranaki and Taihape. These areas were chosen to include urban, provincial and rural settings. While practical considerations limited the number of interviews and discussions, older people from other areas were encouraged to write in giving their views and many did so. Within the research areas, the researchers sought the views of older people of different genders and ages and in different circumstances.

The ages of focus group participants ranged from the mid-50s to the 90s. Half the total, 25 out of 51, were in their 70s and 17 were in their 80s. One was in his 90s. The proportions of women and men reflect the demographics of the age group – women outnumbered men at 36 and 15 respectively. One group consisted entirely of Maori men and women, another included two Maori women. Details are in Appendix II. The interview schedule that formed the basis for the discussions is included as Appendix IV.

While these discussions included older people of varied ages and in different circumstances, they included few older people who were isolated, depressed or had severe disabilities. Three of the eight focus groups were drawn from friendship groups, while one group consisted of volunteers at a local community centre. This raises the possibility of bias in the results and the findings may not be

representative of the views of older people generally.

Older people and family members were also invited to write in describing what has helped or hindered them in maintaining their independence. Seventy-three people responded. Sixty-four of these were older people themselves, nine were family members, friends or neighbours. Representatives of several organisations also wrote. Excerpts from those letters are included throughout the report.

The key informant interviews, focus group discussions, and letters drew on a wide range of opinion. While the views of active older people were well covered, those of older people who are isolated or who have severe disabilities were recorded mainly through the opinions and experiences of key informants and family members. The interviews, discussions and letters have largely been consistent with the findings of the literature review, and have added depth and weight to the findings of those other studies.

Personal factors that affect the independence of older people

This section considers a number of personal factors that affect the independence of older people. These include older people's own attitudes to life, their social networks, health and wellness issues, financial circumstances and paid work. While individuals have a degree of control over some of these factors, the extent of this control varies considerably. They are collected under this heading because individuals'



personal situations affect the way they respond to environmental and other factors.

Attitudes of older people

“After 50 years of happy marriage, my husband died two years ago. I am almost 90 years of age. A friend and I ring each morning for a brief chat. It helps in every way to keep active – exercising, planning and thinking of some good to do for somebody or something. It keeps one thinking outwards. Accept invitations – you cannot back out later when that would be so easy and self-defeating. You probably enjoy it anyway. It’s just making sure you participate. Keep an active interest in your religion or culture even to encourage others. If you are a good listener, you add to your store of knowledge and some good stories to help others be happy and even laugh!” – Nelson

The Prime Ministerial Task Force on Positive Ageing¹⁶, along with Age Concern and the Senior Citizens Unit, identified positive attitudes to ageing and strong social support systems as important in maintaining the health of older people. This research supports that view. Evidence gathered during the study shows that the attitude of older people themselves has a significant impact on their wellbeing and mental health. This in turn affects their independence and their ability to participate in community life. The benefits of a positive attitude

seem to be independent of ethnicity or culture. For example, Maori who are involved in the Maori community benefit from the respect and status accorded older people, and especially kaumatua. A recent study¹⁷ shows that kaumatua are generally optimistic about ageing, despite two-thirds taking medication and having a major or minor disability.

The diversity of older people means there is no general experience of living as an older person. Nevertheless, in a range of surveys, older people have identified common factors that determine quality of life. These include an adequate income, good health, social contact, security, self-management and having a respected place in the community. These factors are closely related with self-esteem, a healthy mental state, and the ability to maintain a positive outlook¹⁸.

Age Concern NZ’s recent consultations with older people¹⁹ about positive ageing identified the following key attitudes as important to successful ageing:

- learning to live within limitations, adapting
- optimism
- believing that you are personally responsible for the way your life progresses
- maintaining a sense of adventure
- guts and determination
- confidence and courage
- a sense of humour.

¹⁶ The Prime Ministerial Task Force on Positive Ageing, 1997a

¹⁷ Te Pumanawa Hauora, 1997

¹⁸ Colmar Brunton Research, 1990; Day and Alice, 1996

¹⁹ Age Concern, 1999, “Successful ageing: an education resource”



There is general agreement that later life sickness and suffering can be partially alleviated by a frame of mind that affirms and embraces life. When people are health conscious they tend to believe they can manage their own health. A theme in research is that older people with disabilities commonly perceive themselves as ‘well and healthy’.

Key informants, correspondents and participants in focus group discussions strongly agreed with this view. Typical comments from older people included:

“There is nothing that any one particular agency can do to keep a person healthy and outgoing. People have to do things for themselves.”

“It’s not what happens to you that determines whether or not you go into a rest home - it’s about what you make of what has happened. It’s all about attitude and how you deal with things.”

A strong faith was important to many older respondents and a number pointed to the influence of the Depression and the Second World War in forming the attitudes of their generation. They described themselves and their peers as ‘frugal and economical’, with a ‘mindset to overcome difficulties’ and a ‘long history of survival on very little and a lot of hard work’. One woman in a rural town believed the attitude typical of her generation was:

“Don’t complain, be grateful, don’t ask for help. It’s hard to ask for help – we’re proud and independent. People say, ‘Ring me’, but I’m not used to ringing people.”

Almost without exception, the older people who contributed to the study expressed a strong desire to remain independent as long as possible:

“I don’t want to end up in hospital or a home. You prefer to stay in your own home with your own things. I won’t be going there unless I just cannot do anything - as long as I can eat, keep clean, dress myself, I’ll stay home.”

Both older people themselves and key informants acknowledged that self-reliance can be both good and bad. For example, older people’s reluctance to seek or accept help may actually limit their ability to stay living independently. Those who have a flexible attitude and accept the changes associated with older age are more likely to acknowledge that they may need help to manage, thus averting a premature shift into residential care.

Social networks

“I am an active independent member of the Red Cross, an active member for Hospice on Rose Day and of Christmas Tree for Cancer. I have been a member of the 60s Up Group from when we began 13 years ago. I am 91. I live on my own and take pride in my cooking and enjoy eating it. My husband died 16 years ago. He was my model indeed because I continued this work after he died and felt I was helping someone. It is better to live in your own home with all your familiar photos. Memories of your lost partner are as important as food for your brain. Keep in touch with your friends, make them welcome and enjoy a good laugh. Use your phone and call the housebound.” – Browns Bay



“I’m 87 years young, live alone and love it. I don’t want to be organised into going into the community “to participate in society”. For heaven’s sake, thousands of us just want to live our lives in our own surroundings with our own furniture and knick-knacks as long as we can, as long as the house is as clean and pleasant as we are used to.” – Wellington

Social networks include family relationships, networks with neighbours and friends and membership of clubs and organisations. Individual need for social contact, and the quality and quantity of contact, varies considerably. In general, a lack of social support is correlated with poorer mental health amongst older people. Loneliness and depression tend to be more common among frail older people.

Older people’s ability to cope with change in older age depends very much on their previous life development and how well they have coped with changes in the past. One key informant noted that while older people are unlikely to alter the patterns of a lifetime, their sense of self worth and esteem could affect their ability and willingness to retain contact with others.

Community involvement was particularly important to participants in a focus group discussion with Maori older people, many of whom had extensive marae responsibilities.

Being actively involved in their communities was also important to Pacific people interviewed as part of a separate ongoing project²⁰. They too were expected to take on additional responsibilities as they grew older, which could be demanding and tiring.

Family relationships

Family relationships are especially important. They can offer an opportunity for mutual emotional and practical support between the generations, and for “the exchange of knowledge, experience and insights, enablement and caring”²¹. Research shows that the presence or absence of family support directly affects older people’s ability to live independently.

Like positive attitudes, the importance of emotional contacts between family members is recognised in all cultures. A study of Chinese and European families in New Zealand²² concluded that “filial obligations are defined in essentially the same hierarchical order by both cultures, both genders and both parents and children”. Both cultures rate respect for and maintaining contact with older family members ahead of obedience, making parents happy and material obligations such as financial support and care giving.

The nature of social contact is affected by family mobility, by the pressure of family members’ other commitments, and personality differences. Telephone

²⁰ Elder research project being undertaken with members of the Samoan, Tokelauan and Cook Island communities by the Pacific Health Research Unit, Whitireia Community Polytechnic.

²¹ From the draft “Charter for a Society for All Ages for International Year of Older Persons 1999”.

²² Ng, Sik Hung et al., 1999



contact is important and some older people had become familiar with email in order to keep in touch. While many of those who took part in the study received both emotional and practical support from their families, others did not. The latter group relied mostly on their own resources, as well as on their contacts with friends and community groups. A number of those interviewed talked about how their family had become scattered, with children living in other centres in New Zealand or overseas.

“Families move a lot these days. If you go and live next door to them they move somewhere else.”

Several described intra-family conflicts that made them unwilling to seek help; many were aware of how busy family members were:

“They are so busy they haven’t even got time to do their own things. You can’t expect them to help.”

The range of family situations covered in interviews and discussions highlights the complexity of family relationships and the difficulties older people may face in asking for help.

Some Maori participants appreciated it when whanau were able to come and help out, including staying the night if necessary. Others commented that they had to be self-reliant because their whanau was no longer around. One participant in a Maori focus group thought that:

“The government should fund kaumatua hui. It’s great when we can

get together and korero and share with the young people our stories.”

Older people also discussed the need to manage their contacts with their families. One described what happened when her husband died:

“The family was in and out quite a lot and I asked for some space because we are private people. They were doing their duty but now they leave me alone. If I want help I will ask for it. I ask if I want to go to the beach. I couldn’t drive by myself. I have to swallow my pride and ask if I want a crayfish.”

Pacific elders interviewed for the Wellington study appreciated having their own space and a number preferred to live on their own or with their spouse rather than with their children. This gave them more control over what they cooked, who they socialised with and how often they saw their children. Because of their community commitments, some had more contact with their peers than with their children or grandchildren. This pattern may not be typical of all Pacific families.

Key informants agreed that while family support can make the difference between independence and dependence for many older people, they should also be allowed to live their own lives and take some risks. It is important that family do not take over and impose their own concerns. They must be realistic about what help they can offer and not be overprotective or do too much.

Friendship networks

The literature suggests that men and



women may differ in both their need for, and ability to maintain, social networks. According to some studies, older women are far more likely than older men to seek out others to satisfy their social and emotional needs²³. An American study²⁴, for example, found that older women with disabilities formed new friendships in older age and extended the friendship network to include more kinds of friends than previously, such as younger people. They had less concern than in the past with maintaining the equity of exchange that is typically associated with friendship. This meant that the older women were able to accept instrumental help, which helped them maintain their independence. Others have found that friends as well as family members play a significant role in helping older people adapt when their spouse dies.

Key informants stressed the importance of friendships.

“It is important for older people to build up relationships. The frail elderly are often lonely and feel isolated. You lose some of your independence if you do not have a circle of friends. If you have friends there is a bigger range of activities that you can share.”

Neighbours

Correspondents and focus group participants mentioned the importance of having close friends or at least compatible neighbours in the vicinity. Neighbours can provide social support and help in an emergency. Examples

given included help with medication and after falls, as well as practical help with chores such as shopping, transport, mowing lawns, chopping firewood and doing small maintenance and repair jobs. Several older people commented on changes in their neighbourhood that led to their increasing isolation as trusted neighbours moved away or died. For some, these changes had precipitated a move to a more congenial environment, such as a retirement home or a suburb with a high proportion of older people. A resident in a retirement village commented:

“There is no longer the street support outside that there used to be. The level of support here is similar to what used to be in communities when I was a child.”

Social support from friends and neighbours can help protect older people against illness, enhance their ability to cope with stress and improve illness outcomes²⁵. Both correspondents and key informants referred to the value of home visitors for the house bound, who have less ability to maintain friendships. Age Concern, churches and community groups provide a home visitor service in some areas, which can lead to new friendships for older people.

Interests and activities

Many focus group participants and correspondents belonged to organisations or clubs. These included friendship, educational and activity groups, sports and fitness groups,

²³ Bonita, R., 1993

²⁴ Lewis, 1997

²⁵ Pearlin et al., 1996, cited in Kendig, H. and Brooke, L. (1997)



gardening, art and craft groups, carers' groups, and service groups such as Red Cross, Maori Women's Welfare League, church groups, Probus, Rotary and the Country Women's Institute. Participants described the benefits of belonging to clubs as companionship, improved health, greater confidence and an opportunity to "keep an eye on each other". They acknowledged that while in most communities there is plenty to do, older people do need to know where to go and have the confidence to take the first step. Marae and churches form the natural hub of a social network for many older people.

Indeed for some Pacific elders, the church can take the place of the village in their home islands. But not all older people have church affiliations and may need support and encouragement to see if taking part in an organised activity suits them. Several participants recognised that:

"Lots of people fall through the cracks. If people are introverted, don't belong to all those clubs, or if they live out in the country, no one knows about them. They won't ask for help from someone they haven't built a relationship with. People say, 'Why doesn't she ask?' but it's not that easy."

"Ironically, other people's positive attitude can make it harder for shy people to break in. It's very hard for newcomers to the area to fit in."

Some correspondents reported that their social networks had become restricted as

a result of deafness, poor eyesight or reduced mobility. For some, this was a cause for resignation, others wanted a social group that accommodated their particular disability, for example, a group specifically for those who were hard of hearing. Overseas studies confirm that visual and/or hearing impairment are associated with a significant worsening in quality of life²⁶. Mobility is also an issue: lack of access to transport adversely affects the size and type of older people's social networks²⁷.

Volunteering

Focus group participants, key informants and correspondents emphasised the value of older people participating in voluntary community activities. The type of voluntary activities older people seem to prefer include those that provide support for other older people. Usually this happens on a voluntary basis and sometimes without adequate support. Examples of such activity by older people included home visiting, advocacy, participating in training and support groups, providing social, educational and recreational services and engaging in activities associated with organisations like the Arthritis Foundation, Stroke Support, the Red Cross, Safer Steps, food and clothing banks and church groups. While focus group participants and correspondents acknowledged the rewards of involvement in terms of confidence building and personal satisfaction, many were finding their involvement increasingly stressful. Key informants reinforced this view.

²⁶ Carabellese, C. et al., 1993

²⁷ Cant, R. and Legge, G., 1994



“If older people make a voluntary contribution to the community, e.g. helping with meals on wheels, they need to know that the service is appreciated. Many older people who have done voluntary work for years would like to get out of such work but there is difficulty in finding replacements. There are particular issues for older people e.g. older drivers who find coping with modern motorways and traffic densities stressful and strenuous.”

Volunteering in rural areas also had its drawbacks:

“Volunteers are generally older – you can’t expect them to drive on those [country] roads or that distance. There’s no transport to get the older people into day programmes or Care and Craft either. They lose their licences, their families get bogged down but there’s no one available to mind the oldies for respite care.”

Health and wellness issues

“The most important thing at this age is to stay independent by keeping fit, physically and mentally. Know your immediate neighbours, make new friends where possible by joining clubs and groups, and have some definite commitment, such as voluntary work, which involves service to other people. The best group I joined at 65 is a tramping club for over 40s and I hope to be still tramping with my pack at 80!” – Christchurch

The link between lifestyle and health in older age is well documented. Indeed, there is a certain degree of circularity in stating that people who enjoy good health also maintain greater independence in old age.

A number of social and economic factors have been shown to have an influence on health. These include “income and poverty, employment and occupation, education, housing, and culture and ethnicity”²⁸. However, research has also shown that it is possible to reduce, postpone or prevent disability and handicap in older people through promoting healthy lifestyles. Risk factors include smoking, nutrition and alcohol consumption together with blood pressure, body weight and blood sugar²⁹. A healthy lifestyle includes both physical and mental activity. A recent report³⁰ notes that there is good evidence that stopping smoking is beneficial, even in old age, and recommends that subsidised smoking cessation programmes should be available to older people. The report also notes that “the relationship between socio-economic status and cardiovascular disease persists in old age and risk factors cluster around the less well educated and less affluent for whom the need to prevent cardiovascular disease is greatest”.

Good health is the most important factor in maintaining independence in older age. Focus group participants and correspondents were aware of the importance of exercise, sensible eating and mental stimulation.

²⁸ National Health Committee, 1998b

²⁹ Richmond, D., Baskett, J., Bonita, R., and Melding, P., 1995

³⁰ National Health Committee, 1998b



The cost and uncertainty of medical care was a concern to focus group participants and correspondents, several of whom wanted “free medical care with immediate access rather than a two-year wait”.

Physical activity

“There is a huge advantage in being physically fit. Now aged 70, I run three miles most mornings and often walk the same route in the afternoon. I have a large garden and do all the gardening, hedge cutting twice yearly and lawn mowing. I grow all my own vegetables and fruit and follow the NZ Heart Foundation guidelines to healthy eating.” – Marlborough Sounds

According to a National Health Committee³¹ report, much of the physical decline associated with old age can be attributed to inactivity rather than the ageing process. For example, approximately one sixth of the 7,800 deaths in New Zealand each year from coronary heart disease, colon cancer and diabetes are attributable to physical inactivity. Physical activity can also reduce the likelihood of coronary heart disease, colon cancer and diabetes obesity, high blood pressure and feelings of depression and anxiety. Moderate exercise helps build and maintain healthy bones, muscles and joints. This reduces the risk of falling and improves older people’s ability to perform daily tasks. Suggestions for suitable activities for older people range from gardening,

swimming and walking to using a wheelchair.

Focus group participants and correspondents engaged in a wide range of activities including aqua fitness, croquet, walking, bowls, pool, yoga, golf and gardening, or attending a women’s health group, a gym group or exercise groups for stroke victims or arthritis sufferers. Older Pacific people also spent time mending nets, fishing, carving, weaving mats, and quilting. All participants and respondents described improvements to their sense of wellbeing as a consequence of their activities. These improvements included feeling physically fit, recovering more quickly from operations or illness, being more outward looking, enjoying life more, being able to do more for themselves, including gardening, and maintaining contact with friends.

While much physical activity is self-motivated and needs no organisational support, a number of organisations, notably the Hillary Commission for Sport Fitness and Leisure, promote or support participation in physical activity by older people. Increasing levels of physical activity has been described as “today’s best buy” in public health, because of the significant benefits that can be gained.

³¹ National Health Committee, 1998a



Mental activity

“Becoming widowed in my 70s I moved into one of the delightful cottages of a retirement village. After the initial interest of furnishing it with my bits and pieces, I arrived at my 80th birthday with a burning desire to find something to do to fill my daily hours, besides my little laundry and cooking. At 80 years, without tertiary education, I enrolled in a correspondence course for English Language and Short Story Writing. To everyone’s surprise, I ended up after applying my mental capacity for 2 1/2 years with 5 As and a Diploma and a most satisfying amount of enjoyable hours. Learning to use the word processor, typing and sending in assignments was a discipline that made a great difference to my days.” – Timaru

*“Books and writing have always been part of my life. For six years I have held a literary circle in a local rest home. We have read so much and discussed many things and older members come out with distant memories.”
– New Plymouth*

Studies have also found that it is possible to slow down or even reverse mental decline associated with ageing through education and training. Once again, participants were engaged in a wide variety of activities including study, writing, membership of historical and similar societies, reciting whakapapa and getting to grips with new technology. A number were members of SeniorNet and had taken courses in word-processing, genealogy, communications, managing

databases and computer art. Some enjoyed using email to keep in touch with their children and grandchildren. The University of the Third Age (U3A) attracted some older people, particularly those from professional backgrounds. Like SeniorNet, the U3A has adopted a self-help model with a lot of the teaching being done by members, which also helps keep them mentally active.

Some local authorities in the larger cities provide mobile library services to rest homes, as well as having talking books or large print books available for people with visual impairment. However, these services are coming under increasing pressure as local authorities seek to manage their budgets.

Financial Circumstances

“To my mind the greatest assistance we had to becoming independent was that I was fortunate to live in an era of history in which I was able to retain full employment for the whole of my working life. In addition to my income, wives of many folk like myself also worked and established and paid off the biggest asset they possessed, their home. Once a home is bought and paid for, the accumulation of savings accelerate.” – Waikanae

“The major threat to my independence, and that of many spinsters I know, is a financial one. Unlike our married, or once married sisters, we are less likely to own our own homes. Therefore we must pay high rent to landlords, in my case \$150 per week, totally unfurnished. The Transitional Retirement Benefit is \$187 per week and the Old Age Pension with



Living Alone Allowance is \$210 per week. A factor that has never been taken into account is that spinsters of my generation:

- *had no access to mortgage finance*
- *worked the best part of our lives for 33% less than the wages or salary of males for the same job*
- *had no option but to pay a huge amount of our income into dead money rentals*
- *had no access to employer-subsidised superannuation benefits.” – Wellington*

Older people have widely different financial circumstances, due to different life experiences. Their financial situation in older age is attributable in part to environmental factors and in part to personal choices. The discussion of financial matters is included in the Personal Factors section of this report, but influence of factors over which they have no control needs to be borne in mind.

Older people are more likely to own rather than rent their homes compared with the adult population as a whole, and to own their house without a mortgage. Older people have lower incomes than the average for all adults, with older Maori, older Pacific and older Asian people respectively having the lowest incomes. Younger old people tend to have higher incomes than older old people, and men more than women³². In equivalent income terms, that is a comparison that takes account of the

size and structure of household, older people, both couple households and those alone, have less income on average than most other household types, apart from single parent families, and young, two parent families. On average, older people living alone had more purchasing power in 1996 than in 1982, but still had less available income than older couples whose average purchasing power was slightly less in 1996 than in 1982.³³ What is not well understood is the extent to which older people have different expenditure needs than other groups, and how this affects their standard of living.³⁴ As an example, older people are more likely to own their home freehold and therefore, on average, their accommodation costs will be lower. However, this may change with increased use of retirement villages and other serviced accommodation that includes substantial annual levies. On the other hand, their need for medical care is greater than for the population on average.

The most important income source for older people is New Zealand Superannuation (NZS), which is a flat rate pension now available to all qualifying older people³⁵ on a non income-tested basis.

In 1997/98, an estimated 407,305 people, around 90% of all people at or over 62, the qualifying age for NZS at the time, received NZS. Of those receiving NZS, 25% had no other income. A further

³² Davey, J, 1998a

³³ Statistics New Zealand, 1999, *New Zealand Now-Incomes* fig 5.6

³⁴ The Ministry of Social Policy will assume responsibility for a study on the standard of living of older people, initiated by the Super 2000 Taskforce, which should throw light on this question

³⁵ Residential criteria apply. The age of eligibility is currently being raised to 65 by 2001



21% had up to \$1,000 per annum income in addition to NZS, and 24% had between \$1,001 and \$5000 per annum income in addition to NZS³⁶. In summary, 70% of older people in New Zealand relied on NZS for their income, while a minority had a substantial income in addition to NZS, largely sourced from pension schemes and earnings.

It is difficult to predict future trends in the income of older people. On the one hand, labour force participation has begun to increase for both men and women at pre-retirement age, and for those aged 65 and over, although the labour force participation of women is still substantially below that of men. This is discussed further in the following section. There is evidence of greater awareness of the importance to save for retirement and of people taking action such as budgeting, debt repayment and saving³⁷.

On the other hand, not everyone is able to increase their paid work. A widening distribution of earnings, and the impact of a larger number of user charges, particularly on people with dependants³⁸, may mean fewer people are able to save for their old age in future.

The importance of income to independence

Income is the single most important determinant of health status³⁹. The links are two-way. Poor health tends to limit income-earning opportunities. Lower

incomes limit people's ability to buy health care, health insurance, appropriate housing and other goods and services that can help maintain their health.

A number of key informants noted the implications of fewer health choices for those on low incomes than those on higher incomes. Two observed that:

“Low-income people have to take short cuts, including health. On the other hand, those on a high-income can become obsessed with health and get tests for all sorts of things. This involves a high level of expenditure and can generate anxiety.”

“Funding tends to focus first on safety and security and then on maintenance. Life enhancement comes third but should be regarded as of equal importance with the first two categories. It is difficult for those dependent solely on the benefit to afford those things which would improve their quality of life. All older persons, regardless of wealth, have common problems of isolation and loneliness. Those with money may still be lonely but money usually gives them more choice and allows them to purchase things which can help.”

³⁶ Department of Statistics, 1998

³⁷ Personal communication, David Feslier, Office of the Retirement Commissioner

³⁸ The impact of user charges can be attenuated for some groups by tax changes or targeted subsidies

³⁹ National Health Committee 1998b, p.23



New Zealand Superannuation

“Super isn’t meant for holidays or buying cars – it’s just for living on. Up until a couple of years ago, I thought it was quite generous. I think it’s tightened up – with electricity going up. It’s subtle rises all the time.”
– Wellington

While some focus group participants were able to manage on their NZS, most were finding it increasingly difficult to do so. They referred to the pressures of increases in rates, electricity charges and home maintenance. A common belief was that the NZS would reduce in the future, or not keep up with price rises.

Single people faced particular problems in that many had the same outgoings as couples. Some couples, including some who had moved into retirement villages, were concerned that if one partner died, the other may not be able to afford to stay on in the home.

“You lose a third [on your super]. It’s too big a drop for a single person. It’s the monthly fee we worry about - it covers gardening, window cleaning, rates, rubbish and house washing.”

Supplementary income support

The main sources of supplementary income assistance accessed by older people are the Disability Allowance⁴⁰, accessed by approximately 18% of NZ superannuitants, and the Accommodation Supplement, accessed

by 5% of NZ superannuitants. A small number of superannuitants also access Special Needs Grants and advances on New Zealand Superannuation or the Special Benefit.

The take-up of supplementary assistance, and the Community Services Card that enables low-income people to access health subsidies, is lower than one might expect given the income levels of older people.

Several correspondents noted that, even with a Disability Allowance, and the home help provided free of charge to low income people⁴¹ through disability support services, they had to draw on their retirement income to pay for the full range of services they needed to live independently.

Financial insecurity

“We are not eligible for Accommodation Supplement if we have any “money in the bank”, nor any of the other “tag ons” like special benefits or food grants, so we have to draw down on our savings. We need the savings because we have no house to sell if we need money for operations. It’s a very frightening situation to be in.” – Wellington

Being unable to manage the financial risks of the additional costs of poor health or disability, or being unable to plan expenditure with any degree of certainty, reduces the quality of life and sense of independence of older people.

⁴⁰ Figures at June 1998. The DA currently provides up to \$43.23 per week to single adults with an income below \$20,813 pa, and to couples with an income less than \$29,933 pa. for regular ongoing additional costs of a disability.

⁴¹ Older people who meet the income test for the Community Services Card, qualify for free personal care and home help where they are assessed as needing it.



Uncertainty about the level of superannuation, and fluctuating interest rates for those with savings, increase older people's anxiety. Money was a particular concern for some older Pacific people⁴². Some were anxious about being able to pay their rent or their mortgages. Others worried that they did not have enough money to meet their family responsibilities. Those who had recently come to New Zealand from small island communities where money was less important were experiencing the most difficulty.

Those older people who did have some investment income have been affected by the prevailing low interest rates. A number of older people wrote describing their situation. Most suggested that taxes be reduced or eliminated on investment income for older people.

A number of respondents discussed the difficulty of borrowing money, even when doing so could enhance their independence:

“Finance should be easier for the elderly to get. You can become an active person again if you have a mobility scooter but a mechanised scooter is very expensive. The government financed returned servicemen, why can't they do it for the elderly? You'd think we had stopped paying taxes. You can't borrow on your house or your pension.”

Costs of care

Some resentment about the lack of

subsidised support for home-based and medical services for those with modest additional incomes, and the income and asset test that applies to residential care⁴³, was expressed in focus groups and letters. “They take all you have”, was one view.

Key informants pointed out that not all family members or older people are aware of the cost of residential care. Many resist paying for home care services; others realise, perhaps reluctantly, that this can be cheaper than paying for residential care:

“If older people or families have money they have choice – they can buy extra services. Only personal cares are neither income nor asset tested. The rest are dependent on having a Community Services Card. When families realise what the cost of rest home care is, they are often prepared to pay more for home care.”

Responses to financial insecurity

One source of income that has been subject to discussion in New Zealand, but accessed by very few older people, is the release of equity in housing that they own and in which they continue to live. At 84%, New Zealand has high home ownership rates amongst older people.

Reasonably common in some areas of the country, is releasing part of the capital by selling larger family homes and “trading down” to a smaller house or pensioner flat. Where house prices are

⁴² Elder research project being undertaken with members of the Samoan, Tokelauan and Cook Island communities by the Pacific Health Research Unit, Whitireia Community Polytechnic.

⁴³ A subsidy to cover the full cost of residential care is available to couples with no more than \$30,000 in joint assets if both partners are in residential care and \$45,000 if only one partner is in care. For individuals, the subsidy is only available to those with assets under \$15,000.



high, as in cities such as Auckland or Wellington, the amount of capital that can be released is limited, and in areas where house prices are depressed, trading down may not be an option. There are also disincentives for older people who access supplementary assistance or have a partner accessing the residential care subsidy, to trade down.

Equity release schemes are another option. These generally take one of two forms: mortgage and annuity scheme, or reversion plans where houses are sold at a discount to investors but the resident retains occupancy rights for life. One study⁴⁴ notes that “fear of indebtedness, misgivings about government policy directions, and to an even greater extent, suspicion of the schemes themselves have emerged as constraints to take-up.” In the view of some older people, such schemes cut across the major base for inheritance and conversion rates are not very favourable. The schemes also involve risks for providers where property drops in value or clients live longer than anticipated. Nevertheless, according to Davey⁴⁵, the prospects for commercial equity release schemes are promising, particularly with government endorsement and a Code of Practice.

Members of one focus group discussed older people being able to access funds, using their homes as a source of debt repayment:

“A positive move could be financial backing for people to make necessary purchases e.g. a community bank to advance money on the security of a house. Repayment would come later out of the estate. The problem would be accumulating interest.”

How to fund long-term care services, whether provided in residential care or at home, in a way that enables older people to have some certainty about their finances, is a concern in many countries, and discussed further in Section VI.

Enduring Powers of Attorney

Several participants discussed financial planning, particularly the importance of Enduring Powers of Attorney (EPAs)⁴⁶. These can allow family members to make decisions that can help older people stay home longer. The cost of an EPA was an issue for some who suggested that Work and Income New Zealand (WINZ) could make a grant or a loan to encourage older people to plan for their futures in this way. One key informant noted with regret that there is no one in the community designated to help older people who have no one to fill the EPA role. Such a person would need to fully understand the welfare responsibilities of being a welfare guardian. They would need to be respectful and not take over the older person’s finances inappropriately. They saw this as an important role for which training could be developed.

⁴⁴ Davey, J., 1998b

⁴⁵ Davey, J., 1998b

⁴⁶ Enduring Powers of Attorney (EPAs) can be set up to manage property or for personal welfare. A property EPA gives authority for someone to look after a person’s financial and property affairs and to act on their behalf during their lifetime, if they are unable to do so. It can come into operation at any time. A personal EPA gives an individual responsibility for a person’s personal care and welfare and begins to operate only when the person granting it becomes mentally incapacitated.



Paid work

“Having a job, voluntary or otherwise, helps older people remain in the community and participate fully in society. Many employment businesses are just not interested in people over about 40.” – Wellington

Past discussions on income adequacy for older people have frequently focused on retirement income. More recently, attention has moved to enabling people to stay longer in the workforce. This represents a significant shift from the early 1980s when earlier, rather than later retirement was being promoted. Recent changes to the Human Rights Act in New Zealand now make age-related compulsory retirement unlawful.

In 1998, 41.9% of 60-64 year-olds and 6.1% of those aged 65 and over were in the labour force. Since 1991, there has been some increase in labour force participation within the 60-74 age group, mainly due to the growth in women's participation⁴⁷. Participation is higher for Pakeha than Pacific populations and Maori, and significantly higher for men than women. Unemployment rates are also higher for Pacific populations and Maori, than for Pakeha⁴⁸.

However, continuing work is not an option for all. Age-related disability and illness do affect a significant minority of people in their fifties. Maori can face obligations as kaumatua even before they reach their fifties, a responsibility that is

all the more significant as proportionately fewer Maori than non-Maori live into old age⁴⁹.

Older workers have some different characteristics from younger workers and often seek flexible or part-time arrangements. Older workers bring a number of benefits to the workplace. These include a positive influence on younger workers, high morale, motivation and productivity⁵⁰.

There are also costs to employing older workers. These will vary depending on employment contracts but may include higher wages, higher costs of health insurance, more time off work for some groups of older workers, and longer recovery time from workplace accidents.

Very few people involved in this study discussed paid work, although one key informant thought there would be value in private firms offering older people part-time jobs, not necessarily in their previous line of work.

Environmental factors that affect the independence of older people

Older people have some control over personal factors that affect their lives. They have less control over environmental factors such as the attitudes of others towards older people, housing options, public transport, and technological change. Yet all these factors can affect older people's ability to remain independent.

⁴⁷ Statistics New Zealand, 1999, *Labour Market 1998*, Wellington

⁴⁸ Davey, J, 1998a

⁴⁹ Maaka, R., 1993

⁵⁰ Age Concern, 1999



Attitudes towards older people

“The government should acknowledge and encourage [older people’s] knowledge, wisdom and skills by recognition. In Sydney a Senior Citizens Card allows cheaper public travel and other benefits, but more importantly it states: ‘The holder of this card is a valued member of our community. Please extend every courtesy and assistance.’” – Dunedin

“The self-esteem that comes from feeling that you still have some relevance to the world is very important for mental wellbeing. This is often lacking in the old and leads to feelings of worthlessness and depression. The latter situation has become more evident in the modern ‘throw away’ society, where old is equated with useless.” – Auckland

Over recent years there has been a growing perception of older people as “dependent” and a burden to society⁵¹. This perception causes some older people to lose confidence and assertiveness both in making contributions to society and in dealing with their own needs. Little is said about the positive economic benefits of an ageing population. These include the considerable contributions older people make to their family and to society. Service providers sometimes underestimate the ability of older people and their families to understand and

negotiate their own support needs. They also sometimes provide assistance in a way that makes the recipient dependent on it.

Attitudes to older people need to be positive in several areas. Particularly important are not discriminating against older people, enabling them to remain in the workforce, flexible retirement provisions, encouraging community and voluntary contribution, and encouraging and facilitating continuous learning, recreation and positive living.

Creating positive attitudes about older women is particularly important. Women experience more discrimination in old age than men, and more negative stereotypes about being older from a younger age⁵². On average, they live longer than men and are more likely to live alone and need care. This also means there are potentially more payoffs from fostering positive attitudes, both for older women themselves and for government expenditure.

Focus group participants, correspondents and key informants agreed that myths and stereotypes about ageing can be harmful. They stressed the importance of being valued and identified several ways of achieving this:

- Including older people in community activities, such as community fairs and festivals and promoting links with schools.
- Providing services in a way that is user-friendly for older people. Services

⁵¹ The Prime Ministerial Task Force on Positive Ageing, 1997a

⁵² Russell, R. and Oxley, H., 1990



include those provided by the commercial sector, such as banking and telephone services, as well as services provided by government and local authorities.

- Portraying older people in advertisements in a positive way, for example, using modern equipment.
- Allowing time for and helping older people to become familiar with new technology, such as ATMs and telephone banking, automatic telephone answering machines and computerised catalogues in libraries.
- Allowing time for people in their daily activities, for example, getting on and off buses.
- Recognising the contributions they have made throughout their lives and still make as older people.
- Encouraging respect for older people.
- Educating the public about disabilities commonly associated with age, such as hearing impairment and loss of sight.
- Publicising the positive aspects of work both for older people and employers. For employers, these include a positive influence on younger workers, high morale, motivation and productivity. For older people, there are income benefits and potential for more saving as well as opportunities to maintain physical and mental agility.
- Changing government and community attitudes that imply that older people are “bludgers”.

A key informant working with older people noted:

“In our society older people are not generally valued. They feel they are a burden to society, which doesn’t help their independence. Most people want to be independent and remain in their own home even if others think they

need help. They believe they will lose independence as soon as they go into care. Older people must be allowed choice and control. Independence can be taken away very quickly, particularly if their standards are ‘lower’ than those who wish to help. Even those with health needs can survive much longer if they are encouraged to be independent. The attitude of the older person is important, but so to is the attitude of others towards older persons.”

Several key informants and focus group participants acknowledged that there is a perception in the wider community that some older people are selfish. They attributed this view in part to older people’s expectation that the taxes they paid during their working lives would pay for services now, and in part to younger people feeling under pressure because of the need to pay more for education and health services and having to save for their retirement.

The Task Force on Positive Ageing outlined goals and an action plan aimed at improving attitudes to ageing and participants in this research were strongly in favour of this happening.

Housing

“Owning my own home and living in an area of Auckland where I have a unit, can see the sea and have my garden to work in is very good for me.”
– Auckland



“The trouble of shifting applies harshly to old people when the garden, lawn and house cleaning grow too much. It would save a lot of trouble if shifting to a smaller dwelling was easy and cheap. See if local bodies, charities or government will build for easy shifting.” – Waikanae

Satisfactory housing is a key factor in enabling people to age successfully “in place”. One UK study claims that “well designed, easy to manage, affordable, warm, and safe housing is as important to independent living as inputs of care”.⁵³

Living arrangements

More than 9 in 10 older people live in private dwellings. This proportion remained fairly constant over the ten years 1986-1996, despite the fact that the older population included an increasing proportion of people over 85.

In 1996, 54% of older people lived with a spouse or partner, just over 10% lived with their children and one in three lived alone. Over 70% of the older people living alone were women, and this percentage is higher in older age groups⁵⁴. The proportion of older Maori people living alone or with a partner is currently lower than for Pakeha, but is increasing. Twenty percent of older Maori live in multiple family arrangements. Around half of all older Pacific people live in multiple family dwellings, and this is expected to decline in the future⁵⁵.

Housing decisions

In 1996, 84% of older people living in private dwellings were owner-occupiers. Homeowners discussed the emotional, financial and practical implications of home ownership. Participants in several focus groups had recently moved to new accommodation and they talked about the emotional impact of moving out of their own home, whether by choice or of necessity. Some had to move because of difficulties with access, others left old homes with large sections in favour of smaller, more manageable properties. Deteriorating health was a reason for some focus group participants to move into more appropriate accommodation, such as a smaller house or a retirement village. Loneliness and fears about security also contributed to the decision to move. In several places, the supply of affordable, modern housing was extremely limited, reducing older people’s options.

Older people’s satisfaction with their housing situation was related to the choices they had made. For example, those who had moved to a more manageable house had done so to retain their independence, but so too had those who had chosen to move to a retirement village. Both these groups of people considered themselves to be at least as independent as they were previously with more time to pursue their own interests. At the same time, those who had decided to stay in their own homes were also quite happy with their level of

⁵³ Oldman and Pleace, 1995, cited in Austin, P., Cram, F., and Kearns, R., 1995

⁵⁴ Statistics New Zealand, 1998

⁵⁵ Davey, J., 1998a



independence, which suggests the ability to make a choice is the key factor in perceptions of independence. Those who wanted to move but could not find appropriate, affordable housing were least satisfied.

Rental accommodation

“Persons on fixed incomes soon become quite unable to pay high rents, so what happens then? “Homes for the elderly” also become increasingly dear, so the elderly cannot afford them. It is all a vicious circle.” – Wellington

“The main problem in our village is the conflict between central government and local government as to who is responsible for housing. Every time there is notification of a rent increase by council, anxiety occurs... We do not just live to eat. Our lives must be balanced and to me secure adequate housing and rent gives us a state of security that allows us to be independent and consequently manage our own lives. But to have to front up maybe, to a Work and Income office to apply for rent supplement is lowering the quality of our lives. It is disrespectful to us in that I have never had to do this and I worked for 48-50 years looking after myself.” – Auckland

In 1996, 11% of older people rented their homes, with a higher proportion of women than men doing so. Of this group, just over a third (35%) rented from Housing New Zealand, just under a third (31%) rented from private

landlords, 29% rented from local authorities while 6% rented from other organisations. Older Maori are more likely to live in rental accommodation than are older Pakeha people.

The proportion of older people renting accommodation has remained reasonably static over the last 15 years. This may change in the future as home ownership rates dropped for 20-39 year olds between 1991 and 1996⁵⁶.

The literature suggests that older people generally want to live in their own homes, whether owned or rented, as long as possible. Tenants, in particular, fear that they will be forced into smaller accommodation as they get older. Bed-sitting rooms or one-bedroom flats make it harder for family members or caregivers to stay overnight. There is also limited space for hobbies. One focus group participant had had this experience:

“I took one look at the kaumatua flat which was very nice but small - only one bedroom so I couldn't have whanau to stay, so I decided to stay in my own home.”

Home maintenance and modification

“I would not be the only one suffering now from worry about maintenance. I've been able to save money from my only income, superannuation, for paint supplies but I'm unable to pay someone to do the painting. Oh, to be able to be more physical.” – Howick

⁵⁶ Davey, J., 1998a



“Prices for essentials never cease to rise - we do need concessions on our rates, phone and light accounts. Any concession offered by the Council is assessed on earnings well below what anyone’s super is. It has not been changed for umpteen years and is absolutely useless.” – Palmerston North

Many focus group participants, correspondents and key informants raised the issue of the cost of maintaining houses. They referred to the importance of affordable tradespeople and the availability of family, neighbourly or community support. Maintenance was a particular concern to older people whose sole income was NZS. Many correspondents and focus group participants expressed concern at the rising cost of rates.

Cost and practical difficulties make repairs and maintenance a major concern for older owner-occupiers, and particularly for women. Some older people do not modify their homes to suit their changing needs, even when they agree that this is a high priority. Some cannot afford to do so, others do not have the energy to make changes or deny that they need to do so⁵⁷. One correspondent questioned the cost effectiveness of making such changes, which are rarely seen as enhancing the value of a house. Limited life expectancy, and the fact that most older people do not realise the investments they make in their homes before they die, further reinforce the disincentives to invest in

modifications. Despite these concerns, the literature identifies the value of and need for home maintenance and related support services for older people, especially where income is a limiting factor⁵⁸.

The Health Funding Authority provides grants to older people with disabilities who need to make essential home alterations. However, grants for alterations that cost more than \$7900 are subject to a means and asset test.

Several initiatives in New Zealand aim to help older people both carry out and meet the cost of home repairs and maintenance. Voluntary organisations such as Age Concern and Grey Power are aware of the cost of home repairs and maintenance. In some areas they offer a home handyperson service to provide low cost, reliable building, plumbing and electrical repairs to older people. Age Concern in Kapiti, for example, provides volunteer drivers, home handypeople, home visitors, security systems, and a radio programme on the local radio station on legal issues for older people. “Hire a Hubby” is a commercial approach to offering similar services. Superannuitants can apply for an advance on their New Zealand Superannuation to meet the cost of home maintenance and repairs. The maximum advance is \$1000, which must generally be repaid within two years.

A recent New Zealand study concluded that energy efficiency improvements to the housing of older people and those

⁵⁷ Steinfeld, E. and Shea, S., 1998

⁵⁸ Taylor, B.B., Neale, J.M. and Allan, B. C., 1981; Rushmoor Borough Council, 1998; Hereford and Russell, 1998



with disabilities provide significant health and quality of life benefits as well as reduced energy costs. The study notes the importance of affordable heating, good lighting and safe hot water systems to the health of older people and this is well documented in the literature. Nevertheless, older people tend to live in less energy efficient homes and often face particular difficulties improving them. A number of specific potentially cost effective measures, such as draught stopping, were identified in the study⁵⁹.

Housing alternatives

“We need a pensioners’ complex, with security, a community hall to meet others, transport to shops and doctor and help if needed, especially when you are sick. I have made enquiries and the houses are usually quite expensive to start with. The fee to cover the cost of facilities is beyond an ordinary ex working person like myself. I don’t need the golf course, swimming pool etc – only somewhere to meet and talk to others.” – Kaitaia

New Zealand has a limited number of housing options for older people who develop disabilities or want to move from family homes. These include retirement villages and kaumatua flats. Research on changes in housing confirms that older people who move tend to do so first for amenity or retirement reasons. Widowhood or moderate disability may lead to a second move to

be closer to family or medical services⁶⁰. This trend is also evident among Housing New Zealand tenants⁶¹.

Retirement villages have been actively promoted in recent years. In 1998, 2.8% of the total New Zealand population aged over 65 lived in a retirement village either in independent units or serviced apartments where residents may receive meals, cleaning and a variety of other care options. Some retirement villages provide a continuum of accommodation and care options so that residents can stay in the same village, even when they need substantial levels of care.

The proportion of people living in retirement villages is increasing, but this is not an option for all older people. Age Concern suggest that people might want to consider a retirement village if they:

- live alone, and would like more company and entertainment while retaining their own space
- are concerned about personal security and the security of their property
- want to be independent, but would like care and assistance to be available if needed
- want to be free of house and/or garden maintenance, or can no longer manage their current property without assistance⁶²

A 1990 study⁶³ found that fewer than one quarter of those surveyed were interested in living in a retirement village. The most appealing factors about retirement

⁵⁹ NZCSS, 1998

⁶⁰ Silverstone, B. and Horowitz, A., 1992

⁶¹ Personal communication, Sherry Carne, Housing New Zealand

⁶² Age Concern pamphlet *Retirement Villages*

⁶³ Colmar Brunton Research, 1990



villages were companionship, availability of medical care and emergency help. In contrast, the factors that most discouraged people from wanting to live in this environment were perceived loss of independence (39%) and privacy (28%). A quarter wished to live in a community with people of all ages.

Other options

A number of kaumatua flats were built under a programme operated by the former Department of Maori Affairs. However, the scheme ceased when the mainstreaming of funding for Maori projects was introduced. Existing flats were transferred to local authorities, marae, runanga and other organisations. There is now no comparable funding programme to support their ongoing development.

Two Abbeyfield houses have also been established in New Zealand. These are based on a British concept and are designed for people who live alone but do not want to be on their own. The houses accommodate between 8-10 residents, each of whom has a bedroom with an ensuite. Other facilities are shared and a cook/housekeeper provides meals. Residents are charged rent that is affordable for those dependent on NZS, with some accessing the accommodation supplement.

The Health Funding Authority has recently contracted Abbeyfield on a pilot basis to support the establishment of more Abbeyfield societies in the country, and to develop their monitoring of the health and support needs of residents.

The society is confident that their housing prevents some ill health and calls on health services, as well as preventing or delaying entry into residential care. The barrier to expansion is the need for capital finance for around half the value of new properties. There is currently no programme within central government that funds community organisations to provide housing for older people.

Research generally suggests the desirability of having various levels of sheltered care available in the community⁶⁴. The trend towards increasing diversity in housing for older people, and in particular housing that includes assisted living, is expected to continue. It is consistent with the growing numbers of older people living alone, and the trend away from large scale, institutional care. In the United States, specialised residential complexes and the growing phenomenon of Naturally Occurring Retirement Communities (NORCs) are resulting in favourable economies of scale by bringing services to where people live.

NORCS are becoming a feature of New Zealand too, with heavy concentrations of older people in Tauranga and Kapiti Coast, for example. One author argues that, in the future, the distinction between care at home and in an institution will blur to the point where “the very notion of ‘institution’ for people who live in housing where long-term care is available, will become an anachronism”⁶⁵.

⁶⁴ For example, Richmond, D., Baskett, J., Bonita, R., and Melding, P., 1995

⁶⁵ Kane, R. A., 1996



There is debate in the literature on assisted housing as to how much accommodation should be modified to meet the needs of particular tenants or residents. One point of view is that residents should move to a more protected environment when their health appreciably declines. Another view favours providing practical support and services as they are needed, to allow older people to age in place. In both cases, managers of rental housing or housing complexes need to work collaboratively with social workers or resident advocates to achieve a balance between the needs of ageing residents and the demands of the environment.

Assuming a future scenario of more housing for older people that provides for assisted living, the decision-making around adapting current environments, or moving into a more protected environment, points to the need for more skilled advice in this area. Such skills will be important in retirement villages, public housing and community housing for older people. Good housing decisions are critical to maintaining independence. Organisations like Housing NZ, for example, face the question of how much their housing stock should be modified for older people or maintained for generic use. Housing designs and modifications that suit older people are also likely to suit other groups such as parents of babies and young children. These include ramps for easy access, flat entry to showers and bathrooms, rails and other supportive or protective devices, wide doorways that can be negotiated by prams and pushchairs and so on. The benefits of

housing design need to be considered in a wider context.

Achieving the appropriate balance requires a level and type of skill that managers are not necessarily trained for. Some authors suggest managers should receive this training, while others believe there is a role for social workers in creating supportive housing environments for older people as they age in place.

The topic of housing options for older people attracted considerable comment from focus group participants, correspondents and key informants. The big issue was the lack of housing options for those with limited means. They identified a shortage of appropriate and affordable rental accommodation. Several thought this was a local government role:

“It is the role of local government to provide appropriate accommodation for those unable to provide their own. Housing stocks must be affordable and acceptable. There needs to be a variety of types of accommodation, including those wishing to live in a more hostel-like manner but with privacy. Older people need both independence and companionship.”

Several key informants stressed the need for more supported accommodation to provide choices along a continuum of care for older people:

“The main need is supported accommodation on the Abbeyfield model. We need lots and lots of them, with a housekeeper who can provide some personal cares. That set-up offers



emotional care and support. It would solve a real ethical dilemma we face where people have valid needs like that but can't go into care. It's a good example of where government agencies need to work closely together. Whose responsibility is it to provide such housing? Housing NZ needs to provide some properties and the health system needs to manage them. Even with pensioner housing, you need a properly trained residential manager."

Kaumatua flats can provide support for residents. Key informants in one area described how the kaumatua flats were built next to the marae. Residents kept an eye on each other and people at the marae would cook for them if they were sick. Other Maori respondents referred to the loss of their land, which means:

"We don't have our own place any more. This means a loss of our spiritual self, not to mention what we could have done if it had never been taken."

Transport and local amenities

"[My mother] is dependent on others for transport, and many of the people she depends on are elderly themselves. She now has no transport to church on Sunday, which is a grief to her, even though someone takes her to a Wednesday communion service. Should transport to other groups fail she could become virtually housebound. This would have a detrimental effect on her well being as she would no longer feel she was a valued member of society, able to make a contribution, however small." – Paekakariki

"I had two strokes in 1997. As a member of the Stroke Club I received half price taxi vouchers enabling me to visit my chemist, the supermarket and the hospital. I go periodically to the hospital for my pacemaker check-up. What helped most were church friends with cars who offered to ferry me anywhere. I can now walk but I would love someone to walk with me in case I fall." – North Shore City

Older people require easy access to transport both for daily living and to maintain their social networks. Without access to suitable transport, older people may become "prisoners of space"⁶⁶. Adult children, other family members and friends may provide help with transport but one New Zealand study found that this is usually much less than is needed⁶⁷. The focus groups confirmed that older people do not wish to be seen as too demanding and limit their requests to "really important errands" such as doctor's appointments, minimising requests for shopping and not asking for transport for social reasons such as visits to friends.

When older people can no longer drive, at best they become dependent on others and at worst they lose the ability to go out at all. Many have to rely on family, friends or community groups to provide transport for shopping, doctor and hospital visits and transport to church, clubs and social outings. The Older and Bolder group in Taihape took account of transport problems in arranging outings:

⁶⁶ Rowles, G.D., 1978

⁶⁷ Legge, V. and Cant, R., 1995



“When we go on Older and Bolder trips out of Taihape, we build in time for shopping. People have more choice, and can get things they can’t get in Taihape, such as a wider range of shoes. Getting to appointments is also a problem. Senior Citizens has a health transport service run by volunteers. There is only one taxi in Taihape, and older people can’t afford it. A lot of families have moved away. The population is falling, so it is harder to rely on families.”

While many correspondents and focus group participants relied on family to provide most of their transport, community groups also played an important role:

“Mostly family provide transport but the Centre will pick up people and take them to appointments if necessary. They have a van at the marae that is used to take older people shopping, on outings and to hui. We provide a hearty lunch on outings so that older people do not need to cook a main meal at night.”

Some⁶⁸ argue that loss of access to transport is a public problem for which public policy remedies must be sought. Among adults in New Zealand, reliance on public transport increases with age and is greater among older women than among older men. At advanced ages, proportionately more people cease to drive, generally as a result of incapacity or lack of confidence. In addition, many older women are of a generation who never learned to drive. In 1996, fewer

than thirty percent of people aged 81 and over held driver licences.

Currently, a proportion of petrol tax revenues is distributed to regional authorities to assist them fund public passenger transport (buses and trains), and programmes for the “transport disadvantaged”. These include concessionary fares and the Total Mobility Scheme, which provides a 50% subsidy on taxi fares to people with disabilities who are limited in their ability to use public transport.

Concessionary fares and the Total Mobility Scheme vary from region to region. The Total Mobility Schemes in many areas are under considerable pressure and access is restricted. The service was highly valued by recipients but some pointed out that even with a 50% subsidy, taxis were still expensive. One key informant noted that:

“Some Territorial Local Authorities say [the scheme] is a social welfare issue and central government should be funding it. They don’t see it as a community issue.”

Under proposed changes to the funding of public transport,⁶⁹ the subsidies from central government would cease. Instead, “regional councils could collect an annual regional passenger transport levy from all public and some other road [service] providing businesses to purchase public transport services of benefit to road users”. Should these reforms be implemented, subsidies for public transport and other services for

⁶⁸ see Legge and Cant, 1995

⁶⁹ Ministry of Transport, 1998



the “transport disadvantaged” will no longer be influenced by central government funding or subject to national oversight, but will be determined and totally funded at a regional level.

The Mobility Parking Scheme run by CCS has benefits for older people with a disability who have private transport. It is self-funded through charging users \$35 for a five-year mobility sticker. Local branches work with local authorities and private firms to get their support.

Focus group participants, key informants and correspondents identified transport as a major issue for older people. While in some areas, like Wellington, public transport was described as “excellent”, in many other areas it is inadequate or non-existent. Most buses are difficult to get on and off, with only a few “kneeling” buses available in the major cities. Older people also feel pressured to hurry in getting on and off buses, and taxis are considered too expensive.

Focus group participants wanted more publicity about the restricted licence option, where drivers are licensed to drive in a limited locality or at certain times of day. Some suggested that defensive driving courses for older people would be useful. However these are expensive and not readily available. While the Land Transport Safety Authority funds “Safe With Age” driver education programmes for older people, they are of limited availability. Focus group participants noted that older drivers are vital for services like volunteer

drivers and meals on wheels, so it is important that as many older drivers as possible retain their licences.

Those who needed and could afford electric mobility scooters described how these had increased their independence:

“Without it, I would be tied to the house or dependent on other people. With it, I do my own shopping, attend meetings, visit friends, take it on the train, visit the museum and attend daytime concerts. I really would urge anyone who has a mobility problem to try to obtain one.”

However, cost is a problem and some would like to see a grant or subsidy for scooters, or a rental system of some kind. Key informants also referred to the need for local authorities to provide space for motorised scooters, and their reluctance to do this.

Safety in moving around

The Senior Citizens Unit⁷⁰ reports that older people are over-represented in pedestrian accident figures and have a higher than average ratio of death to injuries. Attention to hazards could reduce the likelihood of accidents and increase older people’s actual and perceived levels of safety. Suggestions included improving the design of shopping centre parking areas and paying more attention to the needs of older people by, for example, providing more public seats at bus stops, in parks and on the roadside. Surveys of older people have identified a number of safety concerns that could be remedied fairly

⁷⁰ Senior Citizens Unit, 1996



easily. Suggestions for improvement include better street lighting, footpath repairs, paying attention to the location and timing of pedestrian crossings, and greater control over the inconsiderate use of cycles and skateboards⁷¹.

Focus group participants, correspondents and key informants also referred to the need for ramps, well maintained pavements, sound and tactile traffic signals, pedestrian crossings, good street lighting, public seating, and, in some areas, cycleways on the inside, rather than the outside of parked cars. All of these provisions help maintain older people's independence.

Overall, focus group participants were complimentary about the efforts made by local councils to improve safety and comfort in local environments.

Security

“The three things in order of importance that help me keep my independence are (1) my dog, (2) my car, (3) my cordless phone. My dog, which I bought as a puppy, is of a large breed. The dog is my ‘shadow’, never runs away and is always with me, both inside and outdoors. Because of this, I am never lonely or frightened. My car is necessary for occasional shopping, visits to the doctor, hairdresser and other things. The cordless phone can be carried around the house and garden so that I never need to run to answer the phone and can make a call if I want to.” – Alexandra

Many of the older people who participated in the study had no

concerns about security. This included a high proportion of those living in their own homes. Several correspondents and focus group participants commented on the value of medical alert and other home alarm systems in maintaining their independence. Most focus group participants had smoke alarms, a number had security lights, and several had burglar alarms. They appreciated good street lighting and had confidence in the community police in their neighbourhood. For one, security lights have made all the difference:

“I come home, enter the garage with the automatic door, and from inside the garage I can turn on the outside lights and some inside. I used to be very nervous. I just don't worry now.”

Key informants were more likely to refer to security issues, with one describing them as the “biggest single reason why people go into retirement villages and a factor in opting for rest home care”. Another referred to the fear of being in their own home as a threat to independence, particularly for women living alone. Negative recent publicity about attacks in private homes has not helped, as many no longer feel they are living in a safe society. Almost all those who had decided to move to a retirement village or into pensioner housing were influenced by concerns about security. Some saw it as an advantage that, when one partner died, the remaining spouse could stay on in a secure community with support.

Several participants wanted the government to increase numbers in the

⁷¹ Keys, F. and Brown, M., 1993



police force. They thought that if this happened, more police and traffic officers would patrol the streets and deal with skateboarders and “careless drivers”. Others thought that older people needed to take more responsibility for their own safety. One commented:

“Individuals have to get smart and learn not to be duped e.g. opening the door to people they don’t know and getting more than one quote for a job. The biggest group of vulnerable older people is single older women living alone in rented accommodation.”

Technology

“I think one of the most difficult things for our generation is trying to understand and cope with the new technology. Banks closing local branches, especially in the country, is really hard and frustrating. Answerphones and having to deal with recorded voices instead of a person is infuriating. By the time you push the right button you’ve lost the connection. So far I’ve resisted using a window bank and Eft-pos and intend to do so as long as possible.” – Christchurch

While a number of older people recognised the importance for independence of keeping up with technology, many were put off by changes in banking technology and by the increasing impersonality of telephone contact with government departments. While some used automatic teller machines (ATMs) and Eft-pos, very few used telephone banking.

“I won’t use a telephone to do my banking as I want to see the people face to face.”

Some were nervous about using ATMs:

“I’m nervous about using a ‘hole in the wall’ if there’s a lot of people around. I’m anxious people may be wondering if I’m a suitable person to hit on the head. Once I was surrounded by a lot of teenagers who demanded money.”

Several commented on the reduction in services by government departments. Both the Inland Revenue Department (IRD) and the Department of Work and Income have become more telephone-oriented which can be a problem for older people. The IRD used to have a home-visiting service and ran clinics in small towns. Both of these services have ceased. Key informants also raised this point.

Some older people found it hard to locate government agencies and departments in the telephone book because they did not recognise the names, which did not always relate to their function. Some had problems talking on the telephone because of hearing difficulties. Others had problems due to impaired vision. The Royal New Zealand Foundation for the Blind (RNZFB) argued for stronger disability legislation to deal with this. Such legislation might cover:

- the need for speakers on buses and trains to let people know what bus or train it is and what stop they have reached
- standards for banking such as ATMs with braille and voice feedback repeating the instructions on the screen



- more use of voice and tactile markings in the environment
- telephone services with large number telephones and telephone accounts in braille
- menus in braille
- hearing loops in public buildings and telephones. Hearing loops are wires installed in buildings or in telephones through which broadcast sound or announcements are fed. People with hearing aids can tune into the loop and pick up the sound directly

One correspondent pointed out that smoke alarms and appliances such as microwave ovens need to have a low frequency tone or ring so that those with a high frequency hearing loss can hear them.

SeniorNet is an organisation aimed at older people who have been “missed by the computer generation”. As well as helping older people master the new technology, it encourages them to remain mentally alert and socially active. It gives them the satisfaction of achieving new skills. Some local authorities provide subsidised facilities, and the tutors are usually older people who volunteer their services. Members of SeniorNet appreciated the opportunity to use the Internet and keep in touch with their children and grandchildren using email. Others used computers for word processing, accounting and business. However, funding limitations restrict opportunities for expansion which some saw as indicative of the low priority given to education initiatives for older people.

Services that help maintain the independence of older people

This section begins with a discussion of general services. This is followed by a discussion of personal services, ending with a discussion of support and services that help maintain the independence of older people with an illness or disability.

General services

Health promotion and injury prevention

“I am an 88 year-old widow living alone in a flat, and last year I had to have an operation for a knee replacement. I had it done at a private hospital at a huge cost. I now have arthritis in my other leg and hip and have used all my savings, so have to suffer. I haven’t transport, but the Total Mobility vouchers have been of great help in enabling me to do my weekly shopping by half-price taxi fares. I do have a little home help, as I am in a two-storeyed flat and a gardener once a month, both paid for by members of my family. Otherwise I would have to think of a rest home, which, heaven help, I would hate.” – Lower Hutt

Influenza immunisation, the ACC falls prevention campaign and the Hillary Commission Kiwi Seniors initiative are examples of preventive programmes that can reduce the illness and accidents rate for older people. This reduces the flow through to other services, including institutional care in the cases where a short-term event triggers a higher level of care need in the longer term.



Some community groups offer health education and wellness programmes as well as monitoring the welfare of older people in their community. Relationship Services has developed guidelines to ensure that counsellors know about issues older people commonly face, and suggests strategies for dealing with them. Relationship Services receives requests for counselling from older persons, or has older persons referred to them. The service recognises that older age is a time of life-style changes, which include adjusting to such things as retirement, bereavement of partner, intergenerational issues, and changes in relationships, including divorce.

Many community organisations providing health support services receive only modest funding from government and raise most of their funds through other avenues. They have to meet stringent accountability requirements which some saw as disproportionate to the sum provided and a hindrance to the work of the organisation.

“The Association gets a small amount of funding from the HEA – around \$8,000 from a total budget of around \$95,000. In return for this money we have to provide our services to all people, regardless of whether they are members or not. For their \$8,000, which comes in four lumps of \$2,000, we have to provide monthly reports, and renegotiate each year. They ask for a huge amount in return for a small sum. It takes 3-4 hours per month of a field worker’s time to complete the statistics and reporting requirements.”

We have one paid worker and one field worker. Telecom gives us a fax machine and the council charges residential rates otherwise all the rest has to be raised.”

The quality of GP services for older people

The poor quality of interactions between doctors and older women is a common theme in the literature on the loss of women’s independence. One study⁷² noted that older women considered that GPs did not relate well to them and neglected important issues such as incontinence, oral health, polypharmacy and alcoholism. The failure to manage incontinence, in particular, is often a major factor in determining admission of an older person into a rest home.

One Maori health group offered a free GP service on Wednesday afternoons to Community Services Card holders:

“Older people often run out of medication e.g. for diabetes and blood pressure and they can’t afford to pay the doctor to get more. This gets round that. We also have podiatry clinic once a month, a monthly wellness programme and a weekly fitness programme.”

The Taihape Older and Bolder Group liaised with District Nurses to build strategies, especially for confused older people and for home visiting. This arrangement worked well, with all parties agreeing that the service helped prevent premature entry into care. These initiatives were successful and

⁷² Steinberg, M., 1997



appreciated. However, the community group received no health funding for providing this service.

Other support services

“The St John’s emergency alarm system should be more widely advertised and made affordable to older people who live alone to give reassurance that help at any time is only a phone call away. Meals on Wheels is a wonderful service for the ailing elderly and the Red Cross do a wonderful job, but now is the time to revamp the service and make it attainable to all older people no matter what the state of their health is. This could be at a small cost to the individual, who would I’m sure, gladly pay to have a meal prepared and delivered to them. Age Concern does a great job for the elderly in their own homes, giving them caring support, aid and companionship, and all done voluntarily.” – location not stated

Not all the support services that help older people remain independent are associated with their health. Meals on wheels, security services and practical support can do much to aid the independence of older people.

Home delivery of groceries and prescriptions is common in some suburbs and small towns but less common in the cities. One key informant noted the introduction of an Internet ordering service by a large supermarket chain. It includes a \$15 delivery fee. They cited this as an example of a service that is not suited to older people, relatively few of whom have computers or can afford the fee, and suggested that supermarkets might consider an

alternative for those who need home delivery but cannot afford to pay for it.

Financial organisations like insurance and trustee companies do target older people with information and participants appreciated their willingness to provide speakers for groups. Information on the Department of Work and Income entitlements, IRD requirements or strategies for managing money can help older people retain control of their finances and their independence. Many wanted more information, particularly on entitlements, but, as noted above, this can be difficult to access, for example, through the reliance on touch tone telephones.

Some local authorities have demonstrated innovative approaches to meeting the needs of older people. In Auckland, for example, one city council has a council representative at Age Concern meetings who can pass information to and from the council. The council also has a disability advisory group, whose members go out on site visits and advise on access issues. Another city council recently ran a forum with the local disability network and has established an internal working group to look at disability needs, including the provision of mobility car parks, seating, kerbing and space for mobility scooters.

Personal services

Access to specialist and acute care

Timely specialist and acute care can be critical to preventing longer term care needs. The ageing of the population brings with it increased demand for specialist and acute care, as older people



use more health care than younger people. Some rationing of government expenditure on health care does and will continue to occur.

Unevenness in the funding of health services for older people can be problematic, with smaller centres and rural areas being especially disadvantaged. Psychogeriatric services and support for the confused elderly and their families are generally under-resourced, and the voluntary sector needs financial support for administration and field officers. There is a need to develop programmes consistent with the concept of “ageing in place”, as well as multidisciplinary health promotion and education programmes for older people⁷³. Integration of services and funding is a critical issue for the future. At the policy level, the National Health Committee has expressed concern about the pressure that waiting lists for acute services place on the demand for Disability Support Services (DSS) support, within fixed budgets⁷⁴.

Focus group participants identified a number of problems in accessing health services, particularly specialist care. In some areas, some specialists visited on a regular basis. In another, a 10-minute telephone consultation was available with a specialist from the local hospital. This was a new service which some regarded as a dangerous trend, although they acknowledged that it did increase the range of services available. In rural areas, there are costs over and above the actual cost of medical services:

“We need transport and accommodation allowances for specialist services. If someone has to go to a public hospital, directed by their GP, and they need to stay overnight, they need accommodation and transport. At present, it’s old people driving old people – they get a grant for petrol - but it’s a basic essential service. There’s no payment for the cost of staying.”

Others referred to the long-term costs of deferring medical treatment. There was resentment about the age bias that was seen to be part of the priority setting formula for operations.

“The waiting lists are very stressful. The booking system is inequitable, frightening. You lose points if you are older. Older people minimise their problems because they don’t want to be a nuisance. The present system is next door to euthanasia - if you’re 70 we’ll kill you off.”

“There’s a huge irony in the government spending lots of money to support people in their own homes while they wait for a cataract operation, which should be able to be done very cheaply and quickly. In future we will have more people at the point where they will need care because relatively minor ailments are not attended to early enough.”

Costs of health services

Paying for health services privately is an

⁷³ Richmond et al., 1995

⁷⁴ National Health Committee, 1999



option for a limited number of older people. The cost of private health insurance can be prohibitive for older people, with correspondents quoting prices ranging from \$1500 to \$5000 per year. Hearing aids are also expensive – up to \$3000 for modern aids. Government subsidies are available for people who need these aids for their work, but they are not available to non-workers. Spectacles are also expensive but these are not subsidised, yet both spectacles and hearing aids can enhance the independence of older people. An advance on New Zealand Superannuation is available to purchase these aids, however an older person with no additional income may have difficulty repaying the advance.

Pacific people who are not New Zealand citizens can also be required to pay for hospital care. Sometimes families bring older family members to New Zealand to live with them, but these older people are not eligible for free medical care or equipment. Some health professionals have proposed that a pool of equipment be established for hire or borrowing by non-residents so that they can care for their older people appropriately.

Support and services that help maintain the independence of older people with an illness or disability

Failing health is a major reason for loss of independence. Several key informants emphasised the need to acknowledge the interrelationship between health and wellbeing and services and needs. One identified the need for a continuum of services:

“One of the big factors for security of retirement is older people knowing that

the range of services they might need is available. In the past, we only had a hospital with a rest home and continuing care. We’ve since developed a range of services from community to continuing care so they can have that security. They know there’s something there that will repair them quickly when they get acutely ill. They also know that as they gradually deteriorate they can stay in the community with their friends and relatives.”

Family care

“My husband suffers dementia caused by a blood clot to the brain. At 93, surgery is not an option, but his disturbed nights and confusion are so tiring on me. Lack of sleep over 18 months has brought me down. Although our wish is to care for him at home it is becoming obvious that this may not be possible for much longer. One thing the health system doesn’t provide is someone to sleep in so the caregiver can recharge her batteries for another day. Lack of sleep is the main problem as the patient invariably wants to be awake and roaming the house during night hours. Can you help us?” – Napier

“My mother had a stroke 4¹/₂ years ago. She was hospitalised for three months and came home to 24-hour care. For Mum to remain at home, we needed the following:

- *Initial nursing help, support and demos on showering etc*
- *Furniture - bed and a chair, aids, stools, handles, walker etc*
- *Meals on wheels and meals from family for the first year*



- *Paper boy who brought the paper in and milkman who brought milk to terrace*
 - *Family to do grocery shopping and other shopping when needed*
 - *Community groups who collected her for stroke group, blind outings etc*
 - *Household help once a week was really not enough, family did remainder*
 - *Family to do gardens and paid man to do lawns*
- At times we found it difficult...but we are proud we did it for Mum. She was a lovely happy person to be with.”*
– Blenheim.

Whether or not an older person continues to live independently depends to a large extent on whether they have family support. Individuals who do not have a family carer tend to move into residential care earlier than those who do. The presence of a live-in carer is particularly important for older people who have an illness or disability.

Family care is common. A 1994 New Zealand study⁷⁵ found that more than one-third of the total adult population was providing regular informal care to older people, with people who were retired, unemployed and homemakers providing the largest amounts of care. A survey showed that over half the help provided to older people to prepare food, bathe, do housework, get out and shop was provided by family and friends⁷⁶.

Providing care to family members can however be stressful, and the breakdown

of this care is another factor that decreases the likelihood of independent living. A comparative study of residential care and home care for older people in Auckland scored home care ahead on costs and client satisfaction, but found higher stress levels existed for family carers⁷⁷. Key informants noted that families and caregivers vary considerably in their ability to care – both emotionally and practically. Their attitude is important and affects the level of risk they will tolerate. This in turn affects the older person’s ability to remain independent. Education and support may increase family members’ ability and willingness to care appropriately for the older person. One health professional commented:

“We often have to work hard with families, to encourage them to give older people a chance. We need to listen to the family’s concerns and try to deal with them, thinking through the worst possible scenarios and their implications. Families get really worn down. Some families are really positive, others undermine the stay at home option. The role of social workers is to make sure the family has all the information they need to make a decision. They need to encourage the family to think of what will give the older person the best possible care, rather than automatically assuming that having them home is the best option. That can help the family member let go. Moving into a rest home is not necessarily a failure.”

⁷⁵ Abbott, M. and Koopman-Boyden, P., 1994

⁷⁶ The 1992-93 household health survey, cited in “NZ Now: 65 Plus”, Statistics New Zealand, 1998

⁷⁷ Richmond, D. and Moor, J., 1997



Carer stress is also a factor in elder abuse and neglect. Services to deal with this have been established in New Zealand, with many being provided by Age Concern. An elder abuse co-ordinator acts as a first point of contact for all enquiries concerning elder abuse and neglect, and makes referrals, as appropriate, to a range of existing intervention services for clients. In 1998, the Senior Citizens Unit worked with the former NZ Community Funding Agency (now the Department of Child, Youth and Family) to develop service standards for elder abuse and neglect prevention programmes. Child, Youth and Family outreach workers monitor the services and their adherence to the standards. One key informant described a different kind of abuse. In this case, she referred to older Maori people, but other older people could be in a similar situation.

“People don’t think they are abusing the elderly when they go to visit and take a couple of mokopuna with them. That person may be getting meals on wheels. The elderly can’t eat in front of them so the children get the food and the older people go without. They ask for money on pension day to fill their cupboards but the cupboards of the elderly are not being filled.”

Some key informants referred to the cost of caring, noting that it can be financially difficult for some caregivers to give up their careers. One suggested that an option similar to parental leave could be useful. In Pacific communities, some school age children stay home from

school to look after an older parent or grandparent, especially when the latter is sick or has a disability.

A strategy for family caregivers

Acknowledgement and support of the contribution of family carers is of both economic and social importance. It has been estimated that if caregivers ceased to provide care, New Zealand would need 50,000 to 60,000 additional residential care beds⁷⁸. One writer⁷⁹ argues that those who provide the most care should be treated as clients in their own right, with a system that provides them with support, training and advice. Increases in the complexity of care in the home means that family carers, as well as workers, need better training. They also need professional advice and support, help with housework, more understanding from family and friends, a regular holiday, an occasional night sitter, and an occasional half or full day off. Several carers, most of them older people themselves, wrote describing the pressures of caregiving. The greatest need was for night care and weekend relief.

The beginning of a strategy that focuses on carers is evident in New Zealand. Carers are entitled to respite care based on an assessment of their needs. However the level of respite care provided falls a long way short of what many carers would like, particularly in terms of weekend, evening and overnight relief. Relief care is available for up to 28 days per year for those cared for full-time by family.

⁷⁸ Abbott, M. and Koopman-Boyden, P., 1994

⁷⁹ Hennessy, P., 1996



In the 1998/99 financial year, a sum of \$500,000 was available through the HFA for developing training packages for carers. The funding will continue for a further three years. The project is in its early stages and will include videos and training packages for caregivers. The uptake of training will depend on a number of factors including the carer's wishes, the availability of training packages, and the availability of relief care while undertaking training.

Carers are entitled to the Domestic Purposes Benefit if they meet the benefit income test. At 31 March 2000, only 2.1% of recipients of the Domestic Purpose Benefit were carers of the sick and infirmed of any age.

Services provided at home

Home-based services are essential to keep many older people out of residential care, and to prevent the health and abilities of even greater numbers of older people from deteriorating. As part of a broad consensus on the value of moving away from using hospitals to provide long-term care for older people, and of keeping people with low levels of disability out of institutional care altogether, New Zealand has moved towards integrating funding for institutional care and many home-based services and support through DSS. There have subsequently been increases in expenditure on home-based services⁸⁰. Further increases are anticipated as the population ages.

Services provided to older people with a

disability or illness at home include: homecare - personal care, such as bathing and toileting; housework, including cooking and shopping; equipment; visits from medical or health professionals, for example to provide medication; and visits from "home visitors" for social contact. Participants in this study who received home help were immensely appreciative of it, describing it as moral as well as practical support. Nevertheless, the conclusion of this study is that the mix and quantity of services being provided is less than desirable.

"My wife was discharged from hospital in September 1998. She was sent home unable to walk. The staff at the local hospital were convinced we would not be able to handle the problems so we were left without critical information – we were alone! What helped?

A nephew who informed us there was help from Homecare 2000, so I contacted Community Health at the local hospital. Next I found out there was a social worker at the hospital and the system began to function after about a week of frustration. Then we were able to contact the OT⁸¹ at the hospital and find out we were serviced by a "unit" some kilometres away, where resources were available.

Homecare2000 provides 5-day support for the patient (one hour a day). The quality is excellent but the weekend is, in many cases, a real problem. The family is not the coherent unit it used to be and it has proved quite impossible

⁸⁰ Health Funding Authority and Ministry of Health, 1998

⁸¹ Occupational therapist



for our family to provide weekend care. The solution - 'Panacea' will supply staff and we will pay for help. St Johns provides a night care service for which we pay, to put my wife to bed and make her comfortable. And we two are some of the happiest people in our area and hope to celebrate our 60th wedding anniversary in December 1999."

– Auckland

"My neighbour is 82 and never married, having looked after her own parents for many years. She is riddled with arthritis but extremely independent. The last few years she has moved around her unit with the aid of a walker but, due to several steps at both the front and back door, she has not been out of the house for at least six years. She has been visited by several organisations and the only help they could suggest was physio. It appears that there just aren't the people available for home visits. As old age isn't covered by ACC, it is, to an elderly person, just another cost to add to the gardener, lawn mower man and weekly home help who supervises her shower. There is an immediate need for home visits by physiotherapists to help the elderly maintain confidence in movement and stay in their own homes." – Auckland

Accessing services at home

There are a number of different routes to accessing care at home. Care needed as a consequence of an accident is provided free of charge through ACC, and post acute care is generally provided free of charge through public hospital services. In most cases, services needed to meet an ongoing illness, or disability, and are

accessed through DSS. The assessment of need for services is carried out separately from the provision of services and equipment. There are some regional differences in the approach to assessing need and the types of services provided. Home care services are provided free of charge to older people who qualify for a Community Services Card due to their limited means. People with sufficient means typically organise their own care and services.

While there is a high level of appreciation for these services, a number of studies in New Zealand and overseas have identified problems in service delivery. These include emotional, economic, physical, knowledge and communication barriers to access. Several key informants and correspondents commented on the difficulty of obtaining information:

"It's very hard to get reliable information on entitlements. People don't know where to go. Income Support does not advertise entitlements or grants. They need to know about their entitlements – they're always changing the rules. Staff are very difficult to deal with. People need to be assertive and empowered to be successful."

Some focus group participants suggested publishing information on entitlements and agencies in local papers, and broadcasting it on television and talk back radio. Others believed there is a need for advocates to help older people understand the health system and to negotiate on their behalf. In their view, success in obtaining services can



sometimes depend on the sympathy and skills of the older person's GP. Some focus group participants maintained that government resourcing of advocacy groups would be beneficial.

Health professionals and agencies providing care also need to become skilled in meeting the age-related needs of older people. This covers providing an appropriate carer as well as appropriate care, and dealing with people's perceptions of the service sympathetically:

“Perceptions are crucial. They reflect the amount of power people feel they have in accessing services. The amount is determined by the service co-ordinator based on need – people have to have bureaucratic assessments and feel powerless.”

“A key to quality home help services is the careful matching of the person being supported with the help, which means that there is high quality social interaction.”

Services provided at home need to consider differences in culture, gender and class, as well as the “little cultures” which older people construct for themselves. Studies show that while kaumatua make a strong contribution to whanau life, they face barriers to accessing services for themselves. Barriers include cost, lack of culturally appropriate services, lack of appropriate information and a lack of integrated services⁸². Some Maori focus group

participants noted that in their area:

“There are no Maori assessors when they come out to see what we need. They always come with a Maori worker, but it would be nice to have a Maori to talk with about our needs.”

Maori also raised the inappropriateness of DSS assessment processes in a recent investigation into the homecare industry⁸³. Examples raised included the use of non-Maori assessors in Maori families, the focus of assessment and tasks on the individual with a disability as the “client” rather than the household, and maintaining contact about changes in need by phone rather than face to face.

Lack of flexibility in service provision was seen as a major barrier to independence. Key informants referred to the need for more flexibility in the kinds of tasks caregivers can do, as well as the time they are available. At present, decision-making on the provision of services varies by region. Caregivers in some areas are not allowed to do “outside” tasks and none can give medication. In rural areas, the former restriction is particularly relevant. Although older rural residents may be entitled to a disability allowance to cover extra services, such as chopping and bringing in firewood, it can be difficult to find someone who can call in as often as is needed. In both urban and rural areas, the inability of caregivers to give medication attracted considerable comment:

⁸² Te Pumanawa Hauora, 1997, p45

⁸³ Burns, J., Dwyer, M., Lambie, H. and Lynch, J., 1999



“Caregivers theoretically can’t transport them. They can’t chop firewood, which is considered an outside job. They can’t give medication – this is a huge problem, especially in rural communities. It puts the caregiver in a difficult situation. District Nurses can’t visit every day and people have blister packs⁸⁴. They simply have to watch them actually put the pills in their mouths.”

In more urban or suburban areas, shorter allocations of time for delivering home care might be more effective. One person suggested the following approach:

“At present, care is only available in units of one hour. There could be ten minute slots where one carer has a number of people and just pops in to check they’re OK, give medication etc – monitoring. There is unevenness in the availability of home care – when it’s easy to access it, it can keep people out of care; when it’s not, they have to go into care.”

Having appropriate services available was raised as an issue. Some people found there were no services available:

“It’s difficult to find people to sleep overnight. If the government provided payment for people to sleep over, this would mean we’d stay longer in our own homes.”

Others did not know how to access services, even if they were willing to pay. One woman in her late eighties, for

example, wanted help with housework but did not know how to access the services of someone reliable and trustworthy. There is obviously scope for publicising services better.

Some contributors debated the nature of appropriate home support, noting that while home care services can help older people remain at home, they can also entrap them:

“Physical frailty can cause chronic illness. Older people can get help with meals, cleaning and showering, but they need to be able to get through the day on their own, using the toilet and making cups of tea. Those living alone may become socially isolated. Or caregivers [either family or paid workers] may do too much and take away the last shreds of independence, for example, not encourage the person to dress herself.”

Inefficiencies and delays in providing home support services can adversely affect an older person’s ability to remain independent. Access to equipment was a particular concern. One health professional commented:

“Home modifications can take months. It can take 10 weeks to get approval for rails on a path. In one case, the OT⁸⁵ had to go back and get an extra quote. It’s hard not to be cynical that this is a cost-saving strategy. Trialing equipment is another example. It used to be easy to borrow equipment to trial. You can’t put in a funding application

⁸⁴ These are packs prepared by pharmacies with medication sorted into appropriate dosages

⁸⁵ Occupational therapist



till you've trialed it. You have to wait ages for applications to be considered, meanwhile the equipment has gone on to the next person and the client is left without anything."

Another sought easier access to equipment such as wheelchairs:

"To help family members take older people out. It improves their sense of wellbeing, relieves depression and means they can go to tangi, hui and so on."

Several key informants highlighted gaps in respite care. Currently, temporary care in rest homes is available for up to 28 days per year when a carer is not available to care in the home. While many saw this as an excellent and necessary service, it is not available for one-off purposes, for example, for a single person who has a heart attack. If subsidised care was available, an individual could convalesce in a rest home and reduce the likelihood that he/she will either stay in hospital longer than necessary or go home too early. This kind of subsidised care is available through ACC to older people who have an accident.

The lack of subsidy or payment for night care also drew comment. Focus group participants, key informants and correspondents all cited examples of cases where the lack of such care had meant that an older person had had to go into care. One health professional pointed out that paying for such care was

still cheaper than paying for full-time care. Another commented:

"We need better night care services – it's a resourcing issue. Home Support providers are stretched to meet demand. They can't always turn up on time – this can make a real difference to older people. So the issue is not only the number of hours but timeliness – people need to be able to organise their lives."

Managing the costs of care for both government and individuals

The question of income security in old age is being addressed with greater and lesser degrees of success by most OECD countries, including New Zealand. Less attention has been paid to funding the costs of care on a long-term basis in either institutional or home-based settings. In New Zealand, care on a long-term basis is funded through a mixture of private and public expenditure. Older people must have assets below a specified level before they qualify for a residential care subsidy. They must also contribute any income they get towards their care up to a maximum of \$636 per week⁸⁶.

The current policy mix in New Zealand provides different subsidy levels depending on the care being accessed. At the home services end, there are concerns that people who cannot access subsidies do not always pay for, and therefore receive, the services they need. This tendency is confirmed by research⁸⁷, and can result in more rapid deterioration in health. As one key informant commented:

⁸⁶ *Residential Care Subsidy: Income Series* (undated) - Booklet published by Work and Income New Zealand (WINZ), Reference Code A3/7

⁸⁷ Bebbington, A. and Davies, B., 1993



“Costs can be high and a lot of elderly have grown up expecting it all to be free. They won’t part with money if their life depends on it and sometimes it does. They have been frugal and saved and want to pass their money on.”

Several key informants discussed the cost of home care services with one noting that making the service free to Community Services Card holders puts a lot of financial pressure on the system. Different suggestions were made as to how the system could be made fairer and resources freed up for those who really needed them.

At the institutional care end, a small percentage of older people are vulnerable to their savings being eroded very rapidly, at up to \$30,000 a year, when they or their partner require permanent residential care. Of concern also is the extent to which better-off couples and individuals plan their financial affairs in order to avoid their assets and savings being eroded.

Reliable mechanisms for paying for long-term care, whether at home or in an assisted living or residential setting, are needed, so that people have some certainty about payment for their services⁸⁸. There is general agreement in the literature that uncertainties for both purchasers and insurers make it unlikely that private competitive markets will provide adequate insurance for long-term care⁸⁹. The risk of the burden of long-term care costs for individuals is so great that most writers agree that

government needs to be a major player in this area. This is also important for equity, as asset-testing sets up incentives for ways to reduce assets through early gifting and other means⁹⁰.

There is no consensus over whether social insurance or government funding is the best method to fund the costs of long-term care. Most countries have some mix of insurance and tax-based funding, and some have user charges. Germany has moved towards introducing compulsory insurance for long-term care. France and Japan have health insurance schemes that provide considerable coverage of long-term institutional care in hospitals and elsewhere.

Summarising the issues for Maori

Improving life expectancy is an important issue for Maori, so that more Maori reach old age. The gap between the life expectancy of Maori and non-Maori is expected to close, as the life expectancy of both groups increases, although at a slightly faster rate for Maori than for non-Maori. Maori are now only 2.9% of the population over 65 but that proportion is expected to rise to 4.8% by 2011.

Maori in old age have less income than non-Maori. In 1996, the median annual income for an adult over 65 was \$12,040, while for Maori it was \$10,380. Older Maori are also less likely to be in paid employment than Pakeha.

⁸⁸ Hennessy, P., 1996

⁸⁹ Goerke, L., 1996

⁹⁰ St John, S., 1993



Income is a predictor of health status, a finding supported by a 1997 study⁹¹ which found significant differences in the health status of kaumatua according to income. Incomes of less than \$20,000 were more often associated with low, than with high, health scores. A more recent study⁹² found that older Maori had higher hospitalisation rates from injuries, cardiovascular disease, diabetes, respiratory disease and most cancers than non-Maori. Given their income status, older Maori rely heavily on state provision of health care.

The growing proportion of older Maori will have implications for health services.

Maori in this study, as in earlier studies, wanted more appropriate provision of health services, for example, Maori assessors for disability support services. Some believed that health service delivery would also be improved by more home visits by health professionals⁹³. Two Maori key informants gave examples of positive health initiatives designed to meet the needs of older Maori people. In one case, health clinics and education programmes were provided on a local marae, as part of a health service funded through the HFA. The providers of this service would like to see the HFA consider funding rongoa, or traditional Maori medicine. In another service, also funded through the HFA, a Maori nurse attached to a local clinic visited older Maori in their own homes.

Maori focus group participants

emphasised the importance of community involvement to the independence of older Maori, while acknowledging that the demands on older people can be tiring. Older Maori benefit from the status accorded to older people, especially kaumatua who are generally optimistic about ageing. However, age-related disability or poor health can result in weakened marae participation and weakened cultural identity⁹⁴. Participants in the study suggested that the government fund kaumatua hui to strengthen cultural identity and community links.

Maori are less likely than non-Maori to live alone or with a partner - 20% live in multiple family arrangements. They are also more likely to be in rental accommodation. In the study of the health and well-being of older Maori, those kaumatua who did not live in their own home were more likely to report poorer health⁹⁵. A number of kaumatua flats built under a programme operated by the former Department of Maori Affairs have now been sold to marae, runanga, community trusts and local authorities. These can provide a supportive environment for residents, particularly when whanau are not able to provide support. There is no comparable funding programme to support their development. Some Maori focus group participants drew attention to the negative impact of the loss of their land, which not only restricted their housing options but also meant a loss of their “spiritual self.”

⁹¹ Te Pumanawa Hauora, 1997

⁹² National Advisory Committee on Health and Disability, 1998

⁹³ Te Pumanawa Hauora, 1997

⁹⁴ Te Pumanawa Hauora, 1997

⁹⁵ Te Pumanawa Hauora, 1997, p.60



PART IV: SUGGESTIONS FOR CHANGE

Suggestions for change relevant to the goal of maximising “ageing in place”

Critical support issues for older people

This research identified a number of areas as critical to the independence of older people.

Most importantly, what individuals do, and what happens to them before they become old, influences independence in old age. Individuals can enhance their chances of retaining independence by having a successful, healthy and active life before and after reaching old age.

Financial resources, an active mind, good relationships with family and friends, fitness and health, and good self esteem are all associated with being able to stay living independently. Even when serious disability or illness occurs, these personal resources and social capital increase choices and enhance the likelihood that an individual can access services, be supported informally, and stay living independently. From the perspective of habits and confidence, older people are more likely to be active and happy in retirement, if this has been the case earlier in life.

There are, however, no guarantees. Old age is probably the most difficult phase of life for which an individual has to plan. Individuals face more uncertainty about key areas of their life when old than at any other life stage. These include how long they, and any partner, will live, and in

what state of health. From these, flow uncertainty about how long they will have the capacity to earn from work, to undertake jobs around the home, to drive and get around unassisted, to see, hear and communicate, and to remain active and motivated.

Individuals have different earning patterns and expenses over their lives and therefore widely different capacities to save for their needs in older age, and to provide a buffer against the unknown costs of ill health, disability and longevity.

Other areas critical to independence in old age emerged from the research. While the importance of different factors to individual older people varies, they were raised in approximately the following order of priority:

- positive attitudes to ageing
- income
- support with personal health needs and needs arising from disability and degenerative conditions
- housing and security
- access to transport
- recreation, education and use of public amenities
- work

Positive attitudes to ageing

Positive attitudes towards older people make a difference to their independence. A theme throughout the literature, and in the focus groups, letters and interviews, is that “costs” to society flow from the prevalent view that older people are “dependent” and a burden to society. This occurs because regarding older people as dependent:



- fails to preserve an active and useful role for them
- makes them less assertive and confident in looking after their own needs and contributing to society more generally
- contributes to their sense of isolation and depression
- leads to services and amenities disregarding the needs of older people, or hindering their independence
- accentuates divisions between young and old

Older people made a number of suggestions to improve attitudes towards older people including:

- More active support for a positive attitude towards older people, led by central and local government. One contributor described an Australian identity/entitlement card for senior citizens which has a supportive slogan on one side.
- Encouragement of staff in firms and government agencies to treat older people with respect.
- Instigation of a nation-wide project encouraging older people not to be afraid of change.
- Specific inclusion of older people in community activities.
- Promotion of links with schools.
- Portrayal of older people in advertisements in a positive way.
- Publicising the positive aspects of work both for older people and for employers.
- Educating the public about disabilities commonly associated with age, such as hearing impairment and loss of sight.

Our overall impression was that more needs to be done in all sectors to improve attitudes towards, and responsiveness to the needs of older people. Service providers, in particular, could benefit both their businesses and taxpayers by avoiding the trap of treating older people as dependent. As older people become a larger proportion of the population, their numbers and consumer power will add traction to positive attitudes set in place now.

Policies that focus on costs can result in policy for older people being viewed negatively. The emphasis shifts to what can be taken away, rather than being centred on ways to help older people achieve greater levels of independence and productivity.

Other key areas

The other areas identified in this study as critical to the independence of older people largely relate to support needs and the provision of services. The following discussion firstly elaborates on each area, including the issues raised by older people themselves, then looks at the roles of different sectors in better supporting independence.

Service and support - issues and gaps Income

Financial insecurity was a major issue for many of the older people who took part in this research. They were particularly concerned about the unpredictability of costs, especially for surgery and long-term care, and the erosion of their investment income through falling interest rates. In letters, interviews and discussions, older people made a number of suggestions for change. These included:



- Increasing the benefit for people living alone - many of their costs are the same as those of a couple, particularly rates, insurance and utilities such as a phone.
- Making it easier for older people to raise money, e.g. for home repairs, to buy mobility scooter, etc. This could be a charge on older people's estate through an equity release system.
- Supporting community groups to provide financial advice, help older people with paying their bills and act as an Enduring Power of Attorney.
- Providing tax relief for older people whose income has been affected by falls in interest rates.
- Making expenses associated with care fully tax deductible e.g. extra home care and home help, paying for someone to stay overnight.

Personal health needs and needs arising from disability

Having speedy and affordable access to health services was a major concern for older people, many of whom wrote or talked about their anxiety about having to wait for health care or not having sufficient post-operative or long-term support. They identified a number of gaps in social supports and referred to a lack of co-ordination between personal and disability services. Some mentioned the variable quality of GPs' knowledge of the needs of older people and management of conditions such as incontinence. Some older people in their late 80s were caring for partners of a similar age and they and other caregivers noted the stresses they were under and the need for more support and relief. The area of health and disability support services attracted the most

recommendations and suggestions from older people, including:

- Having more specialist medical services available locally, through visiting services or mobile clinics.
- Reinstating district nurses and social workers in the community.
- No restriction of health services on the basis of age.
- Providing public hearing aid clinics and help with buying hearing aids.
- Early intervention for ailments, such as cataracts and hip replacements, to save costs later and improve quality of life.
- Providing more funding for field officers and co-ordinators of support groups and home visitors.
- Streamlining accountability requirements for voluntary organisations.
- Funding rongoa - traditional medicine.
- Restoring subsidies on drugs, for example, for hypertension.
- Subsidising Medic-Alert and other safety alarm systems.
- Subsidising care in rest homes for people who have been ill, so that they don't have to stay in hospital longer than necessary or go home too early.
- Increasing Assessment, Treatment and Rehabilitation services and have them more widely available.
- Having Meals on Wheels available in the weekend.
- Improving co-ordination of the home support services available to people.
- Increasing the flexibility in what home help can do - e.g. give medication, clean windows, change light bulbs, chop firewood.
- Having a pool of health equipment available for hire, particularly for those



with non-resident status who are not entitled to equipment.

- Funding home visits by physiotherapists.
- Speeding up approval for home modifications and applications for equipment.
- Funding a mix of home care providers to increase diversity.
- Supporting services to be culturally sensitive.
- Paying for overnight care to enable carers to get some sleep.
- Providing more support for carers. Suggestions included increasing respite care, establishing a system like parental leave so that carers can retain their jobs, and promoting family-friendly workplaces.
- Providing more appropriate assessment processes for Maori.

Housing and security

After health, housing was the main concern of older people. Many identified a lack of affordable rental or ownership housing options in their community.

They also expressed a need for a range of supported accommodation, especially for low income people who could not afford to buy into commercial retirement villages.

While a few correspondents would like a stronger community police presence, many had taken steps themselves to increase their security by installing security lights, personal and house alarms and smoke alarms.

- Supporting more housing alternatives, including local authority and community groups wishing to provide supported accommodation for people with low incomes.

- Supporting warden or live-in person in housing complexes.
- Help with maintaining homes because the current provision through the Department of Work and Income is not well known and not enough.
- Providing more support for community groups that offer home help and home maintenance services.
- Strengthening building codes to ensure that buildings are user-friendly for older people - examples include improving safety of steps by requiring railings even on short flights of steps and ensuring treads do not overhang risers.
- Providing some support to older people wanting to move house, including cheaper legal fees.
- Providing more help for older people to maintain gardens and lawns so that they can stay at home. One suggestion was for a closer arrangement between local schools and older people following the example of a South Island school where local school children do "community service".
- Helping with making homes more energy efficient.
- Providing smoke alarms and telephones with low frequency ringing options for older people.
- Providing more community policing.

Transport

Concerns about transport were raised almost as often as concerns about housing. Lack of accessible, affordable transport isolated older people in their own homes. It limited their access to health services, reduced their ability to do their own shopping and obtain personal services, and reduced their opportunities for social interaction. Many found it demeaning to have to ask for help; others had few people on whom they could rely.



The high cost of individual taxi services put them beyond the reach of most older people and while the Total Mobility System was greatly appreciated, its availability is severely restricted. Participants in the research made a number of recommendations in relation to transport, including:

- Providing more support for public transport.
- Developing transport systems that are user-friendly for older people e.g. accessible buses.
- Providing consistent and stable support for transport for older people, especially in rural areas, for access to health and hospital services and also for other purposes, such as shopping and social needs e.g. attending groups.
- Providing more funding and more security of funding for the Total Mobility System.
- Providing more publicity for the restricted driver licence option to enable some older people to continue driving.
- Requiring warrants of fitness only once a year for cars that only do a low mileage.

Recreation, education and public amenities

Many of the recreation and education activities enjoyed by older people are provided by community groups, usually with some support from government funding agencies or local authorities. Participants in the research appreciated the support they got, but did not always appreciate the effort they had to put in to obtain and account for relatively small grants.

Many participants were positive about the efforts their local authority made to make civic amenities user-friendly and

wanted more of the same. Some were willing to share in decision-making so that the views of older people are heard. Their specific suggestions included:

- Involving older people in policy making.
- Local authorities continuing to support social services such as resource centres and community centres.
- Local authorities continuing to pay attention to pavements, street lighting, crossings, access, seats so that public areas are user-friendly for older people.
- Improving the design of parking areas, e.g. in shopping malls, so that walking spaces are clearly identified.
- Providing cycle-ways on the inside of parked cars to increase safety for older people.
- Local authorities maintaining verges in residential areas - currently this has to be done by residents and is a burden for older people.
- Reinstating home milk delivery.
- Providing more mail boxes locally.
- Supporting the home delivery of groceries.
- Providing more stable funding for voluntary agencies.
- Using schools as centres of learning outside school hours.
- Continuing and increasing support for local groups.
- Maintaining services such as mobile libraries, talking books and large print books.
- Encouraging more sponsorship of activities for older people.

Work

Relatively few of the older participants in this project were in paid work, although a large number were active in a voluntary capacity. Some were feeling pressured by the demands of voluntary work and were



concerned that changes to the retirement age would reduce the pool of voluntary workers.

Sector roles in the maintenance of independence in old age

As is evident from the discussion above, the actions of individuals, family members, private and not-for-profit organisations, community groups and neighbourhoods, and local and central government all impact on the goal of older people to live independently.

Most of the issues raised by older people in this project referred to areas where government action was seen as important. This is perhaps not surprising considering that the project was funded by central government, and the large role government plays in the service areas identified.

The roles played by the different sectors have arisen from New Zealand's unique set of historical and cultural circumstances. The responsibilities of each sector have not been clearly identified and articulated. The debate about government and individual responsibilities for retirement income is a high profile example of the complexity of resolving responsibilities.

Roles do not always match responsibilities. The private sector, and in some cases the voluntary sector, provides services as a business, but the services can be paid by government or other third parties, rather than by their clients. Roles are also shared, for example, where families and health professionals both provide care. Roles change over time and are influenced by demographic change and migration. The reframing of New

Zealand's social policy to reflect changed views on the role of government and the best ways to achieve welfare has important implications for future roles in supporting the independence of older people. Prevalent values include:

- families being self reliant when they can
- support from government being provided to individuals rather than to services, often targeted on the basis of income
- the importance of choice and diversity in services, particularly for Maori and Pacific peoples
- a larger role for private sector services
- contracts for services replacing grants in the non-profit sector

This section considers the roles of the key players in maintaining the independence of older people.

Individuals, spouses and families

As discussed earlier, life before retirement largely sets in place the main factors that influence the ability of older people to be independent. Older people in this study confirmed that keeping physically active, eating well and maintaining interests and relationships helped them maintain their independence.

The study identified a number of areas where individuals felt they lacked information critical to taking action to maintain their independence, for example, on where to go to get help, what their entitlements were, and how to access them. They had a number of suggestions for improving the situation:



- Having readily available, up-to-date information on all entitlements. For example, health agencies would provide information on income/welfare entitlements as well as on health services.
- Ensuring that GPs have full knowledge of the entitlements and services available.
- Making information available through a wide range of avenues - posters, pamphlets, 0800 numbers, regular television campaigns, local newspapers, better funding of Citizens Advice Bureaux, local Age Concern councils and other groups - the campaign needs to be ongoing and constantly updated.
- Producing information in a consistent form e.g. an older people's brand, not a Department of Work and Income, HFA or IRD brand - maybe Age Concern could continue work in this area.
- Clarifying the layout of the government agencies section of the telephone book - the names of agencies do not necessarily relate to their function.
- Reinstating local services such as visits by IRD to rural areas.
- Providing more help for older people with new technology e.g. banking and telephone systems.

Money worries also constrained independence, both as a result of the “worry” factor and because not having enough money meant some people were unwilling or unable to undertake activities that are important to maintaining independence. Paying for transport and house maintenance or moving to more suitable accommodation are two examples.

The older people in this study did not discuss the challenge of saving for older

age to any great extent but the government has recognised this challenge through the establishment of the Retirement Commissioner. However, this study did provide an insight to the lack of incentives to save for retirement, and also the incentives to disguise savings or not to divest assets. Several older people discussed the lack of good products to protect the value of savings and to enable release of home equity. Others expressed resentment at the low level of publicly funded support for services for older people with modest savings. They were particularly resentful at the erosion of their personal assets to pay for long-term care. There is also evidence of retirement planners specifically advocating the setting up of trusts to avoid the divestment of assets when needing long-term care⁹⁶.

To encourage people who can save for their own retirement to do so, the importance of risk management and gaining some direct benefits from those savings needs to be acknowledged.

The literature review, interviews, focus group discussions and letters confirmed the importance of families as carers of older people with disabilities or poor health. These sources also agree that the support provided to carers is patchy and insufficient. A more explicit strategy to support carers, and acknowledge their rights to time off, training and other supports, will enhance the capacity of families to care. It is also likely to improve the quality of care.

⁹⁶ St John, S., 1999. “Retirement policy issues that we are not talking about” Paper to the NZ Association of Economists Annual Conference, Rotorua



Self help, community groups and voluntary organisations

Self-help, community groups and voluntary organisations provide a wide range of services for older people, including:

- transport to appointments, social events and for shopping
- home visiting
- social and recreational opportunities
- support for people with disabilities or who have had illnesses
- home maintenance

However, the provision of such services is uneven and depends on the availability of people able and willing to provide the service. Key gaps in some areas are help with transport, shopping and managing finances.

This study confirms that most community groups and voluntary agencies rely on even small grants or contracts from government or quasi government organisations to keep going. It also revealed that the lack of integrated and reliable funding means that the viability of many small organisations is precarious. Both paid and unpaid coordinators spend a disproportionate amount of their time applying for funds and meeting accountability requirements. Few are able to plan ahead with any certainty.

Private sector firms and non-profit businesses

The older people in this study appreciated private firms who were responsive to their needs. They cited local firms that delivered goods free or made special arrangements for older customers, or who sponsored local

events through cash payments or by providing goods and services.

However, participants also identified a number of areas where private services have not been responsive to the needs of older people. The two mentioned most often were the new technologies, particularly automated banking and telephone systems, and the reduction in face to face contact. It is not easy for people with loss of dexterity, hearing, sight or response times to use many of the new technologies, and many were concerned about or mistrusting of these developments. While some older people were prepared to travel to find a familiar person with whom they could do business, most simply did not have this choice and many expressed regret at the loss of branch offices that provided familiarity, personal recognition and trusted advice.

Some older people also discussed the inappropriateness of many products for older people. Examples included toothbrush handles that are too slim for people with arthritis to hold, and the small print on many products. Participants suggested that private firms should consider providing aids such as smoke alarms and telephones with low frequency rings, as well as cheaper legal fees for older people wanting to move house. As one man said: *“If they want our pittance make the products suitable for our use.”*

A number of contributors suggested that greater representation of older workers amongst staff would enhance understanding of the needs of older clients. Older people and key informants



agreed that encouraging positive attitudes to older workers and having family friendly workplaces that acknowledge the care needs of older relatives, not just children, are important in supporting the independence of older people.

Private sector firms and non-profit businesses could also do more to portray older people in advertisements in a positive way and provide greater sponsorship for activities that include older people.

Local government

This study did not review local government policies to any great extent. However two trends were evident. Firstly, older people were generally positive about and appreciative of the improvements being made at the local level to make amenities suitable for people with impaired mobility or other disabilities. They acknowledged the benefits to their independence. On the other hand, in many areas, local authorities are reducing their involvement in services that have been important to the wellbeing of older people, such as libraries and pensioner housing, or are introducing user charges. Pressure to constrain rates increases, which many older people would support, is leading to councils to pull back on social support provision. The commitment of councils to providing social services appears to vary considerably.

Local authority policy will be critical to the independence of older people in the future. Local authorities have a limited

range of funding sources available to them. The most common, rates and user charges, are not sensitive to affordability concerns and can fall heavily on older people. Local authorities could do more to publicise rates relief schemes for older people.

The risk for older people, if local authorities have greater responsibility in the future for funding services such as transport, is not that the local authority will be unwilling to provide the services but that they, and other residents, will be unable to pay. This may increase the disparities in transport and amenity provision in different areas of the country. Transport is of great importance to older people. If they do not provide transport systems themselves, local authorities at least need to work with private providers to ensure that transport is available, accessible and affordable for older people.

Local authorities can also assist the independence of older people by endorsing supported housing initiatives, either their own or those of community groups. Local authorities that provide low cost or pensioner housing could enhance the quality of this service by having a paid or subsidised warden or live-in support person in each housing complex.

Local authorities may also consider strengthening building codes to ensure that buildings are user-friendly for older people and keeping a register of tradespeople and community groups willing to offer special rates for older people.



Local authority commitment to older people can be reflected in a number of ways: involving older people in policy-making; supporting social services such as resource and community centres, library services and recreation amenities; and continued attention to ensuring that public areas are safe and convenient.

Central government

Government plays a key role in providing for older people, both living independently and in residential care.

Government expenditure on older people is substantial, particularly in the areas of income support, health and disability services. As the population ages, government expenditure in these areas is predicted to rise. The cost of NZS has been projected to increase from 5.3% of GDP in 1996/97 to 10.7% in 2051, and the cost of health and disability care to rise from 5.9% to 11% of GDP over the same period⁹⁷.

Income

Under NZS policy, older people are guaranteed an inflation-adjusted pension, and this policy is expected to continue. This pension is supplementary to any other income or assets they or their partner receives, and is set at a level to provide a modest income for day to day expenses.

NZS is not designed to provide for all of the additional costs of illness and disability that occur with increasing frequency as people age, but vary from individual to individual. Currently, the supplementary assistance available to

meet additional costs, the Disability Allowance, Community Services Card, Accommodation Supplement, and Special Needs Grants, are all targeted on a slightly different basis to people with low levels of additional income. Assistance with the costs of residential care is more tightly targeted and not available to people with more than modest assets. These policies are not well integrated together, nor are they well integrated with other subsidies in the health and disability sector.

Over the medium term, the work of the Retirement Commissioner in promoting private savings can be reinforced through developing policies that leave an incentive for people who can to save, so that they share the costs of old age with government. As raised earlier, older people considered the risks of their savings eroding due to high additional costs to be unfair. The OECD argues that the need for governments to contain the costs of an ageing population requires not just shifting costs to private individuals, but doing so within a framework that enables older people to have adequate and equitable access to health and care services, lifelong learning and income security. Policy therefore needs to ensure that those who do save do not then have their savings exposed to an uninsurable risk should they require substantial amounts of care.

Government support for the development of feasible and attractive policies that enable older people to release equity from their homes either

⁹⁷ cited as general conclusions of government modelling work in "A wake-up call: The ISI report on Retirement Savings", Investment Savings and Insurance Association of New Zealand Inc, June 1998



for living, for home maintenance or to buy aids such as mobility scooters, could help older people make the best use of their assets. Similarly, the promotion of programmes to assist older people with managing their finances and establishing Enduring Powers of Attorney could reduce levels of dependency.

Health and disability support provision

As discussed above, the most critical issues that emerged for central government in this area were the need to improve the co-ordination of health, disability and welfare services for older people, and the need for a comprehensive strategy to train, support, and relieve carers. Older people themselves made a number of suggestions for improvement:

Partnership and co-ordination

- Having funding agencies and ministries work together more to co-fund initiatives.
- Co-ordinating health and welfare services better so that individuals' needs are met more quickly.
- Encouraging health and welfare agencies and community groups to talk to each other and sort out their strategies and provisions, perhaps through protocols.
- Giving greater recognition to the voluntary contribution of older people and community groups through more respectful and genuine partnerships, and provision of stable funding.
- Streamlining application and accountability procedures for small groups and groups receiving small grants.

The Older People's Health Forum⁹⁸ and Age Concern New Zealand have recommended the development of an integrated strategy for older people. In their view, this should include a separate policy and planning unit within the Ministry of Health for services for older people, rather than the current split between disability support services, mental health services, and personal health services. The lack of integration of funding for acute medical or personal health needs with funding for mental health or disability support has been identified as a barrier to maximising independence at home. Extra costs for DSS result from delays in surgery. Integration contains the promise of cost effectiveness as well as improving the quality of life for older people. Integrated approaches are needed not just between health and disability services, but also with income supplements, such as for disability or housing, and with voluntary and community services.

It may be possible to manage fiscal risk and improve the health status of older people by generating more goodwill with families and community organisations who are partners in care provision. This could also lead to more flexible and responsive opportunities being established at a local level. Older people, older carers and family members all sought more generous support for family carers both directly and through the provision of support services.

The government may consider other suggestions made by older people,

⁹⁸ Older People's Health Forum, 1998



including making expenses associated with care fully tax deductible, and funding early intervention for ailments such as cataracts and hip replacements. Early intervention would not only improve older people's quality of life and ability to remain independent but also save costs of home support and hospital care at a later stage. Subsidised care in rest homes for people who have been ill would allow older people to move out of hospital more quickly but to still receive the support they need before they are well enough to return home. Older people also sought greater flexibility in the provision of home care services.

Housing

There is little focus in current policy on the costs that flow to the government from premature entry into residential care by older people who live in inappropriate housing. Nor is much known about the cost-effectiveness of interventions that assist the supply of group housing and public housing, or let people spread the costs of housing modifications that enable them to stay at home.

The biggest policy challenge in housing is to find ways to ensure older people with limited means can access a wider range of housing choices. In particular, they need more choices that provide for degrees of supported or assisted living than currently exist at an affordable price for them. A lack of research means it is impossible to know to what extent this "supply gap" is a persistent problem, or a temporary lag.

The different subsidy regimes and service boundaries for care provided in homes

and for care provided in residential settings also appear to be a barrier to optimising living arrangements. As in the state of Oregon, the best results both fiscally and in terms of older people's independence may be achieved through creating seamless subsidy streams for care, and on the same basis at home as in institutions.

Well-maintained and safe homes provide health and quality of life benefits to older people. There are a number of voluntary and private sector initiatives that assist older people to maintain and modify their homes, however there are barriers, in particular accessing finance. Policy addressing this area, perhaps using home equity as collateral for loans, could be cost effective through the resultant health benefits.

Transport

Poor transport and limited local amenities can have immediate detrimental effects on the standard of living of older people, and flow onto the public sector as premature needs for acute health services, home-based services and residential care. A "hands off" approach to these policy areas may expose central government to excessive risk. The links between public transport, local amenities, and health need to be better understood.

Forms of publicly accessible transport will need to be available if older New Zealanders are to live independently. The lack of public transport and the high cost of taxis emerged as critical issues for correspondents, focus groups participants and key informants in this study. While sheer numbers of older



people and their increased concentration in certain areas may generate enough demand to ensure public transport is not just viable but regularly available, we cannot be sure this will always be the case.

The proposals in *Better Transport, Better Roads* will effectively place responsibility for subsidising transport at the regional authority level. It would be useful to consult with regional councils as to how they plan to meet the needs of older people should these proposals come into effect.

Work

As an employer, government could take the lead in providing work opportunities for older workers and exploring opportunities for leave provisions to care for older relatives.

Changes that make it easier for older people to work, and support them when they do, are likely to be good for the economy as well. The ageing of the population means that New Zealand, like many other OECD countries, may have its growth constrained if it doesn't make provision for more older, skilled workers to remain in the workforce. This is likely to mean having flexible approaches to training and retirement, and being able to make different choices around hours of work.

Cross-sectoral issues

Co-ordination and partnership

The desire for greater co-ordination between health and welfare agencies and a stronger partnership with community groups has already been discussed. Many participants in the research were also

frustrated by the division of responsibilities between central government agencies as a whole, and between central and local government. For example, one group identified health and well-being benefits from a recreation and home-visiting programme, but they were not eligible for any health funding. Others talked of the frustration of trying to obtain services for clients when funding came from different sources. One key informant with considerable experience in applying for grants commented:

“Government talks co-operation and integration but doesn't do it. If you make a funding application you have to be very careful. If you ask for the wrong thing, you miss out. They need to co-fund things – they and we have to be able to be flexible, to respond to need.”

Older people themselves were aware that government on its own cannot achieve successful ageing. They were quick to acknowledge the part that individuals must play in maintaining their own health and well-being. At some point though, most older people do need some support, and while this may be funded either through central or local government, it has to be delivered locally. As one person commented:

“Much of supporting independence has to happen locally. It is about people staying in touch, going out and being part of the community.”

This requires co-operation at all levels and supports the argument for a coherent strategy on ageing. This would



provide an opportunity to build a positive, longer-term approach to the ageing of the population that was broadly regarded as sustainable and fair. Flexibility and partnership may well prove to be the best way to manage the fiscal risks, and risks of social discord, of an ageing society.

Research

This report and others have identified that problems such as poor housing, inadequate support for family carers, and poor transport infrastructure can translate into higher costs in other areas, particularly health and ACC. There is a scarcity of research investigating the links between policies and independence for older people.

We see a need for policy-oriented research that cuts across departmental and local and central government boundaries, and a commitment to programme experimentation and evaluation.

Addressing Maori issues

While Maori generally have a positive view of ageing and accord older people status and respect, the economic situation of older Maori people is often poor. With high levels of unemployment, younger Maori are not well placed to care financially for older family members or to plan for their own future needs. The expected increase in the number of older Maori people has policy and resource implications, particularly in the provision of health services and housing. While several positive initiatives are already in place, they need to be augmented and supported by long-term

strategies and adequate resources. Developing policies and services appropriate to the status of Maori as tangata whenua is an ongoing challenge.

Building a long term consensus on critical issues

Governments in the future will face significant risks if population ageing results in fiscal costs that are not sustainable, and the population is then divided between the young and a growing voting block of alienated older people. A long-term commitment across political parties will enhance the ability of future governments, ensuring maximum independence for older people at a sustainable cost.

The two most expensive items of government expenditure on older people, NZS and health and disability care, are contested across political boundaries. The consequence of this is an uncertain environment for older people, and for younger people planning for their old age. It can be argued that the uncertain policy environment also detrimentally affects savings levels and private, voluntary and local government provision of new services, such as alternative housing options.

The independence of older people, and a sustainable environment for managing an ageing population, would be greatly assisted by a “de-politicisation” of at least some core elements of these major policies.

As discussed above, improved responsiveness will benefit more than just older people. For example, accessible public transport in urban areas and rural



communities is of concern for other groups in the community. Having a sense of belonging and participating in the community applies to unemployed people and parents of young families as much as to older people. Similarly, housing designs or modifications that suit older people will also suit many families with young children and people with disabilities. Well-designed urban areas and good security systems benefit all citizens. The same is true of having government, local authority and commercial services that are easily accessible, customer-focused and “user-friendly”. In many instances, therefore, improving policies and services for older people are a good investment, which will bring improvements to society as a whole. As a member of Grey Power said:

“If they live long enough, everybody gets old. While we are concerned with our own generation, we also consider ourselves to be intergenerational as what is done for current policy will set the scene for future generations.”



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and the elderly in the context of
economic and social development
in Asia.



APPENDIX I: TERMS OF REFERENCE

The terms of reference set out in the request for proposals were for the research to:

- be positive, focusing on ways of improving older people's ability to maintain their independence and providing empirical evidence of factors which can contribute toward this goal;
- gather and analyse New Zealand data concerning these factors;
- empirically investigate the identified factors and provide evidence on the impact and importance of the factors in assisting the maintenance of independence of older people;
- empirically investigate factors identified as barriers to older people maintaining their independence, and make recommendations on how to remove these barriers;
- fill a gap in the New Zealand research on maintenance of independence of older people, and not simply replicate previous research;
- make recommendations for policy, service delivery and future research that arise from the research, including any information about the potential costs and potential savings to the Crown that would arise from the implementation of any such recommendations.



APPENDIX II: METHODOLOGY

Research Design

Information was gathered in four main ways:

1. A literature review to identify relevant factors and the effectiveness of interventions. This included a review of existing New Zealand statistical and economic data.
2. Interviews with key informants working with older people or having expertise in this area.
3. Focus group discussions with older people in a range of situations.
4. Invitations to older people to contribute individual stories to the study.

Literature review

The literature review discusses both New Zealand and overseas literature under five main headings:

1. Factors that maintain the health of older people.
2. Environmental factors that help older people maintain their independence.
3. Factors which make it more probable that an older person who is ill or has a disability can live independently.
4. Personal services and other initiatives that enable people to stay living independently.
5. Policy issues that are relevant to the goal of maximising "ageing in place".

The review also highlights barriers that restrict older people's independence and examines literature on the incentives older people have to invest in independent living. The review uses census data to identify significant trends in the proportion of people living at home. It compares the circumstances of

men and women, and people in different ethnic, income and age groups. It also discusses data on health expenditure on institutional and home-based care of older people.

Interviews with key informants

Interviews were completed with informants working with older people or having expertise in this area. These included:

1. Lanuola Asiasiga, Pacific Health Research Unit, Whitireia Community Polytechnic
2. Sister Rae Boyle, Community Team Manager, Wesleycare Services for Older People, Wellington
3. Janferie Bryce-Chapman, Age Concern, North Shore
4. Megan Courtney, Senior Policy Analyst, Waitakere City Council
5. David Dobson, Chairman, SeniorNet, Wellington
6. Pat Hanley, CCS, Wellington
7. Christabel Gibson, Ohariu Branch, University of the Third Age, Wellington
8. Sue Hine, Project Leader, Relationship Services, Wellington
9. Gemma Kennedy, Clinical Coordinator, Taihape Rural Health Centre
10. Rihia Kenny and Charlene Williams, Ora Toa Health Centre, Takapuwahia Marae, Porirua
11. Heather Maranui, Past President, Wairarapa Organisation for Older Persons
12. Beverley Park and Shirley Marshall, Social Workers, Psychogeriatric Unit, Porirua Hospital, Wellington
13. Prof. David Richmond, Auckland Medical School, University of Auckland
14. Don Robertson, Grey Power New Zealand



15. Margaret Sander, Senior Social Worker, Elder Care Services, Capital Coast Health
16. Verna Schofield, Lecturer in Social Work, Victoria University of Wellington
17. Rebecca Thompson and Jonathan Mosen, RNZFB, Wellington
18. Betty Tierney, Coordinator, Older and Bolder Group, Taihape
19. Di Valentine, Member, Board of Good Health Wanganui

The interview schedule which formed the basis for most of these discussions is included as Appendix III.

Information was also gathered by telephone and mail from government and local government officials and:

1. Chrissy Dallen, Total Mobility Services, Wellington Regional Council
2. Mrs D. Featherstone, Committee Member, Nelson Arthritis Association
3. Bruce Penny, Manager, Elder Care Canterbury Project
4. Hugh Simonsen, Abbeyfield Society, Nelson
5. Evan Thomas, Age Concern, Kapiti

Focus group discussions with older people

Eight discussions were held with groups of older people. Participants were invited to discuss both the factors that help older people maintain their independence and any barriers to achieving this. They were also asked to make suggestions for improving both policy and service delivery and in particular to identify interventions that they consider would be cost effective.

The interview schedule which formed the basis for these discussions is included as Appendix III.

The focus groups included:

- Members of Older and Bolder, Taihape
- Residents of the Kapiti Retirement Village, Paraparaumu
- Members of the Friendship Centre, Miramar, Wellington
- Members of the Salvation Army Friendship Club, Wellington
- A group of older Otaki people
- A group of volunteers at the Brooklyn Resource Centre, Wellington
- A group of older New Plymouth people
- A group of older Taranaki Maori people.

Fifty-one older people took part in the discussions. Their ages ranged from the mid-50s to the 90s. As might be expected, women outnumbered men - 36 women took part in the discussions compared with 15 men. The discussions generally lasted about one hour and were facilitated by one of the research team while another took notes.

Invitations to older people to contribute individual stories to the study

Information about the research was sent to 30 community newspapers from Kaitaia to Invercargill and included in the information kit sent out by the Senior Citizens Unit. The research was also publicised through the newsletters of Age Concern and Grey Power and the Rural Bulletin. Readers were invited to write to the researchers identifying the factors that have either helped them maintain their independence or hindered them from doing so. The press release is included as Appendix IV.



Seventy-three letters were received from older people and caregivers, along with a number of emails, faxes and telephone calls. A number of people included additional information with their letters and six family members described their condition in considerable detail. Of the 73 letters, 18 came from men and 55 from women. A third of respondents (26) did not give their age and three of this group wrote on behalf of someone else. Three were in their 50s, six in their 60s, 17 in their 70s and 15 in their 80s. Five people in their 90s wrote in.

An item about the research was included in a Local Government New Zealand newsletter. It sought examples of local government initiatives or innovative projects in providing services for older people. Only one response was received; it described initiatives common to many local authorities, including supporting SeniorNet.



APPENDIX III: KEY INFORMANT INTERVIEW SCHEDULE

Introduction

As part of its commitment to the International Year of Older Persons, the government has commissioned research into factors that may improve the ability of older people to remain independent and contributing to the community. Information is being gathered through a literature review, interviews with key informants, focus group discussions with older people and stories contributed by older people and family members. The research will contribute to government policy and help the government and other groups provide better services for older people.

While we will list the people we have talked to in the back of the report, we will not identify comments individually within the report. We will give you the opportunity to comment on the notes we make from our conversation if you would like this.

As background, could you tell me a bit about your experience in this area, for example, how long you have been involved and in what capacity.

1. What do you see as the key factors that help older people to remain independent - in your area of interest/overall? - Prompt as to why /examples if necessary
2. What do you see as the main barriers to older people remaining independent - in your area of interest/overall? - Prompt for why / examples where necessary
3. What can or should be done to increase the independence of older people? We have a list, ranging from individuals to central government. Let's begin with:
 - by individuals themselves?
 - by partners and other family members?
 - by members of the community?
 - by private firms and non-government organisations?
 - by local government?
 - by central government?
4. Are there different issues for people on different incomes?
5. What do you think would be the single most cost-effective initiative the government could take to increase older people's independence? Have you any ideas on how it could be funded or to ensure it was good value for money?
6. Is there anything else you want to add about helping older people remain independent?
7. Is there anyone else we should talk to on this subject?



APPENDIX IV: FOCUS GROUP DISCUSSION GUIDE

Introduction:

Welcome to this discussion. Thanks for taking the time to join us to talk about what helps older people be independent. My name is _____ and this is _____. We're doing some research for the Senior Citizens Unit and the Social Policy Agency which are both part of the Department of Social Welfare. They are doing this study because this is the International Year of Older Persons. They want to know:

- what (has) helped you stay independent?
- what has been hard for you? and
- what changes or improvements would most help older people be independent?

We're having discussions like this with several groups around the country. We want to talk to as wide a range of people as possible. We know you will all have had different experiences and points of view and that's fine. We're interested in whatever comments you have. The discussion is confidential – no names will be included in the report.

The government plans to use the information to develop new policies itself and encourage others to make changes. Of course, we can't guarantee that they will pick up on all your suggestions.

Record number, gender of participants; age range

1. Can I begin by asking each of you what has helped **you** to stay living independently?
Keeping healthy
Having positive attitude
Being valued as individuals
Having interests and skills
Personal safety
Change/technology
Family attitudes and behaviour
Appropriate housing
Enough money
Transport / being able to get around
Home support services
Health services
2. Likely topics - facilitator or assistant to write up - add new topics as required
Keeping healthy
Having positive attitude
Being valued as individuals
Having interests and skills
Personal safety
Change/technology
Family attitudes and behaviour
Appropriate housing
Enough money
Transport / being able to get around
Home support services
Health services
3. What has been hardest for you? - write up/record as separate list.
Keeping healthy
Having positive attitudes
Being valued as an individual
Having interests and skills
Personal safety
Change/technology
Family attitudes and behaviour
Appropriate housing
Enough money
Transport / being able to get around
Home support services
Health services



4. Let's follow up on some of the things you've talked about as being difficult. With X (go through list), what do you think would have made a difference, so that you can/could have stayed independent longer?

Possible prompts: attitudes, knowledge, social opportunities, responsiveness by business/agencies, money, planning, informal/ formal services.

5. Finally, can each of you say what you think would be the single most effective change the government could make to help older people stay independent?
6. Is there anything else you'd like to say while we're here? Have we missed anything?

Thank you very much for coming.



APPENDIX V: PRESS RELEASE

Helping Older People Remain Independent Contributing Members of Society

1999 is the International Year of Older Persons. To mark this event, the Government wants to find out what helps older people remain independent contributing members of society.

The Government has asked us, as a group of independent researchers, to carry out the study which will help the Government and other groups provide better services for older people. As part of the study we want to collect examples of:

- barriers that make it harder for people to remain independent
- initiatives that help older people remain in the community and participate fully in society

We know that a lot of things affect people's ability to be independent. Changes in health are obviously important, but having suitable housing, help with looking after the home, and good social, community and transport networks can also make a difference. We know that while older people do face barriers, many individuals and communities have found creative and innovative ways to enhance the independence of older people.

Please tell us what helped you, a family member, or an older member of your community, remain independent. What helped the most? What would have made a difference? Your stories will be totally confidential.

We will not print your name or any information that will identify you in our report or pass your personal details on to the Government or any agency.

Please send information to:

Alison Gray
Gray Matter Research Ltd
PO Box 28 063
Wellington
Phone/Fax 04 475 9406
Email: agray@clear.net.nz

We would love to hear from you.



APPENDIX VI: A SUMMARY OF THE RECOMMENDATIONS OF THE PRIME MINISTERIAL TASK FORCE ON POSITIVE AGEING

1. Attitudes to ageing

The Task Force recommended establishing flexible approaches to working life, education, care giving and retirement, prohibiting compulsory retirement and communicating positive and diverse images of old age.

2. Planning and preparation

The Task Force supported an environment where people can plan and manage their own futures. This would require the integration of government policies and services, more education about life planning, and opportunities for lifelong education, spiritual growth, fitness at all ages as well as improved access to community and health services.

3. Managing resources

The issue here is to raise skill levels in New Zealand and increase understanding of the ways in which paid and unpaid work is connected to overall wellbeing. The Task Force recommended freeing up workers for voluntary activity, career planning and skill acquisition through life, greater use of mentoring schemes in business and involving all ages in schools and creative endeavours.

4. Policy development and service delivery

The Task Force had four major recommendations in this area. They were strengthening the policy vote for senior citizens, strengthening research and data

analysis on positive ageing and older people, rationalising funding of government community services for older people, and greater consistency in the delivery of health care to older people.

5. Experiencing positive ageing

The Task Force recommended a number of actions to achieve greater appreciation of diversity, and stronger intergenerational and voluntary commitments. These included resolving Treaty grievances, creating more cultural and educational opportunities and expanding programmes that assist people to stay in their own homes. Town planning, housing, transport and local amenities should integrate the needs of different age groups, the status of volunteer workers and unpaid carers improved, and government-community partnerships strengthened.







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We would like to thank all the older people who contributed to this report, through letters, discussion groups and interviews. We appreciated their time, good humour and passion. Thank you, too, to the key informants who gave generously of their time.

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We also want to acknowledge the support of Sue Bidrose of the Research Unit, Ministry of Social Policy and Jenni Nana, of the Senior Citizens Unit.

We hope all the contributors find the finished report interesting and satisfying.

Máire Dwyer
Alison Gray
Margery Renwick





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