

Health Care Services for the Elderly in New Zealand: a Critical Perspective on Current Policy and Practice

MOUSOURAKIS George^{1, 2, 3, 4}

*1: Faculty and Graduate School of International Relations, Ritsumeikan University,
Kyoto, Japan*

2: Graduate School of Social Sciences, Hiroshima University, Hiroshima, Japan

3: Max Planck Institute, Frankfurt, Germany

*4: The New Zealand Centre for Human Rights Law, Policy and Practice, University of
Auckland, New Zealand*

E-mail: geomous@fc.ritsumei.ac.jp

Abstract

In New Zealand, as in many other countries around the world, a rapidly ageing population, combined with rising rates of dementia and chronic conditions, has necessitated the development of health care models capable of meeting the rising demand for service provision in a resource-constrained health environment. The call for high quality, affordable and sustainable health care services in both residential and home-based settings has prompted an increase in long-term care funding along with the promulgation of policy initiatives which emphasize the importance of the elderly for society and the need to adequately plan for rising service needs. Following an overview of the connection between New Zealand's rapidly changing demographics and health care demands, the present paper will outline the development and main features of the country's health care system with particular reference to the services available to elderly persons and discuss some of the challenges the current system faces or is expected to face in the future. With a publicly funded health care system that offers a high standard of emergency and acute care services, as well as legislation that limits how much older people have to contribute towards the cost of long-term residential care, it could be said that the older sector of New Zealand's population is relatively well serviced in terms of access to health care services. It is argued, however, that the system should continuously be adjusted and improved to ensure that the long-term implications of the changing demographics and ageing population can successfully be met through the implementation of high quality and sustainable models that could better address patient needs through the delivery of comprehensive and effective health care services.

Key words: ageing, elderly people, health care legislation, health care services, health care system, New Zealand

New Zealand's Changing Demographics and Health Care

Ageing is a process that applies to all persons, without exception. It is measured by time and proceeds continuously to affect us during the whole of our lives. While individual ageing has always been a human characteristic, the phenomenon of societal ageing is a more recent one in developed or industrialized countries. Until the 19th century, most societies had a relatively steady balance between births and deaths; but the 20th and 21st centuries have brought about the new phenomenon of 'ageing societies', in which the number of middle-aged and older people is rising. The ageing of the population is occurring due to two principal factors: first, the birth rate of the post WWII generation greatly exceeded that of previous generations; second, since the early 20th century, older individuals have experienced unprecedented increases in life expectancy. In particular, the so-called 'baby boomer' generation, which represents people born between 1946 and 1961, has substantially contributed to the size of older population in many countries.

Ageing is a critical driver in the demographic changes taking place in New Zealand. At the 2006 Census of Population and Dwellings, there were 495,600 New Zealand residents aged 65 years and over (in a population of 4,027,947), up by 45,200 on the 2001 Census. This represented the largest growth recorded between censuses for this group in our demographic history. From 2011, the post-war baby boomers have begun to move into the 65+ age group in large numbers. Projections from Statistics New Zealand indicate that 100,000 people aged 65 and over will be added every 5 years from 2012 to 2036. The largest increase is expected to take place in the decade 2021 to 2031, when a further 276,000 people are projected to move into this older age group. The 65+ population is expected to more than double to between 1.17 million and 1.48 million by 2051, when they will make up 25% or more of all New Zealand residents.¹ The ethnic constitution of the New Zealand population is also expected to change during this time, with the proportion of Maori, Pacific and Asian groups increasing relative to the current majority of those of European descent. The Maori population aged 65 and over is projected to increase from 3% currently to 7%, the equivalent Pacific group from 3% to 6%, and the Asian group from 4% to 8%.² The key issue here is that the growth in the elderly sector of the population is not balanced by a corresponding increase in the younger population. With the number of births *per capita* projected to decline over the next decades,³ the ageing of New Zealand's population is therefore inevitable (Table 1).

1 See on this BRYANT (2003).

2 Statistics New Zealand (2004).

3 See POOL *et al.* (2005).

Table 1. Projected New Zealand population of ages 65, 75+ and 85+ years from 2011 to 2051 as a percentage of the total population (Statistics New Zealand 2000).

Age	2011	2016	2021	2026	2031	2036	2041	2046	2051
65-74	13.7	15.8	17.9	20.3	22.6	24.3	25.2	25.4	25.6+
75-84	6.3	6.9	7.8	9.3	10.8	12.6	14.1	15	15.3
85+	1.9	2.2	2.4	2.7	3.2	4.1	4.8	5.7	6.3

This fundamental shift in the demographic structure of New Zealand's population is expected to have a significant impact on, among other things, the quality of social services and accommodation, the composition of the labour market and the rights and self-determination of older people. The combination of these factors is increasingly viewed as one of the main issues of the 21st century that will require considerable organizational changes and long-term care policy development and implementation. Among the most important issues requiring long term planning, strategy and action include: the recognition of the social and economic contributions that older people make; the role of older people in employment and the work place; the transition from work to retirement or part-time retirement; ensuring that older people have sufficient income to live comfortably; ensuring that there is adequate housing for older people; the social isolation of older people; respect for the autonomy and self-determination of older people; issues of safety, abuse and neglect, and the quality and increasing cost of healthcare services. All these issues are essentially about the value society places on older people and the factors pertaining to the future sustainability of their lifestyle: their health, income, and participation and inclusion in society.

In New Zealand the state has recognized the importance of rights and entitlements for the population in general through the inclusion of rights as a key element of social welfare.⁴ In this context, rights are measured by reference to participation in civil and political affairs without being subject to discrimination and abuses of power. The protection of these rights is deemed essential to the organization and functioning of society in a way that enables all people to develop to their full potential. From the point of view of older people, the issue of rights and expectations relates to the question of what they can expect in terms of the availability of five sources of support, namely financial security, residential care, support from the family and support from government agencies and adequate health care. In particular, the provision of good quality, affordable and sustainable healthcare services in both residential and home-based settings is of paramount importance and this is reflected in various state-sponsored initiatives such as the *Health of Older People Strategy*, which draws attention to the importance of the elderly for society and the need to adequately plan for growing service needs.⁵ Health issues form the cornerstone for the wellbeing of older people. But they have an even wider significance. Internationally, questions

4 See, e.g., Ministry of Social Development, Annual Social Report (2008).

surrounding the future trajectory for longevity constitute the focal point of some of the great philosophical and biological-demographic debates on the future of humanity.⁶ Because of the immense cost and service implications surrounding elder health care, these theoretical debates are often highly applied and are constantly being referred to in the fields of population economics and public policy, especially in connection with issues such as income support, service planning and institutional needs.

Older people, especially those aged 85 years and over, are intensive users of health care resources, experiencing high rates of chronic illness, disability and morbidity as compared to other age groups in the population. With universal entitlement to no-fault accident insurance through the Accident Compensation Corporation (ACC), a publicly funded health system that offers a good standard of free emergency and acute care, as well as legislation that limits older people's contribution towards the cost of long-term residential care, it could be said that New Zealand's older population is at present relatively well serviced in terms of access to healthcare services. However, as the number of older people continues to grow, with an expected increase in life expectancy, the overall demand on health services is on the rise. It is clear that this will have a significant impact on how healthcare services for older people are structured and delivered in both the short/medium and long-term. First, the proportion of public expenditure on health services for older people will need to increase in order to meet demand (Table 2).

Table 2. Projected expenditure on older people as a percentage of Vote Health* (New Zealand Treasury 2003).

Age	2002	2011	2021
74-84	16.0%	17.7%	9.9%
85 +	16.0%	12.9%	15.0%

* Each year the government decides how much public money will be spent on healthcare. This is called 'Vote Health'. The government, through the Minister of Health, allocates money to the 20 District Health Boards (DHBs) to purchase health services for the people of New Zealand. This money is allocated using a weighted population-based funding formula.

Furthermore, it will be increasingly difficult for the health workforce to keep pace with the growing demand for life-sustaining interventions for older people with increasingly complex health needs.⁷ As the demographic change reduces the supply of informal caregivers and increases the quantity of formal care required to meet the

5 See Ministry of Health, *Health of Older People Strategy* (2002). Health is one of the different 'domains' identified by the Ministry of Social Development as a key determinant factor of what is referred to as 'successful ageing', 'positive ageing', or 'wellbeing' among older citizens. Consider on this matter KOOPMAN-BOYDEN and POOL (2006).

6 Consider, e.g., TULJAPURKAR *et al.* (2000: 490-91); LUTZ *et al.* (2008: 716-19).

7 See PAWAR *et al.* (2009). It should be noted that the New Zealand Ministry of Health (2006) has anticipated a shortfall of 23,000 in the regular health workforce by 2021.

needs of the elderly, it is expected to considerably decrease the formal workforce pool. The quality of the workforce pool will also be adversely affected in an employment market where people who are work ready with residual skills can get access to higher paying jobs with better conditions than community healthcare agencies are currently able to offer.⁸

The New Zealand Health Care System: an Overview

In New Zealand the NZ Public Health and Disability Act 2000 supplies the legislative framework for the public funding of health care and provision of publicly funded health services. This enactment follows a series of important structural reforms, from an area health board system (1989-1991), a competitive internal market system (1993-1996), a central planning and purchasing system (1997-2000), to the current district health board (DHB) system (from 2000).⁹ It will be instructive at this juncture to consider briefly some of the main features of New Zealand's current health care system.

New Zealand's health care system is a publicly funded, tax-based system.¹⁰ Public funding is derived from general taxation (87.7 %);¹¹ the Accident Compensation Corporation (ACC) (11.3 %);¹² and local government (0.9 %). The government sets an annual budget for most publicly funded health services. This is distributed to 20 geographically based District Health Boards (DHBs) using a weighed, population-based formula.¹³

The principal goals of the publicly funded health system are broadly to:¹⁴ (i) improve, promote and protect the health of New Zealand's population; (ii) reduce health disparities by improving health outcomes of Maori and other population groups (equity);¹⁵ (iii) ensure community voice in matters relating to personal health services, public health services, and disability support services (participation); and (iv) provide appropriate, effective and timely services (access). Furthermore, the integration of all

8 See MOLONEY (2005).

9 Consider GAULD (2001, 2003); ASHTON *et al.* (2005).

10 Government health expenditure amounted to about 81 percent of total health expenditure in 2010-2011.

11 The allocation of public taxation is made by the government under the Public Finance Act 1989 (s. 4) and the relevant appropriation Act.

12 ACC is an independent, quasi-governmental agency regulated by s. 259 of the Injury Prevention, Rehabilitation and Compensation Act 2001 and funded by general taxation and levies. It is responsible for accident-related prevention, care and rehabilitation.

13 It should be noted that the Ministry of Health directly funds around 25 percent of public services.

14 New Zealand Public Health and Disability Act 2000, s. 3(1).

15 Disparities in health care have been a central concern in New Zealand, with Maori people and people of Pacific Island origin having an average life expectancy around eight years shorter than that of other New Zealanders. Maori and Pacific people are also known to experience greater difficulty in assessing health services. Since the late 1990s, governments have introduced a series of measures designed to reduce health disparities. Reference may be made in this connection to Whanau One, a recent policy initiative designed to integrate the various social services providers, including health, to improve services for disadvantaged Maori who often fall between the boundaries of different agencies.

health services, in particular primary and secondary services, and the coordination of care are explicit objectives. At the same time, resource constraints are expressly recognized: the objectives of the system are to be pursued “to the extent that they are reasonably achievable within the funding provided.”¹⁶

Hospital care, community mental health care, and public health services have traditionally been provided to New Zealand citizens and persons ordinarily resident in New Zealand free of charge.¹⁷ Government subsidies partially fund primary health care services and community-prescribed drugs, with co-payments by patients (NZ \$10 to \$60 depending on the level of subsidy, with higher subsidies for those with low incomes or high health care needs).¹⁸ Subsidies for long-term care for the elderly are means-tested — this means that once a person’s assets fall below a prescribed level, they become eligible for public funding. Access to subsidized long-term residential care or home help is also subject to a needs assessment.¹⁹

Most public funding is allocated via funding agreements made by the Minister/Ministry of Health with District Health Boards, which agree to provide or financially support health services in their districts.²⁰ A number of services, such as, for example, public health and disability support, are funded directly by the Ministry of Health. The DHBs provide services at government-owned hospitals and community health centres.²¹ They also purchase other services from private providers, such as GPs, private surgical hospitals for some publicly funded patients, disability support services and community care. Many elderly people receive long-term in-home care funded by DHBs. Accident and injury care is funded by the Accident Compensation Corporation (ACC).

A District Health Board (DHB) is a ‘publicly-owned health and disability

16 New Zealand Public Health and Disability Act 2000, s. 3(2). In principle, the Minister of Health sets the strategic direction for the health and disability sector by setting and reporting publicly on a health strategy, disability strategy and strategy for standards and quality assurance and the monitoring thereof in the health sector, and by setting up key ministerial consultative committees (New Zealand Public Health and Disability Act 2000, ss 8, 9, 11 and 13-18). These committees include: the National Advisory Committee on Health and Disability, which is charged with, among other things, advising the Minister on the kinds and relative priorities of public health services, personal health services and disability support services that should, in the committee’s view, be publicly funded; the Health Workforce Advisory Committee, charged with advising the Minister on health workforce issues; the National Ethics Advisory Committee, charged with giving advice on ethical issues of national significance in respect of any health and disability issues, including issues relating to medical research and health services; the National Health Epidemiology and Quality Assurance Advisory Committee, charged with providing advice on any health epidemiology and quality assurance issues; and the Mortality review committees, whose job is to review and report on specific areas of mortality with a view to reducing the numbers of death and developing strategic plans and methodologies to reduce morbidity and mortality.

17 Non-residents, such as tourists and illegal immigrants, are charged the full cost of services provided by public hospitals or primary health care providers.

18 Primary health care is mostly free for children under the age of 6 and subsidized for the 96 percent of the population enrolled with Primary Health Organizations (PHOs). See para (i) below.

19 Complementary and alternative medicines and treatments are paid for in full, as are private hospital or specialist care and adult dental care.

20 New Zealand Public Health and Disability Act 2000, s 10. The 20 DHBs cover populations ranging from about 30,000 to 520,000.

21 New Zealand has a mix of public and private hospitals, but the former make up the majority, providing all intensive and emergency care.

organisation²² responsible for assessing and monitoring the health needs of its resident population; planning health care services in its district; supplying hospital care; funding services delivered by community and primary care providers (under ‘service agreements’),²³ setting into place processes for Maori participation; and promoting Maori health workforce development.²⁴ The statutory objectives for the DHBs in essence replicate the system’s general objectives, namely promoting population health and equity (partly through community participation), with the further objectives of “exhibiting a sense of social responsibility” for the population and “upholding the ethical and quality standards commonly expected of providers of services and of public sector organizations.”²⁵ Decisions pertaining to a DHB’s operation are made by or under the authority of a board of up to 11 members (including at least two Maori members). These are partly elected (seven members) by the people of a geographic area,²⁶ and partly appointed (up to four members) by the Minister of Health.²⁷ The DHBs are accountable to the Minister of Health, who must grant approval to a board’s district strategic plan and district annual plan.²⁸ DHBs are required to adhere to broader national strategies, national service frameworks and operational requirements. These set out national priorities for health spending and prescribe the minimum range and standard of the services that must be supplied or funded in each district.²⁹

Primary health care is provided by not-for-profit primary health organizations (PHOs): networks of self-employed providers, including GPs, practice nurses, and other practitioners, funded by the DHBs to provide care services for an enrolled population with a preventive, health improvement focus.³⁰ The providers work collaboratively, with nurses playing a significant role in managing and supplying services, especially for patients with chronic care needs. PHOs are expected to involve their communities in their governance, be responsive to community needs and allow all their members to participate in decision-making.³¹ Patient registration is not mandatory, and practitioners are not required to affiliate with a PHO, but physicians and PHOs must have a formally

22 New Zealand Public Health and Disability Act 2000, s 6(1).

23 New Zealand Public Health and Disability Act 2000, s 25.

24 New Zealand Public Health and Disability Act 2000, s 23(1).

25 New Zealand Public Health and Disability Act 2000, s 22(1).

26 As Gauld observes, “a primary motivation for creating the DHB system was to democratize health care governance, particularly in terms of increasing opportunities for public participation in health care planning and decision-making processes”. GAULD (2005: 345). It has been noted that the creation of the DHB system can be seen as “an attempt to increase community understanding and support for the difficult decisions required to deal with the funding/health-service dilemma — at the same time as making more difficult to achieve national decisions to resolve these dilemmas”. See ADAM (2003: 29).

27 New Zealand Public Health and Disability Act 2000, s 29. If the Minister is ‘seriously dissatisfied’ with the board’s performance, he may, by written notice, dismiss all of its members and replace it with a commissioner. See New Zealand Public Health and Disability Act 2000, s 31. It should be noted, moreover, that board members are not liable to third parties for any act or omission of the DHB, nor to the DHB itself, insofar as they “acted in good faith, and with reasonable care, in pursuance of the functions of the organization”. New Zealand Public Health and Disability Act 2000, s 90.

28 New Zealand Public Health and Disability Act 2000, ss 38(3)(c) and 39(1). Although the majority of a DHB’s members are elected and may be said to be accountable both to the government and their constituency, under the New Zealand Public Health and Disability Act 2000 DHBs are accountable mainly to the government. It is required that a DHB strikes a balance in the allocation of funding between its public hospital provider arm and other community health service providers.

registered patient list to be eligible for government subsidies. The PHO system is one vehicle through which the Government's primary health care objectives are sought to be implemented in local communities. The aim is to ensure GP services are better linked with other primary health services to ensure a seamless continuum of care, in particular to better manage long-term conditions.³²

The quality of health services in New Zealand is regulated by a range of generic legislation, encompassing the Health and Disability Commissioner Act 1994, which introduced the office of the Health and Disability Commissioner³³ and furnished the legislative framework for the creation of the Code of Health and Disability Services Consumers' Rights;³⁴ the Health Practitioners Competence Assurance Act 2003, which provides mechanisms to ensure that doctors and other health practitioners are competent and fit to carry out their tasks; and the Health and Disability Services (Safety) Act 2001, which provides for service standards and the certification and audit of providers of health and disability services.

The purpose of the Health and Disability Commissioner Act 1994 is "to promote

29 As Crown agencies, DHBs are also subject to the financial planning requirements of the Public Finance Act 1989 (s 42). Although they are required to "operate in a financially responsible manner" (New Zealand Public Health and Disability Act 2000, s 41), they are not required to be as successful and efficient as comparable businesses that are not owned by the Crown. From 2004 to 2010, the Ministry of Health published a quarterly *Hospital Benchmark Information Report* aimed at enhancing the efficiency of the DHB system. The report encompassed, among other things, patient satisfaction, hospital-acquired infections, acute readmissions and other indicators. From 2010, DHBs are held formally accountable to the government for delivering efficient, high-quality care, as measured by achievement of targets across a variety of indicators similar to those included in the *Hospital Benchmark* reports. Public reports on DHB performance rate each DHB on indicators pertaining, for instance, to hospital waiting times, access to primary care services and mental illness outcomes. Information on individual doctor performance is not regularly available. In 2010 the Health Quality and Safety Commission was established with a view to coordinating the varied approaches to quality improvement across DHBs. Moreover, the National Health Board, created in 2009 as a business unit of the Ministry of Health, is also concerned with quality improvement in DHBs, with special attention to managements systems and clinical services.

30 In New Zealand GPs are usually independent, self-employed providers, paid through fee-for-service and co-payments with government subsidy through PHOs. PHOs are free to determine their own payment arrangements for individual practitioners. The latter receive additional per capita funding for health promotion, for coordinating care and providing additional services for chronic disease patients, and for reducing barriers for patients that experience difficulties in accessing the health care system. PHOs also receive performance payments for meeting certain quality and service delivery targets under what is known as the PHO Performance Program. This requires GPs to reach targets for, among other things, vaccinations, diabetes, cancer and cardiovascular disease screening and follow up. Reports comparing PHO performance are published on a regular basis.

31 See Minister of Health, *The Primary Health Care Strategy* (2001).

32 Since 2008, the government has ordered PHO mergers to improve their functioning. Furthermore, in an effort to improve access to integrated health care that is provided by networks of practitioners in more convenient locations for patients (outside of hospital settings) the current government has commenced development of a larger Integrated Family Health Centers. While still at an early phase of development, there is some expectation that the new larger facilities will see services and providers co-located, or coordination services improved, with funding from both primary care budgets and DHBs.

33 The Health and Disability Commissioner, the government-funded yet independent patients' advocate within the health care system, investigates and reports on patients' complaints arising from, among other things, simple breaches of patients' rights and cases of medical malpractice that may have occurred in either public or private practice. The Commissioner, who reports directly to Parliament, has been an important source of pressure on DHBs for enhanced quality services.

34 The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

and protect the rights of health consumers and disability services consumers, and, in particular, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights".³⁵ The Code of Health and Disability Services Consumers' Rights specifies ten rights of consumers, and corresponding duties of health care providers: the right to be treated with respect; the right to freedom from discrimination, coercion, harassment and exploitation; the right to dignity and independence; the right to services of an appropriate standard; the right to effective communication; the right to be fully informed; the right to make an informed choice and give informed consent; the right to support; rights in respect of teaching and research; and the right to complain.³⁶ The intention of the Code and the Act is to promote resolution of health care-related complaints at the lowest appropriate level. If a complaint is made to a provider, the latter is required to take it seriously and put in place whatever changes are needed.³⁷ Consumers also have the right to lodge a complaint with the Health and Disability Commissioner, who is required to conduct an investigation with a view to determining whether there has been a breach of the Code. If the relevant investigation reveals such a breach, the Commissioner can: report an opinion and recommendations to the service provider; report an opinion and recommendations to the Ministry of Health;³⁸ complain to the relevant professional body; or refer the matter to the Director of Proceedings.³⁹ After reviewing the case referred to him by the Commissioner, the Director of Proceedings may decide to initiate civil proceedings before the Human Rights Review Tribunal.⁴⁰ This body

35 Health and Disability Commissioner Act 1994, s 6.

36 It is important to note that the Code applies to all health care providers, which are defined in s 3 of the Health and Disability Commissioner Act 1994. This definition, as well as including all categories of traditional health care providers such as the members of the medical profession etc, also includes "any other person who provides, or holds himself or herself or itself out as providing, health services to the public or to any section of the public, whether or not any charge is made for those services" (s 3(k)). This all-encompassing definition will capture anyone that consumers are likely to obtain services from. Patients' rights are also covered in the New Zealand Bill of Rights Act 1990, which gives any person the right to refuse medical treatment (s 11). Furthermore, a health care provider has obligations under the Crimes Act 1961. Section 151 of this Act puts a duty on everyone (not only health care providers) to provide the necessities of life to a person in their charge that is unable to make that provision themselves. Tort law also covers the area of patients' rights: inappropriate treatment may give rise to any of the three torts in the category of trespass to person, namely assault, battery and false imprisonment.

37 If a provider receives a complaint directly from a consumer, the Code states that they must: (1) acknowledge the complaint in writing within five working days, and also inform the consumer about the provider's complaint procedures, as well as the consumers rights under the Code, and the availability of an independent advocacy service; (2) within ten working days, the provider must consider the complaint and advise the consumer whether or not the complaint is accepted, or if more time is required to consider it. In the latter case, the provider's reply must be given to the complainant as soon as practicable.

38 The Commissioner's recommendations might include: an apology from the provider; introducing measures to ensure the matter will not happen again; training of providers; and payment of complainant's costs.

39 The Director of Proceedings is a lawyer appointed under the Health and Disability Commissioner Act 1994. When the Commissioner has found a breach of consumer rights, he may refer the service provider concerned to the Director of Proceedings. The latter reviews the case and makes an independent decision on whether or not to take any further action. The Director of Proceedings is assisted by a team of lawyers and other experts, who review files and prosecute cases.

determines afresh whether there has been a breach of the Code of Health and Disability Services Consumers Rights. Where such breach is upheld, there are a number of remedies available including: a declaration that a provider is in breach of the Code; an order restraining the provider from continuing or repeating the breach, or from engaging in or causing or permitting others to engage in conduct of the same kind as that constituting the breach; an order that the service provider perform any specified acts with a view to redressing any loss or injury suffered by the consumer owing to the breach; damages for pecuniary loss, expenses and loss of benefits suffered as a result of the non-compliant activity, and for humiliation, loss of dignity and injury to the feelings of the aggrieved person.⁴¹

Care and Support Services for the Elderly

Older people, especially those aged 85 years and older, are intensive users of healthcare services, experiencing high rates of chronic illness and disability as compared to other age demographic groups in the population. There are numerous risk factors for ill health in older people, the most prominent among them being high blood pressure, physical inactivity, high blood cholesterol and dietary insufficiency. Moreover, while most older New Zealanders enjoy good mental health, dementia in particular is a major mental health issue. Dementia, which is considered a neurological disorder, is caused by a range of illnesses, most of them currently incurable. Its symptoms include memory loss, difficulty in carrying out everyday tasks, personality changes and progressive incapacity to act independently and without assistance. It is anticipated that the incidence of dementia will rise considerably as the population of older people continues to grow. The number of people diagnosed with dementia in New Zealand is at present approximately 41,000 and is expected to increase to approximately 75,000 by the year 2026.⁴²

Gerontology and elder health care have, until relatively recent times, been dominated by the prevailing biomedical understanding of ageing. The ageing process was perceived mainly as a process of physical and mental decline characterized by disability and disease.⁴³ The biomedical model paved the way to theoretical constructs like the disengagement theory of ageing (prevalent in the 1950s and 1960s), which

40 The Human Rights Review Tribunal (HRRT) was established in 1977 under the Human Rights Commission Act, as the Equal Opportunities Tribunal. It became the Complaints Review Tribunal in 1993 and the Human Rights Review Tribunal in 2002. Matters likely to come before the Tribunal include not only alleged infringements of the Code of Health and Disability Services Consumers Rights, but also alleged violations of the Human Rights Act 1993, the Privacy Act 1993, or the Health Information Privacy Code 1994.

41 Damages, apart from punitive damages, will not be awarded if injury to the consumer is covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001. The limit on damages is \$200,000, although in practice awards do not usually exceed the \$20,000. For a closer look on the jurisdiction and powers of the Human Rights Review Tribunal see MANNING (2004).

42 New Zealand Dementia Economic Impact Report, 2008.

43 See in general HOOYMAN and KIYAK (2010); ESTES *et al.* (2003); PHILIP (2002).

institutionalized withdrawal from society by promoting more passive roles for the elderly and by emphasizing a move from extroversion and sociability to introversion and withdrawal as normative behaviour.⁴⁴ Critical gerontologists, especially the adherents of political economy perspective,⁴⁵ also include aspects of power and opportunity in the notion of 'slowing down': social, political and economic constraints, not individual factors, play a prominent role in shaping the experience of ageing and are connected not only to age and class, but also to gender, sexual orientation, functional ability and race. Beliefs about ageing can be disempowering, and health care providers are not immune to the prejudices of the larger culture.

The traditional biomedical approach to ageing seems to ignore the fact that the majority of older people actually get along quite well.⁴⁶ In recent years, a more positive discourse has emerged in opposition to the notion of ageing as an inevitable decline into disease, disability and death. This new discourse is reflected in The New Zealand Positive Ageing Strategy, which was released by the Ministry of Social Development in April 2001. In it special emphasis is placed on the need to promote engagement of all agencies impacting on the lives of older New Zealanders (such as Work and Income, District Health Boards, District Councils and the State Services Commission) to achieve the vision of a society where people can age positively by directing our collective efforts towards meeting specific positive ageing goals. Among the targeted objectives are equitable, timely, affordable and accessible health services; secure and adequate income; affordable and appropriate housing; affordable and accessible transport; culturally appropriate services; elimination of ageism;⁴⁷ and increasing opportunities for personal growth and community participation, allowing for successful 'ageing in place'.⁴⁸

44 According to the disengagement theory of aging "aging is an inevitable, mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system he belongs to." Cumming and HENRY (1961: 227). And see HALE *et al.* (2010); HOOYMAN and KIYAK (2010).

45 The term "critical gerontology" is used to describe a rather broad field of theoretical interests, ranging from constructions and deconstructions of to the issue of power and control in contemporary society. What ties these different perspectives together is that all of them, in one form or another, have been critical of a theoretical understanding of gerontology dominated by an idealized concept of natural science as the representative of 'objective' knowledge. The issues raised have focused primarily on the ideological and socially constructive features of age conceptualizations. Three theories in particular – critical theory, political economy, and social phenomenology – are exemplary in this regard. The political economists argue that to understand the problems of elderly people, one should pay attention to the political and economic conditions surrounding them. This turns attention away from the problems of elders as largely lying, according to gerontological theorists, in "their private troubles" and toward the political economy of growing older. See in general BAARS (1991); COLE *et al.* (1993); ESTES *et al.* (1996); HAZAN (1994); LYNOTT and LYNOTT (1996); MOODY (1988); HOOYMAN and KIYAK (2010: 323).

46 As Philip points out: "A perception of decline in late life extends to the psychological and social as well as physical features of late life ageing, characterized by loss of health, autonomy, financial status and the comfort of family, friendship and marital relations. Yet the experience of late life ageing for many people is not dominated by decline, but by accomplishment and satisfaction with life" . PHILIP (2002: 381-82).

47 The term *ageism* is used to denote a process of systematic stereotyping and discrimination against people because they are old. This term was introduced in 1969 by Robert Butler, the first director of the National Institute on Aging at the University of California, Berkeley. Butler likened ageing to other forms of prejudice, such as sexism and racism. See PALMORE (1990:172).

48 Office for Senior Citizens, Ministry of Social Development, 2004. And see HOOYMAN and KIYAK (2010).

Another important policy initiative is the New Zealand Health of Older People Strategy, launched by the Ministry of Health in April 2002. This required development of models of care for older people capable of promoting a number of objectives. Among the targeted objectives are the ability of older people and their families to make culturally appropriate, well-informed choices for healthy living and health care from integrated health and disability support services and to benefit from population-based health initiatives and programmes capable of supporting older people with complex health and disability support needs.⁴⁹ An integrated approach to health and disability support services is expected to better meet older people's varied and changing needs by facilitating access to the relevant services at the right time, in the right place and from the right health care provider. The development of the required health services for older people also needed to be aligned to broader population-based strategies, such as the New Zealand Health and Disability Strategies,⁵⁰ the Maori Health Strategy,⁵¹ the Primary Health Care Strategy,⁵² the Mental Health and Addiction Plan and the New Zealand Palliative Care Strategy.⁵³

The combined objectives of the New Zealand Positive Ageing Strategy and Health of Older People Strategy emphasize: a life course approach to positive ageing; the promotion of healthy lifestyles throughout life; early intervention to avoid or delay ill health and disability; rehabilitation and maintaining independence through ageing in place.⁵⁴

'Ageing in place' represents a policy ideal of the ability of older people to remain in the community, either in their family homes or in supported accommodation of some type, as they age.⁵⁵ Its underpinning assumption is that it provides for the maintenance of independence in the community, and particularly a continued competence and control over one's environment.⁵⁶ A number of studies have shown that there is a relationship between place and wellbeing.⁵⁷ Therefore, older people who feel in control of their environment are more able to adjust to the process of ageing, which

49 Ministry of Health, Health of Older People Strategy, Wellington, 2002.

50 These set out general principles, goals and objectives for New Zealand's health system.

51 The Maori Health Strategy sets the direction for Maori health development in the health and disability sector. It provides a framework for the public sector to take responsibility for the part it plays in supporting the health status of the Maori people.

52 This Strategy provides a clear direction for the future development of primary health care so that it can play a central role within New Zealand's health system.

53 Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment.

54 The National Health Committee has also been very involved in the Health of Older People with several publications since 2002. These include: Living at Home; Self Assessment; A Process for Older People; Guidelines for the Support and Management of People with Dementia; Care for Older People in New Zealand; Health Care for Older People; and Health and Disability Services for Older Maori.

55 In 1994, the health and social policy ministers of The Organisation for Economic Co-operation and Development (OECD) countries reached an agreement on the general objective of policies for the care of older people: "Elderly people, including those in need of care and support should, whenever possible, be enabled to continue living in their own homes, and where this is not possible, they should be enabled to live in a sheltered and supportive environment which is as close to their community as possible, in both the social and geographical sense" . (OECD 1994:3).

56 See PASTALAN (1990); CUTCHIN (2003); LAWTON (1982); HALE *et al.* (2010).

57 Consider, e.g., LAWTON (1983); Oswald *et al.* (2007).

in turn enhances their wellbeing. It is recognized that the interaction between location and personal characteristics, such as gender and health, affect a person's ability to successfully age in place. Furthermore, commentators differentiate between three aspects of ageing in place: choice, location and support. Choice relates to the decisions older people make in the context of personal and environmental factors; location is the home, which provides a sense of identity and connection to the community; and, lastly, support for older people who live at home may be either formal or informal. These three elements combined account for the increasing diversity of the ageing population and define ageing in place as care and support in the place of the older person's choice.⁵⁸

The ageing in place discourse first emerged in New Zealand in the early 1990s.⁵⁹ Free or in some cases income-based in-home services have been available ever since, after eligibility and needs have been determined through comprehensive geriatric assessment. As more people now live to their 80s or 90s, a growing number of services are required to allow ageing in place. Thus, new community and home-based programmes, including home health care, adult day care, nutritional programmes, transportation, personal care and homemaker services, have all become more widely available in the last two decades. Government and care service providers in New Zealand have embraced ageing in place because of its potential to more effectively meet the care and support needs of older people. A recent New Zealand pilot scheme (Assessment of Services Promoting Independence and Recovery Services or ASPIRE) evaluated three ageing in place support services.⁶⁰ This research found that all three services assessed significantly reduced the risk of mortality and that of entry into residential care as compared with usual services. Moreover, a recent qualitative study on older people and their attachment to place indicates that attachment to place is developed through the relationship between a number of physical and social features, such as location, comfort, proximity to family and involvement in neighbourhood activities. This constantly changing equilibrium between the practical and social-psychological aspects of living in a certain place has a strong influence on the wellbeing of older people. It should be noted that, notwithstanding the positive effects that aging in place may have, the policies that the ageing in place discourse

58 See Schofield *et al.* (2006: 275-306).

59 Ashton (2000: 72-85).

60 Ministry of Health, 2006. The three ageing in place programmes were: the Coordination of Services for the Elderly (COSE), Christchurch; the Promoting Independence Programme (PIP), Lower Hutt; and Community FIRST (Flexible Integrated Restorative Support Team), Hamilton. The services provided varied in content and intensity. The COSE programme gave priority to care management and coordination at the basic or primary care level, whilst the Community FIRST programme adopted a more restorative approach to service provisions for people with acute needs. Residential admissions were reduced in every case, with a reduction in mortality also observed in some of the services. Furthermore, a trend for improvement in daily activities was noted in older people in the Community FIRST service as compared to usual care. For a closer look see Parson *et al.* (2006). Reports from similar studies conducted in several other countries also testify to the efficacy of in-home care for older persons. See, e.g., TINETTI, *et al.* (2002); LEWIN *et al.* (2006); RYBURN *et al.* (2008); BESWICK *et al.* (2008: 725-35); ELKAN *et al.* (2001: 719-725).

entails cannot be regarded uncritically, for what takes place behind closed doors can sometimes be isolating, abusive, violent and far from the ideal notions permeating ageing in place. Furthermore, in New Zealand the relevant programmes are fragmented and there are too many regional disparities in terms of quality of and access to care services.⁶¹ Services require reorganization and a coordinated and interdisciplinary approach to improving elderly people's quality of life and participation.⁶² They must be more targeted and aimed principally at restoring the elderly person's ability to manage independently at home with a reasonably good quality of life. Of course, there will always be frail elderly persons in need of ongoing in-home care and support. But for the many others who are able to rehabilitate, skilled, effective, restorative and time-limited in-home support has the potential to significantly contribute to the recipients' wellbeing.

In New Zealand basic services available to older adults include: personal care (e.g., medication management, assisting with personal hygiene); supplying equipment to help with one's safety at home; household support (e.g., meal preparation, cleaning); and caregiver support, i.e. help for the person who lives with and looks after the elderly person for more than four hours a day. If specialist care is required, this can be provided by: a medical specialist; a geriatrician, who manages an elderly person's health and takes care of his/her specific medical issues; a dietician, who assesses and advise the elderly person on his/her nutrition needs and eating habits; a physiotherapist, who assesses the elderly person's needs for help to maintain his/her physical activity by treating injuries, showing him/her how to prevent future injuries, and advising him/her on enhancing mobility and alleviating painful conditions; a speech or language therapist, who assesses and assists the elderly person with his communication needs; and a social worker, who supports the elderly person through his/her decisions and provides information about advocacy and other community support systems. A recipient's care and support needs are monitored on a regular basis (at least once a year), and the person concerned can ask for a review of the services provided at any time.

Currently, health care and support services, including geriatric assessment, treatment and rehabilitation services (AT&R),⁶³ for older people are financed in the main, though not exclusively, by District Health Boards (DHBs) with funding from the Ministry of Health.⁶⁴ Delayed entry to long-term care is one of the principal goals

61 WILES *et al.* (2009: 664-671); PLATH (2008: 1353-1369).

62 See on this RYBURN *et al.* (2008).

63 These services are provided by multidisciplinary or inter-professional teams in inpatient, day hospital, outpatient or community settings. ACC defines rehabilitation as: 'a process of active change and support with the goal of restoring ... a claimant's health, independence, and participation. It comprises treatment, social rehabilitation and vocational rehabilitation'.

64 Geriatric AT&R services are generally located in inpatient units in a district's main hospital, with outpatient clinics and day hospital services often provided at the same site. Most DHBs offer general geriatric AT&R outpatient clinics. Some DHBs also provide specialist clinics, but they vary considerably in range and number. Community-based AT&R services are generally provided in the main urban centres. These services employ fewer staff than inpatient units and tend to focus on assessment more than treatment or rehabilitation. About half the DHBs provide outreach clinics in suburbs or small towns to varying extents.

of DHB-funded disability support services, as approximately 75% of a DHB's budget for elderly health care is spent on long-term residential care.⁶⁵ Service provision varies across the DHBs: some boards offer separate autonomous services; others have fully integrated services; others provide geriatric AT&R beds as part of generic AT&R units for people aged 16 and over. Furthermore, some boards have separate mental health units for older people; others incorporate beds in general adult mental health units. Geriatric AT&R services are generally located in inpatient units in the district's main hospital, with outpatient clinics and day hospital services often provided at the same site. Most DHBs have general geriatric AT&R outpatient clinics. Some DHBs also have specialist clinics, but they vary considerably in range and number. Community-based AT&R services are generally provided in the main urban centres. These services employ fewer staff than inpatient units and tend to focus on assessment more than treatment or rehabilitation. About half the DHBs provide outreach clinics in suburbs or small towns to varying extents. Moreover, the DHBs have systems that enable geriatric and mental health service staff and clients to access Maori and Pacific cultural services and advice. Population ageing is now beginning to create pressure on some geriatric inpatient services and psychiatry of old age inpatient services. Psychiatry of old age services tend to have a higher proportion of staff working in community teams compared to geriatric services. They also have access to adult mental health community crisis assessment teams for out-of-hours backup. However, psychiatry of old age services are generally much smaller than geriatric AT&R services. In some DHBs with small populations and/or difficulty recruiting specialist staff, services are provided by visiting specialists who are unable to provide the same level of service provided to older people in larger DHBs.

District Health Boards of New Zealand (DHBNZ) co-ordinate a national Health of Older People Steering Group, which is composed of representatives from all DHBs and comes together on a regular basis to coordinate DHBs' activities at a national level on selected issues impacting on the sustainability of health services for older people. The Steering Group monitors the effectiveness of the currently available DHB-funded services and assesses services that may be developed in the future to meet identified needs. Key priorities include: efficient funding of long-term care; nation-wide consistency in the purchase of home-based support services; developing service models for long-term support of people with high and complex care needs; and developing service models to support the expected increasing prevalence of dementia in the

65 Delaying entry to long-term care is achieved by way of increasing the range of community-based services available to support ageing in place, thereby reducing the demand for institutional care; increasing access to early intervention for acute care needs and reducing the rate of functional decline; and by restricting access through modifying eligibility criteria for services, such as raising the age threshold for eligibility. Eligibility for health care services for older people is currently linked to the retirement age (65 years). It should be noted here that there is no compulsory retirement age in New Zealand, but 65 is the current age of eligibility for NZ Super, the government pension. The age required for access to health care services for older people might rise if the age of retirement goes up, but that will probably have little effect on expenditure on the relevant services as the majority of older people using them are aged 75 years or older.

community.⁶⁶

Significant developments to date have generally focused on services for people with high and complex health care needs. Special attention has been given to issues such as: needs assessment and service co-ordination; flexible and responsive health care packages with a rehabilitative or restorative focus; and the use of multidisciplinary teams, including doctors, nurses, social workers and other health professionals. In general, service development can be a slow process because it takes a long time to consult with the community, to implement the changes needed and to adapt the infrastructure. In this process it is important that shifts in attitudes and public expectations occur alongside service changes if the changes are to succeed in the long run.

A number of projects have recently been developed that focus on the need to ensure sustainability of health care service delivery for a rapidly ageing population.⁶⁷ At the same time, new health strategies have been devised to manage the consequences of loss of health care services when there is cost-shifting to other sectors.⁶⁸ The development of a variety of models for both home-based support services and long-term residential care services allows for consistent planning decisions in relation to the sustainability of the relevant services. Special emphasis is placed on the need to form an aggregated local, regional and national data set that will inform the further development of funding models and ensure the sustainability of the services created to meet identified needs.

It is recognized, further, that Primary Health Organizations (PHOs) can play an important role in supplying health promotion and disease prevention services for older people, as well as case co-ordination of persons with complex needs relying upon a variety of community services. PHOs links with community-based services are generally underdeveloped at present, but current policy initiatives promise better interfaces between primary health care, specialist health services, community-based health services, mental health services, home support services and population health services to prevent service duplication and unnecessary wasting of scarce resources. Publicly supported socialization services⁶⁹ are currently also limited, even though demand is high. Such services have been proven to be effective in dealing with the problems of isolation and loneliness that often beset older people leading to health problems associated with self-neglect and depression.⁷⁰ Service gaps have also been observed relating to delays in older people's needs assessment or delays in funding decisions concerning their environmental needs. Such delays can result in older

66 It should be noted that individual DHBs have taken different areas of focus in service development. The scope and pace of development so far has to a large extent depended on the relative priority that a DHB has placed on funding older people's services against all other health services.

67 See, e.g., *Aged Residential Care Service Review*, Grant Thornton New Zealand Ltd, 2010.

68 For instance, the *New Zealand Carers Strategy* (New Zealand Ministry of Social Development, 2008) stresses the increasing pressure experienced by informal caregivers of ageing parents, siblings, partners or other relatives.

69 These include, for example, community access services and befriending services.

70 See on this CHAL (2004).

people not getting timely access to the care and support needed, and this can delay their treatment or rehabilitation and precipitate entry to higher levels of care. Possible solutions to this problem include better targeting of services, modifying procurement practices by District Health Boards and altering access criteria. As previously noted, informal caregivers, such as family members, are an integral part of support programmes for older people and a key element in the continuum of care. A further gap in the current system pertains to the lack of adequate support and training for informal caregivers. Addressing this gap is becoming a priority for many District Health Boards.⁷¹

The growing prevalence of dementia in the older population is expected to pose significant challenges for care and support systems and service providers. Specialist rehabilitation programmes tend to exclude people with dementia where the patient's cognitive and learning difficulties may lead to the impression that there is no benefit to be gained from such programmes. However, the increasing pressure on the elder health care system to include services for the growing number of people with dementia has necessitated the development of initiatives that will make a difference for this sector of the older population and their caregivers. In response to this need, Alzheimers New Zealand⁷² issued the National Dementia Strategy and action plan in 2010. The following strategic goals are identified in the Strategy: recognizing dementia as a national health priority; increasing public awareness of dementia; providing access to affordable and appropriate medication; improving early diagnosis and management of dementia; providing appropriate services to all people with dementia; providing support to family and carers of people with dementia; recruiting and retaining the workforce necessary to deliver quality dementia care; and increasing dementia research and evaluation of dementia practices.

Recognizing dementia as a national priority will ensure that adequate government funding is allocated to address the problem. Early diagnosis and management presuppose the development of education and training programmes for medical practitioners as well as adequate future planning for people with dementia and their communities of care. Of note in the strategy goals is also the section for family and caregivers that includes financial support along other resources. This supports the continued implementation of the New Zealand Carers Strategy launched by the Ministry of Social Development in 2008.⁷³ Finally, workforce development calls for the introduction of minimal standards for dementia specific training for all staff

71 This is also the focus of the New Zealand Carers Strategy launched by the Ministry of Social Development in 2008. See note 74 below.

72 Alzheimers New Zealand Inc is a not-for-profit organisation with 21 Alzheimers member organisations throughout the country that provide support, information, educational programmes and services appropriate to their local community. These services include: support for families and friends coping with the demands of caring; providing information and education to assist with understanding diagnosis and assessment; and supplying information to help cope with the financial challenges of providing care and support; and supporting services and day programmes for people with dementia. At a national level, Alzheimers New Zealand represents people with dementia and their caregivers and families through advocacy, raising public awareness and providing information.

caring for people with dementia. Culturally appropriate skills for dementia care are required to ensure that the needs of people from different ethnic groups are recognized when developing educational packages and resources for people in dementia care employment.

Concluding Remarks

In New Zealand, as in many other countries around the world, a rapidly ageing population, combined with rising rates of dementia and chronic conditions, has necessitated the development of health care models capable of meeting the rising demand for service provision in a resource-constrained health environment. The call for high quality, affordable and sustainable health care services in both residential and home-based settings has prompted an increase in long-term care funding along with the promulgation of policy initiatives, such as the Health of Older People Strategy, which emphasize the importance of the elderly for society and the need to adequately plan for rising service needs. Resources dedicated to the health care of the elderly increasingly focus on effective management and prevention, which have long been promoted as the best way to improve the health of the elderly in the long run and reduce health care costs.

With a publicly funded health care system that offers a high standard of emergency and acute care services, as well as legislation that limits how much older people have to contribute towards the cost of long-term residential care, it could be said that the older sector of the population is relatively well serviced in terms of access to health care services. Fundamental to the success of the relevant programmes is the adoption of more client-centred approaches to care that provide older persons with greater choices of service support. This emphasis on choice is reflected in the vision of the government's Health of Older People Strategy, which seeks to support positive ageing, in part, by enabling older people "to make well-informed choices about options for healthy living, health care and/or disability support needs." At the same time, it is recognized that health care providers have a professional responsibility to help their clients achieve their own goals. This presupposes that care providers are familiar with their clients' overall health situation including, for those clients who experience a decline in function and require help to remain at home, their in-home care and support

73 The New Zealand Carers Strategy covers all informal caregivers in New Zealand, such as family members, friends and significant others involved in supporting a person with a disability. Four governing principles are drawn attention to: (a) recognize diversity; (b) be proactive; (c) enable caregivers; and (d) be inclusive. The principal objectives of the Carers Strategy are: (a) provide information; (b) protect the wellbeing of caregivers; (c) provide financial support for caregivers; and (d) provide training and pathways to employment for caregivers. Moreover, the Ministry of Social Development has produced "A Guide for Caregivers" (2009), providing essential information on matters such as financial assistance; having a break; health and disability rights; and housing. It should be noted, further, that the Accident Compensation Corporation (ACC) is also developing wellbeing and learning programmes for informal caregivers.

plan.

Despite the progress that has been made in recent years, there is still much to be done to improve care and satisfaction levels. In particular, there is a need for improvement around so-called ‘transition points’ between services, especially where older people are moving between acute care or residential care and the community. Services along each transition point in the continuum of care should improve health outcomes by ensuring that service recipients have their health and disability support needs fully assessed; prevent or delay as far as possible the onset of high levels of illness or disability and reduce the need for older people to be admitted to hospital or residential facilities; restore and maintain physical and psychological health necessary for functional independence; and support the further development of best-practice services for people with complex medical, psychiatric and social needs across all delivery settings. Furthermore, the relevant services should be designed to improve the fit between recipients and their environment, thereby enhancing their function. One critically important reform for the future pertains to the need for up-skilling and improving the working conditions of in-home caregivers. The move should be one from domestic assistants to home health aides who possess adequate counseling and rehabilitative skills to not just maintain their clients, but to encourage and facilitate the restoration of function to the extent that this can be achieved. Moreover, in an age of shrinking public budgets and growing public debt, cost savings must also be taken into consideration. New Zealanders are currently financing public health services partly through foreign debt, leaving the payments to future generations. This is a widespread phenomenon driven by global economic forces. There is a moral imperative to address this problem before more damage to intergenerational relations is done. In the context of elderly health care, a better system of asset testing can conserve scarce public resources for those who require services but who are truly unable to pay for these services themselves.

In some ways, New Zealand is in an ideal position to implement the required changes as it has several advantages over other countries in its policy context for improving elderly health care. This is best reflected in, among other things, its strong tradition of using health information technology in the primary and acute care sectors; the trend towards a more coordinated approach to service delivery across settings; and the comparatively more collaborative model of regulatory oversight that has been adopted. It is critical that the country continues to build upon these significant strengths to ensure that the longer-term implications of the changing demographics and ageing population can successfully be met through the implementation of high quality, sustainable and person-centred care models that better address patient needs and ensure delivery of comprehensive and effective care.

References

- ADAM, B. 2003. The Challenges of Running a District Health Board. In: *Continuity Amid Chaos: Health Care Management and Delivery in New Zealand* (Ed. GAULD, R.), Otago University Press 29, Dunedin, New Zealand.
- ASHTON, T. 2000. New Zealand: Long-Term Care in a Decade of Change. *Health Affairs*, 19: 72-85.
- ASHTON, T., MAYS, N. and DEVLIN, N. 2005. Continuity Through Change: The Rhetoric and Reality of Health Reform in New Zealand. *Social Science & Medicine* 61: 253-262.
- BAARS, J. 1991. The Challenge of Critical Gerontology: The Problem of Social Constitution. *Journal of Aging Studies*, 5: 219-243.
- BESWICK, A., REES, K., DIEPPE, P., AYIS, S., GOOBERMAN-HILL, R., HORWOOD, J. and EBRAHIM, S. 2008. Complex Interventions to Improve Physical Function and Maintain Independent Living in Elderly People: A Systematic Review and Meta-Analysis. *Lancet*, 371: 725-735.
- BRYANT, J. 2003. *The Ageing of the New Zealand Population, 1881-2051*. Treasury, Working Paper 03/27, Wellington, New Zealand.
- CHAL, J. 2004. *An Evaluation of Befriending Services in New Zealand*. The University of Auckland, Auckland, New Zealand.
- COLE, T. R., ACHENBAUM, W. A., JAKOBI, P. L. and KASTENBAUM, R. (Eds.) 1993. *Voices and Visions of Aging: Toward a Critical Gerontology*. 368 pp., Springer, New York, USA.
- CUMMING, E. and HENRY, W. 1961. *Growing Old*. 293 pp., Basic Books, New York, USA.
- CUTCHIN, M. P. 2003. The Process of Mediated Aging-in-Place: a Theoretically and Empirically Based Model. *Social Science and Medicine*, 57: 1077-1090.
- ELKAN, R., KENDRICK, D., DEWEY, M., HEWITT, M., ROBINSON, J., BLAIR, M., WILLIAMS, D. and BRUMMELL, K. 2001. Effectiveness of home-based support for older people: Systematic review and meta-analysis. *British Medical Journal*, 323: 719.
- ESTES, C. L., LINKINS, K. W. and BINNEY, E. A. 1996. The Political Economy of Aging. In: *Handbook of Aging and the Social Sciences* (4th edition) (Eds. BINSTOCK, R. H. and GEORGE, L. K.), 346-361, Academic Press, San Diego, California, USA.
- ESTES, C., BIGGS, S. and PHILLIPSON, C. 2003. *Social Policy, Social Theory and Ageing*. 204 pp., Open University Press, Milton Keynes, UK.
- GAULD, R. 2001. *Revolving Doors: New Zealand's Health Reforms*. Institute of Policy Studies/Health Services Research Centre, Wellington, New Zealand.
- GAULD, R. 2003. One Country, Four Systems: Comparing Changing Health Policies in New Zealand. *International Political Science Review*, 24: 199-218.
- GAULD, R. 2005. *Delivering Democracy? An Analysis of New Zealand's District*

- Health Board Elections, 2001 and 2004. *Australian Health Review*, 29: 345-352.
- HALE, B., BARRETT, P. and GAULD, R. 2010. *The Age of Supported Independence: Voices of In-Home Care*. 131 pp., Springer, London, UK.
- HAZAN, H. 1994. *Old Age: Constructions and Deconstructions*. 144 pp., Cambridge University Press, Cambridge, USA.
- HOOYMAN, N. and KIYAK, H. 2010. *Social Gerontology: A Multidisciplinary Perspective* (9th edition). 788 pp., Allyn and Bacon, Boston, USA.
- KOOPMAN-BOYDEN, P. and POOL, I. 2006. *The Demography of Ageing: Analysing Fiscal (Societal Level) and Familial (& Other Micro-Level) Burdens and Capacities*. Paper, Ageing in New Zealand Conference, 13 November, Wellington, New Zealand.
- LAWTON, M. P. 1982. Competence, Environmental Press, and the Adaptation of Older People. In: *Aging and the Environment: Theoretical Approaches* (Eds. LAWTON, M. P., WINDLEY, P. G. and BYERTS, T. O.), 33-59, Springer, New York, USA.
- LAWTON, M. P. 1983. Environment and Other Determinants of Well-being in Older People. *The Gerontologist*, 23: 349-357.
- LEWIN, G., VANDERMEULEN, S. and COSTER, C. 2006. Programs to Promote Independence at Home: How Effective Are They? *Generations Review*, 16: 24.
- LUTZ, W., SANDERSON, W. and SCHERBOV, S. 2008. The Coming Acceleration in Global Population Ageing. *Nature*, 451: 716.
- LYNOTT, R. J. and LYNOTT, P. P. 1996. Tracing the Course of Theoretical Development in the Sociology of Aging. *The Gerontologist*, 36: 749-760.
- MANNING, J. 2004. Informed Consent to Medical Treatment: The Common Law and New Zealand's Code of Patients' Rights. *Medical Law Review*, 12: 181-216.
- Ministry of Social Development. 2008. *Annual Social Report*. Wellington, New Zealand.
- Ministry of Health. 2002. *Health of Older People Strategy*. Wellington, New Zealand.
- Minister of Health. 2001. *The Primary Health Care Strategy*. Wellington, New Zealand.
- MOLONEY, S. 2005. *Home support Purchase and Contracting Models: Report for Central Region DHBs*. Capital and Coast District Health Board, Wellington, New Zealand.
- MOODY, H. R. 1988. Toward a Critical Gerontology: The Contribution of the Humanities to Theories of Aging. In: *Emergent Theories of Aging* (Eds. BIRREN, J. E. and BENGTON, V. L.), 19-40, Springer, New York, USA.
- OECD 1994. *Caring for Frail Elderly People: New Directions in Care*, Organisation for Economic Cooperation and Development. Paris, France.
- OSWALD, F., WAHL, H. W., SCHILLING, O., NYGREN, C., FANGE, A., SIXSMITH, A., SIXSMITH, J., SZEMAN, Z., TOMSONE, S. and IWARSSON, S. 2007. Relationships Between Housing and Healthy Aging in very Old Age. *The Gerontologist*, 47: 96-107.
- PALMORE, E. B. 1990. Predictors of Outcome in Nursing Homes. *Journal of Applied Gerontology*, 9: 172-184.

- PARSONS, M., ANDERSON, C., SENIOR, H., CHEN, X., BROWN, P., JACOBS, S., JORGENSEN, D. and KERSE, N. 2006. *The ASPIRE Study: Ageing in Place in New Zealand*. Ministry of Health, Wellington, New Zealand.
- PASTALAN, L. A. 1990. *Aging in Place: The Role of Housing and Social Supports*. Haworth Press, New York, USA.
- PAWAR, S., AMEY, J. and SCEATS, J. 2009. *A Perfect Storm: Ageing Patients and an Ageing Workforce in Regional New Zealand*. Paper presented at the Population Association of New Zealand Conference, Wellington, New Zealand.
- PHILIP, I. 2002. *The Human Life Cycle: Later Life Ageing*. In: M. The Blackwell Companion to Social Work (2nd edition) (Ed. DAVIES, M.), 378-382, Blackwell, Oxford, UK.
- PLATH, D. 2008. *Independence in Old Age: The Route to Social Exclusion*. *British Journal of Social Work*, 38: 1353-1369.
- POOL, I., Baxendine, S., Cochrane, W. and Lindop, J. 2005. *New Zealand Regions, 1986-91: Population Dynamics*. In: *Population Studies Centre Discussion Paper No. 28*. University of Waikato, Hamilton, New Zealand.
- RYBURN, B., WELLS, Y. and FORMAN, P. 2008. *The Active Service Model: A Conceptual and empirical Review of Recent Australian and International Literature (1996-2007)*. Australian Institute for Primary Care, Victoria, Australia.
- SCHOFIELD, V., DAVEY, J. A., KEELING, S. and PARSONS, M. 2006. *Ageing in Place*. In: *Implications of Population Ageing: Opportunities and Risks* (Eds. BOSTON, J. and DAVEY, J.), 275-306, Wellington: Institute of Policy Studies, Wellington, New Zealand.
- Statistics New Zealand 2004. *Ethnic Population Projections: Issues and Trends*. Wellington, New Zealand.
- TINETTI, M., BAKER, D., GALLO, W., NANDA, A., CHARPENTIER, P. and O'LEARY, J. 2002. *Evaluation of Restorative Care vs Usual Care for Older Adults Receiving an Acute Episode of Home Care*. *Journal of the American Medical Association*, 287: 2098-2105.
- TULJAPURKAR, S., LI, N. and BOE, C. 2000. *A Universal Pattern of Mortality Decline in G-7 Countries*. *Nature*, 412: 490-491.
- WILES, J. L., ALLEN, R. E. S., PALMER, A. J., HAYMAN, K. J., KEELING, S. and KERSE, N. 2009. *Older People and their Social Spaces: A Study of Well-being and Attachment to Place in Aotearoa New Zealand*. *Social Science & Medicine*, 68: 664-671.