UPDATED BRIEFING

to the Minister of Health

Hon Tony Ryall

from

Age Concern New Zealand
He Manaakitanga Kaumatua Aotearoa

21 April 2010

Age Concern is committed to serving the needs of older people, kaumatua and kuia. Through a national office and 34 members, branches and associates, we provide services, information and advocacy to older people in response to local needs. We are active and vocal on issues affecting older people, taking every opportunity to work towards our vision of an inclusive society where older people are respected, valued, supported and empowered.

Older people make a valuable contribution to the rich fabric of society, even when they become frail or need support with every-day activities. When this happens, they must be provided with good quality care, specific to each individual's needs, whether their home is in the community or in a residential care facility.

The aim of this Briefing paper is **to update** you on key issues for older New Zealanders and for our organisation.

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PRIORITY ISSUES

Attitudes, chronic loneliness, income and health remain the top four priorities for older people and for Age Concern New Zealand. Support for older people living in the community and provision of quality aged residential care are key aspects of this work for us. This briefing expands on these issues first then updates you on our other priorities.

1.0 Changing attitudes in residential care

Older people, whether they live in residential care or in the community, have the same human rights as others in society. It behoves residential care staff to respect and promote those rights.

A compassionate and respectful attitude demonstrated by managers, nurses, care workers, policy makers and funders is integral to quality care. Age Concern recognises that respectful attitudes cannot be legislated for, or required by standards. They are, however, key to ensuring that all older people are well cared for, wherever they live. Our experience has shown that **owners and managers of residential care facilities set the 'tone'** and it is they who need to promote an atmosphere of caring and respect for everyone living and working there.

1.1 Preventing Elder Abuse and Neglect in Residential Care

Age Concern New Zealand applauds the work carried out by government to strengthen the certification and audit processes for aged residential care and we have appreciated the opportunity to be actively involved in this work. We applaud:

- The introduction of unannounced ('spot') audits, with a much stronger focus on the day-to-day delivery of care and more stringent guidelines for auditors to ensure national consistency of audit processes,
- Greater transparency through publication of audit summaries and other relevant information on the HealthCert website,
- Third party accreditation of Designated Audit Agencies,
- Improved information sharing and management of complaints

Consistent with this work, we encourage you to ensure the recommendations made by the Controller and Auditor General in her report on the effectiveness of arrangements to check the standard of services provided by rest homes are actioned by the Ministry of Health and District Health Boards.

Unfortunately, a substantial number of issues still need to be addressed to ensure quality residential care for older people now and in the future. **There are a number of ways in which you can help** to generate a culture of care and respect in residential care.

1.1.1 Staffing Levels in Residential Care

Staffing levels appear at times to be inadequate to meet the needs of residents in a timely and appropriate way. Staffing ratios need to be reviewed given the increased care needs of people living in rest homes today.

Age Concern is frequently told of situations where there is insufficient staff available to meet the needs of residents in a timely manner. Inadequate staffing is frequently cited as a cause of the institutional abuse referred to our Elder Abuse and Neglect Prevention Services. Other causes cited include poor leadership and poor supervision, both issues also associated with inadequate staffing levels (*Challenges for the Future* p. 43).[1]

The OPAL study[2] shows that dependency levels of people living in rest homes and private hospitals in Auckland have increased over the past 20 years. Twenty years ago 36% of this group were assessed as of high dependency. Ten years ago this figure had risen to 52%. In 2008, 56% of residents had high dependency. Increased dependency of residents in aged care has a significant impact on caregivers' work, requiring more time per person, and more difficult work. Anecdotal reports from other DHBs echo these findings.

Staffing levels in aged residential care facilities continue to be the subject of much debate in New Zealand. The Indicators for Safe Aged-care and Dementia-care for Consumers (SNZ HB 8163:2005) recognises that "…a comprehensive view of staffing effectiveness relates to a multitude of factors, including but not limited to: staff experience, leadership, supervision, training, skill mix, recruitment, retention, turnover, consumer case mix and acuity" (p. 9).

These are issues which impact on the quality of care provided, and issues which seriously need addressing.

Age Concern New Zealand has written to Mr Chris Fleming, CEO of South Canterbury District Health Board as the DHB leading the review of the Age

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[1] Age Concern New Zealand (2007). *Elder Abuse and Neglect Prevention: Challenges for the Future.* Wellington: Age Concern New Zealand.

[2] Boyd, M. et al (2008) *Changes in Aged Care Residents' Characteristics and Dependency in Auckland 1998 to 2008. Findings from Older Persons' Ability Level Census 10/9/8.* Auckland: University of Auckland.

Related Residential Care Contract. We recommended that the staff-resident ratios stated in the Age Related Residential Care contract be reviewed to ensure that they are adequate to meet the needs of older people in residential care today. In response, Mr Fleming advised that "The staffing ratios stated in the ARRC contract are based on current standards and in our view it is the standards that may need to be reviewed as they inform the requirements as set out in the ARRC Agreement. Staffing ratios is not part of the contract review for 2010/11…" (letter from Chris Fleming to Ann Martin 24 December 2009)

Age Concern New Zealand therefore recommends that you:

- **commission a review of staffing ratio policies and the Standards related to staffing levels, and**
- **incorporate the Indicators for Safe Aged-care and Dementia-care for Consumers (SNZ HB 8163:2005) into mandatory requirements of aged residential care provision**

1.1.2 Quality of Support for Staff in Residential Care

Assurances need to be given about staff qualifications, induction and training.

The Health and Disability Services Standards stipulate staff qualification and training requirements in residential care, including provision of induction for new staff (NZS 8134.1.2.2.7). It appears that some facilities do not meet these standards as lack of an appropriately qualified health professional and lack of training are also frequently cited as causes of institutional abuse referred to our Elder Abuse and Neglect Prevention Services (*Challenges for the Future* p. 43).[3]

We know there is a high turnover of staff in residential care facilities with temporary (agency provided) staff used to cover staffing gaps at times. Consequently, facilities may have, at times, very few staff who are well informed about residents and their care plans. Temporary staff will also not be well informed about the specific facility's policies and procedures in 'outside the usual' events. In addition to compromising a facility's ability to provide quality care, high staff turnover is a disincentive to invest in staff training and provide training incentives like increased pay rates etc. As one woman recently told us:

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[3] Age Concern New Zealand (2007). *Elder Abuse and Neglect Prevention: Challenges for the Future.* Wellington: Age Concern New Zealand.

"I worked as a caregiver for 10 years. I had lots of experience but when I asked for a pay rise the Manager just laughed at me. That's why I left."

Staff training and retention (and the related issue of pay rates) is a serious issue which must be addressed to ensure quality of care. "As the population of the 'oldest old' increases, there will be an increase in the prevalence of neurodegenerative diseases such as Alzheimer's' Disease that require purpose built facilities and specially trained staff. This will increase the need for residential care for people unable to be cared for in the community and will most likely further increase residents' level of dependency in the decades to come."(p. 37 Boyd et al.)

We commend the funding boost given to support and retain nursing staff in aged residential care. **We strongly recommend that you now give attention to the challenge of reducing turnover of caregiving staff.**

1.1.3 Elder Abuse training

Older people living in residential care facilities are vulnerable to abuse and neglect. Many have nobody to protect their interests. Even when this is not the case, family and friends are often reluctant to speak out about abuse or neglect, for fear of the consequences for the older person involved. Staff, too, sometimes choose to remain silent rather than 'rock the boat' with colleagues, or risk losing their job altogether.

All staff should receive training specifically in how to recognise elder abuse and ways to prevent it, so that they can provide abuse-free care and know how to respond if they become concerned about the welfare and treatment of an older person.

There are currently 24 specialist NGO elder abuse and neglect prevention (EANP) services throughout the country. These services provide education for staff of rest homes as part of their core business. Unfortunately funding limits the number of communities in which EANP services have been established - this means many rest homes do not have access to such training. Gaps in EANP service coverage exist in Northland; Rodney; Thames-Coromandel; Whakatane and Opotiki; Rotorua; Marlborough; and Ashburton.[4]

Age Concern New Zealand encourages you to support your colleague the Minister for Senior Citizens to secure funding for additional EANP services to fill these gaps.

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[4] Each of these territorial authority areas has over 4,000 older people. The smallest population of the currently funded Age Concern EANP Services is 4,400 older people.

1.1.4 Putting care before profit

Rest home proprietors need to ensure that their pursuit of profit doesn't force managers to deprive residents of material essentials or the care they need. This is elder abuse.

Examples of cost-cutting measures include rationing of continence products, delays in seeking GP assistance especially outside working hours and provision of nutritionally inadequate meals.

Police checks of prospective staff should be routine procedure.

Older people in rest homes are extremely vulnerable. Their vulnerability is often exacerbated by physical frailty. It is good employment practice to ensure those working with vulnerable people have no previous history of assault against the person (including sexual assault), or convictions of fraud, pecuniary advantage or similar crimes of financial dishonesty.

Greater clarity is needed about additional charging

Many residential care facilities apply additional charges for services they provide over and above those covered by the Age Related Residential Care agreement. Age Concern New Zealand has received complaints from older people about this practice and we are opposed to the way it is currently applied by residential care facilities.

There are two key areas in which greater clarity is necessary to safeguard the rights and well-being of residents:

- additional charging based on room size, and
- additional charging for provision of private toileting and bathing facilities. Toileting becomes more complicated for people with greater dependency so that a higher degree of privacy is necessary to maintain dignity when assisting a person in this most intimate function.

Age Concern New Zealand has heard of residents who have been forced to move because their room was 'upgraded' and they could not afford to pay the extra charges. The philosophy of 'you get the care you pay for' creates dangerous inequities and should be discouraged. Instead, residential care facilities should strive to provide the best possible care and services to *all* residents.

It would appear that some facilities are not open about charging for additional services until a person is on the point of signing the admission agreement. This practice is dishonest and leads to some older people

accepting admission into facilities for which they are unable to afford the additional fees.

Age Concern New Zealand recommends that residential care facilities be required to advertise the fee structure openly in all promotional material facilities provide.

Improve access to GP and other health services

Age Concern is aware that some residential care facilities have experienced difficulty securing the services of a General Practitioner. We are aware of situations where residential care facilities have delayed calling the GP, apparently due to the cost implications of this action. Age Concern New Zealand is also aware that access to hospital care is not always provided in a timely manner. We think a number of factors contribute to this, including the financial and staffing implications of accessing emergency services.

Age Concern advocates that residential care facilities must seek appropriate, timely, general and specialist medical intervention for their clients when it is needed. We are aware that district health boards are currently examining ways to reduce pressure on GP services and still meet the medical needs of rest homes residents. The costs to residential care facilities of providing medical intervention must not be used as a barrier to providing quality care for residents.

Age Concern New Zealand recommends that you seek a review of access to medical (including GP) services by residential care facilities and require DHBs to ensure the costs of such access are adequately provided for through the ARRC Agreements.

Oral Health

Provision of services provided by dentists is excluded from the ARRC agreement (clause D14.1 (d)). However, services to assist with personal hygiene and personal grooming are included (clause D5.4). In their study of dependent older people, Carter et al. (2004) found that “even apparently simple preventive measures (e.g., cleaning teeth and dentures) are not carried out effectively by older people or their carers.”

This research confirms information Age Concern has received from older people and their families. It seems that the link between the state of a person’s oral health and their general health is often overlooked by residential care facilities.

A new training resource is being developed by the New Zealand Dental Association for caregivers of older people.

We recommend that rest homes be required to provide this training to all staff, and to develop practices which attend to the oral health needs of residents.

A residential care facility is a person's home

While this may seem a very basic principle, it is one which is frequently overlooked. The individual needs and preferences of an older person are often denied in favour of organisational expediency.

One simple tool to encourage recognition of the fact that the facility is the residents' home is regular residents'/resident's family meetings. These meetings, facilitated by a neutral advocate for older people, enhance communication between staff and residents. They allow older people and their families to contribute their ideas regarding the activities, processes and ways things are done in their "home".

1.2 Changing attitudes – supporting people living in the Community

Older people generally want to stay in their own homes for as long as they are able. We commend your prioritising support to make this possible. In particular, we endorse your support of carers through the injection of funds to increase the number of dedicated respite care beds.

However, recent events - particularly in the Southern DHB catchment - have raised considerable concern about the reality of support provided for older people living in the community.

We know that domestic assistance, personal cares and respite care help keep people in their own homes for as long as possible, yet these are the very services being scaled back in many DHB areas. **Poor support in the home seriously increases the risk of an event that will lead to an older person to require acute care services or residential care.**

Older people should receive adequate support when they need it to ensure their safety in their own home. Age Concern Elder Abuse and Neglect Prevention Coordinators have observed that people living in the community with high needs and reduced ability to cope are more vulnerable to self-neglect and neglect or abuse by family members.

Assessment of support needs should be done in a consistent and open manner that respects the dignity and knowledge of the older person and their carer.

We acknowledge that increasing use of InterRAI by DHBs throughout the country is providing an internationally validated, consistent assessment tool which offers efficiencies in assessment processes. We recognise that this is an important consideration in the current economic environment. We know the Ministry of Health has recently advised DHBs to establish telephone assessment protocols and has offered recommended practice guidelines for these.

We think that telephone consultations cannot adequately assess the needs of most older people. It is also hard to understand how so much can have changed for an older person who was assessed as needing support, that they no longer warrant this assistance. Under these circumstances we believe that a face-to-face reassessment should be provided. Without this, vital visual and environmental clues as to an older person's real level of wellbeing and coping may be missed.

We are particularly concerned that in commencing telephone interviews, little thought has been given to how the process will work for older people who:

- wish to involve family or whānau in the process
- wish to invoke their right to have a support person present
- need to communicate face-to-face

Improving home-based care is a key commitment of the National Government. We fail to see how the current action by DHBs is meeting that commitment. We want to know:

1. How can it be that people who have been properly assessed as needing domestic assistance are now being told they don’t qualify at all, or need less?
2. After their care is cut, do you know how are they coping? How confident are you they are continuing to live in safety and dignity?
3. Is sufficient support being given to older people, some of them very frail, who think they've been wrongly assessed and are trying to get home-based care cuts reviewed?
4. What is happening to people who would have received this care in the past but now won't even be considered?"

1.3 What actions can the Minister of Health take?

- Commission a review of staffing ratio policies and the Standards related to staffing levels.
- Incorporate the Indicators for Safe Aged-care and Dementia-care for Consumers (SNZ HB 8163:2005) into mandatory requirements of aged residential care provision.
- Give your attention to the challenge of reducing turnover of care giving staff.
- Support your colleague the Minister for Senior Citizens to secure funding for additional EANP services to fill these gaps.
- Remind rest home proprietors that their pursuit of profit must not deprive residents of material essentials or the care they need. This is elder abuse.
- Require police checks of prospective residential care staff as routine procedure.
- Require residential care facilities to advertise their fee structure openly in all promotional material they provide.
- Seek a review of access to medical (including GP) services by residential care facilities and require DHBs to ensure the costs of such access are adequately provided for through the ARRC Agreements.
- Require residential care facilities to provide oral health care training to all staff, and to develop practices which attend to the oral health needs of residents.
- Require all residential care facilities to host regular resident/resident family meetings, facilitated by a neutral person.
- Ask DHBs to improve home-based care by focussing funding reviews elsewhere.
- Fund and support DHBs to implement the Family Violence Intervention Guidelines: Elder Abuse and Neglect.

2.0 Chronic loneliness is a health matter

Older people living alone are particularly vulnerable to a poor quality of life, loneliness and depression. Social isolation is a recognised risk factor for elder abuse and neglect. Loneliness is a risk factor for a range of serious health issues. **Programmes aimed at reducing isolation of older people need to be securely and adequately funded and supported.**

Recent research has shown that 8% of older New Zealanders are severely and chronically lonely. This equates with figures from Australia and the United Kingdom. Using 2006 census data, this means that **the health of about 40,000 older New Zealanders is seriously compromised by chronic loneliness.**

Taking action to combat chronic loneliness will support this group of people to age in good health. It will increase their ability to remain independent and for many it will delay the move into residential care – the ASPIRE study of 2006 showed that an older person who is socially isolated or depressed is almost **twice** as likely to enter residential care.

In 2004 the Ministry of Health conducted an extensive evaluation of befriending services in New Zealand. Conclusions were that these services:

- play a valuable role in the support of older people,
- should be adequately and securely funded, and
- that older people in rest homes should not be ignored when considering befriending needs.

Research has shown links between chronic loneliness and cardiovascular disease, Alzheimer's disease, depression, overall physical and mental health. Indeed, a small amount of social interaction was found to facilitate cognitive performance in people from three different age groups who have a diagnosed dementia.[5]

For people living in rest homes, regular visits from people outside the rest home offers not only friendship but a third party supporting the older person. This outside contact may also act as a protective factor for abuse or neglect.

The **Age Concern Accredited Visiting Service** (AVS) was established in 1989 and is currently provided by 18 Age Concerns.

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[5] Ybarra et al. (2008). Mental exercising through simple socializing: Social interaction promotes general cognitive functioning. *Pers Soc Psychol Journal* 2008;34:248-259.

AVS links chronically lonely older people with accredited volunteers who visit on a regular basis. Visitors provide older people with increased social support, social connectedness and social interaction and are also trained to notice and report developing problems. The service has a restorative focus aimed at increasing the client's social independence and integration. In this way, AVS helps to mitigate the adverse health consequences of chronic loneliness and social isolation.

AVS is currently able to reach between 1600 and 1700 clients at any one time. There is obviously scope for delivering the service to much greater numbers of chronically lonely and very isolated older people, but funding remains a constraint. Around two-thirds of costs are currently being covered by volunteers and the Age Concerns.

The Age Concern Accredited Visiting Service has the potential to meet the needs of the growing number of older people at risk of chronic loneliness and social isolation. These benefits to the individual translate into savings for government. Delaying entry into residential care for a small number of people (21) for a year represents a saving of around $850,000 to Government (approx. $769 in Residential Care Subsidy per person per week). Services such as the Age Concern Accredited Visiting Service are currently generating significant savings, but much more could be achieved. Put another way, it costs the Government around $40,000 per year (excluding pension and other income abatements) to care for a person in residential care, whereas the contribution Government is making to Age Concern's service is around $500 per person per year.

In 2008 Age Concern Otago evaluated a pilot Visiting Service for people in residential care facilities in Dunedin. Age Concern Otago had been providing this service (self-funded) for 2 years using the framework of the AVS. 18 of the 22 clients receiving visits agreed to answer survey questions, and 4 clients agreed to keep a 7-day diary of the social contact they experienced at their rest home. All dairies showed evidence of limited and/or irregular social contact other than with the volunteer visitor. One client had so little contact that he recorded a 4-second interaction when a caregiver dropped off laundry as an event. This man commented, *"Other than my visitor no one else really came to my room that was worthwhile counting".* He described the volunteer visit as the highlight of his week.

2.1 What actions can the Minister of Health take?

- Recognise that chronic loneliness has health implications for people living in the community and in residential care.
- Note that the Age Concern Accredited Visiting Service is a cost-effective health support service for socially isolated older people.
- Encourage the National Health Board to carry out a review of Age Concern's Accredited Visiting Services, particularly in areas where there are gaps (funding question).

3.0 Low income is a health risk

Most New Zealanders aged over 65 currently have New Zealand Superannuation (NZS) as their main source of income and for many it is their only source of income. This makes them particularly vulnerable to increases in the cost of living and makes it more likely that life shocks will impact on their health and wellbeing. They have few prospects for increasing their income, yet are faced with unavoidable expenditure on home heating, health care, and nutrition if they are to maintain their health. Many older people think twice before they go to the dentist or the eye specialist and, despite the increased hearing aid subsidy, many still find the combined cost of aids and fitting prohibitive.

Age Concerns around the country are already assisting older people who have inadequate income to maintain their health, social connection, and ultimately their human dignity. These are people who have cut their food budgets to the point that their basic nutrition needs aren't met; who endanger their health in homes so cold and unheated that our Accredited Visitors become concerned; who lose contact with their communities because they stay in bed all day to keep warm; who face loneliness so severe that it makes them physically ill.

It is unacceptable for older people in their latter years to be experiencing this kind of hardship and poverty. It is also profoundly detrimental to their health. Fresh food, a warm home, the ability to chew, see and hear - these are integral to staying well and enjoying life. When older people are forced to cut costs at this basic level they put their health at risk. In the long run, this will cost the health system.

3.1 Level of NZS

We believe that New Zealand Superannuation should be set at a level that prevents this from happening. A recent study by John Logan shows the current level of NZS to be insufficient to cover the most basic living costs. We sent this study to the Prime Minister, asking him to direct MSD to check the adequacy of the level of NZS against basic budgets and the minimum wage.

If older people in the community struggle to makes ends meet on the full rate of NZS, then subsidised rest home residents also find it impossible to stretch the hospital rate of NZS ($35.55 per week) to cover the services that are excluded from the Age Related Residential Care Agreement. These include care provided by dentists, opticians and audiologists – expensive services that many older people require from time to time. Residents

needing customised personal care or mobility aids, specialist assessment and rehabilitation services must also meet these often high costs themselves. Everyday needs such as clothing and personal toiletries, personal toll calls and insurance for personal items, gifts, newspapers etc. must also be paid for by residents themselves. $35.55 per week is totally insufficient to cover all of these costs.

We recommend that you:

- **Encourage the Minister for Social Development and the Prime Minister to direct MSD to check the adequacy of the level of NZ Superannuation against basic budgets and the minimum wage**
- **Call for an increase in NZ Superannuation to the maximum level allowed by the Act**
- **Support your colleague the Minister for Senior Citizens to seek an increase in the personal allowance for subsidised residents of rest homes.**

3.2 A 'perfect storm' of cost of living increases

We wrote to the Prime Minister in February this year stressing the fact that older people, as predominantly low-income earners, would be particularly badly affected by GST increases.

We think there is potential for any GST increase to combine with price rises already announced and those projected for this year to produce a 'perfect storm' of cost of living increases that would greatly increase the proportion of older New Zealanders living in financial hardship.

Two danger signs are:

1. Statistics New Zealand's latest Food Price Index, which found food prices rose 2.1 per cent in January alone. This is an increase in food prices of 12 percent in the past two years, far outstripping the overall CPI, and therefore the annual Superannuation cost-of-living increases. For comparison, Super was increased just 3.3 percent last year. Economists expect further demand-driven increases this year as international markets recover.

2. A major electricity supplier's 5 percent price increase – despite widespread disbelief (including by the Minister of Energy) – that such a rise can be justified. This again shows the competitive market model is failing to protect retail power consumers. When voluntary price freezes end in October this year, what protection will the government offer electricity consumers, beyond exhortations to shop around?

Age Concern considers that adjustments to NZ Superannuation for CPI and any GST increase must take adequate account of older people's specific circumstances and that adjustments must reflect the change in costs of essential services, such as power, water, phone, housing (rates), and expenses associated with maintaining involvement in society, including transport.

To help prevent the perfect storm of increasing hardship outlined above coming to pass, we recommend that you:

- **Oppose any increase in the rate of GST**
- **Support our call for cost-of-living adjustments to NZ Superannuation based on the real expenses faced by seniors, and that these adjustments be made quarterly, rather than annually**
- **Encourage your colleague the Minister of Energy to take action to contain electricity price rises, beyond relying on a market model which does not protect retail consumers.**

3.3 What actions can the Minister of Health take?

- Acknowledge the link between low income and poor health
- Encourage the Minister for Social Development and the Prime Minister to direct MSD to check the adequacy of the level of NZS using *basic budgets* and the *minimum wage*;
- Call for an increase in NZ Superannuation to the maximum level allowed by the Act
- Call for more regular CPI adjustments to NZ Superannuation using price increases of relevant goods and services rather than the more general CPI
- Support your colleague the Minister for Senior Citizens to seek an increase in the personal allowance for subsidised residents of rest homes
- Oppose any increase in the rate of GST
- Support our call for cost-of-living adjustments to NZ Superannuation based on the real expenses faced by seniors, and that these adjustments be made quarterly, rather than annually

- Encourage your colleague the Minister of Energy to take action to contain electricity price rises, beyond relying on a market model which does not protect retail consumers.
- Acknowledge that oral health is part of general health and provide lifelong subsidies on the costs of dental care (see below)
- Fully fund hearing aids to people over 65
- Institute a free eye examination for people over 65
- Support rates rebate increase to $1,000 and increase the eligibility threshold to $27,000 pa.

4.0 Other Health Matters

4.1 Teeth, ears and eyes

Our messages here remain unchanged:

- when teeth, ears and eyes stop working well, quality of life often suffers dramatically
- cost is a real barrier to receiving timely and appropriate care.

Bad **dental health** can lead to serious health problems, but recent New Zealand research confirms that affordability is forcing older people to make compromises. They put off going to the dentist in order to save money - and risk incurring much greater costs later on.

When making a decision about treatment, older people will often opt to have a tooth extracted, rather than pay for restoration work. While tooth extraction may be the cheapest course of action, it will eventually compromise the individual’s ability to chew and digest certain foods, and in the worst cases can result in malnutrition.

Despite the importance of good dental health, Government support to adults is limited to subsidies towards emergency dental treatment, and dentures for people on low incomes. There is no subsidised general dental care for older people, unlike in the UK where reduced cost dental care is provided under the National Health Service, with additional reductions for people on low incomes.

Age Concern New Zealand regards the lack of subsidised general dental care for older people as a serious health risk. **We want the Minister to see oral health as part of general health and provide lifelong subsidies on the costs of dental care.**

Faced with a recommendation to purchase **hearing aids**, an older person will often settle for the cheapest aid, rather than the one that provides the best hearing. We welcome the recent increase in the hearing aid subsidy, but consider that more needs to be done to make the mid-range and hearing aids affordable. A good hearing aid can enable an older person to continue to be active in the community. Conversely, a poor hearing aid or none at all can result in social isolation with all the concomitant negative effects on mental and physical health.

We are asking for **hearing aids to be fully-funded** for people over 65. This could be done by negotiating a favourable price with a hearing aid

manufacturer to enable government to fully subsidise one brand of basic, mid-range and hearing aid, thus giving older people access to the kind of aid that best suits their needs.

An inability to afford **eye care** can be equally debilitating, and can result in a person becoming housebound or having to make a premature move into residential care. A **state-funded annual eye examination** for every New Zealander over 65 could go some way to preventing this kind of escalation.

If older people cannot afford to care for their teeth, ears and eyes, the detrimental effects on health and wellbeing can be far-reaching, and often out of proportion to the original problem. In many cases, the technology exists to prevent such an unnecessary reduction in quality of life. Age Concern New Zealand believes that it is inexcusable not to make that technology affordable.

4.2 Discharge planning

In May 2009 we asked Age Concerns the following questions about the quality of discharge planning in their area:

Is a plan put in place for each patient?
Does the hospital check whether the patient is living alone?
Is the patient's GP kept informed?
Is the discharge plan carried out?
Who follows up with the patient to ensure that the discharge plan is being carried out and is effective?

The responses received revealed a remarkable lack of consistency in the quality and nature of discharge planning nationwide. Many Age Concerns reported serious problems and lapses examples of which are cited below. We continue to hear stories confirming that these concerns remain current:

- *As a rural area we are continually hearing of difficulties concerning planning of aftercare. In numerous cases there is either none or it is very haphazard.*
- *Sometimes the discharge planning process suffers as a result of pressure to empty beds.*
- *Often it seems there is no home visit to assess the actual circumstances that a patient is returning to. We have had instances of patients who have not been able to manage and leaving their home unsanitary before entering hospital, and then being sent back home alone by taxi to the same circumstances.*
- *In one case there was no food in the unit for the patient to return to. In another, a terminally ill patient in late stages of ill health requiring regular pain relief was sent home over the Christmas period when services are at a reduced level.*

- *Patients, more often than not, receive no follow up and are left to sort things out for themselves. District nurses are sometimes contracted as a provider and delays occur in actioning any care plan. This may take 6-7 days or up to 10 if it is ACC. There seem to be longer delays in a rural area, and we are aware that district nurses are not always available.*
- *Patients discharged from hospital without a check being carried out to establish if the person at home was capable of providing the necessary standard of support - the partner at home was absolutely exhausted after providing care for the patient while waiting to go into hospital for treatment.*
- *Patients discharged without checking if their family could change dressings on operation sites, but providing the dressings to enable the dressing to be changed regularly.*
- *Patients discharged from clinic requiring daily injections but not checking that anyone in the family could administer these injections – luckily a friend and neighbour was able to assist.*
- *It can depend on 'which ward' the patient is discharged from as to how efficiently the discharge plan is put into place. I have experienced cases where services such as home help, grab rails and walkers are not put into place for several days after discharge, causing a lot of distress and resulting in the patient having to rely on the goodwill and availability of family and friends. Yet, in other cases the discharge plan is excellent.*
- *A 78- year-old patient had a full mastectomy on a Friday. She is discharged on Saturday and returns home. She was told that a district nurse would call next day to attend to her. No one arrives. On the Monday she rings the hospital and is told that they have no knowledge concerning her as no paperwork had come through. She was extremely anxious as she had two drains and a full container. Nurse arrived that (Monday) evening.*
- *Lack of communication between funding agencies: Client had no support in her home following discharge recovering from a fractured back. ACC initially accepted the claim but then withdrew due to a pre-existing condition. The NASC agency wouldn't touch it as they had no confirmation that ACC was not managing the funding. On contact with ACC it was clear to them that they would not be assisting this client but it would take some time for the letter to be sent to the client. This is a lack of simple communication that resulted in the client and her husband being unable to manage.*
- *Incorrect assessment of package of cares required: A client being assessed as not needing personal cares as she managed to safely shower herself at the hospital (flat wet shower areas) but not assessing the risk that in her bathroom at home she had to step down into the bath.*

Older people should not be discharged from hospital unless community care that meets their needs has been arranged and can commence immediately. Poor post-discharge planning and follow-up reduces the person's chances of full recovery and increases the likelihood of re-hospitalisation. Urgent attention must be given to this matter.

The response from Age Concern Canterbury to the questions above stood out, as it contained very positive feedback about the "meet and greet" service established by the Canterbury DHB.

As this seems to be a model that works well, **we recommend that the Minister assist DHBs to explore the possibility of adapting it nationwide and that you ensure that older people are never discharged from hospital without the support that they need.**

4.3 Access to primary care

Cost to the patient and health workforce shortages remain the major impediments to adequate access: there is still too much variation in GP fees around the country; closed books and increased waiting times are affecting older people around the country.

In our response to the recent Primary Health Care Advisory Council discussion paper on Service Models for the Delivery of Primary Health Care, we stressed that Age Concern does not support increased gate-keeping at point of entry, or reduced opportunity to access the practitioner of choice.

Long term relationships with individual practitioners remain highly valued by older people who, in non-acute circumstances, are often willing to wait for an appointment with the doctor they know and who knows them. Comfort and 'fit' between patient and practitioner are important elements of quality care from a consumer perspective and are vital for effective and open communication, particularly in circumstances where there may be depression or abuse.

4.4 Access to after hours care

In September 2009 ACNZ responded to a consultation from the OAG about availability of and access to after hours care. As with discharge planning, there was a marked lack of consistency across the country. Cost and transport were identified as the main barriers to access.

We recommend that the Minister ensure that older people have timely access to primary health care and after hours care nationwide.

4.5 Importance of health promotion and prevention

Age Concern was disappointed at the Horn report's lack of commitment to prevention and at the implication that increasing life expectancy may not be worth it. (See our response to the Horn report, attached)

Disease and disability amongst older people must not be accepted as inevitable and irreversible. While increased longevity can result in increased healthcare costs, careful long-term planning, coupled with an emphasis on healthy lifestyles, can help ensure that the health system is able to meet the challenges of demographic change.

Sustained health promotion is one of the keys to improving quality of life and reducing the incidence of the chronic conditions that afflict both young and old. Cutting prevention programmes in order to save health dollars in the short term is a false economy that will result in greater costs in the long term.

4.6 ACC

Age Concern New Zealand chairs the Older People Advisory Group to ACC and this has enabled us to assist ACC to identify and overcome barriers to access for older people.

We remain concerned that an increasing number of older people are being turned down for elective surgery, with ACC citing long-term conditions or the ageing process as a reason for declining the claim. It is apparently not uncommon for ACC to go against a surgeon's recommendation that surgery be covered by ACC – this leaves the older person caught between two expert opinions.

We believe it is unacceptable that older people who have suffered a personal injury should be forced to fight to obtain the care to which they are entitled.

Age Concern New Zealand strenuously opposed the amendment of the definition of personal injury to exclude "any degree of hearing loss that is less than 6% of binaural hearing loss." We regard the move to make ACC cover conditional upon degree of personal injury, rather than cause of personal injury as a radical erosion of the principles of the scheme and as especially unfair to older people.

Men aged over 57 and women aged over 65 are already subject to a threshold based on age when they make an ACC claim after hearing loss injury. The addition of a further 6% to this adjustment penalises older people, many of whom will have sustained their hearing loss because they entered the workforce in an era when workers were not provided with noise protection. For this very reason, it is likely that older people will be disproportionately affected by this change.

4.3 What actions can the Minister of Health take?

- Acknowledge that oral health is part of general health and provide lifelong subsidies on the costs of dental care (see below)
- Fully fund hearing aids to people over 65
- Institute a free annual eye examination for people over 65
- Ensure that older people are never discharged from hospital without the support that they need
- Ensure that older people have timely access to primary health care and after hours care nationwide
- Ensure health promotion and prevention for older people is available in all parts of New Zealand.