

The Health and Wellbeing of Older People and Kaumātua

The Public Health Issues

Public Health Goal

To improve, promote and protect the health of older people/kaumātua.

Relevant Objectives

- ?? To maintain and improve mobility amongst older people/kaumātua.
- ?? To protect older people/kaumātua from preventable infectious diseases such as influenza.
- ?? To reduce disability from incontinence.
- ?? To improve and maintain social support for older people/kaumātua.
- ?? To reduce death rates and disability from injuries.
- ?? To promote older people/kaumātua mental health and wellbeing.
- ?? To increase participation of older people/kaumātua in regular physical activity.
- ?? To reduce the incidence of food-related health disorders by improved nutrition of older people/kaumātua.

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MANATŪ HAUORA

Foreword

This paper is one of a series on public health issues developed by the Public Health Group of the Ministry of Health. This document should be read in conjunction with *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health*, which provides an overall framework for improving the health of New Zealanders.

As a result of the latest amendments to the Health and Disability Services Act 1993, the Ministry of Health is required to improve, promote and protect the public health. In accordance with this Act as amended, the Public Health Group is required to regularly consult the public, those involved in the provision of public health services and other appropriate persons.

I wish to thank staff of the Public Health Group for their efforts in developing this paper. The extensive consultation undertaken by staff has ensured that the issues related to important public health matters have been well canvassed and systematically analysed. Such analysis provides a good basis for quality policy advice to the Minister.

The Public Health Group invites comment on strategies to address the issues contained in this paper. Please send your comments to the address provided at the back of this paper.

A handwritten signature in black ink, appearing to read 'K. O. Poutasi', with a horizontal line extending from the end of the signature.

Karen O Poutasi (Dr)
Director-General of Health

Acknowledgements

I would like to thank the many individuals and organisations who commented on the draft of the issues-based paper *The Health and Wellbeing of Older People and Kaumātua: Public health issues*. These comments helped formulate this final paper *The Health and Wellbeing of Older People and Kaumātua: The public health issues* which was jointly prepared by the Prevention Policy and He Kākano Oranga sections of the Public Health Group of the Ministry of Health. In particular, I would like to acknowledge the contribution made by Te Pūmanawa Hauora with their research project contracted by the Ministry of Health and Te Puni Kōkiri. Comments on the draft document were received from:

- ?? regional health authorities
- ?? Crown health enterprises
- ?? academic departments
- ?? local government
- ?? independent service providers
- ?? ministries and government departments
- ?? individuals and groups with an interest in public health
- ?? non-government organisations and other statutory bodies
- ?? Māori and iwi groups
- ?? Pacific people's groups.

A full list of submissions received is provided at the end of the document.

The issues-based papers form part of the framework for public health presented in the document *A Strategic Direction to Improve and Protect the Public Health* and *He Matariki: A strategic plan for Māori public health* which were published by the Public Health Commission in 1994 and 1995 respectively. The updated proposals from *A Strategic Direction* can be found in the revised document, *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health*. The issues-based papers systematically review the issues associated with public health policies, programmes and research and information relevant to the appropriate objectives listed in the strategic direction. The first review of public health activities and the setting up of outcome monitoring systems is now complete.

I hope that the publication of this paper provided to the Minister of Health illustrates the importance the Public Health Group places on the consultation process.



Dr Gillian Durham
Director of Public Health and
General Manager, Public Health Group

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Introduction

The function of the Ministry of Health in section 3a of the Health Act 1956, is to improve, promote and protect the public health.

Public health services are concerned with whole population groups, such as Māori or older people, rather than individuals. Areas of responsibility include environmental health (for example water quality), food and nutrition, the prevention and control of communicable diseases, major lifestyle and public health problems (such as tobacco, alcohol and mental health), and the public health needs of Māori and special groups.

The Public Health Commission's (PHC) document *A Strategic Direction to Improve and Protect the Public Health* (PHC 1994) provided a framework for public health in New Zealand and set the basis for developing the Public Health Group's (PHG) papers. It has been reviewed and updated, and is succeeded by *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health* (MoH 1997i). *Strengthening Public Health Action* builds on *A Strategic Direction* by updating the public health goals and objectives, and focusing on four cross-cutting themes: focusing on the determinants of health; building strategic alliances; implementing comprehensive programmes; and strengthening the public health infrastructure. *He Matariki: A strategic plan for Māori public health* (PHC 1995a) provided the basis for the kaumātua content of this paper.

This issues-based paper on the health and wellbeing of older people and kaumātua identifies possible outcome targets as well as policy, programme, research and information issues associated with the outcomes. These issues include new initiatives or suggested improvements for increasing the effectiveness and efficiency of established programmes.

All of the issues papers have a common structure which is summarised as follows:

?? **Title**

?? **Background**

?? **Setting the Scene**

This section identifies the public health goals that this paper relates to.

?? **Setting Outcome Targets**

This section briefly describes the health status issues and justifies the choice of some outcome targets. Where relevant, risk factors and protective factors are discussed. Some outcome targets are also proposed.

?? **Healthy Public Policy Issues**

The health and wellbeing of older people and kaumātua impacts on and is influenced by the entire community, not just the health sector. This section therefore briefly reviews the existing major intersectoral, government department and health initiatives relating to the health and wellbeing of older people and kaumātua. It goes on to

identify some of the key policy issues and may provide justification for further policy development.

?? **Public Health Programme Issues**

This section identifies key public health programme issues relating to the wellbeing of older people and kaumātua.

Treatment services are referred to because of the important public health role they play in maintaining wellbeing and managing the impact of age-related disability and chronic conditions.

?? **Research and Information Issues**

These include research issues normally addressed by research funding agencies.

The issues provide information for researchers who may wish to develop research proposals in these areas. Funders such as the Health Research Council may want to consider funding high quality proposals to address the hypotheses put forward.

The information issues also relate to improving the availability or quality of data.

?? **Summary of Benefits**

Benefits of addressing the issues are listed in the papers. As with personal health services, currently formal cost-benefit studies are available for only a minority of public health programmes.

?? **References, Glossary and Appendices**

The references that have been used for each paper are listed along with a glossary of commonly used terms and any appropriate appendices at the end of each paper.

Background

In April this year the Ministry of Health released a draft discussion document for consultation entitled *The Health and Wellbeing of Older People and Kaumātua: Public health issues* which was prepared jointly by He Kākano Oranga and Prevention Policy sections of the Public Health Group. Both the general public and the health sector attended regional meetings, hui and fono that the Ministry conducted in various parts of New Zealand. Written submissions were also received. The feedback from the written and oral submissions has been analysed and the draft discussion document revised accordingly to produce this current paper.

In general the draft discussion document was received well by participants at the meetings, hui and fono as well as by those who sent in written submissions. They indicated that the paper was fairly comprehensive in its coverage of the issues that affect the health and wellbeing of older people and kaumātua without being overly lengthy. However, many submissions pointed out gaps or inadequate attention to particular issues. These points have been considered and common themes have been incorporated into this document.

Purpose of this paper

The purpose of this paper is to outline those issues that impact on the health and wellbeing of older people from a public health perspective. The paper provides an overview of the current health status of all older people (65 years and over) in New Zealand, including specific details on kaumātua (55 years and over).

The paper provides this overview by:

- ?? outlining the risk and protective factors for older people and kaumātua
- ?? proposing targets
- ?? reviewing policy, programme, research and information issues.

These steps will allow assessment on how the health and wellbeing of older people and kaumātua can be improved. For kaumātua this will be important in enabling them to enjoy at least the same level of health as their non-Māori counterparts.

The paper encourages people to think about those issues that will ensure that older people and kaumātua, both in the present and the future, can experience and enjoy healthier lives. These issues include quality of life through independence, mobility, safety and security, social support, and participation.

It is also important to consider the provision of services and programmes that ensure the appropriate management of chronic conditions, early intervention for age-related conditions, prevention of injury, the role of rehabilitation, and the provision of appropriate support services.

This paper provides a basis for policy advice on the health and wellbeing of older people and kaumātua.

Definition of older people

For the purposes of this paper older people refers to those in the age range of 65 years and over. Sixty-five is internationally recognised as the point from which people are known as older people. It is also the age at which entitlement to retirement income in New Zealand will be guaranteed in 2001.

Participants at the fono discussed the meaning of older people from a Pacific people's perspective and came to a similar conclusion expressed by many Māori participants. The status customarily accorded to older Pacific peoples was not necessarily confined by chronological considerations but can be ascribed as a consequence of increased social status. They also noted that many Pacific peoples face illness or limitation to physical participation and mobility, typically associated with older people, at a younger age than the general population.

Definition of kaumātua

For the purposes of this paper, the term 'kaumātua' refers to all Māori aged 55 years and over. This age range allows the flexibility to acknowledge that many Māori face age-related disability and illnesses at a relatively younger age and have a shorter life expectancy than non-Māori.

It is important to define the parameters of the kaumātua population group to understand the important role that they play within Māori society. *Whakapiki Mauri* states that mātua are those Māori between 35–64 years of age (PHC 1995d). *He Matariki* defines kaumātua as wise and experienced older members of the whānau, aged 55 years and over (PHC 1995a).

The term kaumātua more traditionally refers to the status and role that kuia (older woman) and koroua/koro (older man) attain as recognition of their contribution, leadership, knowledge and protection of whānau/hapū/iwi life (Barlow 1991). A definition used by Metge adds in the component of being knowledgeable in tikanga Māori (Metge 1995).

Many oral and written submissions wished to see alternative terms for kaumātua used. One submission preferred that kaumātua be a self-defined term rather than age or role related. It is a difficult task to define older Māori in both the traditional and contemporary context which also fits with a particular age range. It is intended that the term kaumātua encompass the range of diverse realities for older Māori today and in the future.

Statistical data impose an age range on population groups which makes it necessary to adopt an age span so as to enable a meaningful comparison of quantitative statistical analyses. Therefore, this paper has adopted the definition of the kaumātua age range in *He Matariki* (PHC 1995a). *He Matariki* was endorsed by hui participants during an extensive consultation process in 1995.

Public health focus

It is important to stress that this paper will concentrate primarily on public health issues relating to older people and kaumätua. Public health has been defined as ‘the science and art of preventing disease, prolonging life, and promoting health through organised efforts of society’ (Acheson 1988). The focus will therefore be on population-based initiatives or strategies and interventions to achieve the goal and objectives listed at the front of this paper.

The public health sector takes a lead role in disease prevention, health promotion and health protection. It plays a part in ensuring the safety of the air we breathe, the water we drink and the food we eat. The public health sector also focuses on enabling people to make individual and collective choices which improve their health (MoH 1997h).

However, improving the health of New Zealanders is not solely the responsibility of the public health sector. The personal health and disability support sectors, primary, secondary and tertiary health care workers, and the organisations and institutions where they work, are also crucial to improving, promoting and protecting the public health. An example is the promotion of healthy nutrition and exercise for heart disease patients. The public health sector encourages and supports work by the personal health and disability support sectors as well as public health work undertaken by other sectors, such as local government, welfare, transport, and housing.

While this paper will not explore personal health and disability support services in depth, it is necessary to acknowledge the important role that these services play in maintaining the health and wellbeing of older people and kaumätua. This will be done through addressing issues such as timely access and integration of care between community, primary and secondary services, as well as information about the frequency of use of these services by the upper age range of the older population.

Settings approach to health promotion

Traditionally, health promotion programmes have focused on single issues delivered from the one central location. There is growing support for health promotion to be delivered in the settings or places where people spend their everyday lives such as the church environment, residential homes, private dwellings, kōhanga reo, marae and recreation/ sports facilities. Studies have shown that effective and efficient health promotion programmes need to be co-ordinated across topics in terms of timing and content (Tannahill 1994; WHO 1995a).

Strengthening Public Health Action (MoH 1997h) sees the settings approach as one part of the strategy for addressing public health issues. One of the shortcomings of this approach is that it may systematically ignore those older people and kaumätua who do not participate in settings such as church or the marae where programmes are delivered. To counteract this situation, *Strengthening Public Health Action* promotes the implementation

of comprehensive public health programmes that are co-ordinated, holistic and robust and that build on the existing initiatives and ensure effective use of limited resources.

Health promotion

The action strategies of the *Ottawa Charter* (WHO 1986) provide a useful framework within which to consider the wellbeing of older people and kaumātua. Health promotion is the process of enabling individuals and communities to increase control over and improve their health. This is consistent with Māori aspirations to be responsible for providing public health programmes and services that meet their needs (PHC 1995a).

The publication *Mental Health Promotion for Younger and Older Adults* (MoH 1997c) describes empowerment as a central component of health promotion strategies as it allows people not only to be involved but also to take action for themselves. This recognises that communities and individuals are the best judges of their own interests and the best course of action to cater for those interests.

The strategies to achieve this outcome are described in the *Ottawa Charter* (WHO 1986). It provides people with some guidelines that they may interpret according to their particular circumstances. The five components listed in the charter have also been analysed by Messiter (1995) from a Treaty of Waitangi perspective and the following interpretations have been made:

- ?? **Developing healthy public policy**
Māori health having top priority from the highest political levels
- ?? **Creating supporting social environments**
Recognising and acting on Māori health concepts and practices
- ?? **Strengthening community action**
Iwi Māori having control over their own health and being supported in this through the equitable access to health resources and the health dollar
- ?? **Developing personal skills**
Facilitating empowerment through equitable access to training and education
- ?? **Reorienting the health system**
Providing health services for iwi Māori by iwi Māori.

Messiter's model focuses on iwi control in terms of strengthening community action and on health services for iwi Māori provided by iwi Māori (Messiter 1995). In this instance iwi may be viewed in the broadest sense to include whānau and hapū.

The public health programmes section of this paper highlights some of these interpretations.

Overview of New Zealand's older population

Over the next 40 years the number of older people and kaumätua in New Zealand will increase significantly. The largest change will occur in the number of older Māori and Pacific people. This will have particular implications for these population groups in improving, protecting and maintaining their health and wellbeing.

The social, economic and cultural context in which older people and kaumätua live is discussed in the next section on setting the scene. However, there are several issues which the Prime Ministerial Task Force on Positive Ageing has identified and which may contribute to improvement in the overall health and wellbeing of older people. One submission on this paper pointed out that there are a myriad of paths one could take which makes it difficult to plan ahead, but the Task Force considers that 'positive ageing' and positive attitudes towards ageing by society will enhance people's ability to plan for older age. The Task Force believes that 'positive ageing' is about 'positive living', and articulates this vision as:

'People ageing confidently with increasing richness of life.'

This requires:

- ?? everyone understanding the ageing process and being older; planning and preparing for the future while participating and contributing to society in the present
- ?? individuals, families and communities beginning at an early age to share the responsibility for achieving healthy, secure and fulfilling lives for themselves and those around them
- ?? older members of society enjoying the respect and support of a caring community whose values, attitudes and behaviour they have helped to shape and continue to influence by the contributions they make (DPMC 1997).

Older people

In the New Zealand Pākehā population, the most significant growth is predicted to occur in those aged 85 plus, sometimes referred to as the 'old old'. This age group is projected to make up 13 percent of those over 65 years of age in 2031. This means that there is likely to be about 4000 people over 100 years of age in the year 2031.

The increasing life expectancy for men since the 1970s is affecting the ratio of older women to older men. Whereas in 1991 there were over five women 85 years of age or more for every two men of a similar age, by 2031 this ratio is expected to fall to just below 3.5 women to every two men (Statistics NZ 1995).

Kaumätua

Kaumätua are taonga of the whānau, hapū and iwi structures. In their traditional, formal role they are the guardians of wisdom, knowledge and traditions, and of moana, awa, whenua, forests, whānau and the marae. Their role is to nurture the whānau, hapū and iwi

with this knowledge. This responsibility is not assumed upon reaching a certain age but is an honour conferred upon a person depending on whakapapa, experience and ability. It is an earned status. As guardians of the whānau, kaumātua are often responsible for the health and wellbeing of the whānau. A lifetime of knowledge and wisdom is lost when kaumātua die. When kaumātua die prematurely, the loss is greater as they have had little time to enrich their community (PHC 1995a).

As the year 2000 approaches, the health of kaumātua will become an important issue. There are two reasons for this. Firstly, there will be considerably more kaumātua than at present and they will make up a larger proportion of the Māori population. This will occur because the Māori population, along with the non-Māori New Zealand population, is 'ageing', a process resulting primarily from a declining birth rate which eventually leads to an increasing proportion of older people in the population.

Secondly, in the year 2000 and beyond kaumātua may command lower levels of economic and cultural resources compared with kaumātua today, exposing them to greater health risks and limiting their access to services. The significant increase in the numbers of kaumātua will considerably strengthen the pool of traditional Māori leaders, provided that cultural knowledge is transmitted to the present generations of young Māori people (PHC 1995a).

The average life expectancy for Māori women is 73 years and 68 years for Māori men. In 1991, 3percent of Māori were 65 years or older compared with 13 percent of non-Māori. Over the next 40 years, the Māori population will age at a faster rate than the non-Māori population. By 2011, the number of Māori aged 65 years and over is expected to have more than doubled from 10 959 to 26 100. By 2031, this population will have trebled to 9 percent of the total Māori population. Another factor underlying the ageing of the Māori population is the increase in life expectancy over the recent decades (Statistics NZ 1994).

Pacific people

A similar rapid growth is being experienced by the Pacific populations, where those aged 65 years or more are predicted to increase from 1 in 38 people in 1991 to 1 in 12 by 2031. However, the changing ratio of island-born compared to locally born Pacific people affects the ageing pattern. This is influenced by the migration rates and also varies according to ethnicity. To illustrate this point, 1991 statistics show that less than 2percent of older Pacific people living in New Zealand were born here, compared with 46 percent of those under the age of 65 years. Between 1986 and 1991, however, the number of older Pacific people almost doubled due to a change in migration patterns which saw families reuniting in New Zealand rather than in the home islands. Thus, this increase in the number of older Pacific people was almost totally due to those born in the islands migrating to New Zealand (Statistics NZ 1995).

Other ethnic or migrant groups

Older people make up a small percentage in other ethnic groups in New Zealand, with recent migrants contributing more to the numbers of older people than those born in New Zealand (Statistics NZ 1995).

Public health

Strengthening Public Health Action

The Ministry of Health has recently reviewed and updated *A Strategic Direction to Improve and Protect the Public Health* (PHC 1994), which has shaped the policy, purchasing and provision of public health services in New Zealand since its release. Its successor, *Strengthening Public Health Action: The background paper* (MoH 1997h) retains much of the content of *A Strategic Direction*, with some changes and additions. *Strengthening Public Health Action* builds on the earlier strategic approach and proposes to co-ordinate public health action across the Government.

Goals and objectives

The goals and objectives that were identified and recommended in *A Strategic Direction* (PHC 1994) have been retained with some changes. The goals, objectives and targets have been reorganised and streamlined so that they underpin the cross-cutting themes identified in *Strengthening Public Health Action* (MoH 1997i). These themes are:

- ?? focusing on the determinants of health
- ?? building strategic alliances
- ?? implementing comprehensive programmes
- ?? strengthening the public health infrastructure (MoH 1997i).

Many submissions suggested additional objectives or amendments to current objectives so that there would be a more comprehensive coverage of those issues affecting older people and kaumätua. Objectives can and often do apply to a number of goals and services may well be developed for one issue which meet a number of goals (MoH 1997h). Therefore, many of these suggestions will be captured through other goals and objectives that apply across population groups. A copy of these relevant goals and objectives can be found in Appendix 1. This approach seeks to discourage any gaps or overlaps by recognising that there are wider issues that impact on the health and wellbeing of older people and kaumätua other than public health issues.

Mäori public health

Treaty of Waitangi

Any discussions on Mäori health must begin with a reference to the Treaty of Waitangi. As the founding document of the nation, the Treaty defines the relationship between Mäori, as tängata whenua, and the Crown.

He Matariki: A strategic plan for Māori public health

He Matariki: A strategic plan for Māori public health (PHC 1995a) was developed by the PHC after extensive consultation with iwi. Following the disestablishment of the PHC in 1996 and the incorporation of public health issues into the Ministry of Health, *He Matariki* has continued to provide the direction for Māori public health policy development.

Whāia te Ora mö te Iwi

The Government reaffirms its objective to improve Māori health status so that in the future Māori will have the opportunity to enjoy at least the same level of health as non-Māori. The Government acknowledges it must meet the health needs of Māori and help improve their health status so as to achieve its objectives for Māori health. *Whāia te Ora mö te Iwi* (Department of Health 1992) proposed three Māori policy directions:

- ?? greater participation of Māori at all levels of the health sector
- ?? resource allocation priorities which take account of Māori needs and perspectives
- ?? the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.

Diverse Māori realities

Māori are not a homogenous population group. A range of policies, programmes and service delivery systems need to be developed, monitored and evaluated to provide for age and gender as well as rural, urban and socioeconomic groups. Also, hapū, iwi and Māori community-based groups need to be acknowledged as structures with varied abilities and capacities to respond to and participate in the provision of services (Durie 1994; Minister of Health 1995).

Whare Tapa Whā

Māori perceive health in a holistic manner. Health depends on a balance of wellbeing in various aspects of the whānau (and thus kaumātua life) and the surrounding environment. The quality of wellbeing in each of these aspects can be represented by the model known as *Whare Tapa Whā* (Durie 1994). This involves recognising four interactive components of wellbeing: wairua (spiritual), hinengaro (mental), tinana (physical) and whānau (extended family). Te ao turoa (environment) and te reo Māori (Māori language) are also recognised as important components. This approach requires that Māori health be understood in the context of the social, economic and cultural position of Māori.

This holistic approach to health, particularly the emphasis on spirituality, was suggested by many participants, both Māori and non-Māori, in the Prime Ministerial Task Force on Positive Ageing seminars during 1996, as providing a useful basis for promoting positive ageing.

Setting the Scene

This section of the paper looks at the range of factors that influence the health and wellbeing of older people and kaumätua, including demographic predictions and mortality and morbidity data.

Demographic factors

As a starting point, it is useful to look at the current demographic characteristics of the older age group and the projected changes likely to occur over the next 40 years. New Zealanders aged 65 and over are a diverse group constituting about 11 percent of the total population at the 1991 census and predicted to increase to about 19 percent of the total population by 2031 (Statistics NZ 1995). Sixty percent of this group are aged from 65 to 74 years, with 32 percent aged from 75 to 84 years and 8 percent aged 85 years and over.

Men outnumber women in the 65–69 age range but this ratio gradually changes so that by 85 years and over, women outnumber men. The gap between the ratio of older men to older women is closing, partly due to a more rapid increase in the numbers of men in the younger age group (65–69 years), associated with increasing life expectancy of this age group for men since the 1970s. The number of older men is increasing at a greater rate than older women, which is different from the total New Zealand population where the number of women is increasing at a greater rate than men.

The Māori population is ageing significantly faster than the non-Māori population, with predicted increases from 1 in 40 Māori aged 65 years or more in 1991 to 1 in 11 by 2031. The impact of low birth rates, increased life expectancy and the ageing of those born during the high fertility era of the 1950s and 1960s, means that over time, the Māori population structure is becoming similar to that of the non-Māori population.

The growth in the number of people aged 85 years or more, the ‘old old’, is expected to be most significant for all New Zealanders, with a predicted increase from 4 percent of older people in 1991 to 13 percent by 2031. The significant increase in this older age group is particularly relevant to health and social services as the increasing dependency associated with this age group brings increased demands for care and support services. Women are more likely to be widowed than men and the increasing numbers of separated or divorced people in the general population is reflected in the rising numbers of people entering the older age group already separated or divorced (Statistics NZ 1995).

A higher proportion of older people live in urban areas than in rural areas and the majority of this urban older population is female. Older men outnumber older women in rural areas, until age 81 and over, when women are in the majority. There are more rural older women living alone than older men. Greater employment opportunities and closer access to health and disability support services and facilities are estimated to be the main factors that prompt older people, especially single or widowed older women, to shift to an urban area.

The implications of ageing populations

The three scenarios frequently suggested when looking at the implications of ageing populations are that:

- ?? there will be increased years of healthy life
- ?? the improvements in technology and general living will result in fewer disabled years
- ?? improvements will be unable to keep abreast with gains of life expectancy and more years will be spent disabled.

There is little research to support any one of these theories over the other. The third scenario seems to fit contemporary evidence best and concerns policy makers, service planners, older people and kaumätua (Statistics NZ 1995). Several submissions on the draft of this paper considered that the proportion of retirement income that older people would need to meet rising medical costs during a time of health resource rationing could affect these three scenarios. Medical costs need to be seen in the context of other costs that older people face to maintain their health at a time of frequently limited ability to pay. Others suggested that the improved technology is more likely to give rise to a difference in disabled years rather than fewer, that is disability may be less severe or may occur at a later stage of old age.

Self-assessed health

Most older people tend to look positively at their health. What older people frequently think of as “good health” differs markedly from the conception of health which underlies most of the research into health in old age, and which broadly reflects the biomedical model of ageing (Sidell 1995). The alternative view often given by older people is one in which “being healthy” is a matter of “feeling good”; linked to emotional wellbeing, and the ability to cope with the essential tasks of everyday life. This view is reflected in recent New Zealand self-assessments of health status. Submissions and hui participants pointed out the ongoing importance of sexuality for older people, an area that had not been addressed in the draft discussion paper, and that research has shown to be an important contributor to mental and physical wellbeing. Hui participants considered that information and education about changes associated with ageing and menopause were needed so that kaumätua could be better prepared for maintaining intimate relationships as they aged.

In a recent survey of 379 kaumätua, the majority viewed their health positively and led physically, socially and culturally active lives. Thirteen percent regarded their health as excellent, 27 percent as very good and 26 percent as good (TPH 1996). These predominantly positive self-assessments are interesting given the reported levels of disability within the survey group. The majority (61 percent) reported having a minor or major disability, yet reported very low use of disability support services. These results need to be interpreted within the context of a survey sample that was biased towards more traditional older Māori, who were closely connected to their marae, culturally secure and active in their kaumätua role. They are not, therefore, necessarily representative of all kaumätua.

The 1992–93 New Zealand Household Health Survey reported a higher incidence of long-term illness and disability among those aged over 70, than in the total sample (70 percent compared with around 33 percent) (Statistics NZ and MoH 1993). Although there was more disability in this age group, nearly 75 percent of those aged over 65 years rated their health as excellent or good. These findings are similar to those of a Colmar Brunton survey conducted for Age Concern in 1990, where around 25 percent of respondents over 65 years of age regarded their health as “excellent”, 40 percent as “good”, with 25 percent describing it as “fair” (Age Concern 1990). Those on low incomes, those not in the labour force and Māori and Pacific people were also less likely to rate their health as good or excellent in the 1992–93 New Zealand Household Health Survey (Statistics NZ and MoH 1993).

The Household Health Survey also found that over half of those aged 65 and over reported some loss of mobility, compared with 6 percent of those under 65 years. Mobility was described as limited or severely limited by 76 percent of men aged over 85 years, and 87 percent of women in this age group. People over 65 years sought medical advice more often than the rest of the population, with 89 percent visiting a doctor or general practitioner in the previous year compared with 78 percent of the total sample (Statistics NZ and MoH 1993).

The majority of people in their 60s and 70s are largely independent and healthy. Increasing proportions of people in their 70s and 80s become more dependent on assistance because of chronic illness or disability, and/or fewer family members to provide care and support. This need for increased care and support may occur at an earlier age for kaumātua since they currently have lower life expectancy and earlier onset of preventable chronic conditions. The majority of the older disabled population live in the community; less than one in 12 are cared for in institutions or aged care facilities (Richmond et al 1995). Within this population group, less than 2 percent of those aged between 65 and 69 years are in long-term residential care, with the proportion increasing to around 33 percent for those aged 80 years and over. The percentage increases more sharply in the oldest groups and women are twice as likely to be in aged care facilities as men (Richmond et al 1995).

Mortality

The major causes of death and hospitalisation are similar for all older people in New Zealand, though kaumātua tend to have higher overall mortality and morbidity from respiratory disease than non-Māori and ill health from diabetes is over four times that of non-Māori (PHC 1995a).

At present, the major illnesses leading to death for all New Zealanders in the age group 55–64 years, and in the 65 and over age range, are:

- ?? cancers (especially cancers of the lung)
- ?? ischaemic heart disease (IHD)
- ?? chronic obstructive respiratory diseases (CORD)
- ?? cerebrovascular disease
- ?? diabetes.

These debilitating conditions are largely preventable and lowering their prevalence, especially in the 55–64 years age group, could result in a greater number of kaumätua than is projected for the kaumätua population in the years ahead (PHC 1995a). There is a downward trend in the death rates from ischaemic heart disease for all New Zealanders. The majority of deaths from this cause (83 percent) occur in those aged 65 years or more. Cancer was the leading cause of death for all New Zealanders in 1994 (MoH 1997d).

Respiratory conditions are a major cause of both hospital admissions and mortality amongst older people. Cigarette smoking is a key risk factor associated with chronic respiratory disorders and heart disease. The higher smoking rates among women are now being reflected in rising mortality rates amongst mature women (Bonita 1995). The mortality rates for Māori women are higher than for non-Māori, reflecting the higher smoking prevalence in this group. The higher incidence of respiratory conditions and the earlier onset of chronic respiratory conditions in Māori largely imitates the differing rates of cigarette smoking amongst Māori and non-Māori.

Table 1: Male mortality rate, selected causes, Māori and total population, ages 65–74 and 75+ years, 1985–94

	65–74 years*		75+ years**	
	Māori	Total population	Māori	Total population
Bowel cancer	99	170	164	311
CORD [^]	371	271	1017	940
Diabetes	312	66	312	144
IHD [#]	1416	1277	2608	3216
Injuries (all)	92	82	180	232
Lung cancer	604	334	674	523
Other heart disease	522	265	1115	1090
Pneumonia/influenza	92	66	589	802
Prostate cancer	141	125	420	491
Stroke	329	282	904	1245
Falls	13	12	61	120

* Crude rate per 100 000 per year

** Rate per 100 000 age-standardised to NZ population 1985–94

[^] Chronic obstructive respiratory disease

[#] Ischaemic heart disease

Source of data: New Zealand Health Information Service and Statistics New Zealand

Table 2: Female mortality rate, selected causes, Māori and total population, ages 65–74 and 75+ years, 1985–94

	65–74 years*		75+ years**	
	Māori	Total population	Māori	Total population
Bowel cancer	46	121	88	240
Breast cancer	95	115	133	167
CORD [^]	321	139	514	277
Cervical cancer	46	15	49	19
Diabetes	221	47	275	103
IHD [#]	877	576	1994	2114
Injuries	41	41	113	179
Lung cancer	321	125	242	120
Other heart disease	357	147	1170	873
Pneumonia/influenza	65	43	642	625
Stroke	310	212	1111	1284
Falls	3	9	49	128

* Crude rate per 100 000 per year

** Rate per 100 000 age-standardised to NZ population 1985–94

[^] Chronic obstructive respiratory disease

[#] Ischaemic heart disease

Source of data: New Zealand Health Information Service and Statistics New Zealand

Each year about 80 women die from, and 220 women are diagnosed as having, invasive cancer of the cervix. The incidence and death rates are much higher in women aged 40 years and over. In 1994 (the last year for which provisional figures are available) of the 205 new cases, 60 cases or 28.8 percent were aged 60 or over. Of the deaths in that year 46 percent were over the age of 60 (NZHIS in press). Māori women have a higher incidence of cervical cancer: 29.9 per 100 000 women in the period 1989–1993 compared with 11.8 per 100 000 for all women in the same period. The death rate for Māori women is approximately twice as high as for non-Māori though only one Māori woman over the age of 60 died from the disease in 1994.

Studies have shown that a woman's screening history is the most useful indicator of her risk for developing squamous cell cervical cancer, as those most likely to develop the disease are those women who have not been regularly screened (MoH 1997c; MacLean et al 1985; Skegg et al 1985). Enrolments for the five-year cohorts of women aged 55–69 are lower than for those aged 20–54, an average of 65 percent compared with 80 percent or more. In 1997 the National Cervical Screening Programme has focused on increasing the enrolments in the 55–69-year-old population of women.

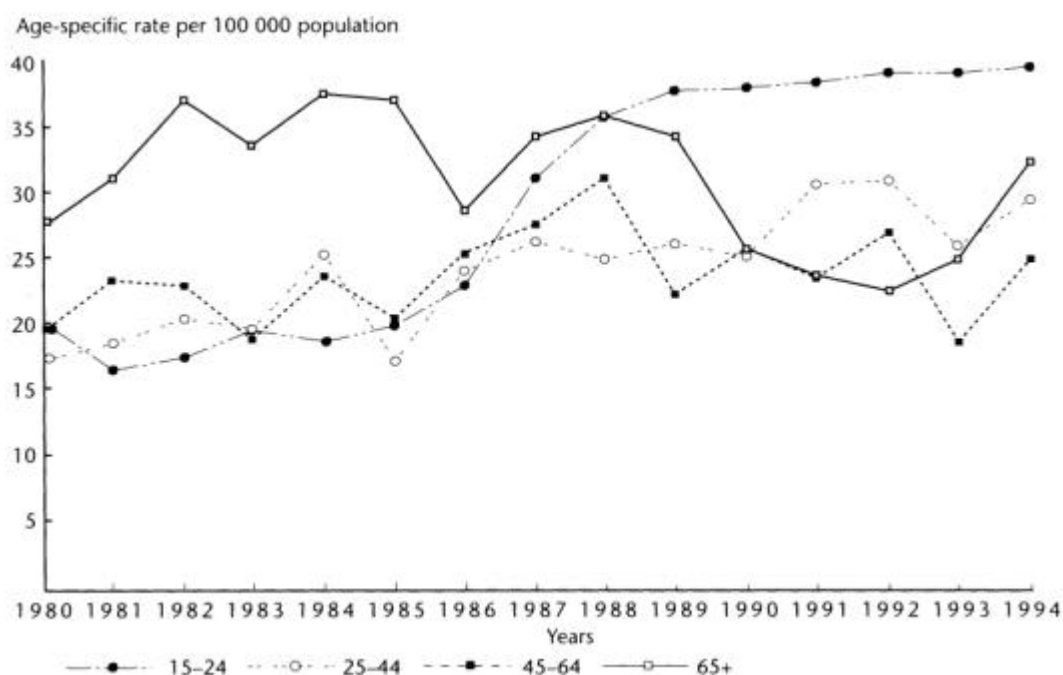
Breast cancer causes around 570 deaths of New Zealand women per year, with the majority of those deaths occurring in women aged 45–64 years (MoH 1997d). There has been little change in the breast cancer mortality rate between 1984 and 1993. Over two-thirds of all breast cancers occur in women over 50 and the risk increases with age. International evidence shows, and New Zealand trials indicate, that breast cancer mortality can be reduced by up to 30 percent through organised mammography screening

programmes, and effective treatment where necessary, in women aged 50–64 years when a high proportion (70 percent) of this at-risk population are screened. There is insufficient evidence of benefit to support screening programmes for women less than 50 years old (MoH 1995).

About 63 percent of all prostate cancer deaths occur in men aged 75 years and over. There is little difference between Māori and non-Māori rates, though there has been a gradual increase in the Māori rate since 1984.

Intentional injuries, including suicide, attempted suicide, homicide and non-fatal assault (Coggan et al 1995) are not a major cause of mortality and morbidity in older people. Suicide rates for all people aged 65 or over are declining, through a 1984 study indicated that suicide rates were highest amongst older men (Langley and Johnston 1990). However, the suicide rates for men aged over 65 are second to those for men in the 15–24 age group.

Figure 1: Deaths due to suicide and self-inflicted injury in men, by age group, 1980–94



Source: New Zealand Health Information Service

Morbidity

In 1995, the leading cause of hospitalisation of Māori and non-Māori males and females aged 55 years and over was diseases of the circulatory system such as ischaemic heart disease and strokes. Other major causes of hospitalisation for men and women in this age group are cancers, diseases of the digestive system (eg, gastritis) and diseases of the respiratory system (eg, pneumonia and asthma).

Unintentional injuries are an important cause of hospitalisation of older people, resulting in approximately nine percent of hospitalisations of people aged 65 years or more in 1995. The two most common causes of injury resulting in hospitalisation of older men (aged 65 years or more) were, firstly, adverse effects of medical or surgical procedures and, secondly, falls. The order is reversed for non-Māori older women with falls being the leading cause of injury hospitalisation. However, in the Māori population the adverse effects of medical and surgical procedures was the leading cause of injury hospitalisation for both men and women, with falls being the second cause (NZHIS 1997).

Table 3: Male hospitalisation rate, selected causes, Māori and total population, ages 65–74 and 75+ years, 1995

	65–74 years*		75+ years**	
	Māori	Total population	Māori	Total population
CORD [^]	3899	1410	5308	2130
Fractured femur	0	15	0	50
Pneumonia/ influenza	2127	624	4700	1824
Falls	937	686	2831	2673

* Crude rate per 100 000 per year

** Rate per 100 000 age-standardised to NZ population 1995

[^] Chronic obstructive respiratory disease

Source of data: New Zealand Health Information Service and Statistics New Zealand

Table 4: Female hospitalisation rate, selected causes, Māori and total population, ages 65–74 and 75+ years, 1995

	65–74 years*		75+ years**	
	Māori	Total population	Māori	Total population
CORD [^]	3306	1032	3841	1079
Fractured femur	0	24	53	79
Pneumonia/ influenza	1339	406	3770	921
Falls	649	1080	3346	4495

* Crude rate per 100 000 per year

** Rate per 100 000 age-standardised to NZ population 1985–94

[^] Chronic obstructive respiratory disease

Source of data: New Zealand Health Information Service and Statistics New Zealand

Non-Māori older people, especially women, are more likely to need hip and knee replacements. Waiting for surgical intervention can have a major adverse effect on mobility, quality of life and independence for older people. A Southern Regional Health Authority commissioned study into the consequences of long waiting times for surgery for hip and knee replacements or prostatectomy, has demonstrated that the effect of living with pain

and disability is considerable and compromises daily living routines (Derret et al 1996). Long waiting times can also involve more frequent visits to a general practitioner or specialist and more prescription drugs; all of which may incur costs that could be avoided by earlier surgical intervention.

Factors influencing wellbeing

The range of biologic, social, cultural and economic determinants that influence the health and wellbeing of older people and kaumātua is common to all population groups (Bonita 1996). When looking at factors which influence the health of older people and kaumātua particularly, it is important to remember the diversity of this age group and the complex relationship between the determinants of health and health status. A number of models have been used to try and describe the relationship between the individual with their fixed biological factors, individual lifestyle factors, family, community and spiritual influences and broader living, working, cultural, socio-economic and environmental conditions (MoH 1997h). The particular combination of factors influencing wellbeing and independence will vary for individuals and groups.

Having positive attitudes, both as individuals and as a society, towards ageing as a normal stage of development, supporting continued independence and preparing for increasing frailty and dependence associated with growing older, are key contributory elements influencing the other determinants of wellbeing in old age.

Biology

Genetics plays a role in many diseases and therefore influences the health and wellbeing of older people and kaumātua, though the interaction between environmental influences and genetic factors is unclear. For example, the increasing evidence of a genetic link between depression and neurological diseases such as Alzheimer's disease and Parkinson's disease (Chiu 1996) means that it is not possible to lower the incidence of these disorders through appropriate health promotion and disease prevention strategies. Family circumstances and other environmental factors such as housing, income and nutrition may be more influential in the onset of disease than the vulnerability caused by genetic factors or anxiety and depression. For example, changes in physical activity and diet, which often accompany a change from a traditional to a more modern lifestyle, have contributed to an increasing rate of diabetes amongst Pacific people over the last 30 years, both in New Zealand and in the Pacific (MoH 1997a).

A healthy childhood and adulthood is probably the most important determinant of healthy ageing (WHO 1995b). There is increasing evidence that adverse circumstances during pregnancy, childhood and adolescence can impact significantly on the health and wellbeing of adults and older people. One of the submissions on this paper questioned the potential long-term health outcomes for large percentages of children perceived to be experiencing a marginal lack of healthy nutrition, education and adequate housing and the implications this has for healthy ageing. Lower socioeconomic status has long been associated with higher risks of disease and poor health status. Recent international studies suggest significant links between inequality of income distribution, health outcomes and mortality trends. Relatively

low levels of social expenditure in areas such as education and health, tend to be associated with increasing gaps between the top and bottom levels of income within a population. Thus, over time, health outcomes are likely to be poorer for those who experience deprivation (Kaplan et al 1996; Smith 1996). Intellectual or physical disability in childhood years also has an impact on subsequent adult health status. Ensuring adequate support, co-ordinated, appropriate care, information about the services and entitlements available to both the individual and the family, and planning for future needs as the person ages, are important elements that maximise an individual's ability and minimise the stress of caregiving (Hand and Reid 1996).

Gender

There are a number of economic, social, cultural and political factors that often place ageing women at a health disadvantage. Positive attitudes towards ageing that allow for personal growth and involvement in society can influence mental health and wellbeing and counteract the negative expectations that many women experience because of conventional attitudes towards older women and menopause (Bonita 1995). The key influential factors are:

- ?? women live longer than men
- ?? women tend to earn less than men
- ?? women are the usual carers of dependants
- ?? older women are often the principal caregiver for another older person.

Since women live longer than men on average, they are more likely to live alone for a greater number of years and with greater disability. The reduced earning opportunities that may occur due to child rearing and the higher proportion of women in the low paid and unpaid workforce create inequalities and can affect women's ability to provide economically for their health and wellbeing in old age. Despite the changes in work patterns, family, income and household structures, women are frequently poorer and experience age discrimination earlier than men (Steinberg 1994).

Women are the main providers of both informal and formal care for older people, which raises issues both of support for them in this role and their ability to continue to be the main source of support given the changing roles and expectations of women in the workplace. The demands of caring are a particular issue for older Māori women who often have charge of mokopuna as well as fulfilment of their kaumātua role and other whānau expectations. Māori women are crucial in maintaining whānau wellbeing. They are workers and individuals in their own right, kuia, partners/ wives, carers, mothers and grandmothers (PHC 1995a).

The difficulties experienced by many women in trying to balance a caregiving role with paid employment and other commitments was an issue raised in submissions and at meetings and hui. The competing demands of personal aspirations, family responsibilities, job expectations and the expectations of the care recipient often lead to tension, stress and unrealistic demands on individuals. Intergenerational differences, particularly where women are caring for both children and older people, can adversely affect family relationships.

Men sometimes experience difficulty in coping with the changed role that retirement and ageing brings. They are often less well prepared than women and frequently depend on their partners for social interaction and the tasks of everyday living. Being placed in the role of caregiver to a spouse or relative can add to these difficulties. Depression and alcohol may be significant problems in these situations (Arber and Evandrou 1993). For some, retirement occurs more as a result of an inability to continue working than as a planned event. A recent New Zealand study for the Ministry of Agriculture and Fisheries looking at retirement preparation among farm families, found that approximately 40 percent of the older men in the study had no plans for retirement and expected to continue being actively involved in the farm until they could no longer physically continue (Keating and McCrostie Little 1994).

Environmental factors

Physical

The quality of the immediate physical environment and the wider community and social environment influences the wellbeing of all older people and kaumātua and their ability to adapt to the increasing frailty and dependence that may occur. Adequate housing is a major factor in older people's ability to remain independent and living within their own homes. Sufficient income for affordable housing with adequate heating and a secure environment, were factors consistently identified in public meetings and submissions. Access to transport and adequate nutrition, together with social support, were often linked to housing as the fundamental determinants of health and wellbeing amongst all older people and kaumātua. Rural people identified particular issues of poor quality housing, difficulty in adapting or selling houses, lack of transport and isolation.

Meeting and hui participants recognised that Māori must plan and think creatively to determine how best to meet Māori aspirations for kaumātua. It will be a challenge to develop options that incorporate Māori holistic approaches, recognise the diversity of Māori, allow choices for individuals and whānau and accommodate changing work, family and living patterns, especially in urban settings. The present residential care services, for example, have no culturally acceptable options for Māori, or for Pacific peoples. Improved resourcing by local authorities and more equitable allocation of those resources to Māori were suggested strategies for addressing some of these issues.

Some older people are in the position of living in housing which is unsuited to their changing needs – it may be too large for them to maintain easily, poorly located in terms of access to community services and public transport, inconvenient in design, and, if sold, unlikely to meet the costs of more conveniently located and designed housing. A similar situation may arise in rental accommodation, either on the private market or in local authority owned housing. Recent reviews of pensioner housing have resulted in some stock being sold because it was unsuitable or too costly to alter. Care is required to ensure that older people are not disadvantaged through increased market rentals or relocation as this could adversely affect their health.

Submissions gave examples of local authority pensioner housing which is successfully meeting the needs of older people, yet is in danger of being sold off or having rents increased to levels unlikely to be affordable by the occupants. There were also examples of local authorities that retain a commitment to pensioner housing and have long-term development plans to improve and increase their current housing stock. The potential for this type of variation, due largely to the three-yearly electoral process and input from electors, was noted in a recent overview of pensioner housing provided by local authorities (Department of Internal Affairs 1996).

Retirement villages/ complexes or low-cost supervised residences, which include a range of accommodation, from independent apartments through to residential care facilities, are an alternative chosen by some older people. These purpose-built facilities offer security, convenience, social interaction and a range of support services to enhance older people's wellbeing and independence. While there are many advantages to this style of accommodation, there is also the potential for older people and kaumätua to become isolated from the rest of society and miss out on the stimulation of social interaction with a mixed age group. Submissions also pointed out that the reverse may happen. Social interaction may be increased due to the range of activities available, the people, the provision of transport, community involvement and a more positive response to staff motivation than to family motivation. Marae support, regular contact with a broader range of kaumätua and older people, a marae-based clinic and programmes are features of some marae with purpose built kaumätua accommodation on site.

Social

“Social isolation and loneliness are issues of relevance to the health of older people. The lack of social relationship is as much a risk factor for health as cigarette smoking, high blood pressure, obesity and lack of physical activity” (Tang et al 1995). This link was demonstrated in a health promotion project in New South Wales, Australia, where older people attending community-based leisure programmes experienced increased self-esteem, participation in activity and social connection. These positive benefits continued after the project worker was withdrawn because of the involvement of local groups and key community stakeholders who were able to maintain the programme. Strong support networks and positive family and social contact are important factors in how well older people cope with loss, disability and increasing frailty. Epidemiological studies show an associated lower mortality risk where people are part of a network of family and friends (Rowe and Kahn 1987). Membership of such a group has an impact across a range of health influencing factors – from participation in physical activity or exercise programmes, to appropriate nutrition, adherence to medication, mental wellbeing and maintaining independence within the community.

Poor social support, loneliness, social isolation (including living alone) and family conflict have been shown to increase rates of anxiety and depression in coping with poor living conditions and the impact of major stressful life events, increase the risk of suicide among those with psychiatric disorders and older people, and significantly increase the risk of major depression (Maxwell et al 1990; NHMRC 1993; MoH 1997c).

Home support

There has been an increased demand for home support services as a result of the current approach, which is consistent with the United Nations Principles for Older Persons (United Nations 1991), of encouraging older people to remain active, independent and living at home for as long as possible. The presence or absence of a live-in carer is recognised as a vital factor in determining whether an older person with a disability can remain at home (Richmond et al 1995). The social interaction and support provided by families are key factors in wellbeing, independence and successful ageing. A Canadian study indicates that mortality is lower when people are married and higher if widowed or single (Darnton-Hill 1995). The majority of older disabled New Zealanders live in the community, either in their own home or with family members.

Recognition of the stress involved in caring for an older person and the importance of adequate support for carers is an important element in preventing elder abuse. Diminishing physical and/or mental health, shrinking support networks and increasing isolation can leave older people particularly vulnerable to physical, emotional and financial abuse (Age Concern 1992). Submissions identified particular difficulties for rural people where stress levels can be high for carers due to limited services and social support. Older people may be more vulnerable to abuse in these circumstances and often less willing to seek help in a small, close knit community. An older person moving from a rural area to town to be closer to services may become isolated from family and friends and experience difficulty in becoming part of a new community.

Culturally appropriate support

The increasing diversity of Māori and Pacific communities and expectations can give rise to a tension between traditional patterns of care, support and status of older people and the capacity of the family or whānau to provide that support. Long-term residential care studies in Auckland in 1988 and 1993, indicate that Māori and Pacific people in urban settings are using rest home and hospital level care at relatively high rates. Māori and Pākehā were occupying beds at the same rate of 69 per 1000, with Pacific people using beds at approximately half this rate (Richmond et al 1995). This finding was questioned at meetings and hui as it does not fit with traditional Māori practices of caring for kaumātua and older Māori. However, participants acknowledged that there is an increasing incidence of kaumātua being separated from their families or whānau due to changing living and working patterns which can leave older people socially isolated. This isolation was seen to be occurring in urban settings as well as in rural areas. There was a perception that rest home care was not a preferred option but one used as a last resort because there were no viable alternatives. Increasing the trained Māori workforce to provide care within the community and in residential care situations was identified as a priority for improving the quality of care and support available to kaumātua.

Mental wellbeing

The ability to participate in and contribute to society is an important aspect of maintaining self-esteem and is as relevant for older people and kaumātua as for any other age group. A sense of coherence and personal control over life circumstances and living conditions are recurring factors associated with mental health and wellbeing. Programmes that enhance

personal skills and help people cope with life circumstances have been shown to improve mental health and lower psychological distress among population groups in a variety of settings (MoH 1997c). Submissions indicated that spirituality can be important for mental wellbeing, positive attitudes and adaptability. It was also considered a major component of coping with dying.

There are a number of factors associated with ageing that can adversely affect the mental wellbeing of older people and kaumätua. These include increased anxiety as a result of increasing frailty, decreasing mobility, diagnosis of a life-threatening disease, or lifestyle changes such as retirement. Depressive illness is prevalent later in life and even mild depression may reduce the quality of life of older persons and can adversely affect the person's family. The risk of depression is higher for those who live alone, or who are caring for someone with a psychiatric disorder which has altered the original relationship. Inadequate housing or income or chronic health conditions are other factors which may contribute to depression. The death of a spouse, partner, close relative, or friend is more likely in older age and can have a cumulative and specific negative impact on mental health and general wellbeing.

Failure by the older person or their family members to recognise depression, hesitancy in reporting psychiatric symptoms, even when asked, and a tendency for physicians to focus on physical problems, to the exclusion of mental, are considered to be risk factors frequently involved in suicide (Pearson and Conwell 1995). Depression is also associated with a higher risk of suicide among males aged 75 and over (Pearson and Conwell 1995). Common risk factors identified in Pearson and Conwell's research sample include the presence of depression prior to suicide, a low ratio of attempted suicides to completed suicides, virtually none of those who had suicided had sought mental health services and over 70 percent had visited their primary care doctor within the month of their suicide. Alcoholism is linked to depression and is an associated risk factor for suicide. Twice as many men over 65 years of age drink alcohol on a daily basis as women in the same age group. This is slightly less than for the 45–64 age group and much larger than for those under 45 years. However, overall older people drink less alcohol than any other age group over 20.

Cognitive disorders and dementias such as Alzheimer's disease have a major impact on the quality of life and independence of older people and kaumätua. The loss of cognitive function and the behavioural disturbances which develop with Alzheimer's disease place great care and support demands on families and caregivers, and may also cause distress and anxiety for the individual, particularly in the early stages. While these conditions are not preventable, early diagnosis, early intervention and education can minimise the impact of the disorder and ensure appropriate management and support (Richmond et al 1995). Prevention strategies aimed at reducing the incidence of cerebrovascular disease and heart disease have the potential to reduce dementias associated with multiple infarcts.

One submission suggested a need for public health initiatives aimed at improving understanding among Māori of dementia and related disorders. Some Māori experience practical and cultural difficulties in managing these conditions appropriately and incorporating them into a holistic health philosophy.

Socioeconomic conditions

Improved health status and decreased rates of morbidity and mortality are consistently linked with higher socioeconomic status and choice and control over employment and living conditions. A recent Canadian study that looked at health status measures in relation to income adequacy, education and occupation amongst older people living in the community, found that income adequacy was the most consistent predictor of health status (Cairney and Arnold 1996). The sample study group was taken from the Canadian 1991 General Social Survey of Health, with high blood pressure, heart disease, respiratory problems, arthritis and sleep problems being the health status indicators used. Participants were also asked to provide a self-assessment of their health status in relation to other people of the same age. It is not clear from the study why income adequacy was the most consistent predictor of the selected conditions. The study does indicate, however, that those planning disease prevention and health promotion strategies or developing public health policy need to take account of these non-health sector influencing factors.

The self-assessments in the 1993 New Zealand Health Survey demonstrated a similar link between self-reported health status and employment, housing and income (Statistics NZ and MoH 1993). Adequate housing, sufficient income to afford heating and healthy food were consistently stressed in submissions and at meetings as basic factors contributing to wellbeing in older people and kaumätua. The relationship between poor health status and poor socioeconomic status, such as low income and poor housing, were seen as key public health factors for decision makers across all sectors to understand.

Generations of persistent levels of socioeconomic disadvantage are reflected in low educational achievement, institutionalisation, unemployment and poor health outcomes for Māori youth and adults. The early onset and prevalence of lifestyle-related disorders among Māori adults, such as heart disease, diabetes and smoking-related disorders, have resulted in relatively few Māori over 65 years of age (PHC 1995a).

Cultural factors

Māori

Tribal origin, fluency in Māori language, spiritual awareness, involvement in marae activities and integration within a family are sociocultural factors seen by Māori as relevant influences on the health and wellbeing of kaumätua (PHC 1995a). These factors were strongly endorsed by hui participants and were a consistent theme in submissions on the discussion draft of this paper. A key focus of current health policy, programmes, services and workforce development is on achieving health gains for Māori so that their health status is at least equal to that of their non-Māori counterparts.

A recent survey of 379 kaumätua indicated that the majority had a high level of marae participation, were comfortable with their kaumätua role and secure in their cultural identity (TPH 1996). Many experienced greater independence as they reached kaumätua status, were socially active, mobile and optimistic about their health status and ageing.

Being in their own home, in a familiar marae environment, being able to contribute to their community and pursue their own interests engendered a sense of wellbeing and value for kaumätua. Kaumätua were also usually involved in caring for other whānau members, including children, those with a disability and frail older people.

The majority used general practitioner services, preferred home visits, received and preferred health information from their doctor and saw a need for improved health services to better meet kaumätua needs. Cultural issues ranked third after cost and transport as barriers to using health services. Over 70 percent stated no preference for Māori versus non-Māori service providers, with 23 percent of those who stated a preference choosing a Māori service.

The diverse nature of Māori society and the importance of providing choice are major factors to consider in public health policy and health service planning. Not all Māori have the same cultural background or experiences and therefore will not benefit to the same degree from similar cultural inputs. Some Māori are comfortable in a mainstream setting, while some may be strongly disadvantaged if a health programme is not consistent with tikanga Māori. Others may be uncomfortable in either setting (Durie 1994).

Different health promotion strategies are required for the different groups within Māori society (MoH 1997h).

A clear preference emerged from hui participants for progress towards developing services by Māori for Māori and for improving the cultural acceptability of mainstream services. Enabling existing Māori providers working within mainstream organisations to work with Māori clients whenever possible was considered preferable to allocating non-Māori workers to these clients. At the same time, participants recognised that quality and appropriate expertise were important factors to consider when determining the particular mix of services provided in an area. Choice of service providers may not, therefore, be possible.

Concern was expressed about urban and rural kaumätua experiencing instances of isolation and separation from whānau and the impact this had on general health and mental wellbeing.

Research indicates that supportive iwi networks influence Māori women's sense of security, identity and wellbeing. Traditional Māori grieving processes were also found to be healthy with less need for prescription drugs, proportionately fewer visits to a general practitioner and fewer delayed grief reactions at six months after a bereavement (TPK 1993). This is particularly relevant for kaumätua, as older people experience more frequent loss of family and friends than do younger whānau members. Kaumätua are also important role models, not only for Māori but for all people coping with grief and loss.

Submissions to the policy advice paper *He Matariki* identified a range of factors believed to contribute to the major determinants of Māori health status (PHC 1995a). These social and economic determinants included household income levels, employment, income support, cost of services, education, language, health literacy, information, poverty, isolation, land loss, urbanisation, socialisation, identity, pollution, other environmental issues, religion, wairua, whānau breakdown, racism, colonisation, political status and a monocultural health system.

Pacific people

People 65 years and over represent about 3 percent of the total Pacific population in New Zealand. However, this is projected to increase by 150 percent by the year 2031 (MoH 1997b). There is little data on the health needs and health status of older Pacific people, on their use of health and disability services or traditional remedies or healers. There is some anecdotal evidence, based on consultations undertaken in Auckland, that suggests that many older Pacific people experience language, transport and cost barriers in trying to access primary health care services, such as a general practitioner. They are often unable to locate information about the available services. In some instances they feel the services or health professionals involved are culturally inappropriate.

Factors influencing the health of older Pacific people include the impact of chronic or degenerative diseases such as diabetes, heart disease and respiratory conditions, which are linked to diet and lifestyle and are the most common causes of hospital admissions and death. The disproportionate prevalence of these diseases amongst Pacific people highlights the need for improved information and health promotion programmes which are acceptable to younger Pacific people in order to prevent or delay the onset of these conditions and minimise the impact on older people.

Providing security and dignified care for older people within the family community can be challenging for Pacific people, when 80 percent of workers earn less than \$20,000 per year, compared with 64 percent in the total New Zealand population (Statistics NZ and MoH 1993). This is particularly so when some of the more traditional support systems, such as those centred around church and village in the Islands, may not be present in New Zealand communities.

Health services

Timely access to personal health care services is important in influencing the health of older people and kaumātua, particularly those in the 85 years or more age group where frailty and chronic conditions are more likely. Early recognition and prompt assessment/ referral and treatment of physical and mental conditions or disabilities is essential for promoting the health, independence and mobility of all older people, including kaumātua. It is not uncommon for older people to experience a number of chronic conditions, which may be minor or major in nature and in their individual or collective effect on health. Early recognition and appropriate management of age-related vision and hearing impairment enables an older person to continue an active, independent life, maintain social networks and foster mental wellbeing. Delays in treatment, for example where there is visual impairment due to cataract combined with osteoporosis, can have a significant impact on an individual's mobility and heighten the risk of falls. Delays in receiving necessary hip or knee surgery, for example, can adversely affect the ability to carry out daily tasks of living, as well as restricting physical activity and social interaction and affecting mental wellbeing. Many participants at hui and public meetings felt that delays in accessing the surgery they required, and had been assessed for, resulted in unacceptable levels of functional disability that had major effects on the quality of their daily lives.

The need for plain English and more translations of information material into Māori and Pacific languages was consistently identified during consultation as an important factor in assisting kaumātua and older Pacific people to use health services and reduce confusion about medication or treatment.

Rehabilitation and prevention

Rehabilitative services are essential for restoring self-confidence, independence and enabling older people and kaumātua with injuries or debilitating illnesses to regain maximum possible mobility to manage daily living tasks. The location, duration and appropriateness of these services also contribute to successful outcomes of treatment (Richmond et al 1995). Submissions emphasised the importance of retaining community-based, multidisciplinary rehabilitation services and ensuring that families and individuals were informed about their service entitlements. It was suggested that functional assessments could be beneficial where relatively minor difficulties occurred. In the instance of a comparatively minor stroke, for example, the loss of functional ability may require hospital admission for initial rehabilitation and recovery of functional ability followed by community-based rehabilitation support when the person returns home. There were perceived gaps in some of the current CHE-based rehabilitation services.

Effective liaison between public and personal health care planners, purchasers and providers of health services for older people and kaumātua can be important in ensuring that health services are conveniently located, easily accessible and acceptable to older people and kaumātua, and therefore are more likely to be used. Co-ordination and communication between various health and disability support service providers, community-based agencies, religious organisations and health professionals are key components in providing comprehensive health services for older people and kaumātua.

As longevity and the percentage of healthy older people increase there is a trend for people to be entering residential care at an older age. The emphasis on “ageing in place” and remaining in the community also contribute to a different demand for residential care as well as increased demand for home support services. More frequent use of periodic or respite care may be one way to assist people to remain mostly in their own homes. Promoting healthy ageing requires a package of services and care, developed with the person themselves and taking into account their particular circumstances, including physical, mental, social and economic considerations. One submission noted the need for policy and practice to support the availability of quality residential care when it may be inappropriate to remain at home.

Urinary incontinence is a significant health issue for many older people, particularly women. The prevalence of this condition increases with age with approximately one in eight women and one in 15 men having a continence problem (Dovey et al 1996). While there are continence health services in most regions, many people are reluctant to seek help, often because of embarrassment or a belief that the condition is a normal part of ageing. Incontinence can give rise to much anxiety, for both the individual and their family and can limit an individual’s social contact, physical activity and mobility and mental wellbeing. Incontinence is often a major factor in determining the admission of an older person into residential care. Many people are unaware that most continence problems can be cured or

improved through a range of behavioural techniques, including pelvic floor exercises designed to strengthen pelvic floor muscles, bladder retraining and medical or surgical treatment. There are also a number of continence aids available to provide protection against accidents and avoid social embarrassment. Seeking help and early diagnosis and treatment of urinary infections also helps to maintain continence.

Annual influenza vaccinations can decrease the incidence of influenza among those vaccinated and reduce the occurrence of complications in those who do contract the illness. For older people living in the community, immunisation has been shown to lead to a reduction in hospitalisation of 48–57 percent for pneumonia and influenza and 15–39 percent for all other respiratory conditions. Despite the evidence of the safety and effectiveness of the influenza vaccine that has been available in New Zealand for some years, uptake is relatively low compared with Australia and other western countries (PHC 1996). People over 65 years of age and those who are vulnerable to respiratory infections or have low immunity are encouraged to be vaccinated. In 1997, annual influenza immunisation became available free of charge to all New Zealanders 65 years and over.

Lifestyle

Enjoying good health and wellbeing in older age is largely dependent on the lifestyle people lead in younger and adult years. Individuals and families can contribute to their quality of life and health status by adopting healthy living practices, including appropriate nutrition and exercise, which provide a sound basis for healthy ageing and the prevention of many illnesses and the disabilities that may result from them. Lifestyle choices need to be seen within the context of the particular economic, social, environmental and cultural circumstances of individuals and families' as these are key factors influencing the range of healthy options available to them.

Older people and kaumātua can also benefit from adopting disease prevention strategies that can be influential in preventing or delaying the onset of chronic conditions such as ischaemic heart disease. Preventive measures to reduce diet-related diseases, such as cardiovascular disease and the commonest form of diabetes, non insulin dependent diabetes mellitus (NIDDM), can be beneficial for older people and contribute to a healthier and more active life, especially for those aged 65–75 years (MoH 1997a). Key disease prevention factors for these conditions are reducing obesity by increasing physical activity, increasing intake of vegetables, fruit, cereals and grain, especially those of a high fibre content and decreasing the intake of fats and salt.

Activity and nutrition

Being mobile for as long as possible is vital for the wellbeing of all older people. The key factors in maintaining mobility are physical activity to maintain strength and balance, injury prevention, effective, timely management of conditions that restrict mobility and access to transport. Ideally, regular exercise and physical activity habits will be established in youth and young adulthood so that people are healthier as they age and are accustomed to regular exercise and appropriate nutrition for maintaining health. Adequate calcium intake in

childhood and adolescence, for example, is essential to develop peak bone mass and prevent osteoporotic fractures later in life (PHC 1995b).

International studies demonstrate that muscle strengthening exercises can improve balance and co-ordination, reduce the risk of falls in both active and frail older people, and help to prevent injury (Buchner et al 1989; Hornbrook et al 1993). Increasing physical activity and maintaining mobility are also important protective factors for mental alertness, the prevention of depression, minimising pain from chronic conditions such as arthritis or other physical disabilities, lowering blood pressure, preventing osteoporosis or maintaining social involvement (Shephard 1993). Participants in a Canadian exercise study experienced improvement in bone mass and general wellbeing as a result of increased physical fitness over a year (Chow et al 1989).

The loss and restriction of mobility for kaumätua has a significant effect on their wellbeing. It affects their ability to continue their everyday lives and it increases their dependence on others. Cataracts, for example, often a complication of diabetes, are a health risk for kaumätua who are 1.6 times as likely to require cataract treatment as non-Māori. Pain and functional disability due to arthritis were identified by a number of hui participants and submissions as a particular mobility issue for kaumätua.

Reliable, regular public transport at reasonable costs and retention of a driving licence encourage older people to be active and independent and are especially important in rural areas. The kaumätua study showed that the majority of kaumätua were still driving and those who no longer did had access to whānau transport (TPH 1996). East Coast participants at a Gisborne meeting, for example, pointed out the difficulties existing in their isolated rural area with few remaining local facilities, no subsidised community transport and only expensive courier van transport, other than family and friends' vehicles, to travel to Gisborne.

Access to public transport was less of an issue for urban older people as there were more examples of community vans or subsidised transport available. Nevertheless, participants felt retaining a driver's licence, if only in their local area, was important for maintaining mobility and wellbeing.

Osteoporosis

Osteoporosis prevention is a particular issue for women, especially non-Māori women, because of their longer life expectancy and the loss of bone density following menopause. Bone loss is a normal occurrence in both men and women after the age of 30. Regular physical activity, a balanced diet including calcium-rich foods, smoking cessation and a moderate alcohol intake are some of the preventive measures that can help to maintain bone density and strength. Osteoporosis can be a contributory factor in fractures of the hip, spine or wrist, particularly amongst women. The risk of fractures and the risk of disability, decreased mobility, or complications arising from fractures increases with age with the risk being higher in those over 85 (Bonita 1996).

Hormone Replacement Therapy (HRT) can be a useful preventative measure for women who are at high risk of osteoporotic fractures and possibly coronary heart disease. Long-

term treatment with HRT is recommended for women with a past history of fracture associated with trauma, including those with a bone mineral density so low as to confer a risk of fracture (NACCHDS 1993). In these circumstances the likely benefits from long-term HRT will generally outweigh the possible harms, including increased risk of breast cancer.

Other factors

Other factors such as failing or poor eyesight, inappropriate use of prescription drugs, especially sedatives or hypnotics, environmental factors such as slippery rugs, poor lighting, lack of staircase or handrails also play a major role in up to half of falls amongst older people living in the community (Hornbrook et al 1994). It has been estimated that about one-third of people over the age of 65 living in the community will fall at least once in any year, with about 1 percent of those falls resulting in a hip fracture. Falls have a significant impact on an individual's sense of confidence and safety from further falls and may result in limited ability to continue the ordinary tasks of daily living and use public transport. Having suitable rehabilitative services available, within reasonable distance, when needed and for sufficient time, are important factors in regaining independence, mobility and as near a return to usual activities as possible (Richmond et al 1995).

Summary – Key factors influencing health and wellbeing

The key influences on the quality of life and health and wellbeing of older people and kaumätua can be summarised as follows:

- ?? having positive attitudes towards ageing as a developmental lifestage
- ?? having good social networks and support
- ?? genetic and biological factors
- ?? health status during childhood and adulthood
- ?? healthy nutrition and being physically, mentally and socially active
- ?? participating in and contributing to marae/ community/ society
- ?? secure cultural and spiritual identity
- ?? acquiring skills to cope with predictable losses and increased risks of ill health and disability associated with ageing
- ?? feeling valued and able to exercise control over life circumstances
- ?? sufficient income for adequate, appropriate, warm housing
- ?? knowing what services are available to support a healthy, active lifestyle and being able to access them
- ?? sufficient support and rehabilitation to maintain independence and successfully adapt to increasing interdependence and dependence over time.

Setting Outcome Targets

This section looks at the issues involved in establishing outcome targets in relation to the wellbeing of all older people, including kaumätua. Outcome target setting is used to measure progress against achieving public health goals and objectives and to guide purchasing of population-based public health services. Data collated from routine surveillance systems, such as mortality, morbidity and cancer data, special research studies, and national periodic health surveys (eg, the New Zealand National Health and Nutrition Survey 1996/97), is used for monitoring target progress.

Existing and recently developed outcome targets

There are a number of existing public health outcome targets, developed in relation to specific issues and reported on annually, which are relevant to health outcomes for all older people, including kaumätua (MoH 1997e). These include targets on ischaemic heart disease, tobacco, alcohol, physical activity and nutrition (MoH 1997e), that are related to decreasing death, illness and disability rates amongst older people and kaumätua (Appendix 2).

Submissions on the draft paper generally supported the existing targets, but identified a number of modifications and additions considered necessary to relate them more specifically to older people and Māori. For example, age specific amendments were suggested for physical activity, alcohol, influenza and some of the nutrition targets, and the absence of diabetes targets was noted.

Current nutrition targets will remain unchanged until the results of the National Nutrition Survey are available and trends can be discerned. Separate targets for people aged 65 or more can then be considered. Two targets have been developed for diabetes as part of recent work to identify diabetes prevention and control strategies for New Zealand. These targets aim to reduce the age-standardised mortality rate from diabetes among the total population and the Māori population by the year 2002.

A new influenza target was set in 1996 and the 1997 progress report details its development. The variability of influenza epidemics from year to year makes it difficult to set outcome targets based on influenza mortality and morbidity. For this reason, New Zealand has established an interim process target to raise the level of immunisation coverage from the current 20–25 percent of the at-risk population to at least 75 percent by the year 2000. This target will help to measure progress on achieving the objective to protect older people from preventable infectious diseases; in particular to prevent influenza complications (hospitalisations and deaths) by increasing the use of influenza vaccine. All older people are included in those considered to be at higher risk of these complications.

Influenza (MoH 1997e)

To increase the proportion of the defined high-risk population immunised annually against influenza to 75 percent or more by the year 2000.

Diabetes (MoH 1997e)

To reduce the annual age-standardised diabetes mortality rate among the total New Zealand population to 8 per 100 000 or less, by the year 2002.

To reduce the annual age-standardised diabetes mortality rate among Māori to 30 per 100 000 or less, by the year 2002.

New outcome targets

There are plans to develop outcome targets for mental wellbeing, anxiety and depression both for the total population and high risk groups, such as older people living alone or people with a disability, when baseline data from the 1996–97 New Zealand Health Survey becomes available. Specific targets for Māori and Pacific people will be included. It will then be possible to track changes in self-assessed health status over time through the five-yearly repetition of the New Zealand Health Survey and to measure improvements in mental health and wellbeing through annual reports on progress against the targets. The Ministry of Health is considering measuring the health and wellbeing of clients who are already accessing mental health services. The recommendations of the discussion document *Mental Health Information Requirements* (Hallwright 1995) are being used as the basis for determining measurements. Improved treatment can have an impact on disease incidence and prevalence by lowering relapse rates, speeding recovery and reducing comorbidity of mental illnesses and serious sequelae such as alcohol abuse and suicide (MoH 1997c).

Submissions generally supported setting new outcome targets specific to older people and kaumātua. There was a preference for targets focusing on disability and social support outcomes as being more relevant to quality of life, functional ability, independence, wellbeing and healthy ageing. Several submissions expressed concern about the range and quality of current statistical information to use to establish and monitor targets. More consistent definitions, methodologies and classifications were considered important in enabling comparisons over time and integrating data from a variety of sources. A comprehensive overview of existing information sources and a critical assessment of adequacy was suggested as a first step towards developing a coherent framework for public health statistics.

Hui participants were similarly concerned about the accuracy and quality of Māori data, and called for a needs analysis survey of Māori consumers as a basis for developing public health responses and identifying targets relevant to kaumātua.

A number of submissions stated that more research was needed into data requirements, epidemiological evidence and effective, costed interventions before developing appropriate targets for achieving the objectives and addressing the major causes of illness and death in

older people and kaumätua. The diversion or redistribution of resources to public health that might be necessary for implementing preventive initiatives was another factor to be considered. Some information may be provided through current work by the National Health Committee on a range of effective preventative interventions for older populations.

Age-specific targets for falls are proposed since falls contribute significantly to injury, disability, illness and death amongst the older population. This category will also include fractures, which was a target suggested in submissions and is relevant to the objectives of improving mobility and reducing injuries amongst older people and kaumätua. Existing information collection systems can provide baseline data for monitoring.

The stroke targets proposed in the draft discussion paper have been expanded to include age-specific categories and incorporate hospital admissions as well as mortality. Five-yearly disability surveys offer the potential for disability target setting but further work is required before realistic targets can be developed.

Proposed new outcome targets

Falls

To reduce the falls mortality rate in men aged 65 or more years (from 36 per 100 000 in 1994) to 10 per 100 000 by the year 2010.

To reduce the falls mortality rate in women aged 65 or more years (from 37 per 100 000 in 1994) to 10 per 100 000 by the year 2010.

To reduce the falls hospitalisation rate in men aged 65 or more years (from 1298 per 100 000 in 1995) to 1200 per 100 000 by the year 2010.

To reduce the falls hospitalisation rate in women aged 65 or more years (from 2080 per 100 000 in 1995) to 2000 per 100 000 by the year 2010.

To reduce the falls hospitalisation rate in Māori men aged 55 or more years (from 978 per 100 000 in 1995) to 900 per 100 000 by the year 2010.

To reduce the falls hospitalisation rate in Māori women aged 55 or more years (from 912 per 100 000 in 1995) to 900 per 100 000 by the year 2010.

Stroke

To reduce the stroke hospitalisation rate in men aged 65 or more years (from 1739 per 100 000 in 1995) to 1100 per 100 000 by the year 2010.

To reduce the stroke hospitalisation rate in women aged 65 or more years (from 1240 per 100 000 in 1995) to 800 per 100 000 by the year 2010.

To reduce the stroke hospitalisation rate in Māori men aged 55 or more years (from 1294 per 100 000 in 1995) to 800 per 100 000 by the year 2010.

To reduce the stroke hospitalisation rate in Māori women aged 55 or more years (from 1340 per 100 000 in 1995) to 800 per 100 000 by the year 2010.

Note: There are insufficient Māori falls deaths to warrant a separate target from the ones for all older men and women. For example, in the five years to 1994 there were only seven male, and five female, falls deaths among Māori aged over 55 years.

Note: All rates mentioned above are age-standardised to Segi's world population.

Healthy Public Policy Issues

The increasing life expectancy of New Zealanders raises questions about the quality of those extended years of life and calls for a change in health and disability services and focus. Comprehensive national policies and programmes that promote healthy lifestyles throughout the lifespan of individuals are required in order to prolong healthy, productive and disability free lives (WHO 1995b).

When determining what policy issues need addressing to improve, protect and promote the health of older people and kaumätua, it is important to recognise that public health activities that contribute to wellbeing occur across sectors and are not limited to the health sector. There will be policy issues specific to health for the public health sector, the personal and disability support sector and to other areas such as housing and local government. Health promotion and personal health issues are vital for promoting healthy ageing, maintaining wellbeing and managing chronic conditions and disability in this age group. The challenge for policy makers, and one of the purposes of this paper, is to determine what are the public policy issues most relevant to older people and kaumätua within the context of a growing ageing population. This section will comment on relevant policy initiatives in the health sector, government initiatives, intersectoral initiatives and other sector initiatives, and identify public health policy issues requiring development.

Complementary public health issues papers

Policy issues identified here for older people and kaumätua take account of other relevant public health issues papers already completed and the strategy proposed in *Strengthening Public Health Action* (MoH 1997i) which builds on the previous *Strategic Direction* for public health (PHC 1994). This strategy identifies four cross-cutting themes to be considered for effective and efficient public health policy, purchasing and provision for any population group and the achievement of public health objectives. The four themes are:

- ?? focusing on the determinants of health
- ?? building strategic alliances within and between sectors
- ?? implementing comprehensive public health programmes
- ?? strengthening the public health infrastructure.

These themes are particularly relevant for older people and kaumätua because of the variety of agencies and sectors that interact, and contribute to the wellbeing of older people.

Issues-based papers, recently produced, that can be referred to for more detailed coverage of issues relevant to healthy ageing are listed below.

- ?? *Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand* (MoH 1997b). This document provides guidance for the health and disability support sector to improve the planning, implementation and monitoring of service delivery to Pacific people. A number of issues raised by Pacific people at meetings and in submissions on older people's wellbeing, are addressed in this strategy. In particular, the involvement of Pacific people in the planning and delivery of health services and health promotion activities and specific issues for population groups, including older people.
- ?? *Mental Health Promotion for Younger and Older Adults* (MoH 1997c). This document outlines the risk and protective factors relating to mental health and wellbeing of all adults, including older people, proposes outcome targets and reviews policy, programme and research issues. The key focus is on intersectoral initiatives, support for older people living alone or in isolation, intersectoral action on support for caregivers and developing positive community attitudes towards the role of older people in society.
- ?? *Diabetes Prevention and Control: The public health issues: The background paper* (MoH 1997a). This document provides background information about the technical and policy issues related to diabetes control and prevention in New Zealand. *Strategies for the Prevention and Control of Diabetes in New Zealand* (MoH 1997g) identifies key strategies for preventing and controlling diabetes and its complications.

Diabetes prevention and management is an issue of particular concern for older Māori and Pacific people, as well as being relevant to other older people.

A small number of submissions on the discussion draft of this paper expressed concern about the adverse impact of alcohol misuse or abuse on older people. Alcohol was cited as an emerging key issue in relation to elder abuse and neglect. Alcohol and drug harm is currently being addressed through policy and programme development associated with implementation of the National Drug Policy (MoH 1996d).

Current health sector public policy issues and advice

Care and support issues

A 1995 report commissioned by the National Advisory Committee on Core Health and Disability Support Services (NACCHDS), now the National Health Committee (NHC), on the reasons for older people needing care, comprehensively examined some of the support issues involved in enabling older people to remain in their own homes (Richmond et al 1995). The complex interaction of personal health care services, community programmes and support services, family and voluntary caregivers and respite care services that are often required to maintain health, support independence, and cope with increasing dependence of

older people, are explored. While the report mainly focuses on older people who are physically or psychologically frail, it also refers to the role of government policy, structures and systems, personal health and disability support services within the health sector, other sectors and agencies and identifies a number of health promotion, health education and disease prevention issues that need to be addressed.

The National Health Committee is undertaking further project work based on responses to the issues described in the *Care for Older People in New Zealand* report (Richmond et al 1995). A discussion paper is being prepared on issues facing carers in New Zealand, with the main focus being on those who provide unpaid care for people aged over 16 with a disability, or frail older people. Appropriate support for carers, as well as for the individual requiring care, is one of the elements that will be included. The increased demand for carers following mounting emphasis on enabling older people to live in their own homes as long as possible and be supported to live in the community, raises questions about the quality, quantity and resourcing of home care services. Guidelines for the management of care for people with dementia/ Alzheimer's disease have been developed and will be trialled in at least one centre in New Zealand.

Participants at meetings and submissions on this paper expressed substantial concern about training, support and respite provision for carers of older people and kaumätua. The financial support available to family members, often women, who gave up paid employment to take on a full time care role, was considered inadequate. Those on lower incomes, such as many Māori and Pacific people, experienced particular difficulty in maintaining their traditional care role for older people at home as alternative residential care facilities generally were not culturally appropriate. Co-ordination of carer and support services and access to respite and day care services could be improved. It was considered that inadequacy of some supervision, monitoring and accountability mechanisms placed older people in a vulnerable position. Information for carers about support services and entitlements was not always as readily available or well distributed within the community as it might be.

Preventive interventions for older people

The National Health Committee has commissioned reviews of evidence indicating the effectiveness or otherwise of intervention strategies for older populations. Experts involved in older people's health have prepared four consultation documents covering the clinical, behavioural and environmental interventions for preventive dental strategies for older populations (Thomson 1997), the prevention of osteoporosis (Sainsbury and Richards 1997), falls prevention in the community (Robertson and Gardner 1997) and falls and fall-related injuries in institutions (Norton and Butler 1997). A further consultation document on the primary prevention of cardiovascular disease in older people is being prepared. Researchers critically reviewed and evaluated the evidence on prevention to determine whether a particular strategy (eg, calcium supplementation, physical activity, hormone replacement therapy and screening for decreased bone mass) results in improvement in health outcome and is worth pursuing as a prevention strategy. The reviewers determined whether the interventions were effective and also identified any areas where there was insufficient evidence to determine whether a strategy was effective or not.

The conclusions from the final review documents and the other projects will guide further public health policy, programme and guideline development with likely contributions to improved health outcomes for older people.

Issues for kaumätua

Recommendations specifically referring to Māori in the *Care for Older People in New Zealand* report (Richmond et al 1995), together with submissions on *He Anga Whakamana: A framework for the delivery of disability support services for Māori* (Ratima et al 1995), were used as the basis for recommendations to the Minister of Health in the National Health Committee 1996/97 annual report. The Committee recommended that purchasers and providers of services for older New Zealanders implement strategies (including workforce development and cultural awareness training) to ensure services are more accessible to older Māori, and that policy makers, purchasers and service providers recognise and specifically address the particular health profiles and cultural needs of Māori (NACHD 1996).

Hui participants and written submissions on the draft of this document considered support for Māori defined and controlled initiatives to be an urgent priority.

A national focus for older people

One of six goals identified in the *Care for Older People in New Zealand* report (Richmond et al 1995) was the need for national policies to underpin planning and purchasing decisions for comprehensive health promotion, care and support services for older people and kaumätua. Written submissions on the discussion draft of this document generally supported this concept while a public meeting and hui participants held a range of views. Some people favoured the use of broad guidelines or principles to provide a strategic direction for policy and planning. Certain characteristics, such as encouraging partnership and co-operation, allowing for changes and choice, adopting a preventative and wellness approach, respect and value for the role of the older person in the community, and an ability to cope with issues like rural health, elder abuse, culture and religious values, were considered essential components to include.

The Ministry of Health, key government departments, non-government, community, rural and iwi agencies, health professionals involved with older people, local government and older people themselves were identified as the most appropriate people to involve in developing a national framework. It was clear that people believed there was considerable expertise, knowledge and experience that could be drawn upon to provide a more cohesive approach across sectors, as well as within the health and disability sector, to more effectively meet older people's needs.

A few submissions called for a separate, parallel Māori framework that would reflect a Māori holistic approach, more appropriately preserve the special status of kaumätua, and be developed by Māori. Others stressed the importance of ensuring that any national framework incorporated Māori values and philosophy and that Māori actively participated in the development and consultation.

Intersectoral initiatives

Positive ageing and issues for the future

Early in 1996, the Prime Minister established a Prime Ministerial Task Force on Positive Ageing to develop comprehensive intersectoral policy and programme advice on the positive place of older people in our communities. In July 1997, the Task Force published its final report, *Facing the Future: A strategic plan* (DPMC 1997). This strategic plan defines a vision for positive ageing, and a set of core values that underpin the recommended strategic approach. There are 15 long-term goals described under five issue headings of:

- ?? attitudes to ageing
- ?? individual planning and preparation
- ?? managing resources
- ?? policy development and service delivery
- ?? experiencing positive ageing.

A total of 34 action plans are included for achieving the goals, with milestones for assessing progress. Four of the milestones are specific to the health sector and include the public health goal and objectives for older people and kaumätua that form the basis of this issues paper. The Task Force has also identified eight initial actions necessary if the other recommendations are to be achieved. Those initial actions are:

- ?? create a Senior Citizens Division
- ?? establish a Positive Ageing Fellowship at Victoria University
- ?? conduct a communication campaign to build community understanding about positive ageing
- ?? review the social science research agenda
- ?? hold a national conference on age and work in the year 2000
- ?? remove age related criteria, initially in the public sector
- ?? implement a time-use survey to show how New Zealanders spend their time
- ?? establish a positive ageing certification programme, similar to ISO 9000 framework (DPMC 1997).

Submissions generally saw the health sector as well placed to lead policy development based on researched information, a holistic approach to wellbeing among older people and kaumätua, and strong links between government, community and professional organisations.

Addressing the major inconsistencies in government policy, particularly in the areas of housing and transport, were action areas highlighted by meeting participants and in submissions. Māori representation at national, regional and local levels, and adequate resourcing for policy implementation through Māori initiatives, were also considered relevant.

Current government focus for older people

The Senior Citizens Unit of the Department of Social Welfare currently provides national co-ordination and leadership on issues affecting older people in New Zealand. This unit is the key government agency providing policy advice on older people in government policy-making forums, promoting positive attitudes to older age in society and fostering networks between community agencies and government departments in relation to the wellbeing of older people. The unit provides a central national focus for older people's concerns and is potentially well placed to respond to calls for more co-ordinated national policy and planning between various government sectors and other agencies. The key areas where improved policy co-ordination could be of benefit to older people and kaumätua are housing, health, retirement income, welfare and education.

The Ministerial Advisory Council on Senior Citizens provides independent advice to the Minister for Senior Citizens on matters related to older people and is funded and supported by the Senior Citizens Unit. The Council has brought a number of health-related issues to the Minister's attention and has been influential in initiating and contributing to collaborative work on issues such as elder abuse prevention and mental health services. Current work on improving community mental health services will begin to address some of the council's concerns regarding the quality and level of services available to older people and kaumätua.

The recent competitive environment in the health sector was considered by many at meetings and in submissions to be detrimental to good communication at the provider level and created difficulties for effective service planning. There was a strong plea for closer working relationships with community agencies where a number of agencies may be providing services for an individual or a family. The current assessment process for identifying the support needs of an individual, for example, was a topic of concern at meetings and in submissions. Concerns centred around the process itself, the variation in the way assessments were carried out around the country, timely access to assessment and gaps between the support services provided and those assessed as necessary. There was a strong call for improved co-ordination, a simpler, more flexible assessment tool focused on positive outcomes and maintaining and restoring independence. Greater consistency of assessments in line with the national standards and a single agency responsibility for assessment, funding and provision of support services was also advocated.

Regional and local government issues

Adequate community facilities and programmes, a safe neighbourhood and secure home environment help reduce anxiety and fear of crime amongst older people and kaumätua and encourage them to be physically and socially active. Regional and local government authorities are key agencies in providing a safe, supportive community environment.

Under the Local Government Act 1974, territorial authorities are able to enhance community welfare, development and recreation by promoting, encouraging or developing services and facilities to maintain and promote the general wellbeing of the public and promoting or assisting in welfare activities (PHC 1995c).

In 1993, with the assistance of member authorities, the New Zealand Local Government Association developed a Charter for Local Government on Social Justice Issues, Community Development and Social Services (Appendix B MoH 1996e). The Charter outlines the role of local government, having regard to the principles of the Treaty of Waitangi and distinguishes its issues from the responsibilities of central government. It acknowledges that local government is the most effective level of government to recognise and effectively respond to local needs and aspirations. The Charter has not yet been formally adopted and remains a draft initiative of Local Government New Zealand.

Effective planning and provision of community services and facilities will take account of aspects such as location, hours of availability and access, the safety and ability of those using the facilities, such as older people, people with a disability, or young children (Richmond et al 1995; MoH 1996e). Providing and maintaining adequate street lighting and footpaths, for example, can assist in discouraging crime and avoiding unintentional injuries. Care in the design of public facilities likely to be used by older people or those with disabilities, so that features such as handrails and non-slip flooring are incorporated, can contribute significantly to reducing injury and encourage mobility and community participation. Many local bodies provide affordable housing for older people, those who are economically disadvantaged or people with mental, intellectual and physical disabilities. Ensuring that pensioner flats and rest homes, for example, are located close to shops and services, well served by regular public transport and not in hilly locations, can encourage social contact and independence.

Many of the written submissions identified a lead role for the health sector in working with local authorities to increase awareness of their responsibilities and potential for influencing the wellbeing of their local communities. Policy setting, facility planning, housing and health promotion activities were some of the areas felt to benefit from more collaborative consideration and a broader approach. One example was given of joint strategic planning between the local authority and local government and community agencies. Others sounded a caution about expecting local authorities to expand their responsibilities beyond their core business without adequate resources to do so. It was pointed out that some district councils with diverse communities and a high proportion of older people experience difficulty in providing public facilities with appropriate features for older people and those with a disability. Health agencies were considered to be ideally placed to act as advocates for older people, particularly in drawing local authorities' attention to effective Māori organisations providing services for kaumātua and older Māori. One submission suggested establishing specialist sub-committees within local councils as a way of more appropriately addressing the needs of particular groups such as older people, Māori, Pacific people and refugees, where there are concentrations in the local population.

Mobility and physical activity

Transport

Access to public transport and retaining a driving licence are important for older people wanting to maintain mobility, independence and social contact. The majority of kaumätua who participated in the Te Pūmanawa survey (TPH 1996) indicated that transport was not a major issue for them as other members of the whānau were able to assist them if they did not have their own transport. Feedback during the Task Force on Positive Ageing consultation indicated that there are, however, issues for rural people. These are of particular concern where travel to larger centres is needed for medical or specialist health care. Infrequent services that relate poorly to appointment times and long journeys can make the experience stressful for many older people. Public transport issues, including timetabling of services, route definition and types of vehicles used, are all best pursued by regional and local bodies through their policy, planning and contracting processes to ensure that the needs of older people and other groups are not disadvantaged.

Specific policy issues related to older drivers and licensing requirements are being examined by the Land Transport Safety Authority (LTSA 1997). Proposed policy changes including shifting the age of the first medical check from 70 years to 75 years, strengthening the medical assessment for older drivers, requiring a practical test at age 80, and thereafter every five years and strengthening the practical driving test used for older drivers at age 80 and subsequent five yearly intervals.

There was a strong call from meeting participants and in submissions to consider the mobility implications for older people when making decisions to close, reduce or change locally based services, particularly health services. People endorsed a number of existing transport schemes they considered should be retained, better resourced or extended. Examples included:

- ?? the Total Mobility Scheme and disability parks
- ?? more innovative support and use of community or voluntary group provided transport
- ?? continuation of concession rates for older people on public transport and for access to recreational facilities such as swimming pools
- ?? transport subsidies for rural people needing regular clinic or hospital visits less than an hour away when no public transport is available.

There was strong support in both submissions and at meetings for greater use of mobile services and the one-stop-shop approach to reduce travel demands on older people, especially in poorly serviced rural areas. The provision of intersectoral, mobile services was seen as an effective and efficient use of resources and particularly suitable where there are existing community, marae or Pacific church centres that are actively used by older people. Access to community programmes and services that promote activity and provide social contact can be improved by ensuring that transport services or vehicles are available for older people and kaumätua.

Physical activity

The Hillary Commission has the lead responsibility for promoting physical activity amongst New Zealanders and has a number of regionally based programmes to foster activity amongst older people. There are also a number of Māori marae-based initiatives, designed to encourage a healthy lifestyle, that include physical activities. *The National Plan of Action for Nutrition* identified the importance of regular physical activity for maintaining mobility and enhancing mental and physical wellbeing (PHC 1995b). The recent US Surgeon-General's report provides further guidance on the value and general health benefits to be gained from regular, moderate intensity, physical activity and reinforces the scientific evidence that links regular physical activity with health benefits (US Department of Health and Human Services 1996). The recommended level of physical activity is at least 30 minutes of moderate intensity physical activity on most, preferably all, days of the week, for example, brisk walking. General practitioners have an influential role in encouraging older people to remain or become active and in providing advice on building physical activity into daily routines, as they are the health professionals most often consulted by older people.

Older people and kaumātua also acknowledged the importance of purposeful activities, low-cost exercise options and a social, 'fun' context to encourage moderate physical activity. Some examples given were gardening, walking to local shops or on outings with grandchildren and family, taking part in local marae line-dancing groups, or helping at Kōhanga Reo.

Retirement issues

The Office of the Retirement Commissioner is responsible for monitoring the effectiveness of retirement income policies being implemented in New Zealand, advising the Government on these matters and promoting education and information about retirement income issues. The phasing out of a specified retirement age of 65, which comes into effect in 1999 in compliance with the Human Rights Act 1990, will have implications for individuals' retirement savings, employment practices and attitudes towards older people in the workplace. The potential changes in workplace attitudes and practice have policy implications in regard to the role and viability of voluntary agencies, which often rely on a pool of healthy older people for their organisation and activities.

There was a general view in submissions and at meetings that the work and contributions of voluntary groups were under-valued and under-resourced. Older people and kaumātua are both contributors to, and recipients of, voluntary and community groups. Demands on and expectations of, voluntary agencies increase when resources are limited.

The demand for home-based care and support for older people and kaumātua, the majority of which is provided by family members, mostly women, is increasing. The opportunity to remain in paid employment longer could be viewed positively by many older people as an opportunity to continue to participate in the workforce and enhance their financial independence. Consequently there is a possibility that the number of unpaid home-based care providers will decrease. Fewer available voluntary home care providers could increase

the demand for residential health care services, with accompanying cost implications, particularly as the generally frail group of older people aged 80 years and beyond increases in numbers.

Some submissions saw the phasing out of a specified retirement age as an opportunity to focus on the positive contributions that older people can make and to address funding and resourcing of public health initiatives that promote wellness and healthy ageing. Some emphasised the need to take a more flexible approach to preparing to withdraw from, or reduce hours of paid work, and to seek more appropriate, innovative solutions to cope with changing policies and expectations. There was a call for balance in considering the employment needs and aspirations of younger and older adults.

Kaumätua and Pacific peoples were identified in submissions as a disadvantaged group because of the generally earlier onset of chronic conditions or disability, shorter life expectancy and smaller earning capacity. It was, therefore, generally considered unrealistic for kaumätua to participate in the workforce beyond the current retirement age of 65. Meeting participants and submissions acknowledged that women were placed in a different situation from men due to their overall reduced earning opportunities, their longer life expectancy and the fact that they are more likely to be caring for other dependent family members.

Summary – Healthy public policy issues

An agreed national framework or guidelines to provide a strategic planning and purchasing direction for health care services for all older people and kaumätua.

Improved national, regional and local co-ordination and integration of existing and new health services for older people and kaumätua.

The provision of effective, comprehensive health promotion and disease prevention programmes for older people and kaumätua.

Contributing public health input to key government initiatives promoting and supporting healthy ageing.

Working with relevant agencies to determine what changes are needed to develop positive community attitudes towards the role of older people and kaumätua in New Zealand society.

Establishing and strengthening existing intersectoral links between government, Māori, community and professional organisations concerned with the wellbeing of older people and kaumätua to promote information sharing, co-ordinated planning and purchasing.

Identifying and minimising barriers to enable access to co-ordinated information about services and entitlements for all older people.

Building and maintaining collaborative working relationships between health, welfare, police and local authorities to ensure that local authority policy and planning takes account of the health, safety and security of older people and kaumätua.

Improved regional and local co-ordination in the planning and provision of public services, including transport, to take account of the increasing numbers and particular needs of older people and kaumätua and their ability to be mobile.

Identifying and minimising transport barriers to enable access to primary care and health promotion activities for all older people and kaumätua.

Ensuring appropriate physical activity to promote strength and balance is a component of comprehensive health promotion programmes for older people and kaumätua.

Intersectoral action to ensure that the implementation of changes in retirement policy allows for any necessary adjustments in other sectors, such as housing, health and welfare.

Intersectoral action to ensure needs-based support for older people and kaumätua living alone, those experiencing social isolation as a result of a disability or chronic health problems and those experiencing a major life transition such as retirement, bereavement, or diagnosis of a major life-threatening disorder.

Public Health Programme Issues

Introduction

This section addresses key public health programme issues relating to the health and wellbeing of older people and kaumätua. Public health programmes and information resources are essential policy implementation. Organised community and government initiatives can help to manage and minimise the effects of disease and disability associated with old age. New Zealand's public health programmes are based on the *Ottawa Charter* (WHO 1986) strategies outlined earlier in this paper. It has been recognised that Mäori programme and service development, requires that Mäori-specific resources and services be developed and provided by Mäori (MoH 1997h).

Public health services are based on the needs of population groups rather than on the consequences of ill health at an individual level. The focus is also on health promotion and disease and injury prevention. Clearly identifying what older people and kaumätua need to keep themselves healthy and independent for as long as possible, can enable resources to be targeted to promote action on these factors. This action will extend beyond the health sector because broad health determinants include factors that are the responsibility of other sectors such as housing, welfare and income.

Identifying the issues

It is important to recognise and provide for the diverse circumstances of older people and kaumätua when developing and implementing public health programmes for this population group. The ability to tailor-make programmes that cater to these circumstances may contribute to whether or not a programme is successful. Some issues to consider may relate to:

- ?? the age range of older people (as defined earlier in this paper)
- ?? ability to access programmes
- ?? physical ability to participate in programmes
- ?? cultural and social attitudes towards ageing
- ?? social support systems.

The report *Care for Older People in New Zealand* (Richmond et al 1995) raises additional programme issues that may be useful to think about. They include:

- ?? developing programmes consistent with the concept of 'ageing in place'
- ?? multidisciplinary health promotion and education programmes for older people accompanied by appropriate resources
- ?? national and local sickness and disability prevention programmes for older people.

Comprehensive public health programmes

A number of submissions emphasised the need for programmes to be inclusive rather than exclusive by recognising that there are older people and kaumätua who, for various reasons, do not find traditional methods of programmes delivery or content suitable to their needs. One of the cross-cutting themes referred to in *Strengthening Public Health Action* (MoH 1997i) focuses on implementing comprehensive public health programmes as a means of reaching the target population group, particularly those who may be unintentionally but systematically ignored in the settings approach. Implementing comprehensive public health programmes would focus on:

- ?? key public health issues
- ?? holistic programmes that meet the needs of older people and kaumätua
- ?? programmes which straddle the interface between public health and personal care to deliver integrated public health services from both the personal and public health sectors
- ?? programmes that employ a range of public health strategies including health promotion and health protection strategies as appropriate (MoH 1997i).

Settings approach to health promotion programmes

The settings approach, as supported by Tannahill (1994), provides a useful framework in which to develop successful health promotion programmes by analysing the elements that enable older people and kaumätua to actually participate in these programmes. Submissions and participants during the consultation process supported the settings approach as they saw this as a useful way to reach many older people and kaumätua. They saw programmes designed and implemented according to the following criteria as more likely to achieve success.

Co-ordinated health promotion programmes that are centred on settings facilitate:

- ?? comprehensive coverage of the community; reaching people wherever they live, work, spend their leisure time, or seek help
- ?? the drawing together of issues in a systematic and co-ordinated way
- ?? the appropriate phasing of action on the various issues; avoiding overloading the public, providers and professionals at any one time
- ?? the development of mutually reinforcing activities in multiple settings, as appropriate
- ?? the development of infrastructures and methods tailored to the needs and circumstances of each particular setting
- ?? responsiveness to the needs of the community (Tannahill 1994).

Strengthening Public Health Action highlighted additional benefits of the settings approach as: identifying the potential for relevant community action, capitalising on existing social structures and networks, and providing focused funding and resources. Settings such as the community, churches, home, marae, health care and workplaces are promoted as useful places to deliver programmes that are identified by target groups, such as older people and kaumätua as being needed and a priority (MoH 1997h).

A co-ordinated response

Another concern raised in submissions revolves around the issue of greater co-ordination and support internally in the health sector and with other sectors at a national, regional and local level when developing, implementing and delivering programmes. *Strengthening Public Health Action* (MoH 1997h) identifies leadership from the centre as being important for developing alliances and communicating strategies to the regions and localities.

Another cross-cutting theme that is pertinent to ensuring that this happens is building strategic alliances. This theme recognises that public health is a co-operative effort that involves people working together to improve health. Effective public health relies heavily on strong and effective relationships between:

- ?? the public health sector and the public through the identification of the public's needs and their involvement in the resulting policies and programmes and evaluation process
- ?? public health agencies through a clearer understanding of each other's roles as policy advisors, funders and providers of public health services
- ?? the health sector and other sectors at a central level through intersectoral strategies that are linked to regional and local efforts
- ?? public health agencies and the personal health and disability support sector.

Building strategic alliances for public health action enables those working in public health to add to each other's good work. It helps to avoid duplication of effort and to fill gaps (MoH 1997h).

Programmes for Mäori

Mäori participants at hui and public meetings as well as written submissions favoured programmes that were designed specifically to meet the needs of kaumätua. However, it is also important that programmes are accessible to those kaumätua who may not access Mäori-specific programmes, thus recognising the diverse realities and needs of kaumätua.

There was strong support for marae and community-based initiatives that encompassed a range of issues and were based on whanaungatanga. Such initiatives were seen as a stepping stone to empowering people and giving them the responsibility for addressing their own issues.

The marae/Māori community-based physical activity programmes are an example of such an initiative. Kaiwhakahaere (Māori Sports Co-ordinators), in association with the Regional Sports Trusts, promote health messages through sport and physical activity. These Kaiwhakahaere organise events for Māori at the marae, hapū and iwi level as well as in other settings such as sports clubs or community locations. Although the events are aimed at total whānau involvement rather than at any specific age group, successful activities such as line-dancing have been initiated for kaumātua. Line-dancing has successfully targeted sedentary kaumātua who claim that there has been a definite improvement in their health and wellbeing (Harawira 1996). Health promotion messages such as food and nutrition, diabetes, injury prevention or breast cancer screening are integral to the events.

There are already many Māori health providers providing primary health care services and delivering health promotion programmes for their communities. However, submissions identified a clear need for the development of programmes and information resources specifically for kaumātua, particularly in rural areas. Information resources need to incorporate tikanga and te reo Māori that support the health promotion message along with positive Māori images in relevant settings.

Submissions indicate inadequate resourcing of these initiatives is an ever present threat to their continued existence. The funding process is perceived as a frustrating, time-consuming exercise that requires that applications be prepared for multiple agencies. This frustration is further exacerbated by problems created in the contractual split between personal and public health services (MoH 1997c).

Another issue raised in submissions is the development of Māori health providers and professional community workers and volunteers and supporting more Māori in pursuing careers in health and caring. Appropriate training will enable this workforce to provide information and further education on health and wellbeing issues for kaumātua to their communities and clients. Training and education also:

- ?? increases awareness and understanding of those issues associated with the ageing process
- ?? allows whānau to support kaumātua health and wellbeing by encouraging them to visit appropriate health services
- ?? encourages whānau to identify and adopt appropriate strategies that lead to healthier lifestyles and therefore increase the likelihood of a healthy ageing process.

Appropriate training for health professionals and workers in general is also encouraged so that services and programmes are delivered in a culturally appropriate manner.

Programmes for Pacific people

Participants at the fono emphasised the diversity of the different South Pacific cultures and the need to recognise those differences when developing, delivering and evaluating programmes. It is also important to recognise that the needs of island-born people may differ from those who are New Zealand-born and, therefore, participation of Pacific people in that process is particularly important.

The paper *Mental Health Promotion* (MoH 1997c) summarises some of the issues for Pacific people that were also expressed during the public consultation phase for this paper regarding programme issues. They believed that Pacific organisations that foster and develop programmes should be the bodies used to promote health and wellbeing issues to older Pacific people, thereby maintaining or strengthening existing networks and facilitating access to services. Numerous organisations provide for the welfare, social and/or educational needs of their ethnic groups at a local level. Consultation on, and co-ordination, delivery and monitoring of health promotion programmes should be undertaken in partnership with such organisations. As mentioned earlier, it is important to recognise changing social structures within communities and ensure that programmes also cater for those older Pacific people who do not associate with church or community organisations.

Trained community and health workers who currently work among Pacific communities will need support from trained and culturally aware health professionals. Therefore, Pacific language interpreters who have a detailed understanding of health and wellbeing issues for older Pacific people should be advanced to work alongside professionals, in both mainstream services and in community-based initiatives.

Fono participants identified the development of videos and other resources for older Pacific people's health promotion in relevant languages as an important issue. Videos and other resources in relevant languages, promoting older Pacific people's health should be disseminated widely through various avenues that older Pacific people access such as church, Pacific community organisations, Pacific radio and television, newsletters and newspapers. Fono participants felt that visual and verbal media would have greater impact than printed material.

Existing initiatives and programmes

Health issues for older people and kaumätua are generally addressed from a personal health perspective, that is, through managing or intervening in illnesses and diseases of an individual that are either lifestyle-related or associated with the ageing process. However, public health is concerned with improving, protecting and promoting health and wellbeing and preventing disease and illness through a variety of population strategies. As discussed earlier, two of the most effective public health strategies to enable older people and kaumätua to enjoy healthy and active lifestyles is to participate in physical activity and to adopt good eating practices.

Many existing initiatives and programmes are of an intersectoral nature in which the health and wellbeing of older people and kaumätua may be addressed. *Strengthening Public Health Action* (MoH 1997h) describes public health as a co-operative effort that involves people working together to improve health. The background paper identifies three relevant points for effective public health that can be transferred into the context of developing, implementing and evaluating programmes for older people and kaumätua:

- ?? strong and effective relationships between those who work in the field of public health and older people and kaumätua

- ?? public health agencies working well together fostering a climate of professional collaboration and information sharing
- ?? the health sector developing intersectoral strategies at the central level which will improve, promote and protect health through various policies and programmes of other sectors of government.

The third point is particularly relevant when identifying programme issues for older people and kaumätua. It acknowledges that other sectors outside health have the lead role for addressing many of the public health objectives for this population group.

Information resources and services

The production and effective distribution of appropriate public health information resources for older people and kaumätua, such as printed material, video kits and self-help kits, is an important component of an effective health promotion and information initiative. The settings approach is a useful model for ensuring that information resources are effectively distributed and used so that the relevant key health promotion messages actually reach older people and kaumätua.

The majority of submissions identified the need for health information for older people and kaumätua that is user-friendly, gender, race and reading level appropriate, promotes positive ageing and is accessible through a variety of outlets. Many submissions also supported using radio and television media campaigns as an effective way to access, raise awareness and inform older people and kaumätua about health and wellbeing issues that affect them. A few submissions suggested installing a freephone number and developing or updating local and national directories of available services and how to access them.

The Public Health Commission, Department of Health and Ministry of Health have produced primarily written material that focuses on food and nutrition-related issues, the needs assessment process and disability support services and residential care services for older people. However, material needs to be evaluated and updated to complement existing education and information material produced by the wider health sector, community-based organisations and advocacy groups.

Other sectors also provide information services for older people and kaumätua. One specific example is the Income Support Services (ISS) Super Centres which cater for their older customers. ISS intend to open 38 Super Centres over the next four years throughout New Zealand. Staff will be trained to provide a personalised service that takes into account the particular needs of older people.

Super Centres will be clearly identified and will provide an office environment that has appropriate seating, lighting and privacy. They will also have an information area that will enable older people to find out what services are available to them in the community. Super Centres welcome information from other organisations and agencies. Mobile services will also visit people in their homes or at a community location.

Regular Keeping Independent Now (KIN) seminars will also be run by ISS in conjunction with other local agencies concerned with the health and safety of older people to provide them with information that allows them to remain independent and safe in their own communities.

Crown health enterprises, community-based organisations, non-government organisations, independent service providers and local authorities are also vital producers and sources of local information for older people and kaumätua. Many examples were quoted during the consultation process and in submissions on subjects such as dementia, food and nutrition and physical activity, to name a few.

Programmes for older people and kaumätua

Physical activity

As discussed earlier, physical activity is a key element to promoting health and wellbeing among older people. One submission provided a definition of physical activity as any movement produced by the skeletal muscles that expend energy. Physical activity includes walking and cycling for transportation, domestic work in and around the home, gardening, stair walking and exercise and physically active recreation.

The Hillary Commission for Sport, Fitness and Leisure

The Hillary Commission is the lead agency with the mandate to facilitate the physical, mental and social wellbeing of New Zealanders and enhance their quality of life.

In its submission the Hillary Commission supported research showing that regular physical exercise has been proven to defer or prevent the disablement process of ageing and that the benefits of physical activity for older people can result in the following:

- ?? increased period of independent living
- ?? improved balance and co-ordination, with reduced risk of falls
- ?? improved mobility and pain reduction for people with arthritis
- ?? strengthening bones
- ?? reduction and control of body weight
- ?? improved cardiovascular function
- ?? reduced high blood pressure
- ?? improved muscle function and posture
- ?? reduced fatigue and better sleeping patterns
- ?? increased confidence and wellbeing
- ?? reduced anxiety and depression
- ?? increased social interaction and enjoyment of life.

The Hillary Commission's recent evaluation of television promotions on exercise and nutrition for older people has demonstrated significant improvement in strength, mobility and self-confidence in those who participated regularly (Hillary Commission 1996).

The Hillary Commission also supported existing strategies and encouraged the health sector to contract with regional sports trusts to deliver physical activity programmes for older people and kaumätua.

Fifties Forward

The Hillary Commission funds and promotes physical activity for all age groups including older people. The Commission's Active in Age co-ordinators, based in the 17 regional sports trusts, co-ordinate and facilitate the various activities and programmes within their regions. One of the Commission's successful longer-term projects is the *Fifties Forward* programme, which is based in a local facility such as a pool or hall and usually involves partnership with other community agencies such as the YWCA, local authorities and fitness centres.

The activities in each region are developed according to local needs and resources and over time become self-sufficient in terms of funding and management. A 1994 Wellington-based sample study of participants in this programme found that most people taking part had integrated physical activity into their lifestyle long past the traditional six-month drop off period (O'Neill 1994).

Personalised exercise programmes

A home-based personal exercise programme (PEP), aims to motivate inactive older adults in the community to begin exercising at home, using a regional television programme, an exercise book, a diary and personal contact and support. People may then gradually move out into community groups or programmes that interest them, or continue with a home-based exercise programme. The Hillary Commission has evaluated the effectiveness of the two pilots, in Hamilton and Christchurch, with a view to extending these programmes to other areas of New Zealand.

The Accident Rehabilitation Insurance and Compensation Corporation has also helped develop PEP and assisted in its funding and evaluation. Their interest in this programme stems from the work they are undertaking on injury prevention among older people. PEP contributes to their objective of promoting and improving balance and physical co-ordination among older people to reduce the rate of accidents and falls in this age group. The results from the recent evaluation of the pilot's reports was that the main benefit for the participants in this programme was an improved feeling of wellbeing. A follow-up survey of the participants is planned to see if they maintain their level of physical activity.

One submission has questioned the suitability of promoting this programme for older people as they do not believe the intensity of the programme will change aerobic capacity or strength and therefore would not improve function or independence for activities of daily living.

Green prescriptions

Another pilot scheme designed to increase physical activity and exercise amongst New Zealanders, which the Hillary Commission is planning to promote further, is Green Prescriptions. This is a programme based on an exercise prescription given by the general practitioner as written advice to those people whose medical condition would benefit from increased physical activity. Green Prescriptions were trialled in Auckland and Dunedin in 1995. The Hillary Commission has contracted the North Health division of the Transitional Health Authority to undertake a further pilot in 1997. An evaluation of this pilot will provide the basis for a decision to extend it nationwide. The New Zealand General Practitioners Association in its submission states that many GPs are enthusiastic about Green Prescriptions and particularly the ability to recommend a range of activities through regional activities such as regional sports trusts.

Te Puni Kōkiri

Te Puni Kōkiri supports the use of physical leisure as a vehicle for promoting health and wellbeing amongst Māori. Te Puni Kōkiri facilitates meetings of an intersectoral group called Omangia Te Oma Roa that focuses on physical leisure, health and wellness. A number of strategies have been proposed under the umbrella of this group. These strategies include:

- ?? the introduction of a 'Healthy Māori Environment' award (Tohu Hauora Māori)
- ?? the establishment of He Oranga Poutama which is supported by the Hillary Commission, Health Sponsorship Council, Community Employment Group and Te Puni Kōkiri. This project seeks to establish the Kaiwhakahaere (co-ordinators) who will promote health, wellness and employment through the medium of physical leisure
- ?? the establishment of Whare Oranga or marae-based health and fitness centres.

These strategies will be further developed and/or implemented between 1996 and 1999.

United States Surgeon-General report on physical activity and health

In July 1996, the United States Surgeon-General released a report entitled *Physical Activity and Health* where the major findings were that all people will benefit from moderate intensity physical activity. The recommended level of physical activity is at least 30 minutes of moderate intensity physical activity, preferably on most days of the week. The physical activity need not be strenuous to achieve health benefits. Greater health benefits can be achieved by increasing the amount (duration, frequency and intensity) of physical activity (US Department of Health and Human Services 1996).

This report discusses the prevention of falls and physical activity, stating that physical activity helps older adults become stronger and better able to move about without falling. The report also states that promising evidence shows that strength training and other forms of exercise in older adults enables them to remain living independently and reduce the risk of falls.

Falls prevention research group

The Otago Medical School-based New Zealand Falls Prevention Research Group recently completed a one year home-based physical therapy programme for older women living in the community that reduced falls and related injuries. The Research Group reported that the programme was easy to deliver, enjoyed by participants, showed good compliance and could be effectively run from a general practice setting making it accessible to more older people and kaumätua. Because long-term compliance and commitment is required for any programme, encouragement from an appropriate person such as a general practitioner or health worker is recommended. Appropriate training by a physiotherapist is also recommended.

The Research Group supports the development of programmes that prevent or reduce falls and related injuries and promote regular physical activity in older people. They assert that the health sector ought to assess that programmes are:

- ?? acceptable to most groups of older people and kaumätua
- ?? effective in achieving the desired outcomes
- ?? promoted by the appropriate people in the most appropriate setting.

In line with the US Surgeon-General's report, the New Zealand Falls Prevention Research Group proposes that community programmes be developed that aim to help older people, whether community-based or in residential care, to commence and maintain a safe programme of regular moderate exercise that is implemented by trained health professionals. Any information resources that are developed also need to promote physical activity by emphasising the health benefits. Many submissions acknowledged the importance of physical activity and supported the need for developing community-based programmes and information resources for older people and kaumätua and providing ongoing support and assistance for existing initiatives. One submission endorsed a role model approach where older people ran physical activity programmes themselves.

Food and nutrition

Health education and programmes promoting good food and nutrition are other essential elements for ensuring that older people and kaumätua enjoy health and wellbeing. A number of healthy eating guidelines have been developed that target population groups including *Food and Nutrition Guidelines for Healthy Older People: A background paper* (MoH 1996b). These guidelines provide technical background information for health professionals. A number of health promotion pamphlets are also available for the general public. One submission suggested this document was extremely informative and could be used for training or continuing education for the public health workforce.

The guidelines recommend a varied diet that includes foods such as vegetables, fruit, breads and cereals, milk and milk products. These elements, together with lean meats and fish, an adequate daily fluid intake and regular physical activity help maintain a healthy body weight and include adequate nutrients, such as calcium that protects against osteoporosis. The Ministry of Health publication *Progress on Health Outcome Targets* (MoH 1997e) reports

on strategies in place for achieving improved nutrition, such as public education programmes or promotional campaigns.

Another area of work that the guidelines refer to is nutritional screening. Nutritional screening programmes are carried out in the US, Canada and Australia. New Zealand is currently working on implementing a screening initiative for older people that will be adapted from the US model.

The public health services of Crown health enterprises provide programmes on food and nutrition at a local and regional level. Other programmes and campaigns are provided by the National Heart Foundation, Te Hotu Manawa Māori, the Cancer Society of New Zealand and the Nutrition Foundation. There are Community Nutrition Pilot programmes that focus on improving nutrition and physical activity in Māori communities. They are not, however, aimed at older people and kaumātua. An evaluation and revision of these pilots will provide the basis for any decisions about expanding to other parts of New Zealand.

Several submissions identified the need for better programme co-ordination and information resources for older people regarding food and nutrition. One submission was concerned about the lack of cooking skills and nutritional knowledge of older people particularly if they are widowed or living alone. This submission suggested various options such as community cooking classes, shared meals, delivered meals or one-to-one training.

Health, wellbeing and safety

A common concern expressed by many submissions was the vulnerability of older people and kaumātua who are isolated and living alone, particularly those in rural areas, as well as those older people and kaumātua who have regular contact with family, friends and health professionals. This vulnerability is often the result of such factors as being neglected or abused by and/or dependent on others, socially isolated, feeling insecure about leaving a safe environment, or suffering from conditions such as incontinence.

Many submissions endorsed the need to develop health promotion programmes or enhance existing programmes such as those described earlier and below as positive strategies to alleviate these concerns. Another integral part of successful strategies is the development of media campaigns and information resources as well as the maintenance and enhancement of existing ones that focus on issues of social support, incontinence, abuse and neglect of older people, and safety and wellbeing. Submissions saw the combined efforts of various sectors including health, justice, local government, and non-government organisations as having an integral role in ensuring the health, wellbeing and safety of older people and kaumātua through the provision of co-ordinated programmes and information.

Confident living pilot programme

This is a pilot programme aimed at older persons, with a strong crime prevention message and also a clear message as to the likelihood of older persons being victims of crime, although older people are less likely to encounter or be victims of crime than any other age group. It is designed to enable older people to discuss issues of concern to them such as the

fear of crime. The pilot is operating under the sponsorship of the Christchurch City Council. The programme requires support from local Police Crime Prevention Officers and Community Constables.

Police programme for identifying confused straying older people

The New Zealand Police, in conjunction with the Alzheimer's Society, have developed an information package that includes:

- ?? an information sheet designed to assist police officers in identifying and dealing with people with Alzheimer's disease or a related dementia
- ?? an information sheet for carers offering Police advice on what to do if a person with a dementia goes missing
- ?? an identification profile form to be completed by caregivers to assist Police in searching for missing persons
- ?? a telephone contact list of Alzheimer's Society offices for Police information.

Local government initiatives

Local government is an elected authority, partner, service provider, planner, and community advocate which has the responsibility and interest in the governance in its area. Local government is required to operate intersectorally through a complex statutory framework. It has the potential to link into a wide range of central government agencies, business and voluntary groups and the public (MoH 1996e). Many submissions, including local government bodies themselves, acknowledged the important role that local government plays in contributing to the health and wellbeing of older people and kaumätua. Many positive examples were cited of initiatives supported by local government such as physical activity programmes, Sixty Plus Centres, one-stop shops and funding welfare or community officers/co-ordinators for older people and kaumätua.

Healthy Cities/Communities

Healthy Cities/Communities is a World Health Organization programme to introduce health concerns more definitely into the priority setting and decision-making process at the local level. A Healthy City/Community is defined as 'one that is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential' (WHO 1988: 24).

A Healthy City/Community is not restricted to a geographical community but may also include communities of interest such as church communities or communities of people with a common identity such as older people (MoH 1997h).

There is close interaction between the community, its social and economic activities and the available resources and environment. Local government plays an important role in the

success of the programme through its planning, co-ordination and service delivery. Local government and health service agencies generally support the project as a means of encouraging intersectoral activities and community development (MoH 1997h).

The Healthy Cities/Communities programme has operated in New Zealand in various centres since the mid-1980s and a range of activities have been undertaken such as injury prevention, environmental protection and awareness, health and fitness promotion, and food and nutrition awareness. The Transitional Health Authority (which becomes the Health Funding Authority from January 1998) funds some of these programmes (MoH 1996e).

Safer Community Councils

The Safer Community Councils is an initiative which involves close collaboration and co-operation between central and local government and local communities. It is designed to encourage and facilitate action on crime prevention at the local level. The Councils are a mechanism for providing programmes and encouraging projects on safety, raising public awareness, public displays of security, and educational programmes. Personal safety, crime and fear of crime are a reality in the daily lives of older people and kaumätua. The Safer Community Councils have the potential to play a positive role in instigating programmes and projects that help to allay such worries about crime and personal insecurity (MoH 1996e). Some submissions also saw a role for these Councils in raising awareness in the community about elder abuse and neglect which would be consistent with their role in the prevention of family violence including elder abuse and neglect.

Elder abuse and neglect

Age Concern New Zealand is a long-established, voluntary agency active in promoting information for older people and initiating programmes which foster dignity, wellbeing, equity and cultural respect for older people, families and carers in the community. The agency produces a range of information and educational material, has accredited visiting services for volunteers to visit older people who may be lonely or isolated in rest homes and the community, and works with other agencies and government departments to develop programmes, as well as making submissions on relevant policy advice papers.

Age Concern played a key role in raising professional and community awareness of abuse issues and in developing a comprehensive resource kit that identifies positive, practical strategies for preventing elder abuse and neglect. The kit can be adapted to suit specific groups or individual needs and is designed for use by older people, carers, service providers, policy makers and the general public. The kit acknowledges the multiple factors that can give rise to neglect or abuse of older people and suggests positive actions to prevent abuse occurring. Many submissions strongly advocated ongoing support for these programmes and, as mentioned earlier, suggested that a national awareness campaign be developed.

Incontinence

Urinary incontinence is a condition that seriously affects the quality of life of older people and kaumätua, particularly women. There are a number of multidisciplinary continence advisory services throughout the country and a national association of continence advisors that aims to improve health professionals' knowledge of incontinence management. Many submissions advocated ongoing support for existing services and emphasised the need for additional services, particularly in rural areas. They also supported the development of a national awareness campaign. One submission cautioned raising the profile of incontinence without first addressing the issue of availability of services.

Social support

In the *Mental Health Promotion* (MoH 1997c) issues-based paper, effective social support was identified as one of the most important correlates of subjective wellbeing and a major protective factor against the development of mental illness. The document also identified a number of population groups who have less social support arising from life circumstances including: older single men and women, people facing major life transitions such as retirement, separation or bereavement, people on low income, and people with disabilities.

Many of the programmes discussed earlier will contribute to improving self-esteem and self-worth and will provide social support to older people and kaumätua. Some submissions indicated that such programmes and the promotion of positive messages about ageing would contribute to older people and kaumätua feeling valued, a part of the community, safe and empowered.

Support groups perform three functions (MoH 1997c):

- ?? provision of opportunities to share experiences, coping strategies and a sense of mutual understanding and validation
- ?? provision of a potentially useful mechanism for information exchange and transfer
- ?? in some cases they perform the advocacy function, mobilising community support and providing education.

Community directories are a useful source of information as they list a wide range of agencies that provide services and education and promotion programmes for older people, such as Age Concern New Zealand, the Alzheimer's Society and the Red Cross Society. Many of these organisations exist to provide support to people in need of their services as well as their caregivers. A number of city and district councils employ community development and/or Healthy Cities staff who provide support for self-help groups and provide information to the public who may wish to access these groups.

The *Mental Health Promotion* paper also found that the principles and practice underpinning development of successful group initiatives have been described by many authors including Rappaport (1986), Pilisuk et al (1986), Wilson (1989 and 1994), Riessman (1990), and Raeburn (1994) (MoH 1997c).

Experience had demonstrated:

- ?? groups must be structured around meeting the needs of their members rather than the needs of professionals
- ?? initiatives to help foster social support should be responsive rather than innovative
- ?? initiatives should avoid creating dependency on either professionals or purchasers
- ?? peer self-help should be fostered by sharing tasks realistically amongst group members, new and old, in order to foster self-efficacy and self-esteem
- ?? support from funders and purchasers of services should be needs-based, and concentrate on removing structural barriers to effective functioning and fostering good practice. This may include facilitating access to meeting rooms, advice on accessing media for publicity purposes, training to foster skills to manage the group (account keeping, listening skills, group facilitation skills), assistance in developing newsletters, and facilitating access to supportive health professionals.

In its submission the [former] Southern Regional Health Authority provided information on a new two-year pilot that their Disability Support Services Age-related section purchased in March 1997. This pilot will be monitored closely and evaluated for effectiveness and value. The pilot is a counselling service and it will be provided by the Presbyterian Support Service in Christchurch. It will include individual counselling sessions, group work and social support for people with age-related disabilities and their carers. The services will address issues such as ageing and loneliness, grief and loss, interpersonal relationship difficulties, and coping with the role of carer. It is expected that the service will result in an improved level of independence and functioning for people with an age-related disability and their carers.

The Oranga Kaumātua Study indicates that many of the participants have found that their mental health status did not significantly deteriorate as they aged, despite the fact that many of them reported having a major or minor physical disability. For the majority of these kaumātua, social support, whether through whānau, hapū or iwi and marae participation, was a significant feature in their ability to maintain wellbeing (TPH 1996).

A recent example of a community awareness raising initiative which was conceived, developed and promoted by the members of Age Concern is the *Wrinkle in Time* video and poster display. This project used interviews with a sample of older people to demonstrate the diversity of older people, their capacity to participate in and contribute to their communities and how much social participation and support contributed to their individual wellbeing.

Summary – Public health programme issues

Developing appropriate information resources for kaumätua

Fostering culturally appropriate holistic health programmes that are marae or community-based to promote the health and wellbeing of kaumätua

Ongoing training for Māori health providers and professionals, public health service staff and students, community workers and volunteers to provide information on health and wellbeing issues for kaumätua and facilitate further development of culturally appropriate programmes

Developing information resources for older Pacific people in Pacific languages

Fostering culturally appropriate holistic health programmes to promote the health and wellbeing of older Pacific people

Training for Pacific professionals, public health service staff and students, community workers and volunteers to provide information on health and wellbeing issues for older Pacific people and facilitate further development of culturally appropriate programmes

Maintaining and further developing resources promoting health and wellbeing amongst older people and kaumätua to complement education and information material produced by the health sector, other sectors, community-based organisations and advocacy groups

Older people and kaumätua need comprehensive information about healthy living strategies, programmes, support services, and normal ageing processes

Ongoing promotion of physical activity programmes for older people and kaumätua which help to promote mobility, injury prevention, mental wellbeing and social interaction

Promoting and enhancing current resource material and programmes for older people on food and nutrition and good eating habits

Developing new and enhancing existing central/local government initiatives that make a positive contribution to the health, wellbeing and safety of older people and kaumätua

Promoting and enhancing current resource material and programmes on elder abuse and neglect as well as promoting awareness of this issue

More comprehensive promotion of current services for incontinence that are available through public health services

Developing an awareness campaign that informs people about incontinence issues and helps to dispel stigma associated with this condition

Fostering community-based support programmes for older people and kaumätua, which should include the following key elements:

- ?? building on existing community-based initiatives
- ?? giving structural support to support/self-help initiatives
- ?? providing information and training to foster good practice
- ?? fostering positive working relationships with relevant professionals
- ?? education to increase awareness of key issues relevant to older people and kaumätua.

Research and Information Issues

There is a lack of research available or commissioned in New Zealand about the effectiveness or impact of new service initiatives or rehabilitation methods for older people and kaumätua. The *Care for Older People in NZ* report identifies a number of areas where research projects could better inform health service planning and purchase for older people (Richmond 1995). The unique New Zealand mix of differing ethnic, age and rural/urban populations calls for local research to form an evidence base for resolving health service and health promotion issues that are particular to New Zealand and our systems of health care. We have little information about the health service needs of older Māori and Pacific people, for example, or about effective methods of health promotion and education of older people, or current levels or trends in disability among older people and kaumätua.

A number of submissions identified the need for longer-term academic, investigator-led research, as well as applied research to assist policy analysis, programme development and realistic outcome target setting. Outcomes-based needs research to assist evidence-based resource allocation, and surveys to address the most urgent needs were proposed. For example, Age Concern in association with Massey University is developing qualitative research to establish the needs of older men in the 75+ age group.

The Health Services Research Centre recently convened a national symposium on ageing to encourage networking between those engaged in research on ageing and to promote quality research to inform policy and assist the promotion of wellbeing among older people in New Zealand. This initial step towards developing a national focus for researchers on ageing could assist a more co-ordinated approach and priority setting, as recommended in submissions.

Māori research and information

There is a need for rigorous research by Māori for Māori on all aspects of kaumätua health to enable evidence-based policy and programme development to advance gains in Māori health. This should include comparisons between the challenges faced by rural and urban Māori.

Before contemplating Māori health research it is important to address issues related to:

- ?? ethics (eg, ensuring informed consent prior to agreeing to participate, determining who in terms of Māori will benefit from the research)
- ?? research questions (eg, being clear on why the research is being undertaken, and by whom, to minimise the potential redefinition of Māori concepts, values and beliefs)
- ?? intellectual property considerations (determining who owns the collected data and ensuring that culturally specific knowledge is appropriately protected)
- ?? research methodology (eg, ensuring that the chosen methodology is implemented in a culturally safe manner, developing mechanisms to ensure the integrity of the research data collection, storage and retrieval) (MoH 1997f).

Further, there are ongoing concerns about the comparability of existing Māori health data as a basis for Māori research. This is due to the inconsistency between government agencies regarding the collection and recording of ethnicity data, if it is collected at all. Although improvements in the coding of ethnicity data, including iwi affiliation, are slowly being made, it is difficult at present to get an accurate picture of Māori health status. Therefore it is also difficult to get an accurate picture of the impact of social and economic factors on Māori health status. The information that is available provides little grounds for optimism that gaps in health outcomes between Māori and non-Māori are closing. There is a clear need for more culturally appropriate research to better understand trends in Māori health status and their causes (MoH 1997f).

New Zealand Health Survey information

Baseline information on health status will be available in 1998 after completion of the 1996/97 health survey. The results will provide information for setting further outcome targets for older people and kaumātua.

Quality of life information

Baseline data on protective factors such as social support, self-esteem and coping skills is lacking and these factors are difficult to define for research purposes. Self-assessed health status information that includes eight dimensions of physical, mental, social, and general wellbeing, can be gathered using the SF-36 questionnaire. This questionnaire was developed in the United States and has been validated for the English, American and Australian populations. Midland Health validated the use of this survey instrument for New Zealand populations when it was used as part of a 1993 survey to identify the health status of the Midland region (Midland Health 1997). The SF-36 was included in the 1996/97 New Zealand Health Survey which surveyed around 8000 people 15 years or over. Te Pūmanawa Hauora also used the SF-36 as part of a recent study on kaumātua health and wellbeing (TPH 1996).

A survey instrument (WHOQOL) recently developed by the World Health Organization (WHO), may also be of value in better assessing changes in protection and risk factors related to healthy ageing, identifying priority groups of older people and kaumātua with special needs and in measuring the success of programmes designed to improve the wellbeing of older people.

Summary – Research and information issues

Culturally appropriate research by Māori for Māori on all aspects of kaumātua health.

Research and evaluation pilots that will inform the purchase and planning of health services for older people and kaumātua in New Zealand.

Assessment of the suitability of the WHOQOL instrument in a New Zealand context for measuring and assessing changes in protective and risk factors closely associated with the wellbeing of older people and kaumätua.

Summary of Benefits

To achieve a significant change in the health status and wellbeing of Māori as they move into the next millennium, strategies and policies will need to take into account not only the wellbeing of kaumātua but also of tamariki, rangatahi and pakeke/mātua, as future kaumātua. This will enable them to enjoy greater economic and cultural security which they can pass on to subsequent generations.

The benefits of improving the health and wellbeing of older people and kaumātua can be summarised as follows:

- ?? positive attitudes towards older people and ageing
- ?? recognition of ageing as part of the life cycle and not a separate area of health care
- ?? improved quality of life for a greater portion of older people and kaumātua
- ?? increased independence, mobility and participation in the community and society and on the marae
- ?? increased years of disability-free life
- ?? secure cultural and spiritual identity
- ?? greater choice of living arrangements
- ?? more equitable access to and provision of community support services and residential care
- ?? reduction in mortality and morbidity due to falls
- ?? reduction in the incidence and prevalence of preventable diseases.

References

- Acheson D. 1988. *Public Health in England: A report of the Committee of Inquiry into the future development of the public health function*. London: HMSO.
- Age Concern. 1990. *The Lifestyle and Well-being of New Zealand's Over 60's*. Wellington: Colmar Brunton Research for Age Concern New Zealand Incorporated.
- Age Concern. 1992. *Promoting the Rights and Well-being of Older People and Those Who Care for Them: A resource kit about elder abuse and neglect*. Wellington: Age Concern New Zealand Incorporated.
- Arber S, Evandrou M (eds). 1993. *Ageing, Independence and the Life Course*. United Kingdom: Jessica Kingsley Publishers Ltd.
- Barlow C. 1991. *Taikanga Whakaaro: Key concepts in Māori culture*. Auckland: Oxford University Press.
- Bonita R. 1995. Older Women's Health. *World Health Forum: An international journal of health development* 16(4): 366–8.
- Bonita R. 1996. *Women, Aging and Health: Achieving health across the life span*. Geneva: World Health Organization.
- Buchner DM, Pearson DC. 1989. Factors associated with participation in a community senior health promotion programme: a pilot study. *American Journal of Public Health* 79(6): 775–77.
- Cairney J, Arnold R. 1996. Social class, health and aging: socioeconomic determinants of self-reported morbidity among the non-institutionalized elderly in Canada. *Canadian Journal of Public Health* 87(3): 199–203.
- Chiu E. 1996. Unpublished paper presented at Alzheimer's Society New Zealand National Conference 1996. Dunedin.
- Chow R, Harrison J, Dornan J. 1989. Prevention and rehabilitation of osteoporosis program: exercise and osteoporosis. *International Journal of Rehabilitation and Research* 12(1): 49–56.
- Coggan A, Fanslow J, Norton R. 1995. *Intentional Injury in New Zealand*. Wellington: Public Health Commission.
- Darnton-Hill. 1995. Healthy aging and the quality of life. *World Health Forum: An international journal of health development* 16(4): 335–43.
- Department of Health. 1992. *Whāia te Ora mö te Iwi*. Wellington: Department of Health.
- Department of Internal Affairs. 1996. *Pensioner Housing Provided by Territorial Authorities: Overview and key trends*. Local Government Information Series 14. Wellington: Department of Internal Affairs.

- Derrett S, Morris J, Paul C. 1996. *Consequences of Long Waiting Times for Patients Requiring Hip Replacements, Knee Replacements or Prostatectomy*. Dunedin: Department of Preventive and Social Medicine. University of Otago Medical School. Unpublished Report to HealthCare Otago.
- Dovey S, McNaughton T, Tilyard M, et al. 1996. General practitioners opinions of continence care training. *New Zealand Medical Journal* 109: 340–3.
- DPMC. 1997. *Facing the Future: A strategic plan: The final report*. Wellington: Prime Ministerial Task Force on Positive Ageing: Department of Prime Minister and Cabinet.
- Durie MH. 1994. *Whaiora Māori Health Development*. Auckland: Oxford University Press.
- Hallwright S. 1995. *Mental Health Information Requirements: A discussion document*. Unpublished report to the Ministry of Health.
- Hand JE, Reid PM. 1996. Older adults with lifelong intellectual handicap in New Zealand: prevalence, disabilities and implications for regional health authorities. *New Zealand Medical Journal* 109: 118–21.
- Harawira W. 1996. *Mana: the Māori magazine for all New Zealanders* 14: 64–5.
- Health Canada. 1995. The determinants of health. *Seniors Information Exchange*. Spring 1995. Canada: Ministry of Health.
- Hillary Commission. 1996. *Making Sport Happen: A background of the Hillary Commission 1996/97*. Wellington: The Hillary Commission.
- Hornbrook MC, Stevens VJ, Wingfield DJ. 1993. Seniors' programme for injury control and education. *Journal of the American Geriatric Society* 41(3): 309–14.
- Hornbrook MC, Stevens VJ, Wingfield DJ, et al. 1994. Preventing falls among community-dwelling older persons: results from a randomized trial. *The Gerontologist* 34(1): 16–23.
- Kaplan GA, Pamuk ER, Lynch JW, et al. 1996. Inequality in income and mortality in the United States: analysis of mortality and potential pathways. *British Medical Journal* 312: 999–1003.
- Keating NC, McCrostie Little H. 1994. Retirement and succession in farm families in New Zealand (South Island). MAF Policy Technical Paper 94/7: 55–57.
- Kennie D. 1993. *Preventative Care for Elderly People*. United Kingdom: Cambridge University Press.
- Langley JD, Johnston SE. 1990. Purposely self-inflicted injury resulting in death and hospitalisation in New Zealand. *Comm Health Studies* 14(2): 190–9.
- LTSA. 1997. *Driver Licensing Proposed Policy*. Wellington: Land Transport Safety Authority.
- MacLean AB, Lay MP, Kelleher PR, et al. 1985. Cytology, colposcopy and cervical neoplasia. *New Zealand Medical Journal* 98: 756–8.

- Maxwell GM, Flett RA, Colhoun HC. 1990. Taking the psychosocial pulse: how to measure the psychological health of New Zealanders. *Community Mental Health in NZ* 5(1): 11–30.
- Messiter D. 1995. *Māori Well Women's Programme Hui Report*. Wellington: Public Health Commission.
- Metge J. 1995. *New Growth From Old: The whānau in the modern world*. Wellington: Oxford University Press.
- Midland Health. 1997. *Family Health Services in the Midland Health Region*. Prepared by Health and Disability Analysis Unit. Hamilton: Midland Health.
- Minister of Health. 1995. *Policy Guidelines for Māori Health. Ngā Aratohu Kaupapahere Hauora Māori 1996–97*. Wellington: Minister of Health.
- MoH. 1995. *Breast Cancer Screening in New Zealand*. Wellington: Ministry of Health.
- MoH. 1996a. *Child Abuse Prevention: The health sector's contribution to the 'Strengthening Families' initiative: Public health issues 1995–1996*. Wellington: Ministry of Health.
- MoH. 1996b. *Food and Nutrition Guidelines for Healthy Older People*. Wellington: Ministry of Health.
- MoH. 1996c. *National Cervical Screening Programme Policy*. Wellington: Ministry of Health.
- MoH. 1996d. *National Drug Policy Part 1: Tobacco and Alcohol*. Wellington: Ministry of Health.
- MoH. 1996e. *The Public Health Role of Local Government: A public discussion document*. Wellington: Ministry of Health.
- MoH. 1997a. *Diabetes Prevention and Control: The public health issues: The background paper*. Wellington: Ministry of Health.
- MoH. 1997b. *Making a Pacific Difference: Strategic initiatives for the health of Pacific people in New Zealand*. Wellington: Ministry of Health.
- MoH. 1997c. *Mental Health Promotion for Younger and Older Adults: The public health issues*. Wellington: Ministry of Health.
- MoH. 1997d. *Mortality and Demographic Data 1994*. Wellington: Ministry of Health, New Zealand Health Information Services.
- MoH. 1997e. *Progress on Health Outcome Targets: The state of the public health in New Zealand*. Wellington: Ministry of Health.
- MoH. 1997f. *Rangatahi Sexual Wellbeing and Reproductive Health: The public health issues*. Wellington: Ministry of Health.
- MoH. 1997g. *Strategies for the Prevention and Control of Diabetes in New Zealand*. Wellington: Ministry of Health.

- MoH. 1997h. *Strengthening Public Health Action: The background paper*. Wellington: Ministry of Health.
- MoH. 1997i. *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health*. Wellington: Ministry of Health.
- NACCHDS. 1993. *Hormone Replacement Therapy: A consensus development conference report to the NACCHDS*. Wellington: National Advisory Committee on Core Health and Disability Support Services.
- NACHD. 1996. *Fifth Annual Report*. Wellington: National Advisory Committee on Health and Disability.
- NHMRC. 1993. *Scope for Prevention in Mental Health*. Canberra: National Health and Medical Research Council.
- Norton R, Butler M. 1997. *Prevention of Falls and Fall-related Injuries among Institutionalised Older People*. Wellington: National Advisory Committee on Health and Disability.
- NZHIS. 1997. *Public Hospital and Selected Morbidity Data 1995*. Wellington: Ministry of Health.
- NZHIS. *Cancer: New registrations and deaths 1994*. Wellington: Ministry of Health, in press.
- O'Neill DM. 1994. *Moving Through the Years: Why do older people take part in physical activity programmes and continue their involvement?* Thesis submitted for the Degree of Master of Arts in Recreation and Leisure Studies. Wellington: Victoria University of Wellington.
- Pearson JL, Conwell Y (eds). 1995. Suicide in late life: challenges and opportunities for research. *International Psychogeriatrics* 7(2): 131–6.
- Pilisuk M, Hillier Parks S. 1986. *The Healing Web: Social networks and human survival*. Hanover and London: University Press of New England.
- PHC. 1994. *A Strategic Direction to Improve and Protect the Public Health: The Public Health Commission's advice to the Minister of Health 1993–1994*. Wellington: Public Health Commission.
- PHC. 1995a. *He Matariki: A strategic plan for Māori public health: The Public Health Commission's advice to the Minister of Health 1994–1995*. Wellington: Public Health Commission.
- PHC. 1995b. *National Plan of Action for Nutrition 1994–1995*. Wellington: Public Health Commission.
- PHC. 1995c. *The Local Environment: The Public Health Commission's advice to the Minister of Health 1994–1995*. Wellington: Public Health Commission.
- PHC. 1995d. *Whakapiki Mauri: Māori health advancement*. Wellington: Public Health Commission.

- PHC. 1996. *Influenza: The Public Health Commission's advice to the Minister of Health 1995–1996*. Wellington: Public Health Commission.
- Raeburn J. 1994. The community in health research and policy. In J Spicer, AD Trlin and JA Wanton (eds). *Social Dimensions of Health and Disease: New Zealand perspectives*. Palmerston North: Dunmore Press.
- Rappaport J. 1986. Collaborating for empowerment: creating the language of mutual help. In: H Boyle, F Rossman (eds). *The New Population: The politics of empowerment*. Philadelphia: Temple University.
- Ratima MM, Durie MH, Allan GR, et al. 1995. *He Anga Whakamana: A framework for the delivery of disability support services for Māori*. A report to the National Advisory Committee on Core Health and Disability Support Services. Wellington: National Advisory Committee on Core Health and Disability Support Services.
- Richmond D, Baskett J, Bonita R, et al. 1995. *Care for Older People in New Zealand: A report to the National Advisory Committee on Core Health and Disability Support Services*. Wellington: National Advisory Committee on Core Health and Disability Support Services.
- Riessman F. 1990. Restructuring help: A human services paradigm for the 1990s. *American Journal of Community Psychology* 18(2): 221–30.
- Robertson MC, Gardner MM. 1997. *Prevention of Falls in Older Populations: A community perspective*. Wellington: National Advisory Committee on Health and Disability.
- Rowe JW, Kahn RL. 1987. Human ageing: usual and successful. *Science* 237 (July): 143–9.
- Sainsbury R, Richards R. 1997. *Prevention of Osteoporosis in Older Populations*. Wellington: National Advisory Committee on Health and Disability.
- Shephard RJ. 1993. Exercise and ageing: extending independence in older adults. *Geriatrics* 48(5): 61–4.
- Sidell M. 1995. *Health in Old Age*. United Kingdom: Open University Press.
- Skegg DCG, Paul C, Seddon RJ, et al. 1985. Recommendations for routine cervical screening. *New Zealand Medical Journal* 98: 636–39.
- Smith GD. 1996. Income inequality and mortality: why are they related? *British Medical Journal* 312: 987–988.
- Statistics NZ. 1994. *New Zealand Now: Māori*. Wellington: Statistics New Zealand.
- Statistics NZ. 1995. *New Zealand Now: 65 Plus*. Wellington: Statistics New Zealand.
- Statistics NZ and Ministry of Health. 1993. *A Picture of Health*. Wellington: Statistics New Zealand and Ministry of Health.
- Steinberg M (ed). 1994. *Towards a Research Agenda for the Well-being of Older Women*. Report of the Research and Grants Advisory Committee Workshop into the

- Health Needs of Older Women, Research Advisory Committee: Issues for Research 3. Australia: Commonwealth Department of Human Services and Health.
- Tang K, Sullivan S, Fisher J. 1995. Resourcing health through leisure: a health promotion project with older people in the St George District of New South Wales. *Health Promotion Journal of Australia* 5(2): 22–6.
- Tannahill A. 1994. *From Priorities to Programmes: Health education and health promotion*. Edinburgh: Health Education Board for Scotland.
- Thomson WM (ed). 1997. *Preventive Dental Strategies for Older Populations: A report to the National Health Committee*. Wellington: National Advisory Committee on Health and Disability.
- TPH. 1996. *Oranga Kaumātua: The health and wellbeing of older Māori*. A report prepared for the Ministry of Health and Te Puni Kōkiri. Unpublished. Palmerston North: Te Pūmanawa Hauora Massey University.
- TPK. 1993. *He Kākano: A handbook of Māori health data*. Wellington: Te Puni Kōkiri.
- TPK. 1994. *Te Ara Ahu Whakamua: Proceedings of the Māori health decade hui*. Wellington: Te Puni Kōkiri.
- TPK. 1994. *Te Māori me te Waipiro*. Wellington: Te Puni Kōkiri and Kaunihera Whakatupato Waipiro O Aotearoa.
- United Nations. 1991. *United Nations Principles for Older Persons*. New York: Department of Public Information.
- US Department of Health and Human Services. 1996. *Physical Activity and Health: A report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
- WHO. 1988. *Promoting Health in the Urban Context*. WHO Healthy Cities Papers No. 1. WHO Healthy Cities Project Office. Copenhagen: FADL Publishers.
- WHO. 1995a. *Moving Health Promotion into the 21st Century*. Geneva: World Health Organization.
- WHO. 1995b. *New Horizons in Health*. Regional Office for the Western Pacific: World Health Organization.
- World Health Organization, Health and Welfare Canada, Canadian Public Health Association. 1986. *Ottawa Charter for Health Promotion*. Ottawa: World Health Organization, Health and Welfare Canada, Canadian Public Health Association.
- Wilson J. 1989. Supporting self-help – six years of work in an English city. *Health Promotion* 4(3): 215–24.
- Wilson J. 1994. *Two Worlds: Self-help groups and professionals*. Birmingham: Venture Press. Cited by *Social Care Research* 60 (November).

Glossary

Age standardised rates: Mortality or morbidity rates in which there has been an adjustment for differences in age distribution of the populations being compared.

Alzheimer's disease: A type of dementia characterised by gradual onset and significant functional impairment.

Awa: River.

Cerebrovascular disease: Also known as stroke.

CHE: Crown health enterprise.

CORD: Chronic obstructive respiratory disease.

Dementia: These disorders are characterised by the development of multiple cognitive deficits (including memory impairment) that are due to physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple aetiologies.

Epidemiology: The study of the distribution and determinants of health-related states or events in specified populations.

Family: The 1996 Census of Population and Dwellings defines four types of family: an economic family is a person who is financially independent or a group of people who usually reside together and are financially interdependent according to current social norms; and extended family is a group of related people who usually live together in the same household and consists of a family nucleus and one or more related people, or two or more related family nuclei, with or without other related people; a familial relationship is a relationship in which a person is related to another household member by blood, marriage (registered or de facto) or adoption; a family nucleus consists of two or more people, who are members of the same household, and who comprise either a couple, or at least one parent role/child relationship, or both.

Goal: A general aim to strive for.

Hapū: Groups of whānau with common ancestral links.

He Matariki: A strategic plan for Māori public health was prepared by the Public Health Commission (PHC). *He Matariki* constituted the PHC's advice to the Minister of Health, 1994–1995.

Health status: A set of measurements which reflect the health of populations. The measurements may include physical function, emotional wellbeing, activities of daily living, etc.

Health Funding Authority (HFA): Formerly the Transitional Health Authority.

Hospitalisation: A term commonly used to give some indication of the morbidity of diseases and conditions in a community. A hospitalisation in the New Zealand health statistics includes inpatients who leave hospital to return home, transfer to another hospital

or institution, or die in hospital after formal admission. This is, therefore, a count of episodes of care rather than individuals. For example, a patient who is transferred will be counted twice.

Hui: A meeting or gathering of people for a specific reason.

Incidence: The number of new cases or deaths that occur in a given period in a specified population.

Incontinence: Inability to control the bowel or bladder.

Information: Information on health matters is an important precondition to ensure that people are able or willing to make healthy choices. The way in which people access and use information varies according to their general literacy, their personal and social skills, and the social and physical environment in which they live and work.

Intersectoral: Involving various sectors of society – governmental (health, education, welfare etc), local government, community and non-governmental organisations (Rotary, Lions, the Cancer Society of New Zealand) and the general public and/or individuals.

Intervention: A specific prevention measure or activity designed to meet a programme objective.

Ischaemic heart disease: Also known as coronary heart disease.

Iwi: Tribe or people.

Kaumātua: Wise and experienced older members of the whānau who may be knowledgeable in tikanga Māori; in the context of this paper, people aged over 55.

Kaupapa: Theme or groundwork.

Kōhanga Reo: Māori language ‘nests’, describes a movement established by Māori people in the 1960s to teach the Māori language to preschool children.

Koroua: Older man.

Kuia: Older woman.

Mana: Influence, power.

Marae: Area set aside for the practice of Māori customs; usually associated with permanent physical structures.

Mātua: Adult/Parent.

Mauri: Spiritual strength.

Moana: Sea.

Mobility: The ability to be physically active within a variety of settings such as home, marae, local community, society.

Mokopuna: Grandchildren.

MoH: Ministry of Health.

Monitoring: The performance and analysis of routine measurements, aimed at detecting changes in the environment or health status of populations.

Morbidity: Illness.

Mortality: Death.

Objective: The end result a programme seeks to achieve.

OECD: Organization for Economic Co-operation and Development. The OECD countries are Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, United Kingdom and the United States.

Older people: For the purposes of this paper 'older people' refers to people in the age range of 65 years plus. Sixty-five is internationally recognised as the age from which people are known as 'older people'. It is also the age at which entitlement to retirement income in New Zealand will be guaranteed in 2001.

Osteoporosis: Thinning of bones due to loss of bone mineral.

Ottawa Charter: The Charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This Charter defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion action means: building healthy public policy; creating supportive environments; strengthening community action; developing personal skills and reorienting health services.

Pakeke: Adult.

Personal health services: Health services provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose.

PHC: Public Health Commission.

PHG: Public Health Group, Ministry of Health.

Prevalence: The number of instances of a given disease or other condition in a population at a designated time. Prevalence includes both new (incidence) and existing instances of a disease.

Primary health care: The essential health care made universally attainable to individuals and families in a community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part of the country's health system, of which it is the nucleus, and of the overall social and economic development of the community.

Public health services: Goods, services, or facilities provided for the purpose of improving or protecting public health.

Rangatahi: Young adults.

Rate: In epidemiology a rate is the frequency with which a health event occurs in a defined population. The components of the rate are the numbers of deaths or cases (numerator), the population at risk (denominator) and the specified time in which the events occurred. All rates are ratios, calculated by dividing the numerator by the denominator.

Reo: Language or voice.

Risk: The probability of harmful consequences arising from a hazard.

Risk factor: An aspect of personal behaviour or lifestyle, an environmental exposure of an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.

Rongoa: Medicine.

Tamariki: Children; can be used to include young people who have not yet reached adulthood.

Tangata whenua: The indigenous people of a country (Māori in the case of New Zealand).

Taonga: Prized gift.

Target: An intermediate result towards the objective that a programme seeks to achieve.

Te Pūmanawa Hauora: Māori health research centre based at Massey University, Palmerston North.

Te Puni Kōkiri: Ministry of Māori Development, a government department.

THA: Transitional Health Authority.

Tikanga: Customs.

Turangawaewae: Tribal homeland.

Wānanga: An intensive, focused period of learning that can be short- or long-term.

Whakapapa: Genealogy.

Whānaungatanga: Relationship, kinship.

Whare wānanga: A tertiary institution.

Whānau: Relationships that have blood links to a common ancestor. Modern configurations can also include a number of groups with common bonds and goals.

Whenua: Land or placenta.

WHO: World Health Organization of the United Nations.

WHOQOL: A World Health Organization Quality of Life assessment tool.

Appendix 1:

Relevant Goals and Objectives

The following goals and objectives are also relevant to the health and wellbeing of older people and kaumätua.

Goal

To ensure the social and physical environment which improves, promotes and protects public health and whānau public health.

Objectives

To maximise the positive aspects of whānau development on Māori health.

To reduce the adverse health effects of unemployment, income inequalities, housing, transport, and illiteracy.

To improve provision of appropriate primary health care.

To optimise the safety of all food and drinking-water available for consumption in New Zealand.

To improve access to, understanding of, and use of information.

To reduce the adverse health effects of violence including family violence.

To reduce the adverse health effects of gender inequalities.

To implement comprehensive public health programmes in settings such as communities, health care organisations, homes, marae, schools, and workplaces.

Goal

To improve, promote and protect Māori health status so in the future Māori will have the opportunity to enjoy at least the same level of health as non-Māori.

Objectives

To ensure that all services funded are culturally appropriate and compatible with gains in Māori health.

To show an understanding of and commitment to the Treaty of Waitangi.

Goal

To improve, promote and protect the health of Pacific people.

Objectives

To provide Pacific people with the opportunity to play a major role in the design, development, implementation, and evaluation of public health services which affect their communities.

To ensure that all services are culturally appropriate and relevant to Pacific people in structures, settings and languages that Pacific communities can identify with and use.

To ensure funding of education and cross-cultural training opportunities in public health which reflect the health and cultural needs of Pacific people and to increase the recruitment of Pacific people to reflect their representation in the local population.

To recognise and respond to the needs for co-ordination in the delivery of public health services, consistency in monitoring the effectiveness and efficiency of health promotion and the management of these services.

Appendix 2:

Relevant Existing Outcome Targets

Ischaemic Heart Disease (MoH 1997e)

To reduce the age-standardised ischaemic heart disease mortality rate among New Zealand males to 110 per 100 000 or less by the year 2000.

To reduce the age-standardised ischaemic heart disease mortality rate among New Zealand females to 50 per 100 000 or less by the year 2000.

To reduce the age-standardised ischaemic heart disease mortality rate among Māori males to 120 per 100 000 or less by the year 2000.

To reduce the age-standardised ischaemic heart disease mortality rate among Māori females to 70 per 100 000 or less by the year 2000.

Physical Activity (MoH 1997e)

To increase the percentage of people participating in frequent physical activity to 56 percent by the year 1997.

To prevent any further increase in prevalence rates of obesity beyond 10 percent for males and 13 percent for females, by the year 2000.

Nutrition (MoH 1997e)

To increase the consumption of breads and cereals so that 75 percent or more of the population are consuming at least six servings per day by the year 2000.

To increase the consumption of vegetables and fruit so that 75 percent or more of the population are consuming at least five servings per day by the year 2000.

Tobacco (MoH 1997e)

To prevent any further increase in the age-standardised death rate from lung cancer in males of 3.5 per 100 000 males by the year 2000.

To prevent any further increase in the age-standardised death rate from lung cancer in females of 18.4 per 100 000 females by the year 2000.

To reduce tobacco products sold to 1000 cigarette equivalents or less per adult by the year 2000.

To reduce the percentage of adults (15 years and over) smoking any type of cigarette to 20 percent or less by the year 2000.

To reduce the percentage of Māori smoking any type of cigarette to 40 percent or less by the year 2000.

Alcohol (MoH 1997e)

To reduce the overall consumption of alcohol by the general population to 8.7 litres of pure alcohol per adult or less by the year 2000.

Cervical Cancer (MoH 1997e)

To reduce the age-standardised mortality rate from cervical cancer to 3.5 per 100 000 women or below by the year 2005.

To reduce the age-standardised mortality rate from cervical cancer to 7.5 per 100 000 Māori women or below by the year 2000 and to 5.3 per 100 000 or less by 2005.

To reduce the age-standardised incidence rate of cervical cancer in women to 8.6 per 100 000 women or below by the year 2005.

To reduce the age-standardised incidence rate of cervical cancer in Māori women to 11.0 per 100 000 women or below by the year 2005.

To ensure that less than 30 percent of invasive cervical cancers are beyond Stage 1 at the time of detection, by the year 2000.

To increase the proportion of eligible women enrolled and screened in the previous five years to 85 percent or more by the year 2000.

Melanoma (MoH 1997e)

To reduce the age-standardised melanoma mortality rate to 7 per 100 000 or less among males, and 3 per 100 000 or less among females, by the year 2005.

To reduce the age-standardised incidence rate of thick melanomas (>1.5 mm) to 6 per 100 000 or less, by the year 2005.

Submissions Received and Consultation Meetings, Hui and Fono

Written submissions

ACC Injury Prevention, Wellington, Programme Manager, Adams, Brian J

Alzheimer's Society New Zealand, National Executive Director, Christchurch, Harrison, Jan

Ashburton District Council, Health Sub-Committee

Central RHA, Public Health Services, Wellington, Maling, Cynthia

Child and Family Pacific Island Team, Auckland, Community Health Services, Walters, Waireti and Knutsen, Lorraine

Christchurch School of Medicine, Consultant Physician/Senior Lecturer, Wilkinson, Tim

City of Hamilton, Corporate Group, Chief Executive, Marryatt, AJ

Crown Public Health, Christchurch, Scanlon, Wendy

Elderhealth-Elderwise, Goldstraw, Paul and Lynden

Family Planning Association New Zealand, Chief Executive Officer, Wellington, Ineson, Sue

Far North District Council, Kaikohe, Hokianga Community Board, White, Sue

Far North District Council, Kaikohe, Kawakawa Community Board Liaison Officer, White, Sue

Franklin District Council, Research and Policy Officer, Tuahine, Leanda

Good Health Wanganui, Public Health Centre, Manager, Day, Pam

Health and Disability Commissioner, Wellington, Stent, Robyn K

Healthcare Otago Ltd, Dunedin, Health Promotion Advisor, Hobbs, Melissa

Healthlink South, Christchurch, Lactation Co-ordinator, Hunter, Dawn C

Healthways Consultancy New Zealand, Tauranga, Managing Partner, Loughlin, Murray

Hillary Commission for Sport, Fitness and Leisure, Chief Executive, Wellington, Dale, Peter

Lincoln University, Canterbury, Department of Human and Leisure Sciences, Ross, Dr Jenny

Local Government and Community Policy, Wellington, Secretary for Internal Affairs, Jackman, Sally

Marlborough Public Health Unit, Blenheim, Public Health Nurse, Griffiths, Mary

MidCentral Health, Palmerston North, Elderly, Rehabilitation and Rural Services, Group Manager, Public Health, Udy, Denise

Midland Health, Hamilton, Public Health Unit, Manager, Hoskins, Richard

Ministerial Advisory Council for Senior Citizens, Wellington, Chairperson, Francis, Ron

Ministry of Agriculture, Wellington, Rural Policy Unit, Policy Analyst, Anderson, Diane

Ministry of Pacific Island Affairs, Wellington, Acting Chief Executive, Lackey, Kate

Nelson City Council, Director Corporate Services, Barker, IP

New Zealand Association of Gerontology, Wellington, President, Guthrie, Margaret

New Zealand Association of Occupational Therapists, Inc., Wellington, Executive Director, McKenna, Christine

Noble, Lys, Wanganui

North Shore Hospital, Auckland, Faculty of Medicine and Health Science, Professor of Geriatric Medicine, Anderson, Craig

NZ General Practitioners' Association Inc., Chief Executive, Wellington, Pettett, Andrea M

NZ Gerontology Association, Bay of Plenty Branch, Scott, Thomas

NZ Nurses Organisation, Wellington, Chief Executive Officer, Wilson, Brenda

Owen, Megan

Patients Rights Advocacy, Waikato Inc., Hamilton, De Jonge, Anna and members

Southern Public Health Services, Invercargill, Health Promoter, Ayson, Zola

Southern Regional Health Authority, Consumer Relations Co-ordinator, Carr, Louise

Southland District Council, Invercargill, Community Development Officer, Broomfield, Rachel

Statistics New Zealand, Wellington, Chief Analyst Social Policy, Brown, Denise

Taihape Community Health Group, Valentine, DM

Te Ohu Whakatapu, Wellington, Manager, Snowden, Paula

Te Pūmanawa Hauora, Palmerston North, Research Officer, Waldon, John

Thomson, Dr Kenneth, Wanganui

Turanganui A Kiwa Hauora, Gisborne, Manager, Blue, Robyn

Tuwharetoa Health Services Ltd, Turangi, Establishment Services Co-ordinator, Gosman, Kamiria

Tuwharetoa Health, Turangi, Tatai Korero Consultants

University of Otago Medical School, Dunedin, NZ Falls Prevention Research Group,
Research Physiotherapist, Gardner, Melinda

Victoria University of Wellington, Department of Anthropology, Pollock, Dr Nancy J

Wairarapa Organisation for Older Persons, Masterton, Co-ordinator, Parkinson, Rita

Waitakere City, Community Injury Prevention Programme, Devlin, Margaret

Waitakere City, Fenton, Audrey

Waitemata Health, Auckland, Mental Health Services for Older People, Consulting
Psychiatrist, McIvor, Bede Dr

Wanganui District Council, Executive Officer, Hovey, Rosemary

Wesley Wellington Mission, Manager Services for Older People, Jacobs, Stephen

Western Bay Health, Tauranga, Quality Care by Quality People, Beard, Claire

Women's Electoral Lobby, Waikato, Andrew, Chris

Wong, Grace

Total written submissions: 61

Consultation meetings, hui and fono

Hamilton 22 April 1997

Wellington 29 April 1997

Auckland 30 April 1997

Dunedin 7 May 1997

Gisborne 14 May 1997

Auckland 17–18 April 1997

Bay of Plenty 20–21 April 1997

Palmerston North 1–2 May 1997

Christchurch 8–9 May 1997

Porirua 28 April 1997

Total consultation meetings, hui and fono: 10.

Meeting, hui and fono participants

Ahiao, Kau, Porirua
Arahill, Gennie, Gisborne
Armstrong, Karla, Auckland
Averell, Susan, Gisborne
Barwick, Sharon, Gisborne
Bayley, May, Gisborne
Bayley, Patricia, Lower Hutt
Bidois, Alf, Tauranga
Birch, Dawson, Wainuiomata
Blanchard, T, Tokomaru Bay
Bowring, Raewyn, Gisborne
Brund, Virginia, Gisborne
Burt, Roberta, Christchurch
Butler, Daisy, Ruatoria
Carrington, Te Noho Pani, Titahi Bay
Clarke, Adelaide, Gisborne
Clements, Sabina, Lower Hutt
Clerk, Mama Tu, Porirua
Couch, Maera M, Lyttelton
Cowan, Noo, Lower Hutt
Dargie, Ngaire, Tokomaru Bay
Dewes, Reremoana, Tikitiki
Emery, Herb, Feilding
Emery, Huia, Feilding
Empson, Russell, Christchurch
Ewart, K, Porirua
Ferrick, Noele, Gisborne
Findson, Sharon, Gisborne
Fisher, Barbara, Gisborne
Floyd, Tuhi, Ruatoria
Forrester, M R, Gisborne
George, N, Porirua

Gerrard-Scott, Alice, Gisborne
Gledhill, Ethel, Gisborne
Green, Janet, Gisborne
Gremmell, Te Raukura, Porirua
Haereroa, Ivy, Ruatoria
Haig, Ireonui, Tokomaru Bay
Hauraki, Tuahine, Ruatoria
Hegarty, Margaret, Gisborne
Heka, Janine, Tikitiki
Heni, Margaret, Titahi Bay
Hetutu, Mailigi, Wellington
Honey, Yvonne, Gisborne
Huey, Donna, Gisborne
Iafeta, I, Porirua
Iosefa, Feagai, Porirua
Jocelyn, Gisborne
Johnston, Manu, Ruatoria
Kaewan, Mate, Ruatoria
Karaka, Jacob, Tikitiki
Kelso, Vicki, Gisborne
Kereopa, Sandi, Lower Hutt
Kohi, Ruatoria
Kopua, Kay, Gisborne
Kupa, Sipaia, Porirua
Laity, Brian, Gisborne
Lawtana, Pearl, Palmerston North
Lerm, Malina, Naenae
Letufuga, Tausili'a, Gisborne
Lewis, Olive, Gisborne
Lukitau, Flo, Porirua
Mackey, Wahine, Ruatoria
Maki, Mama, Lower Hutt
Martin, Muriel, Gisborne
Matwell, Sarah, Ruatoria

McClutchie, Pani, Ruatoria
McIntyre, Eunice, Gisborne
McKay, Betty, Gisborne
Mitaera, N, Porirua
Moeke, Wiremu, Gisborne
Moo, Keu, Lower Hutt
Morete, Erana, Ruatoria
Morrissey, Thelma, Gisborne
Murray, Dana, Porirua
Nepe, Haromi, Ruatoria
Ngarimu, Rae, Ruatoria
Normanton, Lu, Gisborne
Parai, Hannah, Lower Hutt
Patea, Agalelei, Porirua
Pendiak, Miriama, Gisborne
Peri, Kathy, Christchurch
Pokoati, Mrs M, Porirua
Proffit, Kirika, Otakou
Puhiatau, Mile, Tawa
Pure, Carolyn, Gisborne
Rakete, Denise, Dunedin
Rameka, Puawai, Auckland
Rapatu, Karaka, Dunedin
Ratahi, Mihi, Ruatoria
Reedy, Ika, Ruatoria
Rehua, Tuki, Auckland
Rihia, Toni, Gisborne
Risati-Taiera, Lina F, Porirua
Rogers, Letty, Ruatoria
Rota, Tungane, Porirua
Ryan, Les, Gisborne
Siriatt, Rachel, Gisborne
Smith, Margaret, Tokomaru Bay
Taiaroa Briggs, Mekura, Lyttelton

Takarangi, Tui, Ruatoria
Tamatoa, Mrs A, Lower Hutt
Tangaroa, Akapoe, Porirua
Tangaroa, Makea, Porirua
Te Arahanga, R K, Christchurch
Te Mano, Morehu, Ruatoria
Te Maro, Margaret, Ruatoria
Te Reo, Elder, Gisborne
Thorpe, Margaret, Gisborne
Tiaitu, Lower Hutt
Tinielu, Hiupolu, Porirua
Tiraa, Erena, Porirua
Tohill, Pam, Gisborne
Ukarangi, Pati, Porirua
Ululua, Setaita, Gisborne
Valiamu, Oloka Pou, Porirua
Vincent, Susan, Gisborne
Waimotu, Janette, Te Puia Springs
Waipu, Matiria, Ruatoria
Walker, Maea, Gisborne
Wharehinga, Frances, Te Puia Springs
Wilco, Hine, Tokomaru Bay
Wilkinson, Audrey, Auckland
Wilson, Andrea, Gisborne
Woodland, Marcus, Hamilton
ACC, Gisborne, Greening, Vaughn
ACC, Gisborne, Jacobs, Gail
Age Concern, North Shore, Auckland, Chapman, Janferie
Age Concern, Wellington, Wright, Norman
Alzheimers Day Care, Gisborne, Larsen, Barbara
Alzheimers Society, Gisborne, Anderson, Colleen
Arohaina Resource Centre, Gisborne, Payne, Alison
Arthritis Division, Gisborne, Manson, Celia
Association of Anglican Women, Gisborne, Smith, Zillah

Asthma Foundation, Auckland, Goodhall, Joccanna
Asthma Society, Gisborne, Ashwell, Bernice
Auckland Healthcare Limited, Māori Health Co-ordinator, Auckland, Forbes, Mata
Auckland Healthcare Limited, Sexual Health Services, Auckland, Day, Idiana
Auckland Healthcare, Public Health Promotion, Auckland, Thompson, Sisi
Baptist Mental Health, Auckland, Chase, Rebecca
Baptist Mental Health, Auckland, Reti, Catherine M
Baptist Mental Health, Auckland, Theodore, Tom
Baptist Mental Health, Auckland, Wharepapa, Lisa
Baptist Mental Health, Auckland, Wihongi, Alwood
Baptist Mental Health, Auckland, Wihongi, Dion
Baptist Mental Health, Central Auckland, Gregory-Hunt, Quentin
Baptist Mental Health, Central Auckland, Layne, Ross
Baptist Mental Health, Kaumātua, Auckland, Theodore, Tom
Baptist Mental Health, South Auckland, Popata, Laurie
Blind Association, Gisborne, Bain, Sally
Blind Association, Gisborne, Mierronerey, Lou
Blind Association, Gisborne, Ploughman, Joyce
Blind Association, Gisborne, Scholes, Edith
Breast Cancer Support, Gisborne, Ericson, Peggy
Capital Coast Health Limited, Sexual Health Service, Wellington South, Te Whaiti, Sharlene
Capital Coast Health Limited, Sexual Health Services, Wellington, Roa, Margaret
Capital Coast Health, Porirua, Winera, Andrea
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Capital Coast Health, Wellington, Collier, Cheryl
Capital Coast Health, Wellington, Marshall, Shirley
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Cervical Screening Programme, Christchurch, Flecto, Tina
Chaplain for the Unemployed, Gisborne, Te Aho, Marianne
Chelsea Hospital, Gisborne, Evenden, Denise

Child and Family Services, Auckland, Mohr, Alamein
Child and Family Services, Auckland, Rehu, Maria
Citizens Advice Bureau, Gisborne, Mossman, Peggy
Citizens Advice Bureau, Gisborne, Naden, Trish
Community Cervical Screening Co-ordinator, Tauranga, Barnaby, Jo
Community Health (Waikato), Hamilton, McNicol, Anne
Consumer Advocate, Te Puia Springs, Coleman, John
Council of Elders, Hamilton, Dallinger, Pat
Counties Manukau Health Limited, Community Health, Auckland, Brampton, Ataroa
Counties Manukau Health Limited, Health Promotion, Auckland, Roberts, Mavis
Counties Manukau Health Limited, Mental Health, Auckland, Thompson, Eru
Crown Public Health, Senior Citizens Unit, Kaiapoi, Kipa, Huia
CWI, Gisborne, Garfield, Alison
Diabetes Society, Gisborne, Muir, Elaine
Disability Information Centre, Gisborne, Zane, Theresa
Disability Resource Centre, Hamilton, Tai Rakena, Tamehaua
District Nurse, Gisborne, Cook, Christine
Domiciliary Worker, Tikitiki, Karaka, Robyn
Dunblane Centre, Gisborne, Hodgson, Sue
Dunedin School of Medicine, Ngai Tahu Māori Health Research Unit, Dunedin, Broughton, John
Early Intervention, Te Puia Springs, Tuheke, Connie
Eastbay Health, Whakatane, Greenway, Pam
EIT Nursing Student, Gisborne, Baty, Natasha
EIT Nursing Tutor, Gisborne, Maude, Heather
Epilepsy Association, Gisborne, Egan, Judy
GDC, Gisborne, Swarbrick, Miriam
Gisborne Bowling Club, Gisborne, Hopkinson, Reece
Gisborne Bowling Club, Gisborne, Taylor, Dent
Gisborne Cancer Society, Gisborne, Hobbs, Janice
Gisborne Craft Centre, Gisborne, Whittaker, Nalda
Gisborne Diabetes Society, Gisborne, McKeague, Margaret
Gisborne Diabetes Society, Gisborne, Owen, Murray
Gisborne Hospital, Gisborne, Carter, Eileen

Gisborne Hospital, Gisborne, Malone, Cynthia
Gisborne Plunket Society, Gisborne, Wilson, Teo Arani
Gisborne Stroke Support Group, Gisborne, Serpi, Owen
Gisborne Stroke Support, Gisborne, Brown, Eliza
Giscoss Schizophrenia Fellowship, Gisborne, Allen, Janice
Grey Power, Gisborne, Crone, Margaret
Grey Power, Gisborne, Leslie, Audrey
Grey Power, Gisborne, Tagg, Kath
Havelock Village Resthome Limited, Havelock North, Fraser, Tau Aroha
He Tohunga Ora mo Ngati Awa, Whakatane, Wilson, Carin
Health & Disability Commissioner, Gisborne, Fisher, Lesley
Health & Disability Commissioner, Gisborne, Webb, Tom
Health & Disability Commissioner, Kaiwhakahaere, Wellington, Milne, Moe
Health Consumer Service, Gisborne, Sibley, Nancy
Health Promotion, Papakura, Thompson, Sisi
Health Waikato, Community Health, Hamilton, Brown, Carol
Health Waikato, Community Health, Hamilton, Shortland, Moana
Health Waikato, Hamilton, Singh, Satvir
Healthcare Otago Limited, Diabetes Department, Dunedin, Murphy, Eleanor
Healthcare Otago Limited, Health Protection Unit, Dunedin, Hobbs, Melissa
Healthcare Otago Limited, Waikari Hospital, Care of the Elderly, Dunedin, White, Lenore
Healthcare Otago Limited, Waikari Hospital, Care of the Elderly, Dunedin, Howie, Auts
Healthcare Otago Limited, Waikari Hospital, Care of the Elderly, Dunedin, Busby, Wendy
Healthcare Otago, Dunedin, Lewis, Alison
Healthcare Otago, Dunedin, Moar, Teresa
Healthy Communities, Masterton, Karaitiana, Lianne
Hine Hou Tou Ariki Trust, Napier, Macrae, Wiremu
Hutt City Council, Community Development PI Officer, Lower Hutt, Taramai, Tuerei
Hutt City Councillor, Lower Hutt, Dalziel, Scott
Hutt Valley Health Corporate, Public Health Service, Lower Hutt, Tusa, Olivia
Hutt Valley Health, Wellington, Soutar, Angela
IHC, Advocacy Centre, Wellington, Brook, Jane
IHC, Gisborne, Gordon, Anne
IHC, Gisborne, Leitch, Sally

Income Support, Gisborne, Haenga, Karyn
Inland Revenue, Gisborne, Practer, Ian
Kahungunu Community Health Services, Lower Hutt, Atkin, Bobby
Kahungunu Community Health Services, Lower Hutt, Cook, Dan
Kahungunu Executive Hauora, Wairoa, Hammond, Miriama
Kau Papa Hau Ora, Gisborne, Clark, Maraea
Kohanga Reo Whai Te Mataranga, Auckland, Crichton, Angela
Kokohinau Marae Committee, Te Teko, Hunia, Kanui
Kokohinau Marae, Chairman, Kawerau, Eruera, Hemana
Kokohinau Marae, Marae Health Projects, Te Teko, Hunia, Hanui
Kuia Ngati Kauwhata, Palmerston North, Lawton, Pearl
Kupenga Hao ite Ora, Opotiki, Edwardson, Dee
Kupenga Hao ite Ora, Whakatane, Araroa, Waina
Kupenga Hao ite Ora, Whakatane, Haereroa, Pearl
Le Banyan Enterprise, Lower Hutt, Pea-Wall, Seela
Leighton House Rest Home, Gisborne, Johnstone, Marion
Lincoln University, Christchurch, Gray, Maurice
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The Public Health Group, Ministry of Health, would like your comments on the implementation of issues discussed in this document. They should be addressed to:

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