



**Wairarapa DHB**

*Wairarapa District Health Board*

Te Poari Hauora a-rohe o Wairarapa



# W.E.L.L.

## **Wairarapa Elder Local Links**

*He Ara Watea mo nga hiahia Hauora, o nga kaumatua*

The integrated continuum of care within a partnership model



Well Wairarapa – better health for all  
*Wairarapa ora – hauora pai mo te katoa*

***“You tell me I am getting old.  
I tell you that’s not so.  
The ‘house’ I live in is worn out  
and that, of course, I know.***

***“You only see the outside,  
which is all that most folks see.  
You tell me I’m getting old,  
you’ve mixed my ‘house’ with me.”***

(Anonymous, from “The other side of Growing Older”  
McMillan Press, 1982)

**W.E.L.L. – Wairarapa Elder Local Links** plan is produced by the Wairarapa District Health Board and may be downloaded in PDF format from [www.wairarapa.dhb.org.nz](http://www.wairarapa.dhb.org.nz)  
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## Executive summary

***“Here is Edward Bear, coming downstairs now, bump, bump, bump, bump, on the back of his head behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think of it.”***

(A. A. Milne)

Developing a plan for implementing an integrated continuum of care for older people gives an opportunity to ‘stop bumping downstairs for a moment and think of another way’. This document describes a way forward for the Wairarapa DHB to develop an integrated approach to health and disability support services that is responsive to older people’s varied and changing needs.

Older people form a larger part of the Wairarapa population than in New Zealand in general and by 2021, it is predicted that more than a quarter of the local population will be over 65 years. It is timely that the DHB addresses the health and disability support needs of older people to ensure that:

***“Older people participate to their fullest ability in decisions about their health and well being and in family, whanau and community life. They are supported in this by co-ordinated and responsive health and disability programmes.”***

(Health of Older Peoples Strategy, 2002)

Issues identified by older people/kaumatua in the Wairarapa and those interested in their wellbeing have been linked with key strategies and policy frameworks to give direction to this document.

The 'way forward' presented in the document is based on building a partnership model for the health of older people through a systems approach. The partnership model is described in the document and partners are identified. The systems approach to applying the partnership model ensures that the health of older people is considered at all levels for the dimensions of:

- Effectiveness (Health and wellbeing)
- Access and equity
- Safety
- Efficiency (Continuum of links)

Within this framework, the interactions of individuals, teams, organisations and the overall system will centre on older people (collectively and individually). The cumulative result will provide an integrated continuum of care that is unique to the Wairarapa and the needs of its older people/kaumatua.

"The medium is the message". A larger than usual font size has been deliberately chosen for the presentation of this document.

Submissions on this document have been invited from a wide range of relevant people (see appendix 1). Consideration of these submissions has resulted in a clear picture of the way forward to implementing an integrated continuum of care for older people in the Wairarapa.

# 1. Introduction

***“Every man desires to live long; but no man would be old.”***

(Dean Swift, 1859)

The majority of older people are fit and healthy. A minority are frail, vulnerable and require high levels of care and disability support. Older people are at risk of many of the same diseases and conditions as younger people, as well as being vulnerable to specific age related conditions. In addition, their lifestyles are often affected by disability, bereavement, loneliness, living arrangements, lower than average levels of income and transport difficulties.

They are a growing segment of our population and are some of our biggest users of health and disability services, yet apart from the designated services for older people, generic services make little provision for this group. Service responses that are specifically appropriate to older people’s requirements need to be developed across the whole continuum of services encompassing:

- Population Health
- Primary Health Care
- Secondary Health Care
- Disability Support Services
- Mental Health

The Health of Older People Strategy (2002) has led to a significant opportunity in 2003 with the devolution of Older People’s funding to District Health Boards. The aim of this devolution is to improve the outcomes for older people by developing an ‘integrated approach to health and disability support services that is responsive to older peoples’ varied and changing needs’ (an integrated continuum of care).

Older people should be able to access services at the right time, in the right place and from the right provider.

We know that this is not always happening. This document, developed in response to feedback provided and in consultation with older people, their advocates and service providers, addresses the identified gaps in services within the Wairarapa.

The Health of Older People Advisory Group, which was established early in 2003, has enabled the DHB to move forward in meeting the needs of older people and their families. Composition of the group includes community based advocacy for older people, kaumatua, and people who are part of Maori Health, District Nursing, Allied Community health, Mental Health, Residential Care, Primary Health,

Non-government organisation (e.g. Accredited Visiting Services/ Age Concern), ACC, Assessment, Treatment and Rehabilitation (A.T.&R) and WINZ.

This document, **W.E.L.L. – Wairarapa Elder Local Links** is the Wairarapa DHB's strategic framework to implement an integrated continuum of care for older people/kaumatua over the next ten years.

## 2. Purpose of this document

This **W.E.L.L.** document aims to describe an integrated continuum of care that:

- Assists older people, their families and whanau to make well informed choices about options for healthy living, health care and/or disability support needs
- Reduces fragmentation of care so that services meet the needs of the older person and are provided in a timely way, which is efficient, effective and the least disruptive way to support positive ageing
- Improves older people services for older Maori
- Improves access to Mental Health Services for older people
- Considers the needs of families/whanau and carers

It is not within the scope of this document to attempt to allocate funding, prioritise projects or allocate specific timelines. It is intended to provide the framework in which these specific tasks can be implemented.

## 3. Alignment with other key documents and policy frameworks

### Wairarapa District Health Board Strategic Plan

Issues relating to the health of older people span the majority of the Wairarapa DHB strategic priorities and other New Zealand Health Strategy priorities. The District Strategic Plan highlights improvement of the health of older people through planned health initiatives (e.g. in respiratory health, mental health) and disability support services. The Plan states:

“The provision of an integrated continuum of care is the cornerstone of the national “Health of Older People Strategy” and will be developed in the Wairarapa as part of the overall development of primary and secondary services.”

The Wairarapa DHB has taken a health and disability sector-wide approach to planning for the health of older people in line with its vision:

**“Wairarapa Ora – Hauora pai mo te katoa”**

**“Well Wairarapa – Better health for all”**

## The Treaty of Waitangi

The Wairarapa District Health Board acknowledges that the Treaty of Waitangi/Tiriti O Waitangi is the founding document of New Zealand and provides a useful framework for addressing the Crown’s objective for Maori health. This is to reduce health disparities by improving health outcomes for Maori so that Maori enjoy the same level of health as non-Maori.

The Wairarapa District Health Board will ensure that the Treaty of Waitangi Articles and Principles are implemented across the organisation at all levels, to ensure that progress is made toward the improvement of health outcomes for Maori.

The Treaty of Waitangi Policy applies to all services provided and/or funded by the Wairarapa DHB.

## Positive Ageing In New Zealand (2001)

The New Zealand Positive Ageing Strategy provides a framework for all sectors for setting direction for not only today’s older New Zealanders but also for all generations of New Zealanders to come.

It focuses on:

- The diversity of older people
- The continued participation of older people in all aspects of society
- The opportunities provided by the changing population in New Zealand
- The need for intersectorial action

The approaches to the provision of services for older people outlined inside this **W.E.L.L.** document are consistent with the theme of the Positive Ageing in New Zealand Strategy. It is the platform for intersectorial collaboration.

## Health of Older People Strategy(2002)

The Health of Older People Strategy sets the direction for health sector responses to the Positive Aging Strategy. It proposes that health sector action be focused on development of integrated care and sets the expectation that District Health Boards will achieve this over the next 8 to 10 years.

The **W.E.L.L. – Wairarapa Elder Local Links** plan for an integrated continuum of care for older people is the District Health Board's response to the Health of Older People Strategy. It is based on the strategy's vision:

***“Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whānau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes”***

The objectives of the strategy are reflected in the goals identified within this document.

## The Wairarapa District Health Board Partnership Model

The District Health Board's Clinical Services Plan and the business case for the redevelopment of Masterton Hospital propose that over the next three years Wairarapa DHB will redesign and develop all of its services to operate within a partnership model. Partnership with Maori is a fundamental component of future developments. Effective partnerships are required for all services at many different levels. The delivery of all services will be enhanced as new partnerships and collaborations are forged within and between services. The partnership approach has been adopted in this document to ensure a continuum for older people that include all levels of involvement within the major dimensions of effectiveness, access and equity, safety and efficiency. (Refer to Page 21).

## 4. Older people in the Wairarapa

***“To know how to grow old is the masterwork of wisdom, and one of the most difficult chapters in the great art of living.”***

(Henri Frederic Amiel, 1821 – 1881)

### Who are they?

Over the past two years, the DHB has increased its knowledge of older people in the Wairarapa and their health related issues. Current knowledge about the older population includes:

- Based on 2001 census data, the 2003 estimate is that people over 65 years account for 15.5% of the total Wairarapa population (see Appendix 1 for demographic data).
- The proportion of older people in the Wairarapa is higher than in the New Zealand population in general. This proportion is expected to exceed 25 percent of the Wairarapa population by 2021.<sup>1</sup> Wairarapa will be 30 years ahead of the nation wide prediction of 25% by 2051.
- The Wairarapa socio-economic environment in which older people live has a more deprived profile than New Zealand as a whole.<sup>2</sup> It also has a lower adult (working age) population to support the needs of the older people than New Zealand in general.<sup>3</sup>
- 30 people over 65 years in the Wairarapa are Pacific Island people.
- The 2001 census indicated 342 kaumatua (60 years and over) in the Wairarapa. This group account for 6.3 percent of the total Maori population.
- A third of the older population lives in a rural area (New Zealand Census data 2001).
- 5.7 percent of people aged 65 or over (351) are in residential care; more than half of these are over 85 years old. Proportionately fewer people are in residential care in the Wairarapa compared to New Zealand as a whole (see Appendix 2).
- 17% of people over 65 years in the Wairarapa do not drive and many that do are not comfortable driving long distances.

<sup>1</sup> Health of Older People in New Zealand – A statistical Reference, Ministry of Health, 2002

<sup>2</sup> An Assessment of Health Needs in the Wairarapa, Public Health Consultancy, Wellington School of Medicine and Health Services 2001

<sup>3</sup> NZ Census of Populations and Dwellings 2001

## What are their health issues?

- People over 65 years account for 32% of all Masterton Hospital discharges compared to 27% for New Zealand.
- For 2003, the Wairarapa rate of hospitalisations that could have been prevented through intervention in the community was 7.66% of people in the 65 to 74 age group. This figure is considerably higher than the New Zealand average of 6.55%.
- Cancer, cardiovascular disease and diabetes are prevalent in the age groups over 65 years.
- 9.5% of all hospital discharges for 65 to 74 years (2003) were attributed to angina.
- About 8% of people over 65 years have been diagnosed with diabetes. Hospitalisation for people in the Wairarapa with diabetes is 50% above NZ average.
- Respiratory infections are the most common infectious cause of hospital admission for older people. With COPD, they account for the second most common cause of avoidable admissions.
- Influenza vaccination rate for residential care (80.1% in 2002) is above national target (80%). Influenza vaccination rate for this age group in the community was 54% in 2002.
- ACC report a higher rate of falls for people over 65 years in the Wairarapa than the national rate.
- There is very limited capacity for psycho-geriatric care in the community. There are no funded long-term psycho-geriatric care beds within the Wairarapa.
- Medication management is considered by providers to have increasing costs and is a major health risk for older people, especially those with multiple medications.
- Inadequate access to audiology services. Loss of hearing is considered to be a major factor in social isolation of older people.

## What are the needs of Maori?

- Given that Maori present with age-related conditions earlier than others, it is appropriate that services relating to the health of older people address the needs of koroua and kuia.
- 75% of 210 kaumatua (>60 years) who attended a social gathering organised by a Maori health provider in December 2002 identified themselves as having a respiratory illness.
- Higher numbers of Maori, older people, and lower incomes indicate higher risks of poor nutrition, obesity and reduced physical activity. Maori providers are increasingly interested

in kaumatua health. Two forums for involving kaumatua in health planning for older people already exist through the Kaumatua Council and Kaumatua Kaunihera. In addition, the Maori Health Committee identifies needs and gives direction.

- Whilst Maori staff working in residential care account for 8 percent of staff in that sector, only 2.3 percent of all requests for assessment for residential care were for Maori (2001); in a survey of 14 residential care providers, only one Maori resident was identified.
- Transport to appointments and appropriate support when dealing with health professionals have been identified by kaumatua as being major problems for them. For inpatient experiences, privacy and cultural support are important.

## What are their social issues?

- Social isolation of older people is seen to be a common problem by provider survey respondents<sup>4</sup>. Community Agencies are involved with nutrition, activity and social opportunities for older people (e.g. Sport Wairarapa, Wairarapa Organisation for Older People).
- Volunteer and interest groups are in need of more support. Volunteer contributions are stretched and the majority of volunteers are over 65 years old (e.g. Accredited visitors, Meals on Wheels, Citizens' Advice Bureau, Wairarapa Organisation for Older People)<sup>4</sup>.
- Transport and mobility has been identified as a major problem for older people in the Wairarapa, especially for those in rural areas<sup>5</sup>. Lack of appropriate transport increases social isolation for older people both through difficulty in travelling to services and friends and family/whanau travelling to visit. Access to clinics at Wellington, Hutt, and Palmerston North poses particular problems. A recent report was presented to the DHB on the provision of transport services and accessibility of those services for the general population, especially older people and those with a disability. This has led to a joint initiative with the Regional and Local Authorities to address issues.
- While drivers over 65 years account for 16% total Wairarapa driving-licence holders, they only account for 3.3% reported road accidents in the Wairarapa. 75.7% people over 65 years in the Wairarapa hold a current driving license (11/01/03). As 7% of this population is in residential care, this indicates that 17% of those over 65 years who live in the community (982 people) do not have a driving licence.

<sup>4</sup> Report on Survey of Wairarapa Organisations providing Disability Services, 2002

<sup>5</sup> Getting Started on a Continuum of Care for Older People Workshop, 20th Nov. 2002

- This factor has major implications for older people accessing services in other District Health Boards<sup>6</sup>.
- Currently, there is a non-nurturing environment in the Wairarapa. Generally, 2% to 5% of the older population are victims of elder abuse. Of these, only approximately 16% reach service agencies. A number of agencies are dealing with the victims of abuse, but there is no consistent means for monitoring the efficacy of interventions, for identifying the gaps in prevention or obtaining statistics of elder abuse in the Wairarapa.
- Alcohol misuse was considered by provider survey respondents as common for older people, especially those living alone.

It is apparent from this information that there will be an increasing need for effective and efficient Health and Disability services for Older Persons within the Wairarapa over the next 10 to 15 years. To ensure these services are delivered in the most appropriate way, current service delivery must adapt and change to meet the immediate needs and long term requirements of a significant part of the Wairarapa Population – The Older Person.

## 5. Services currently provided

Health and Disability Services for Older People are currently provided in the primary, transitional, secondary and tertiary settings on an outpatient, inpatient, day patient and community basis. The services cross the spectrum of personal health services and disability services. In the past this has led to some confusion as to what services could be provided from what bucket of money and for whom. It has also resulted in confusion for health professionals as to who is providing what care and has led to gaps in service provision and funding.

Older People and their families/whanau can directly access Primary Health (GP), Secondary Health (via the Emergency Department) or Disability Services through FOCUS (the Wairarapa DHB Needs Assessment and Service Co-ordination Service). Alternatively, they may be referred to services by health professionals in primary, secondary or residential care settings.

### FOCUS – Needs Assessment & Service Co-ordination

FOCUS is the gateway to disability support services. Referral to the service may be received from anyone (including self referral). In addition to FOCUS assessors, trained assessors in the AT&R Service

<sup>6</sup> Wairarapa DHB Transport Report, December 2003

and Whaiora Whanui also provide needs assessment and link with FOCUS Service Co-ordination. Approximately 800 older people are clients of FOCUS. This figure currently represents 14% people over 65 years. 86% older people are living at home independent of disability support services, with most being fit and healthy. However, as indicated by the disproportional low access to disability support services for Maori and Pacific Island people, a number of those at home maintain their independence through their social and family/whanau support.

Recent national changes in needs assessment and service co-ordination have led to more flexible packages of support to meet individual needs more appropriately. Packages of support, developed with the individual and family/whanau, are subject to an appeal process. Such support packages may include any components of home support (home management/personal care), carer support (respite care/carer relief in the home) or residential care (rest home/continuing care/dementia care facilities). Increased flexibility in disability support packages is enabling more appropriate home support for Maori.

In addition to providing for people under and over 65 years with a disability, FOCUS also acts as a portal for people with health needs who require support in residential facilities (e.g. people who are chronically medically ill or in the transitional “Health Recovery Programme”).

## Assessment Treatment and Rehabilitation (AT&R)

“The hallmark of AT&R services is a co-ordinated multidisciplinary response that is customised to meet the complexity of needs of people with disability and/or age related disorders in order to restore their functional ability and enable them to live as independently as possible”<sup>7</sup>. In the Wairarapa, therapists, nurses, a physician and a visiting psycho-geriatrician provide the service across a variety of settings including inpatient, outpatient, day patient and community based services. Older people comprise about 90% patients receiving this service.

Patients are assessed within 24 hours of referral and admitted within 24 – 48 hours of acceptance by the service. Therapy services include occupational therapy, physiotherapy, speech language therapy, dietetics and social work. Therapy sessions may occur on the hospital campus or in the community. Occupational therapists provide home assessments for adaptive equipment.

<sup>7</sup> Assessment, Treatment & Rehabilitation Service Specification 2002

## Health for older Maori people

Whaiora Whanui is the main Maori Health provider for older people and provides a number of services for kaumatua within the Whanau Ora Service. The needs of kaumatua are addressed within a whanau setting. Staff who work with FOCUS provide needs assessment and are involved in service co-ordination for Maori with disability support needs. Whaiora Whanui also provides a number of unfunded services for kaumatua such as transport to appointments if necessary.

Marae and urban outreach clinics are regularly provided for Maori and Pacific Island people who have specific health issues. These outreach clinics provide free access to a range of health providers (e.g. Diabetes Nurse Educator, Asthma Nurse Educator, Cardiac Outreach Nurse, Physician, Dietician). The clinics provide an accessible forum for kaumatua and other older people (e.g. Pacific Island people) for health education, development of action plans and monitoring of health status.

## Mental health for older people

Disability and age related supports are focused on maintaining independence and supporting people in their own home and communities. Needs assessment is provided by the Mental Health Service for its clients. Residential support is not promoted as an option until community based options have been exhausted. Currently, community support is offered by the Mental Health Service, Maori Mental Health and Disability Support Services.

A limited in-patient psycho-geriatric facility is provided as part of the AT&R Unit. Long term residential support for older people with mental health needs is provided by the Hutt DHB if no Wairarapa solutions are appropriate for the individual. Plans for future regional provision are being developed by Mid Central DHB.

## Home Support Agencies

Three Home Support Agencies provide disability support through home management and personal care. The three agencies cover the whole area of Wairarapa, although service provision is sometimes difficult in the more remote areas.

As a DHB provider arm health service, one of these home support agencies (Homelinks) also provides Short Term Home Help and Meals on Wheels.

## Residential Care facilities

There are 14 residential care facilities for older people in the Wairarapa: Twelve facilities provide Stage 2 Residential care (rest home) beds, seven facilities offer Continuing Care, and one facility in Masterton provides exclusively for Dementia Care. In addition to long-term residential care, these facilities also provide respite care to support carers and all but two provide a day care service.

Continuing Care facilities are being increasingly used for provision of Health Services as well as Disability Services (e.g. palliative care, chronically medically ill services, and the transitional Health Recovery Programme). This expanded role of residential care facilities requires a higher level of staff skills and knowledge.

Staff of these facilities are able to use DHB upskilling opportunities related to providing a range of services.

All residential care facilities in the Wairarapa are registered with a Designated Auditing Agency (DAA) in preparation for achieving certification by October 1st 2004. Their unique support group (WAICAP) enables providers to be supported and helped towards achieving certification.

## Supported Living environments

Most older people would prefer to live as independently as they can in their own home. Half the residential care facilities in the Wairarapa either already offer or plan to provide supported living facilities (e.g. independent units with assistance available). There is a wide spectrum of supported living facilities in the Wairarapa; from village units with a residential manager, to units linked with residential care facilities. The level of support provided to residents varies considerably and residents are deemed to be eligible for the same health and disability services as if they were living totally independently in the community.

## Public Health, Primary Health and Community Health Services

Primary Health services are provided through the newly established Wairarapa Community PHO. Older people are major users of these services and can access them without referral. Public Health promotions (e.g. Influenza Vaccination) and Primary Health initiatives (e.g. Care Plus) have a direct impact on the health of older people.

DHB Specialist Community Health Services require referral from a health professional. These services are mainly provided in the home (e.g. wound care, IV at Home, Home Oxygen Service). It is estimated that approximately 75 – 80% Community Health patients are over 65 years

Inter-disciplinary outreach services are provided for people with diabetes, respiratory disease and cardiac conditions. The services are provided at Marae and urban outreach centres.

### Secondary services

As for Primary and Community Health services, Secondary services in the Wairarapa do not have specific service provision for older people. In-patient facilities are provided at Masterton Hospital and outpatient clinics are provided at both Masterton and Greytown.

Older people represent the majority of those admitted to the medical ward and those who use other Secondary Health services.

## 6. Current service issues

A full range of Health and Disability Services for older people is offered in the Wairarapa, with the exception of long-term psycho geriatric residential services and care for the older Mental Health consumer. In most instances, the current services adequately meet client needs. As in any review of services however, the focus is on how to improve the quality of services delivered.

The current systems and processes for care of older people within the Wairarapa have evolved over time resulting in some duplication or gaps in service. As the result of feedback from consultation with older people and those interested in their wellbeing, some service issues have been identified.

### FOCUS – Needs Assessment & Service Co-ordination

As FOCUS is emerging as the entry point for health and disability services for older people, resource demands for this service are increasing. Such resourcing is essential if timeliness and accessibility to appropriate support services is to be assured.

FOCUS also provides services for people under 65 years with disability. Changes in provision of service in this sector can have implications for services for older people. For example, the planned introduction of a service for recruitment, training and coordination for carer relief for those under 65 years (by the Ministry of Health), needs to also be offered to those over 65 years to ensure equitable care options (by the DHB).

The Ministry of Health has recently launched nationally consistent, evidence-based guidelines for the assessment processes for Older People. Implementation of the guidelines will be staged and will provide appropriate and effective assessment processes for identifying personal, social, functional and clinical needs in people aged 65 years of age and over.

### Assessment, Treatment and Rehabilitation (AT&R)

Historically, the AT&R service has had an in-patient emphasis, with a high number of hospital-generated referrals in comparison to community-based referrals.

The philosophy of AT&R at Masterton is currently being reviewed, with provision of services aligned more with disability than acute illness. An increased focus on promoting referral from primary health providers and providing a flexible service in a variety of contexts is becoming a priority for service development.

## Health for older Maori people

Proportionately, Maori and Pacific Island people are not accessing services. The entry point for kaumatua to access services needs to be known and appropriate for them – as do the services that are offered. Despite provision of needs assessment by Maori assessors, a number of kaumatua do not access a system that could give them appropriate support, which is acceptable to them and meets their needs. A range of other support services need to be developed with Maori providers (e.g. koroua and kuia day programmes for recreational, educational and therapeutic benefit).

Transport is identified by kaumatua as a major issue, especially for those in South Wairarapa and those who need to access services outside the Wairarapa (e.g. renal dialysis) on a frequent basis.

## Mental Health Services

Although older people form a considerable portion of the population, actual numbers are small (see appendix 1). The number of older people in the Wairarapa who need mental health services is minimal and dedicated long term care for these people in the Wairarapa is not financially or clinically viable. At present, there are three people receiving residential psycho-geriatric care out of the District.

Older people are occasionally caught in service boundary debates between the Mental Health Service and Disability Support Services (e.g. AT&R). Flexible funding for individual support packages has resulted in resolution and FOCUS has been seen as the lead agency for these few clients.

0.28% of people over 65 years in the Wairarapa (16-17 people) receive dedicated Mental Health Services per month compared to a national average of 0.5%. This indicates that there may be a number of older people who are not currently receiving the Mental Health service they need.

## Home Support

The main issues for home support centre on capacity and capability.

Recruitment, training and retention of staff pose a problem for Home Support Agencies. Clients being approved for increasingly flexible support packages exacerbate the staffing problem (e.g. services needed once a day for seven days of the week). Packages of care generated through ACC also place a demand on the capacity of home support providers in the Wairarapa. The inequity of only

one agency having the benefit of providing short-term home help needs to be addressed.

Workforce development and standards of care are of national and local concern. Supervision of staff is generally by an administrative phone call to the client to check that “all is OK”. However, there are concerns that remote ‘supervision’ cannot guarantee health and safety standards of a vulnerable group of older people.

## Residential Care

The occupancy patterns of North and South Wairarapa differ considerably. Masterton is chronically short of rest home beds, while South of Masterton is short of continuing care beds. Within the whole of the Wairarapa, facilities are available to provide an adequate number of beds, however their geographical distribution limits choices for older people.

A very limited capacity for respite care beds in Masterton is leading some residential care providers to support carers by using continuing care beds for respite.

Recruitment (especially for Registered Nurses) and workforce development (especially for residential carers) are ongoing issues locally and nationally.

## Supported Living environments

These living arrangements are privately contracted between the provider and the older person seeking a home in a supported environment. Problems may arise if residents are not given informed choices about funded services that are available.

## Primary and Community Health Services

Although there is a wide range of services provided in the community, there is lack of awareness of information about service options available for older people and how to access them. Addressing this issue will be central to the development of a co-ordinated, integrated approach.

Transport is again raised as an issue for older people accessing their doctor. Public transport is not linked with the need for older people to attend health and social service appointments. Through their voluntary driver service, the Red Cross provides about 640 trips per year for people to access secondary health appointments. They also frequently receive requests to transport people to their doctor and are unable to respond to this demand (which would be met by an effective public transport system).

An aging and reducing population of volunteers poses an issue for many services provided for older people (e.g. drivers, meals-on-wheels, accredited visiting service). In addition, a lack of support and financial resources threatens the viability of voluntary agencies. Inclusion of the voluntary sector in developing an integrated continuum of care for older people will be crucial.

## Secondary services

One of the main issues identified by older people is the lack of public transport and difficulty in accessing secondary services, especially for appointments outside the Wairarapa. A recent consumer group report to the Board on the transport status in the Wairarapa is being followed by a collaborative venture with the DHB, Local Authorities, and the Wellington Regional Authority.

The need for travel to Wellington for outpatient bone density scans is an example of difficulties facing older people with regard to accessing secondary health services. Provision of a Dexascan unit in the Wairarapa would ensure that people are treated on the basis of a scan result rather than supposition.

Some admissions to hospital that should have been avoided have been linked to failure of disability support services for older people (e.g. dehydration, impaction, foot and skin conditions). Other admissions could be avoided through use of current services in the community (e.g. Subcutaneous fluid replacement by providers of continuing care or District Nurses).

Effective discharge planning for older people also poses a problem within current systems and referral processes. This is reflected in discharge documentation. The challenge of timely transfer of relevant information to GPs and referred providers (e.g. residential care providers) is not yet being met. It is recognised that discharge planning for older people needs to enable more continuity between secondary and primary health care services and for some a transitional service is needed to enable a safe return home.

Health professionals express considerable frustration with the current arrangements for provision of palliative care in the Wairarapa, its fragmentation and the limitations of once-a-week consultant services. Following the current NZ Palliative Care stock-take it is likely that the way in which Palliative Care is contracted will change.

## 7. Building the partnership model for the health of older people

***“The whole is more than the sum of its parts.”***

(Fritz Perls, 1969)

Over the next three years the Wairarapa DHB intends to rebuild all of the services it provides, using the Partnership Model. The partnership model describes the working alliances that should be implemented in new service structures and redeveloped hospital facilities if the District Health Board’s strategic vision for ‘Well Wairarapa’ is to be realised.

The partnership model encourages each partner to contribute to a holistic programme of services while being supported comprehensively by a wider team (of individuals and/or agencies) within an informed and supportive community environment. The older person will move smoothly from one service to another – and sometimes back again as their needs change.

Partners will need to develop relationships and information systems that support the sharing of information about the wellbeing, care and treatment of an older person and support the movement between levels of the partnership model.

### Implementation of the partnership model will:

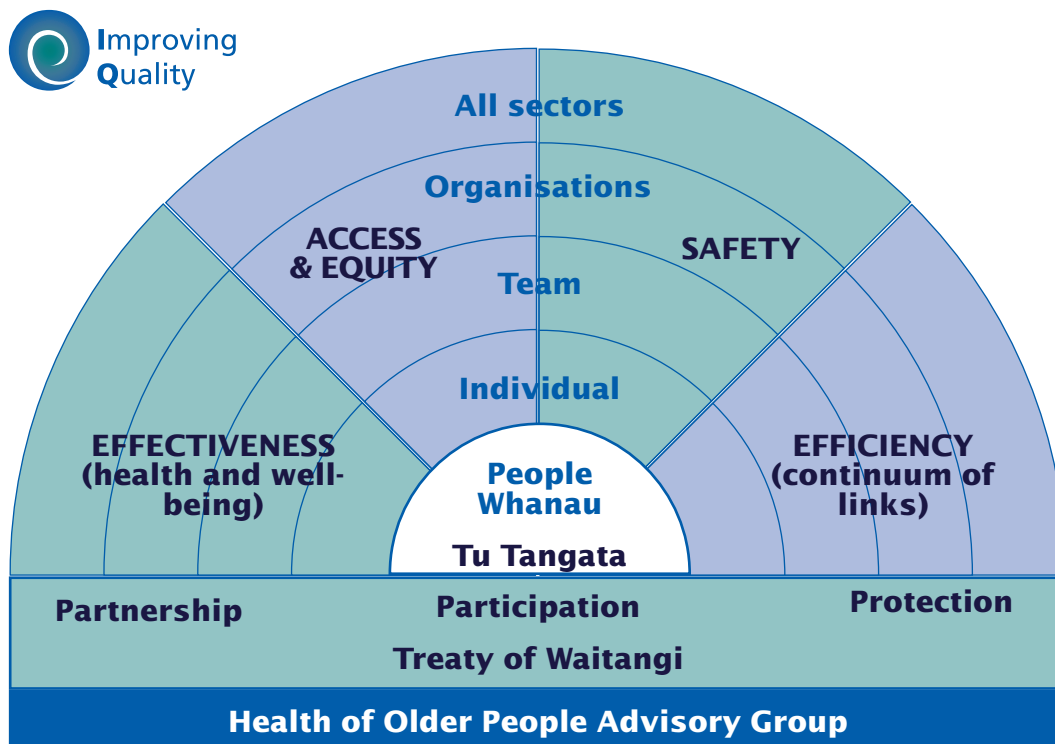
- Promote an emphasis on the wellbeing of older people across all sectors
- Involve and engage the community and other key stakeholders
- Ensure comprehensive and co-ordinated services for older people
- Maximise use of the funding available to ensure sustainable progress in improving health outcomes and reducing inequalities for both individuals and populations
- Ensure Maori have the opportunity to participate at all levels of planning service delivery
- Ensure services and facilities enable culturally effective practice
- Remove barriers between primary and secondary providers so that services are no longer fragmented or duplicated but provide a true continuum
- Continue to build strong relationships between providers to provide co-ordinated services for older people and to create opportunities for joint ventures and business partnerships

## 8. The partnership model for the continuum of care of older people

In developing our partnership model for older people, we have used and adapted the system model shown in “**Improving Quality (IQ): A systems approach for the New Zealand Health and Disability Sector**”, Ministry of Health, 2003.

This model has been adopted because it acknowledges the cumulative result of the interactions of people, individuals, teams, organisations and systems. It enables a partnership model to be addressed in a systematic way.

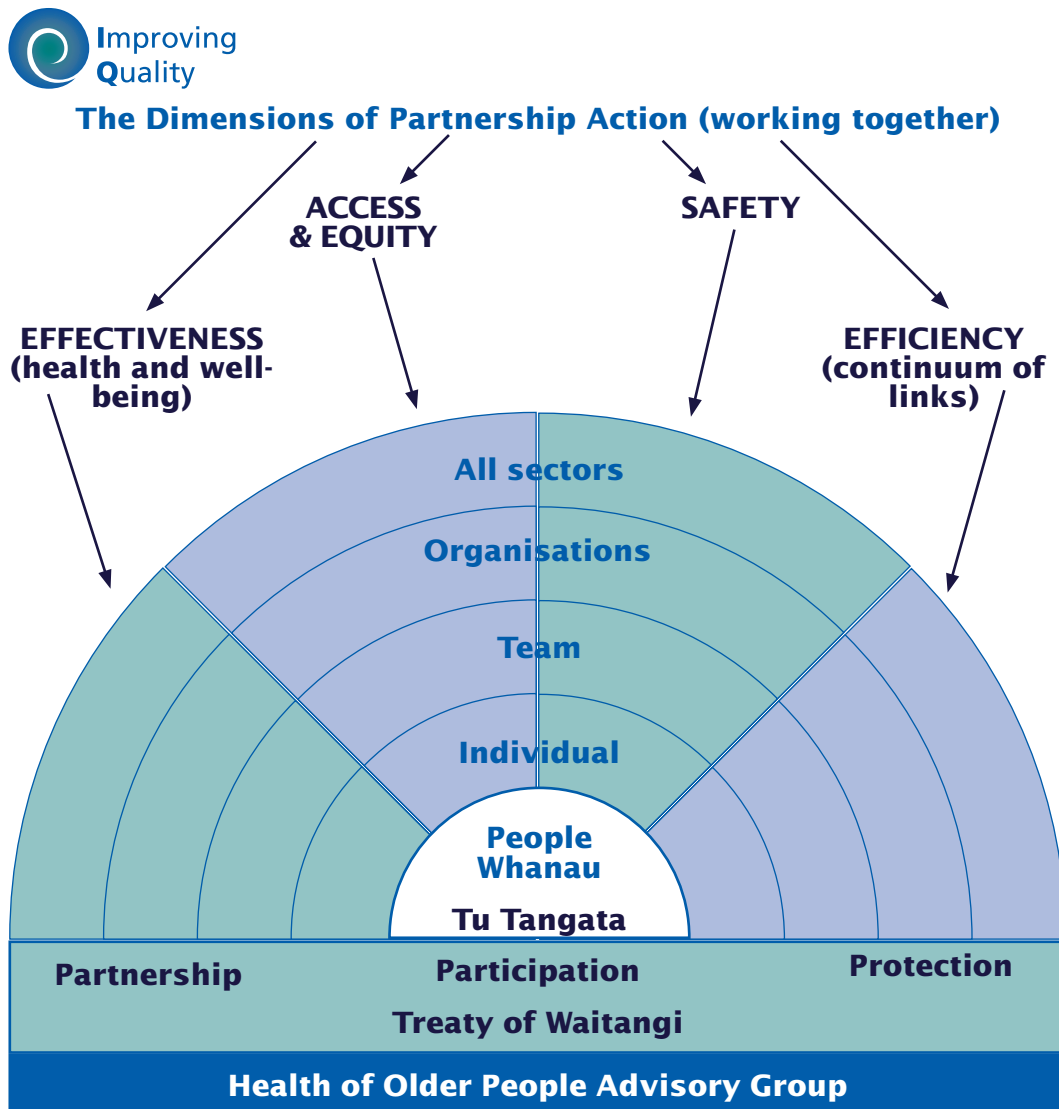
Underpinning all levels & dimensions of the model is the Treaty of Waitangi.



## People at the centre

The partners at all levels are there to serve those at the core of the model, the people. Individually and collectively, people are at the heart of the model. They are older people, their families and Whanau, Tu Tangata and the community. They are the essential component in the model.

Partnerships exist within every level and between levels in order to achieve an integrated continuum of care for each individual. The dimensions (segments depicted in the model) provide a framework for addressing the key components of a quality health and disability service at all levels.



## 9. Who are the partners?

### Individual

Individual partners include all health professionals, staff providing services, carers, etc. As well as perhaps sharing a collective purpose within a team or organisation, each person has an individual role to play.

### Team

A team can be viewed as a collection of individuals with a common purpose and role or as a segment of an organisation, contributing in partnership with other teams to the organisation's direction. Clearly identifiable teams for the health of older people include

- FOCUS (the NASC agency)
- AT&R
- Community Health (District Nursing and Allied Health)
- PHO
- Maori Health (e.g. Whanau Ora service)
- Choice Health (Public Health)
- Inpatient wards
- Outpatient services
- Emergency Department
- Mental Health Service

### Organisation

A number of partners can be identified at the organisation level. They include:

- The District Health Board
- Mana Whenua
- The DHB Provider Arm
- The PHO
- Maori Health Providers
- Residential Care providers
- Home Support Agencies
- Non-government Mental Health providers
- Elder Abuse Co-ordinator
- And all other contracted providers

## All sectors


This includes all partners outside the Wairarapa DHB organisation. It comprises not only the Health and Disability sector beyond the Wairarapa DHB, but also wider systems and other sectors.

Partners include:

- Iwi
- Volunteer and community support/advocacy groups (e.g. Wairarapa Organisation of Older Persons, Red Cross, Age Concern)
- Kaumatua Councils
- Special interest health and disability support agencies (e.g. CCS, Asthma Society, Arthritis Foundation, Post Polio Support, Blind Foundation, Heart Foundation, Alzheimer's Society) – Field Officers
- Sport Wairarapa
- Local Territorial Authorities (District Councils)
- Wellington Regional Council
- ACC
- WINZ
- Power Co and Energy Efficiency Authority (EECA)
- Neighbouring DHBs
- DHBNZ
- Ministry of Health

## Continuum of care

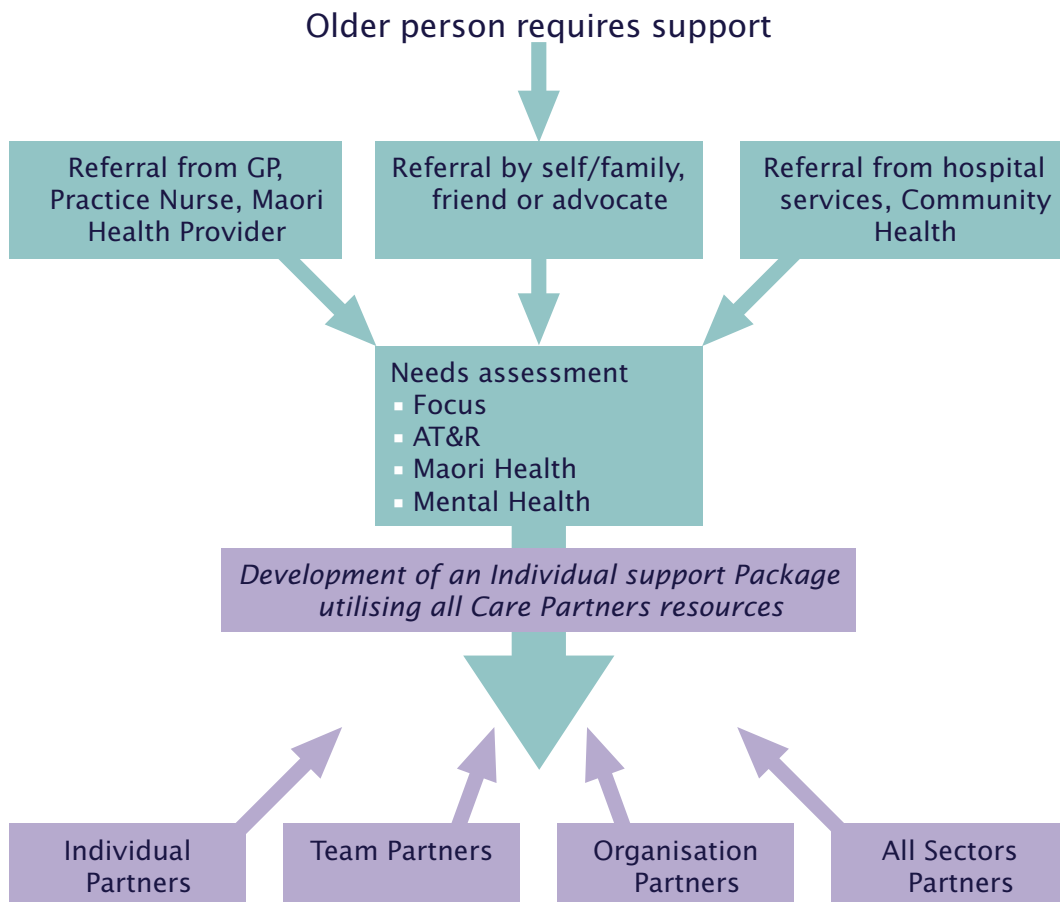
The responsibility of the care providers (at all levels) is to work together to ensure the needs of older people are met effectively and appropriately through provision of an integrated continuum of care for the whole system and integrated care pathways for individuals. The table below illustrates service needs and responses throughout a continuum of care<sup>8</sup>.



Health State	Fit & Healthy Minor complaints	At risk of deterioration	Chronic illness and/or disability with activity limitation	Significant co- morbidity and/or disability
Service needs	Episodic care	Early intervention/ rehabilitation and shared management	Care pathways/ plans/disease management approaches	Co-ordinated care and support
Service Responses	Population level health promotion	Population level health promotion	Population level health promotion	Population level health promotion
	Information about service access and support for self management	Information about service access and support for self management	Information about service access and support for self management	Information about service access
	Primary Care	“Preventative” primary Care	“Enhanced” primary care (active management)	Case management/ key worker
	Secondary care if needed	Care plans covering primary health, secondary services and disability support where hospital admission is needed  Effective discharge planning – involvement of all relevant services	Disease management approaches covering primary health, secondary services and disability support where needed  Shared management	Shared plans covering primary health, secondary services and disability support  Inpatient treatment in specialist older peoples’ unit where needed
	Rehabilitation if needed	Rehabilitative packages where needed	Rehabilitation as part of disease management approaches	Rehabilitation as part of long-term care
	Informal and community support where needed	Home support/ aids, equipment, informal and community support &/or carer support where needed	Informal and community support; home support/carers support if needed	Home support, carer support, respite care, supported housing or residential care as needed
				Palliative care where needed

<sup>8</sup> Information on DDS for DHBs, Disability Services Directorate, Ministry of health, August 2002

## The individual's care pathway



## 10. The way forward

***“Whatever you vividly imagine, ardently desire, sincerely believe and enthusiastically act upon... must inevitably come to pass.”*** (Paul J Meyer)

For our vision of Health of the Older Person to be achieved, and the key issues addressed, changes in the current services are needed. The changes can broadly be grouped into the four dimensions of Wairarapa DHB model:

- Effectiveness (Health and Wellbeing)
- Access and Equity
- Safety
- Efficiency (Continuum of links)

This leads to four groups of goals, which incorporate the objectives identified in the Health of Older People Strategy.

## 1. Effectiveness – health and wellbeing

- Population based programmes promote health and wellbeing as well as positive ageing
- Older people are valued, participate in social activities and contribute to their community
- Health is maintained through their environment & personal lifestyle

## 2. Access and equity

- Older People, their families and whanau are given the information and opportunity to make well informed choices
- Older people have timely access to primary care, secondary care, assessment and rehabilitation, and community health services
- Older people with high and complex needs have access to packages of care that are flexible, with culturally appropriate services and living options

## 3. Safety

- Older people are supported in a safe living environment
- Workforce development ensures safe practice in residential care and the community
- All services provided for older people evidence continuous quality improvement

## 4. Efficiency – continuum links

- Hospital services are integrated with the community-based care and support that older people require
- Appropriate, integrated Personal Health and Disability Support Services meet the needs of older Maori and their whanau
- Funding and service delivery supports access to quality integrated health and disability support services

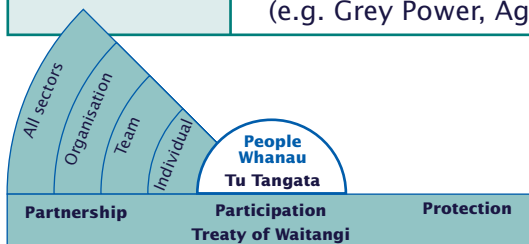
Progress may be made towards the goals at all partnership levels by effective communication within and between levels and by implementing a series of actions. Some actions can be implemented within a few months, others may take much longer to achieve, but it is the intention that an integrated continuum of care will be in place for older people by 2010. Achievement of these goals will reflect the success of partnerships.

Improvement in health outcomes and services for older people requires actions at all levels and along all four dimensions. The Wairarapa Integrated Continuum of Care model will be used to guide future developments and ensure that activity is ongoing in all levels and dimensions.

## EFFICIENCY GOALS – Health and wellbeing

- Population based programmes promote health and wellbeing as well as positive ageing
- Older people are valued, participate in social activities and contribute to their community
- Health is maintained through the environment and personal lifestyle of older people

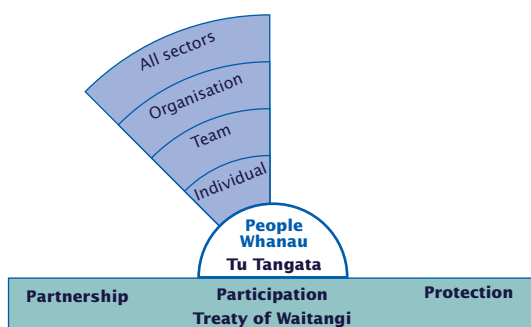
	Partnership Actions
<b>All Sectors</b>	<ul style="list-style-type: none"> <li>▪ Improved transport services</li> <li>▪ Older people involved in projects/service planning/ consumer groups</li> <li>▪ Carer support group is provided on a district-wide basis</li> <li>▪ Cancer prevention is promoted and support is available for Wairarapa older people</li> <li>▪ Falls Prevention Project – ACC, Public Health, primary and secondary health sectors</li> </ul>
<b>Organisation</b>	<ul style="list-style-type: none"> <li>▪ Health Education and Advice through contracted providers (e.g. Whanau Ora contract)</li> <li>▪ Communication strategy – to inform about health issues and services available.</li> <li>▪ Emphasis on retaining health and independence in the home environment</li> <li>▪ Carers are supported through carer relief network and respite care</li> <li>▪ Flexible Packages of Care are developed to address identified need (e.g. Day Care, Carer relief).</li> <li>▪ Mental Health Services are developed for older people.</li> </ul>
<b>Team</b>	<ul style="list-style-type: none"> <li>▪ Public Health promotion e.g. influenza vaccination</li> <li>▪ WOOPs Older and Bolder Week, Kaumatua social events</li> <li>▪ Sport Wairarapa/Choice Health – nutrition/walk (Hikoi), Heart Foundation – Walk for Health</li> <li>▪ Health Recovery Programme to ensure safe transition home</li> <li>▪ Community mental health needs are met through service development</li> <li>▪ FOCUS Independent Living Guide</li> </ul>
<b>Individual</b>	<ul style="list-style-type: none"> <li>▪ Education for older people – staff training included in the Healthy Homes project</li> <li>▪ Energy efficiency health education for wellbeing of older people (e.g. nutrition, falls prevention, hydration, warmth, safe environment)</li> <li>▪ Information given about social and community opportunities (e.g. WOOPS)</li> <li>▪ Information given about advocacy for older people (e.g. Grey Power, Age Concern).</li> </ul>



## ACCESS AND EQUITY GOALS

- Older people, their families and whanau are given the information and opportunity to make well informed choices
- Older people have timely access to primary care, secondary and assessment and rehabilitation, and community health services
- Older people with high and complex needs have access to packages of care that are flexible, culturally appropriate and with living options

	Partnership Actions
<b>All Sectors</b>	<ul style="list-style-type: none"> <li>▪ Appropriate Transport systems are provided for Older People to access services</li> <li>▪ Partnership with other sectors in distribution of information (e.g. WINZ, ACC)</li> <li>▪ Intersectorial Resource Kit for Older People available at key identified sites and updated annually.</li> <li>▪ Range of living options developed and provided in the Wairarapa.</li> </ul>
<b>Organisation</b>	<ul style="list-style-type: none"> <li>▪ Continuous improvement tool used for communicating with older people</li> <li>▪ Involvement of older people, family/whanau/ support people in lifestyle and healthcare planning.</li> <li>▪ Flexible packages of care to meet assessed need developed with person and support people (e.g. Health Recovery – Transitional Plan).</li> </ul>
<b>Team</b>	<ul style="list-style-type: none"> <li>▪ Central referral point for supporting the needs of older people and their carers</li> <li>▪ Primary health recall systems for diabetes, chronic respiratory and cardiac conditions</li> <li>▪ Secondary health focus on elder-friendly communication and service processes</li> <li>▪ Community Health and Disease State Management Nurse (Whaiora Whanui) partnership.</li> </ul>
<b>Individual</b>	<ul style="list-style-type: none"> <li>▪ Information about services and how to access them is available</li> <li>▪ Referral to appropriate services and care partners</li> <li>▪ Effective discharge planning through care partnerships</li> <li>▪ Offer of appropriate ethnic support services and appropriate referral</li> <li>▪ Input into Hui and public meetings to involve older people in planning services for older people.</li> </ul>

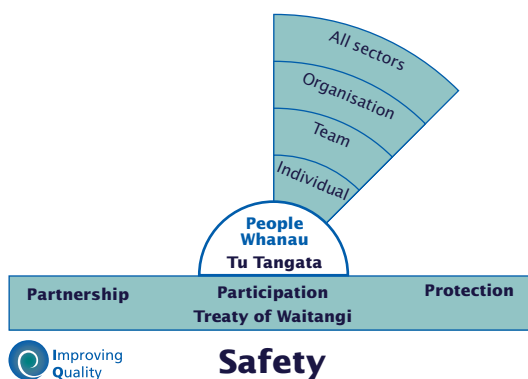



**Access & Equity**

## SAFETY GOALS

- Older people are supported in a safe living environment
- Workforce development ensures safe practice in residential care and the community
- All services provided for older people evidence continuous quality improvement

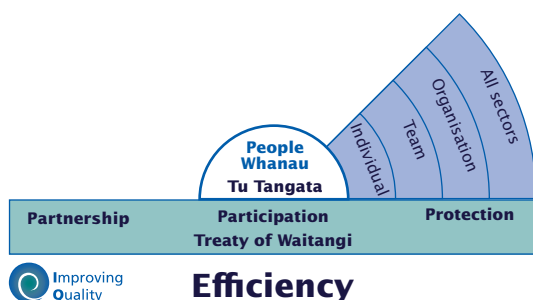
	Partnership Actions
<b>All Sectors</b>	<ul style="list-style-type: none"> <li>▪ Certification (Licensing) of all Health Care providers</li> <li>▪ Multisectorial partnership in Healthy Homes (energy efficiency) project</li> <li>▪ ACC and Public Health regional Falls Prevention Programme</li> <li>▪ DSS Quality and Safety Project (Workforce Training).</li> </ul>
<b>Organisation</b>	<ul style="list-style-type: none"> <li>▪ Training and coordination for Carer Relief</li> <li>▪ Assessment Guidelines used to ensure appropriate and timely assessment.</li> <li>▪ DHB monitoring of residential care services</li> </ul>
<b>Team</b>	<ul style="list-style-type: none"> <li>▪ Residential care providers demonstrate links with local community and Marae</li> <li>▪ Residential care facility in partnership with ACC Hip Protector programme</li> <li>▪ Health Recovery Programme to ensure safe transition home</li> <li>▪ Medication management</li> </ul>
<b>Individual</b>	<ul style="list-style-type: none"> <li>▪ Promotion of Influenza Vaccine</li> <li>▪ Identification of falls risk and reduction of factors</li> <li>▪ Professional competency requirements are met</li> </ul>



## EFFICIENCY GOALS – Continuum of links

- Hospital services are integrated with community-based care and support that older people require
- Appropriate integrated personal health and disability support services meet the needs of older Maori and their Whanau
- Funding and service delivery supports access to quality integrated health and disability support services

	<b>Partnership Actions</b>
<b>All Sectors</b>	<ul style="list-style-type: none"> <li>▪ Lead Agency Model (Carelink) used for older people with complex needs</li> <li>▪ Single point of entry for health and disability support Services (NASC)</li> </ul>
<b>Organisation</b>	<ul style="list-style-type: none"> <li>▪ Focus – single point of entry for service coordination</li> <li>▪ Assessment processes for older people as per NZ Guidelines Group (2003)                             <ul style="list-style-type: none"> <li>– Emergency Department</li> <li>– Older Maori</li> <li>– Complex Needs</li> </ul> </li> <li>▪ Development of contracted service for Carer Relief Training and Co-ordination.</li> <li>▪ Flexible packages of support.</li> </ul>
<b>Team</b>	<ul style="list-style-type: none"> <li>▪ AT &amp; R service development with increasing community based focus.</li> <li>▪ PHO Care Plus is implemented for older people with complex health needs.</li> <li>▪ Secondary and primary health partnerships are developed for effective discharge planning</li> <li>▪ Health Recovery Programme to ensure safe transition home</li> <li>▪ Partnership with Maori Health providers in meeting the needs of kaumatua</li> </ul>
<b>Individual</b>	<ul style="list-style-type: none"> <li>▪ Referral for needs assessment and service coordination</li> <li>▪ Health Professional involvement in service planning forums and DHB advisory groups</li> <li>▪ Partnership in interdisciplinary assessment &amp; care planning</li> <li>▪ The roles of nurse specialists are clarified in relation to providing a continuum of care</li> </ul>



# APPENDIX 1

## Consultation

The following people and organizations have been invited to give feedback and comment on the draft WELL document:

Health of older people group (see list)	All GPs
DHB Board Members	Practice Nurses of each practice
Mana Whenua Caucus	All physicians
PHO	Clinical Nurse Leaders –
Maori Health Committee	All Wards and Departments
Senior Management Team	Rural Nurses
All local authorities	Supervising Occupational Therapist
Kaumatua Councils	Supervising Physiotherapist
	Supervising Social Worker
	Community Health Co-ordinator
	All Hospital Supervisors
	Choice Health (Public Health)
	FOCUS (Needs Assessment & Service Coordination Agency)
	Mental Health
	Rangitane
	Ngati Kahungunu Ki Wairarapa
	Tai Whenua
	All Maori Health Providers
	All field officers
	All residential care providers
	The Manager, Abbeyfield, Church St.
	The Manager, Panama Village, Ngamutawa Rd
	Nurse Manager, Masonic Village
	Healthcare New Zealand
	Access Homehealth
	Wairarapa Organisation for Older Persons (WOOPS) / Age Concern
Wairarapa MPs	
Wairarapa Councillors, Wellington Regional Council	
Grey Power	
Community Coordinator, Positive Aging,	
Local Libraries	
All Marae	
Pacific People Ministers	
Senior Citizens	
ACC Manager	
WINZ Manager	
Wellington Region DHBs (Planning & Funding)	
Technical Advisory Service (TAS)	
Ministry of Health	

## Health of older people: Advisory group

<b>Name</b>	<b>Position</b>
Autumn Bell-Cooke	Supervising Social Worker
Dianne Chapman	Coordinator, WOOPS
Jane Dwane Fred Lindop	Case Manager, WINZ
Joanne Edwards	Project Manager, Wairarapa DHB
Pauline Holland	Team Leader – FOCUS
Shelly Ireland	RN – Mental Health Nurse Manager, Titoki Manor
Alexis McKenzie	District Nurse South Wairarapa
Gail Morrison	Occupational Therapist Community Health
Hiria Tua	ACC Injury Prevention Consultant
Mihi Namana	Maori Health Coordinator Masterton Hospital
Anne Savage	Nurse Manager, Glenwood Hospital
Muri Jaro	Whaiora Whanui
Nick Crozier	GP, Masterton Medical

Additional copies also sent to two DHB Board Members, Carter Society

# APPENDIX 2

## Older people in the Wairarapa

### Population classification by Age (Over 65 years) and by region

	<b>Wairarapa Total Population</b>	<b>Wairarapa 65+ yrs Population</b>	<b>Wairarapa % &gt;65 yrs Population</b>	<b>New Zealand % &gt;65 yrs Population</b>
Masterton	22617	3506	15.5	12.1
Carterton	6849	981	14.4	12.1
*Greytown	2813	550	19.5	12.1
*Featherston	3422	390	11.4	12.1
*Martinborough	2507	346	13.8	12.1
<b>Wairarapa</b>	<b>38208</b>	<b>5773</b>	<b>15.1</b>	<b>12.1</b>
*South Wairarapa	8742	1286	14.7	12.1

Source: Census 2001

### Population classification by Age (Over 65 years) and Ethnicity

	<b>Wairarapa Total Population</b>	<b>Wairarapa &gt;65 yrs Population</b>	<b>Wairarapa % &gt;65 yrs Population</b>	<b>New Zealand % &gt;65 yrs Population</b>
Maori	5403	222	4.1	3.4
Pacific Island	603	30	5.0	3.7
Others	32202	5520	17.1	14.1
<b>Wairarapa</b>	<b>38208</b>	<b>5773</b>	<b>15.1</b>	<b>12.1</b>

Source: Census 2001

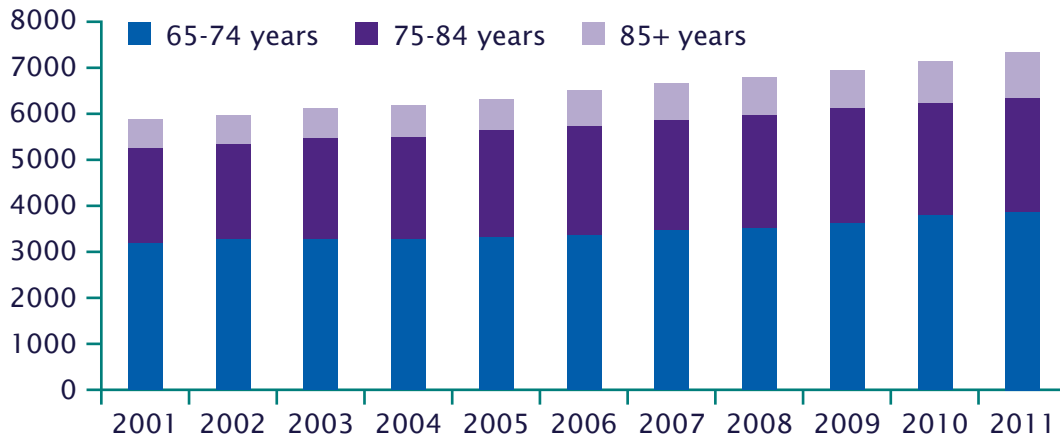
### Population classification by Age (Over 85 years) and Ethnicity

	<b>Wairarapa Total Population</b>	<b>Wairarapa &gt;85 yrs Population</b>	<b>Wairarapa % &gt;85 yrs Population</b>	<b>New Zealand % &gt;85 yrs Population</b>
Maori	5403	6	0.1	0.1
Pacific Island	603	3	0.4	0.2
Others	32202	561	1.7	1.6
<b>Wairarapa</b>	<b>38208</b>	<b>570</b>	<b>1.5</b>	<b>1.3</b>

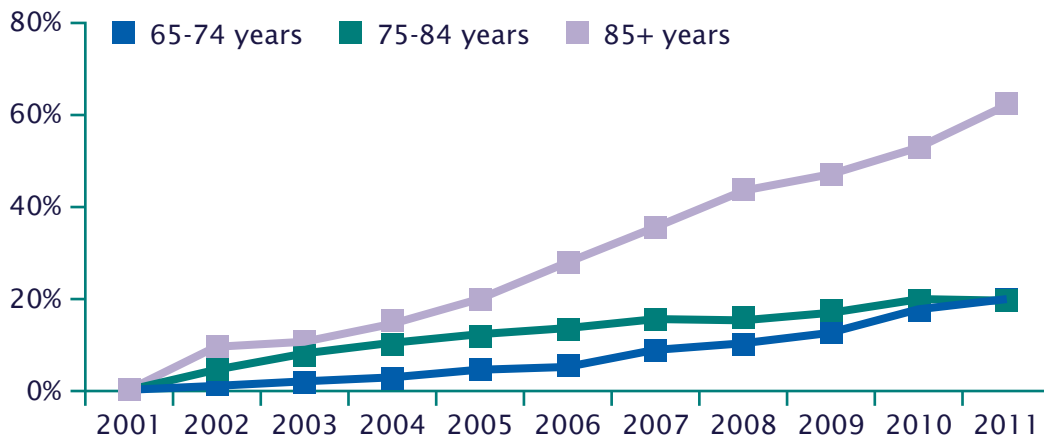
Source: Census 2001

The projected population trend for the proportion of people in the Wairarapa who are over 65 years (based on the 2001 census) is illustrated in the table below.

### Estimated Number of older people by age group



### Projected percentage growth in number of older people by age group



Percentage Growth in Number of Older People by Age Groups (Base year 2001)											
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
<b>65-74 years</b>	0%	1%	1%	2%	3%	5%	9%	10%	12%	17%	21%
<b>75-84 years</b>	0%	1%	6%	9%	12%	14%	14%	16%	17%	19%	18%
<b>85+ years</b>	0%	7%	9%	14%	17%	28%	36%	43%	47%	53%	62%

Projected estimated population of older people in the Wairarapa (at June 2000)					
Year	65 - 74	75 - 84	85+	Total >65	% Pop
2001	3260	2040	580	5880	15%
2002	3280	2070	620	5970	15.3%
2003	3290	2160	630	6080	15.5%
2004	3310	2230	660	6200	15.9%
2005	3350	2290	680	6320	16.2%
2006	3430	2320	740	6490	16.7%
2007	3540	2330	790	6660	17.1%
2008	3590	2360	830	6780	17.5%
2009	3660	2390	850	6900	18.1%
2010	3800	2420	890	7110	18.5%
2011	3930	2410	940	7280	19%
2021	5300	3070	1280	9630	26.3%

## 2001 Census of population and dwellings

District Health Boards (Using 2001 Meshblocks) and Ethnicity (comparable to 1996 prioritised) by Age Groups for the Census Usually Resident Population Count

Age Bands	Wairarapa				New Zealand			
	Maori	Pacific	Other	Total	Maori	Pacific	Other	Total
Less than 1 Year	162	15	345	522	13,998	5,139	35,499	54,636
1-4 Years	588	51	1521	2,160	53,562	19,161	143,445	216,168
5-9 Years	738	63	2154	2,955	66,114	23,613	196,473	286,200
10-14 Years	705	75	2394	3,174	62,805	21,702	206,232	290,739
15-19 Years	492	60	1932	2,484	49,530	18,129	197,622	265,281
20-24 Years	375	42	1233	1,650	42,093	17,292	180,399	239,784
25-29 Years	318	45	1524	1,887	40,161	16,476	190,2633	246,900
30-34 Years	342	45	1953	2,340	39,249	16,698	223,329	279,276
35-39 Years	387	39	2286	2,712	38,325	15,051	244,086	297,462
40-44 Years	330	36	2580	2,946	32,856	12,048	240,714	285,618
45-49 Years	261	39	2490	2,790	25,095	9,759	216,930	251,784
50-54 Years	207	33	2469	2,709	19,473	7,758	208,938	236,169
55-59 Years	162	15	2007	2,184	13,824	5,553	162,885	182,262
60-64 Years	120	9	1794	1,923	11,560	4,389	138,630	154,569
65-69 Years	108	6	1518	1,632	7,941	3,081	116,892	127,914
70-74 Years	60	15	1524	1,599	5,070	2,214	110,973	118,257
75-79 Years	39	6	1149	1,194	2,688	1,245	90,570	94,503
80-84 Years	9	0	768	777	1,218	621	59,271	61,110
85 Years and Over	6	3	561	570	726	324	47,589	48,639
<b>Total</b>	<b>5,403</b>	<b>603</b>	<b>32202</b>	<b>38,208</b>	<b>526,281</b>	<b>208,253</b>	<b>3,010,743</b>	<b>3,737,277</b>

Kaumatua 60 years & over: **342 or 6.3% of total Maori population in Wairarapa**

Prepared for Ministry of Health by Central TAS

Ref No: C10592GB

# APPENDIX 3

## Wairarapa residential care occupancy

*“Slice of Time – 12th February 2004”*

The following data relating to occupancy and subsidised residents was obtained from all residential facilities in the Wairarapa for one day (12/02/04). This cross-sectional data also enables a snapshot view of occupancy in residential facilities in the Wairarapa according to age bands.

### SUBSIDISED RESIDENTS:

Care Level	<65yrs	65 – 74yrs	75 – 84yrs	85+ yrs	Total People
Rest Home Level 2	1	15	52	71	<b>139</b>
Continuing Care	0	10	22	31	<b>63</b>
Dementia Care	0	1	6	2	<b>9</b>
<b>ALL LEVELS</b>	<b>1</b>	<b>26</b> <b>(12%)</b>	<b>80</b> <b>(38%)</b>	<b>104</b> <b>(50%)</b>	<b>211</b>

It can be seen from the above table that at this date, people over 85 years accounted for half of all the older residents in Wairarapa who were being subsidised for their care by the DHB. 88% of all the people subsidised for their residential care were over 75 years.

### AGE GROUPS OF TOTAL RESIDENTS:

Care Level	<65yrs	65 – 74yrs	75 – 84yrs	85+ yrs	Total People
Rest Home Level 2	2	20	72	138	<b>232</b>
Continuing Care	3	10	35	54	<b>102</b>
Dementia Care	0	2	10	5	<b>17</b>
<b>ALL LEVELS</b>	<b>5</b> <b>(2%)</b>	<b>32</b> <b>(9%)</b>	<b>11</b> <b>(33%)</b>	<b>197</b> <b>(56%)</b>	<b>351</b>

## SUBSIDISED / NON SUBSIDISED RESIDENTS:

All Levels	<65yrs	65 – 74yrs	75 – 84yrs	85+ yrs	Total People
Subsidised	1	26	80	104	<b>211</b>
Subsidised %	20%	81%	68%	53%	<b>60%</b>
Non-Subsidised	4	6	37	93	<b>140</b>
<b>TOTAL People</b>	<b>5</b>	<b>32</b>	<b>117</b>	<b>197</b>	<b>351</b>

The table above illustrates that, for all older people in residential facilities in the Wairarapa, 60% are subsidised by the DHB. However, it should not be assumed that the other 40% are paying privately. The residential facilities also provide services for Palliative Care, Chronically Medically Ill Service and the Health Recovery Programme.

People over 85 years account for 56% of all residents. Only 11% of residents are under 75 years.

## POPULATION OVER 65 YEARS IN RESIDENTIAL CARE:

Based on 2001 census data the 2003 estimate is that people over 65 years account for 15.5% of the total Wairarapa population.

### WAIRARAPA

Care Level	65 – 74yrs	75 – 84yrs	85+ yrs	Total >65 yrs
People >65 in residential care	32	117	197	346
Est. June 2003 Wairarapa pop. For age groups	3290	2160	630	6080
<b>&gt;65 in residential care /1000 pop – Wairarapa (2003)</b>	<b>9.7</b>	<b>54.2</b>	<b>312.7</b>	<b>56.9</b>

### NEW ZEALAND

Care Level	65 – 74yrs	75 – 84yrs	85+ yrs	Total >65 yrs
People >65 in residential care	2901	8751	12348	24000
NZ pop. for age groups	225987	122814	30969	379770
<b>&gt;65 in residential care /1000 pop – NZ</b>	<b>12.8</b>	<b>71.3</b>	<b>398.7</b>	<b>63.2</b>

# Comment

In New Zealand, the growth in residential care (20% between 1996 and 2001) has been strongly concentrated in the 85+ age group. In 2001, people 85 and over in New Zealand represented over half the residential population of older people<sup>1</sup>. This pattern is reflected in the Wairarapa and residential care providers noted that the number of residents over 90 years was increasing.

Of note is the fact that proportionately fewer people are in residential care in the Wairarapa compared to New Zealand as a whole.

Generally, there are very few residents under 75 years and residents are more disabled on admission to a residential facility than in the past. Only one resident under 65 years, in a rest home level 2 facility, was subsidised.

The main focus of this exercise was on subsidised residents and age bands within residential care settings. The DHB is not able to access this information without the co-operation of the residential care providers. Other demographic data such as ethnicity and gender was not collected for this exercise, but would provide useful data in the future to enable benchmarking with national trends.

It was only through the residential care providers' willingness to give their time and effort to this "Slice of Time" exercise that we now have a clear picture of the patterns of residential care. It is suggested that an annual "Slice of Time" would illustrate any trends and be useful for providers and the DHB in meeting the needs of people over 65 years.

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<sup>1</sup> [Life at 85 Plus: A Statistical review](#) Judith A Davey and Susan Gee, NZ Institute for Research on Ageing, 2002

# When I was old

*You think that I am getting 'old',  
I've lived so many years.  
I first turned 'old' at twenty one  
And bought my friends some beers.*

*Then I turned 'old' at thirty three,  
Ready for a challenge:  
A wife, a house – a mortgage,  
And then, a baby's carriage.*

*Next, I was 'old' at forty five,  
A man of middle years.  
My father died before his time.  
I learnt to shed some tears.*

*'Old' at fifty – turning grey  
From teenage offspring fun.  
Then 'very old' at sixty two  
When offspring have offspring.*

*At seventy, when I am 'old'  
I make the most of life.  
I polish up my lifelong joy  
And ride my Harley bike.*

*At eighty, I proclaim my age.  
I swim a length for fun.  
I feel no older than I was,  
When I was twenty one.*

Joanne Edwards  
17th February 2004



**Wairarapa DHB**  
Wairarapa District Health Board  
Te Poari Hauora a-rohe o Wairarapa

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