DISABILITY SUPPORT ADVISORY COMMITTEE (DiSAC) MEETING
16 August 2017

Venue: Meeting Room 6, CM Health Board Office, 19 Lambie Drive, Manukau, Auckland
Time: 1.00pm

Committee Members
Colleen Brown – Committee Chair
Catherine Abel-Pattinson – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
Katrina Bungard – CMDHB Board Member
Dr Lyn Murphy – CMDHB Board Member
Reece Autagavaia – CMDHB Board Member

CMDHB Management
Gloria Johnson – acting Chief Executive
Jenny Parr – Director of Patient Care, Chief Nurse & Allied Health Professions Officer
Dinah Nicholas - Secretariat

APOLOGIES

REGISTER OF INTERESTS
• Does any member have an interest they have not previously disclosed?
• Does any member have an interest that may give rise to a conflict of interest with a matter on the agenda?

AGENDA

1.00pm 1. AGENDA ORDER AND TIMING

2. CONFIRMATION OF MINUTES

1.05pm 2.1 Confirmation of Previous Minutes of the Disability Support Advisory Committee Meeting – 16 November 2016
1.10pm 2.2 Action Items Register
1.15pm 2.3 Terms of Reference/WDHB-ADHB Terms of Reference

3. FOR DISCUSSION

1.30pm 3.1 NZ Disability Strategy/WDHB-ADHB Disability Strategy Plan 2016-26 (Jenny Parr)
2.00pm 3.2 Improving NZ Disability Data/Stats NZ Improving NZ Disability Data/Auckland Council Report on Older Aucklanders/Stats NZ Supporting Disabled People: 2013 Article (Doone Winnard)
2.30pm 3.3 Deaths of Intellectually Disabled People/Radio NZ Article February 2017 (Vanessa Thornton)

Afternoon Tea Break (3.00 – 3.10pm)

3. FOR DISCUSSION (continued)

3.10pm 3.4 Video Remote Interpreting Service Trial/Deaf Action NZ Article April 2017/VRI Update (Colleen Brown/Henry Mulligan, hA)
3.40pm 3.5 Disability Friendly Hospital Maps/Parking at MMH/Link to Mobility Parking/MMH Site Map/Mid Central Media Release June 2015/Mid Central Disability Parking Map (Colleen Brown/Chester Buller)

4. GENERAL BUSINESS

Next Meeting: 22 November 2017
# BOARD MEMBER ATTENDANCE SCHEDULE 2017 – DiSAC

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<th>Name</th>
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# DiSAC Members’ Disclosure of Interests
## 16 August 2017

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<tr>
<th>Member</th>
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<tr>
<td>Colleen Brown (DiSAC Chair)</td>
<td>• Chair, Disability Connect (Auckland Metropolitan Area)</td>
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<td>• Member, Advisory Committee for Disability Programme Manukau Institute of Technology</td>
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<td>• Member, Auckland Council Disability Advisory Panel</td>
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<td>• Member, NZ Disability Strategy Reference Group</td>
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<td>Catherine Abel-Pattinson</td>
<td>• Board Member, Health Promotion Agency</td>
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<td>• National Party Policy Committee Northern Region</td>
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<td>• Member, Directors Institute</td>
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<td>Dianne Glenn</td>
<td>• Member, NZ Institute of Directors</td>
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<td>• Life Member, Business and Professional Women Franklin</td>
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<td>• Member, UN Women Aotearoa/NZ</td>
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<td>• President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust</td>
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<td>• Life Member, Ambury Park Centre for Riding Therapy Inc.</td>
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<td>• Vice President, National Council of Women of New Zealand</td>
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<td>• Member, Pacific Women’s Watch (NZ)</td>
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<td>• Member, Auckland Disabled Women's Group</td>
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<td>Katrina Bungard</td>
<td>• Chairperson MECOSS – Manukau East Council of Social Services.</td>
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<td>• Deputy Chair Howick Local Board</td>
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<td>• Member of Amputee Society</td>
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<td>• Member of NZ National Party</td>
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| Dr Lyn Murphy | • Member, ACT NZ  
• Director, Bizness Synergy Training Ltd  
• Director, Synergex Holdings Ltd  
• Trustee, Synergex Trust  
• Member, International Society of Pharmacoeconomics and Outcome Research (ISPOR NZ)  
• Member, New Zealand Association of Clinical Research (NZACRes)  
• Senior Lecturer, AUT University School of Interprofessional Health Studies  
• Member, Public Health Association of New Zealand |
|--------------|--------------------------------------------------|
| Reece Autagavaia (DiSAC Deputy Chair) | • Member, Pacific Lawyers’ Association  
• Member, Labour Party  
• Member, Tangata o le Moana Steering Group  
• Trustee, Epiphany Pacific Trust  
• Trustee, The Good The Bad Trust  
• Member, Otara-Papatoetoe Local Board  
• Member, District Licensing Committee, Auckland Council |
## DISABILITY SUPPORT ADVISORY COMMITTEE MEMBERS’ REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 16 August 2017

<table>
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<tr>
<th>Director having interest</th>
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Minutes of Counties Manukau District Health Board
Disability Support Advisory Committee

Held on Wednesday 16 November 2016 1.30 – 4.00pm, Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau.

Present: Mr David Collings, Ms Dianne Glenn, Mr Ezekiel Robson, Mr John Wong, Ms Wendy Bremner and Mr Sefita Hao'uli.

Apologies: Dr Lee Mathias, Ms Colleen Brown, Mr Reece Autagavaia, Ms Sandra Alofivae, Mr Geraint Martin (Chief Executive), Mr Sefita Hao'uli (for late arrival) and Ms Wendy Bremner (for early departure).

In Attendance: Mr Martin Chadwick (Director Allied Health) and Ms Dinah Nicholas (Secretariat).

1. Welcome
Ms Dianne Glenn chaired the meeting given Ms Colleen Brown was not able to attend.

2. Governance

2.1 Attendance & Apologies
Noted

2.2 Disclosure of Interest/Specific Interests
The Disclosures of Interest were noted with no amendments.

There were Specific Interests to note with regard to the agenda for this meeting.

2.3 Confirmation of Public Minutes – 9 March 2016 and 24 August 2016

Resolution
That the Public Minutes of the Disability Support Advisory Committee meetings held on Wednesday 9 March 2016 and Wednesday 24 August 2016 were taken as read and confirmed as true and accurate records.

Moved: Ms Dianne Glenn   Seconded: Mr David Collings   Carried: Unanimously

2.4 Action Items Register Public
Noted.
3. Presentation

3.1 Localities
Ms Penny Magud gave the Committee an update on the Eastern Locality.

400 patients have been through reablement to date and expect this to increase to 2,500 next year.

Minor adaptations (ie) installation of grab rails, are currently being funded through the DHB as there is a gap in how the MoH provide services to the population. At the moment, if somebody needs a hand rail (for example) for functionality more than disability, it would not be funded. All four localities are providing this service and are meeting next week to work through the path for requests. Currently, individuals are identified through the PPC programme (previously ARI). The next challenge will be looking at more complex adaptations. A lack of functionality can lead to disability as often people just go without.

Resolution
That DiSAC recommend to the Board that it considers the funding of minor adaptations and equipment for the reablement needs of people who fall outside the MoH Disability funding criteria.

Moved: Ms Dianne Glenn    Seconded: Mr Ezekiel Robson    Carried: Unanimously

The Committee asked Ms Magud to come back in March with an update on this pilot and the agreed pathway for requests.

4. Reports

4.1 Clinician Literacy
Ms Kim Wiseman took the Committee through her report.

Since the last update to this Committee, there has been considerable activity aimed at building clinician capability in a number of broad areas. We anticipate that this will have a positive impact on the experiences of our disabled community when accessing our services.

Activity update:
Values – the organisational values have become a ‘golden thread’ which is weaved through virtually every course or interaction that the Building Capability team are involved in. This includes Welcome Day so that all new staff members are introduced to them.

Refresh of AI²DET has incorporated the principles of health literacy.

CALD8 course focusses on people with disabilities however, the uptake to date has been very low. This will be reviewed in light of the outcomes from the patient experience workshops.

Data - Previously we had no information regarding specific experience data related to patients/clients who identified themselves as disabled. This has changed with the publication of the CM Health report number 6 on inpatient experience (July 2016). We are now in the position to undertake further targeted work which will enable us to understand in more detail where specifically we are falling short for our disabled community.

Work plan - Kim Wiseman to connect with the Te Roopu Waiora work being led by Tania and to discuss how to identify people for the focus groups who have used our services with Ezekiel Robson.
(Ms Wendy Bremner departed at 3.05pm)

4.2 Response to Action Items

The DHBs process in situations where a disabled person, who is medically dependent on an uninterrupted power supply, has their power disconnected was further discussed. It is the DHBs responsibility to notify the power company of an individual who is a Medically Dependent Consumer (MDC). It is the power company’s responsibility to notify the customer of a power outage. It is the customer’s responsibility to ensure they have an emergency back-up plan. There was discussion whether the DHB could have a bank of temporary resources that patients could access in an emergency (ie) back up batteries or whether alternatives could be explored through the localities. It was acknowledged that this is a problem but no clear resolution was determined other than to ensure this conversation is kept going regionally and is an agenda item for the next regional DiSAC meeting.

Mr Chadwick to set a date for a regional DiSAC meeting in 2017.

4.3 Disability Data

At the 1 June regional DiSAC meeting, a discussion took place regarding the collection of data for patients with disabilities and the activities of a working group formed by the Office for Disability Issues to develop a Disability Date & Evidence Plan.

On 6/10/16, on behalf of the Auckland metro Disability Support Advisory Committees (DiSACs), correspondence was sent to the Office for Disability Issues regarding the work of the Disability Data and Evidence Working Group, and the wishes of the Auckland Metro DiSACs to engage with the Working Group throughout the consultation process and on-going activities relating to the development of a Disability Data and Evidence Plan. The letter informs on the view of the Committees that there needs to be a consistent approach across the Auckland region in the way such data is collected and that information needs to be collected regarding different impairment and age groups as these can make a positive difference to health outcomes. It also advised that the Auckland metro DiSACs wished to engage with the Disability Data & Evidence Working Group throughout the consultation process and on-going activities.

A response as received 31/10/16 advising there will be an opportunity for DiSAC to contribute to the public consultation on the draft Disability Data & Evidence Plan which is expected to take place in early 2017.

4.4 Disability Survey Update

Disabled people and the disability sector are unhappy that the Disability Survey is planned for 2023 and that there was no consultation with them about this.

Statistics NZ have agreed that it will ensure there is consultation with disabled people and the disability sector in future. They are also working to ensure disabled people are included in other household surveys and undergoing some testing of a new set of disability questions to see if disability can be included in the 2018 census. The Government Statistician will make a decision on this in 2017.
5. **General Business:**

   It was suggested that the Committee need to anticipate that disabled presenters may come to these meetings as this is the Disability Support Advisory Committee and be proactive in ensuring that any assistance that could be required is put in place (ie) having an interpreter present, ensuring meeting venues are accessible etc.

The meeting closed at 3.35pm. The next meeting of the Disability Support Advisory Committee will be held on **Wednesday, 15 March 2017** in the Manukau Boardroom, CM Health Board Office, 19 Lambie Drive, Manukau.

The Minutes of the meeting of the Counties Manukau District Health Board Disability Support Advisory Committee held on **Wednesday, 16 November 2016** are approved.

Signed as a true and correct record on **Wednesday, 15 March 2017**.

Moved :    /Seconded:

Acting Chair

Dianne Glenn

15 March 2017

Date
Items once ticked complete and included on the Register for the next meeting, can then be removed the following month.

Disability Support Advisory Committee Meeting – Action Items Register – 16 August 2017

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 Counties Manukau District Health Board – Disability Support Advisory Committee

16 August 2017

010
Disability Support Advisory Committee (DiSAC)

1 Establishment

1.1 The Committee is established by the Board of CMDHB under Section 35 of the New Zealand Public Health and Disability Act 2000 (“the Act”).

2 Functions

2.1 The functions of DiSAC are set out in clause 3 of Schedule 4 of the Act and are to give the Board advice on:

a) the disability support needs of the resident population; and

b) priorities for use of the disability support funding provided.

2.2 The aim of the Committee’s advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence of people with disabilities within CMDHB’s resident population:

a) the kinds of disability support services the DHB has provided or funded or could provide or fund for those people; and

b) all policies the DHB has adopted or could adopt for those people.

c) The Committee’s advice and recommendations to the Board must consider and align with the New Zealand Disability Strategy. The New Zealand Disability Strategy is issued under Section 8 of the Act, and provides the framework for the Government’s overall direction for the disability sector in improving disability support services.

d) The Committee’s advice and recommendations to the Board must also consider and align with the United National Convention on the Rights of Persons with Disabilities (the Convention). New Zealand signed the Convention at the United Nations on the 30 March 2007, and ratified it on 26 September 2008. All new policy should be consistent with the Convention, or New Zealand will be in breach of its obligations.

e) In carrying out their functions the Committee must also have regard to other strategies and policy documents that the Government is accountable for implementing from time to time, including the Health of Older People Strategy and the New Zealand Positive Ageing Strategy.

2.3 In carrying out the functions set out at paragraphs 2.1 and 2.2, it is expected that the Committee shall have regard to the specific needs of both the disability community and the older adult population in relation to each function to be performed.

3 Responsibilities

Note ~ Mental Health
Mental health services are dealt with by the Hospital Advisory Committee (CMDHB provider aspects) and the Community and Public Health Advisory Committee (funder aspects).
3.1 To carry out its functions the Committee will undertake the following activities:

**Disability**

a) develop an explicit philosophy that values diversity and self-determination for disabled people and operate under this philosophy;

b) support the development of a quality improvement culture;

c) review disability support service funding and service provision in the district, in regard to the New Zealand Disability Strategy;

d) advise the Board on the development of strategies and policies related to disability support services and health service provision for disabled people in the district. Advice to the Board must consider and align with the New Zealand Disability Strategy and the United Nations Convention on the Rights of Personal with Disabilities, and when considering older people with the Health of Older People Strategy and New Zealand Positive Ageing Strategy. When carrying out its functions, the Committee must also consider other relevant national and international strategies that the Government is accountable for implementing from time to time.

e) provide the Board with advice on the criteria, priorities and systems to be used in disability support services service provision, audit and monitoring;

f) Oversee the management of risk central to CMDHB achieving its objectives relative to the support needs of the resident population;

g) advise the Board on issues related to the delivery of health services accessed by disabled people;

h) advise the Board on issues related to the delivery of disability support services in the district;

i) advise DSS funder(s) through the Board on disability issues for the district, including strategic planning, prioritisation and implications of funding decisions;

j) advise the Board on the district perspective to be contributed to the development and implementation of regional and national funder and provider policies related to disability issues;

k) advise the Board on development and maintenance of relationships with disability stakeholders to develop district and regional intersectoral collaboration and coordination;

l) advise the Board on how it can effectively meet its responsibilities towards the government’s vision and strategies for disabled people; and

m) advise the Board on issues arising in the regional DiSAC forum.
Health of Older People

a) review the provision of services for Health of Older People within the district;

b) advise the Board on the development of policies related to the provision and monitoring of Health of Older People services;

c) provide the Board with advice on issues relating to the delivery of Health of Older People services within the district, including strategic planning, prioritisation and implications of funding decisions;

d) Oversee the management of risk central to CMDHB achieving its objectives relative to the health of older people;

e) advise the Board on the development and maintenance of relationships with Health of Older People stakeholders to develop district and intersectoral collaboration and co-ordination; and

f) advise the Board on how it can effectively contribute towards the government’s vision and strategies for older people.

4 Accountability

4.1 The Committee is accountable to the Board of the CMDHB.

4.2 The Committee is advisory only although the Board may specifically delegate to the Committee authority to make decisions and take actions on its behalf in relation to certain matters.

4.3 Any recommendations or decisions of the Committee must be ratified by the CMDHB Board (unless authority has already been delegated to the Committee).

4.4 The Committee may only give advice or release information to other parties under authority from the Board of the CMDHB.

4.5 The Committee is to comply with the provisions of the New Zealand Public Health and Disability Act 2000 and the standing orders of CMDHB, including the requirements relating to Committee meetings.

5 Committee Membership

5.1 The Committee will comprise of 7 members of the Board, plus 5 external appointees as determined by the Board, to enable it to carry out its functions.

5.2 The Board will appoint the Chairperson and Deputy Chair.

5.3 The Board will ensure that the Committee includes representation for Māori and Pacific people.

5.4 The Board will ensure that the Committee includes disability community and older adult representatives.
5.5 All Committee members are bound by the Act and CMDHB standing orders, whether or not they are CMDHB Board members or external appointees.

6 Quorum

6.1 If the total number of members of the Committee is an even number, half that number; but

6.2 If the total number of members is an odd number, a majority of the members.

7 Frequency of Meetings

7.1 The Committee will meet twelve weekly.

8 Management Support

8.1 The DHB’s Director of Strategic Development will ensure provision of management and administrative support to the Committee.
Board Committees ToR

4. Auckland and Waitemata DHBs’ Disability Support Advisory Committees (DiSAC)

1. Establishment
The Disability Support Advisory Committees (DiSAC) are established by the Boards of the Auckland District Health Board (“ADHB”) and Waitemata District Health Board (“WDHB”) under section 34 of the New Zealand Public Health and Disability Act 2000 (“Act”). The Boards may amend the terms of reference for the Committees from time to time. While constituted as each Board’s separate DiSAC they will meet and act as one committee.

2. Functions of Committee
The functions of the DiSACs of the ADHB and WDHB are to:
(a) Give the Boards advice on:
   • The disability support needs of the resident population of ADHB and WDHB
   • Priorities for use of disability support funding provided
(b) The aim of the Committees’ advice must be to ensure that the following promote the inclusion and participation in society, and maximise the independence, of disabled people within ADHB’s and WDHB’s resident populations:
   • The kinds of disability support services ADHB and WDHB have provided or funded or could provide or fund for those people
   • All policies ADHB and WDHB have adopted or could adopt, and how these policies could impact on persons or groups of people with a disability
(c) The Committees’ advice must not be inconsistent with the New Zealand Disability Strategy.
(d) The Committees are to ensure that disability support needs of the community are reflected in all ADHB and WDHB strategic planning processes, including the Northern Region’s Health Plan and Annual Plans, and to ensure that appropriate processes, including consultation, are followed in preparation of all documents.
(e) In carrying out their functions the Committees shall also have regard to the Health of Older People Strategy and the New Zealand Positive Ageing Strategy.

3. Responsibilities

Note 1 Health of Older People
Because it is difficult to distinguish between disability and personal health issues for older people, it is expected that DiSAC will deal with Health of Older People across the full range of issues and services for this age group.

Note 2 Mental Health Services
Mental Health services are dealt with by the Hospital Advisory Committees (DHB provider aspects) and the Community and Public Health Advisory Committees (funder aspects)
(a) To carry out its functions, the Committees will develop and operate under an explicit philosophy that values diversity and self-determination for people with disabilities.
(b) In particular, the Committees will review and advise the Boards on:
   • the overall performance of disability support service delivered by or through ADHB and WDHB.
   • the development of strategies and policies related to disability support services, disability issues and health service provision for people with disabilities in the districts having regard to the New Zealand Disability Strategy and the Health of Older People Strategy.
   • assessment of the disability support services’ performance against expectation set in the Annual Plans and other relevant accountability documents, documented standards and legislation.
Board Committees ToR

- issues related to the delivery of mainstream health services accessed by disabled people.
- the ADHB and WDHB districts’ perspective to be contributed to the development and implementation of regional and national policies related to disability issues in the ADHB and WDHB districts.
- developing and maintaining relationships with disability stakeholders to develop district and regional inter-sectoral collaboration and co-ordination.
- focusing on the disability support needs of the population and developing principles on which to determine priorities for using disability support funding.
- ensuring that the Annual Plans demonstrate how disabled people will access health services and how ADHB and WDHB will ensure that the disability support services they provide are co-ordinated with services of other providers to meet the needs of disabled people.
- advise the Boards on how they can effectively meet their responsibilities towards the government’s vision and strategies for people with disabilities.
- in accordance with the functions of DHBs:
  - establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement.
  - continue to foster the development of Maori capacity for participating in the health and disability sector and providing for the needs of Maori.
- in accordance with the functions of DHBs:
  - establish and maintain processes to enable Pacific people to participate in, and contribute to, strategies for Pacific health improvement.
  - continue to foster the development of Pacific capacity for participating in the health and disability sector and providing for the needs of Pacific people.
- improving collaboration and coordination of services between the ADHB and WDHB to effectively and efficiently provide for the needs of the populations served.

4. Relationship with Boards and Management
   (a) The Committees are established by and accountable to the Boards. The Committees’ role is advisory only, and unless specifically delegated by a Board from time to time in accordance with clause 39(4) of Schedule 3 of the Act, no decision-making powers are delegated to the Committees.
   (b) The Committees shall receive all material and information for review or consideration through the respective Chief Executive Officers.
   (c) The Committees shall provide advice and make recommendations to the Boards only.
   (d) The Committees are to comply with the standing orders of the ADHB and WDHB based on the model standard standing orders.

5. Membership
   (a) The membership of the DiSACs will compromise of:
      - ___ Board members from ADHB
      - ___ Board members from WDHB
      - ___ appointed members
   (b) The Chairperson(s) of both ADHB and WDHB will mutually agree upon the appointment of the Chairperson of the DiSACs.
   (c) The Boards will endeavour to appoint, as members of the Committees, persons who together will provide a balance of skills, experience, diversity and knowledge to enable the Committees to carry out their functions.
Board Committees ToR

(d) The Boards will ensure that the Committees include representation for Maori in accordance with section 34 of the Act and for Pacific people.
(e) The Boards will appoint any external appointees as members in accordance with the following process:
    • The Chair and Deputy Chair of each Board together with the respective Chief Executive Officer will evaluate potential members in accordance with the criteria determined by the Boards and make recommendations to the Boards as to the proposed appointments.
    • The Boards will make the final appointments (if any) to the Committees.

6. Meeting Procedure
   (a) The Committees shall meet in a combined forum quarterly. Meetings shall be conducted in accordance with:
       • The requirements of the Act
       • The Standing Orders of the ADHB and WDHB based on the model standing orders.
   (b) ADHB and WDHB CEOs will ensure adequate provision of management and administrative support to the DSACs’ function including attendance of the CEOs and Chief Planning and Funding Officers.
   (c) The venue for the meeting will be agreed between ADHB and WDHB, with technology (e.g. video or teleconferencing) aiding from remote locations where appropriate.
   (d) The quorum of each meeting shall be, if the total number of members of the Committees is an even number, half that number; but if the total number of members is an odd number, a majority of the members.
Recommendation

It is recommended that the Disability Support Advisory Group:

Receive the recommendation to the New Zealand Disability Strategy paper.

Endorse Counties Manukau District Health Board to work with Waitemtata and Auckland District Health Boards to produce a Regional implementation plan.

Prepared and submitted by: Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer

Background

The Disability Support Advisory Group (DiSAC) Chair has asked to hold a discussion on the New Zealand Disability Strategy 2016-2026 and how this may affect Counties Manukau District Health Board’s operations. A copy of the strategy is attached as Appendix 1.

The Counties Manukau Health Executive lead of the New Zealand Disability Strategy 2016-2026 was the previous Director of Allied Health, and this transferred to Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer in January 2017. The Director of Allied Health continues to be fully involved.

Regional Alignment

Waitemata DHB and Auckland DHB have been working together on the development of a joint New Zealand Disability Strategy implementation plan (Appendix 2).

Counties Manukau Health has not participated in this process to date.

Draft Waitemata DHB and Auckland DHB New Zealand Disability Strategy Implementation plan

The Reo Ora Health Voice team at Auckland District Health Board circulated an online survey on 9th August 2017 to subscribers of their online patient panel asking for comments from interested patients and public on their draft joint implementation for Waitemata and Auckland District Health Boards. Feedback and comments on this draft plan will ensure it is meeting the health needs and aspirations of communities. In their survey they ask about the five key outcome areas of the NZ strategy that align with the work of District Health Boards:

- Outcome 2: employment & economic security
- Outcome 3: health & wellbeing
- Outcome 5: accessibility
- Outcome 6: attitudes
- Outcome 7: choice & control
They are also holding two community meetings on 30 August and 1 September 2017 for people who prefer to communicate their thoughts and ideas face-to-face.

**Summary**

There is an opportunity to join the work of the Waitemata DHB and Auckland DHB’s over the coming months by initiating and progressing similar public engagement. The feedback would need to be gathered in a timely fashion in order to ensure it contributes to the final outcome. At this stage it is due to be considered at the joint Waitemata DHB and Auckland DHB DiSAC meeting scheduled for December 2017.
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We have come a long way since the first New Zealand Disability Strategy was agreed in 2001. The aim of the strategy was to eliminate barriers to enable disabled people to reach their potential and participate fully in the community.

The progress that we have made in partnership with disabled people is something that we can all be proud of.

Our journey since 2001 has seen the development of initiatives that will oversee the transformation of the disability support system, an increased focus on supporting disabled people into employment, improvements in inclusive education opportunities for disabled children, and New Zealand Sign Language becoming one of our official languages.

There is much to celebrate.

Together, this work has helped New Zealand take a lead role in the negotiation on the United Nations Convention on the Rights of Persons with Disabilities.

Since ratifying the Convention in 2008, we have established a unique mechanism for independent monitoring, actively considered and responded to recommendations from the Committee on the Rights of Persons with Disabilities, and supported Robert Martin in his successful candidacy for the Committee.

We have reaffirmed our lead role internationally on the rights of disabled people.

The development of the New Zealand Disability Strategy 2016–2026 has given us an opportunity to reflect not just on our progress, but also what we are still learning as a country about disability and how we can keep improving the lives of disabled people.

We must continue to acknowledge and respect the diversity within the disability community and recognise the value it adds to the community.

People can experience disability in different ways depending upon age, gender, ethnicity, impairment and many other factors.

For example, during the consultation to develop this Strategy, disabled adults shared the importance of having a meaningful job and being able to support their families. Disabled children talked about wanting to fit in at school and get out and about with their friends.

Despite what we have learnt and the progress that has been made since 2001, many disabled children and adults still face some barriers that prevent them from reaching their full potential.

If these barriers are not dismantled and removed, then all of us miss out. We will not prosper if disabled people are not able to participate in and contribute to our communities on an equal basis with others.

The United Nations Convention on the Rights of Persons with Disabilities has reinforced that disabled people have the same rights as others. It is about making sure everyone is treated with dignity and respect at all times, and that no one is left behind.
Our government is committed to continuing to improve the lives of disabled people and the New Zealand Disability Strategy will guide the government to achieve this over the next 10 years.

The direction and priorities outlined in the Strategy are based on what disabled people have said is most important to them.

During the two-stage consultation process, more than 1130 people attended the workshops we held throughout the country. We also received around 770 submissions from individuals and organisations via our ‘Join the Conversation’ website.

It is this strong foundation that gives us confidence in this Strategy guiding the work of government agencies for the next 10 years. After all, disabled people are experts in their own lives.

The Strategy will be critical in ensuring we are all working together towards achieving the same vision. There is much to be done and it is vital that we have a consistent framework from which to make decisions on where to focus our efforts.

We would like to acknowledge and thank members of the New Zealand Disability Strategy Revision Reference Group. Their expertise and advice proved invaluable in shaping this Strategy into something we are very proud of.

We want to thank the disabled people who participated in and supported the consultation to develop the New Zealand Disability Strategy.

You shared your hopes and dreams through this process with honesty and integrity. Your experience matters and your voices have been heard; it has become the foundation upon which this new Strategy has been built.

Finally, thank you to all the families, whānau and others who were involved in this process, particularly when disabled children or adults were not able to speak up for themselves.

We all have roles and responsibilities for achieving the vision of a non-disabling society. The Government will lead by example and we encourage others to join us too.

Hon Nicky Wagner
Minister for Disability Issues
The New Zealand Disability Strategy (the Strategy) will guide the work of government agencies on disability issues from 2016 to 2026.

The vision of this Strategy is:

- New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.

Three sets of principles and two approaches will help implement the Strategy

The principles and approaches will help make sure the disabled community is visible, acknowledged and respected on an equal basis with others, and that disabled people can live a life with dignity and feel valued.

The three principles are: Te Tiriti o Waitangi, the Convention on the Rights of Persons with Disabilities, and ensuring disabled people are involved in decision-making that impacts them. The two approaches are: Investing in our whole lives – a long-term approach, and Specific and mainstream services – a twin-track approach.
The Strategy identifies eight outcome areas

The outcome areas that will contribute to achieving the vision of the Strategy are:

- **Outcome 1 – education**
  We get an excellent education and achieve our potential throughout our lives

- **Outcome 2 – employment and economic security**
  We have security in our economic situation and can achieve our full potential

- **Outcome 3 – health and wellbeing**
  We have the highest attainable standards of health and wellbeing

- **Outcome 4 – rights protection and justice**
  Our rights are protected, we feel safe, understood and are treated fairly and equitably by the justice system

- **Outcome 5 – accessibility**
  We access all places, services and information with ease and dignity

- **Outcome 6 – attitudes**
  We are treated with dignity and respect

- **Outcome 7 – choice and control**
  We have choice and control over our lives

- **Outcome 8 – leadership**
  We have great opportunities to demonstrate our leadership.

**Targets will be developed, measures will be in place, and actions will be undertaken to implement the Strategy**

An Outcomes Framework will be developed in 2017 which will set targets and measures for the Strategy. Annual reporting against the Outcomes Framework will be published on the Office for Disability Issues website. The Disability Action Plan will be the primary vehicle for implementing the Strategy. Figure 1 on the following page outlines the Strategy’s framework.
New Zealand is a non-disabling society — a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.
Our journey – an introduction

He aha te mea nui o te ao?
He tangata! He tangata! He tangata!

What is the most important thing in the world?
It is people! It is people! It is people!

The New Zealand Disability Strategy – A map to guide our way

The New Zealand Disability Strategy (the Strategy) will guide the work of government agencies on disability issues from 2016 to 2026.

It can also be used by any individual or organisation who wants to learn more about, and make the best decisions on, things that are important to disabled people.


The way we look at disability in New Zealand has changed

Since the first New Zealand Disability Strategy was developed in 2001 there has been real progress in the lives of many disabled people and their families and whānau. A significant milestone was the development of the Convention, which New Zealand ratified in 2008.

Disabled children are growing up wanting the same things as non-disabled children and the expectations of disabled adults have changed and grown. There is also a growing recognition that disabled people are experts in their own lives, and ensuring their right to be involved in the decisions that impact on them will lead to better outcomes.

There is still more work to be done

Even though there has been progress since 2001, this revised Strategy is needed because disabled people remain worse off than non-disabled people across all social and economic outcomes.¹ This persistent gap has a flow-on effect. When disabled people are not able to participate in society, the entire country misses out on their contribution.

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Written from the perspective of disabled people

The development of this Strategy was supported by the New Zealand Disability Strategy Revision Reference Group, of whom the majority of members identify as disabled people.² It is also based on what disabled people said was most important to them during public consultation in 2016.

In order to remain true to the vision and priorities of the people at the centre of this Strategy, the Who we are, Principles and Approaches and Outcomes sections have been written from the perspective of disabled people.

Some words and terms can be understood by different people in different ways. Wherever possible, an explanation of how a word or term has been used in this Strategy has been included. A Glossary is available on page 49.

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² The New Zealand Disability Strategy Revision Reference Group members are listed in Appendix 1 on page 50.
Our vision – where to from here

New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.

The Strategy’s Vision

A note on terms:

Non-disabling is about removing the barriers in society that disable people with impairments. We consider this to be stronger and more meaningful than ‘enabling’, which will only help disabled people get around barriers rather than remove them completely.
Who we are – our community

We are children, young people and adults, we are parents and grandparents. We are also friends, family and whānau. What we want is no different to anyone else in New Zealand; we want to belong, contribute to our families and whānau and participate in our communities.

We are 1.1 million New Zealanders and we represent almost a quarter (24 percent) of New Zealand’s population.

What disability means to us

Disability is something that happens when people with impairments face barriers in society; it is society that disables us, not our impairments, this is the thing all disabled people have in common. It is something that happens when the world we live in has been designed by people who assume that everyone is the same. That is why a non-disabling society is core to the vision of this Strategy.

Every human being is a unique individual. Even if we have the same impairment as someone else, we will experience different opportunities and barriers because of where we live and how we are treated by those around us. The time and context in our lives when we may acquire our impairment(s) also informs what barriers or opportunities we may experience.

This is the social model of disability and it is how we understood disability in the first Strategy in 2001. It still holds true today. It is also the same understanding of disability that is embodied in the Convention. The Convention says that disabled people include:

“…those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others...” (Article 1).
The language about disability is really important

There are many words and terms that are used to identify disability. The way these are understood differs and this was apparent during consultation to support the development of this Strategy. For some of us, the term ‘disabled people’ is a source of pride, identity and recognition that disabling barriers exist within society and not with us as individuals.

For others, the term ‘people with disability’ has the same meaning and is important to those who want to be recognised as a person before their disability.

This Strategy uses the term ‘disabled people’. This is based on advice from the New Zealand Disability Strategy Revision Reference Group and in recognition of the history of the term in the 2001 Strategy. In future, it is possible that our community reaches a consensus on a different way to describe us. If this happens, the language in this Strategy can be changed to reflect this.

Not all members of our community identify with disability-focused language. For example, older people and their families and whānau sometimes think that disability is a normal part of the ageing process. People with invisible impairments such as mental health issues can sometimes identify as part of the mental health community, and not the disability community. Deaf people identify as part of the Deaf community with its own unique language and culture, and do not always identify as being disabled. Most Māori disabled people identify as Māori first. The importance of their cultural identity, which encompasses language, whānau, cultural principles, practices and linkages to the land through genealogy, is paramount to how they live their day to day lives in both Te Ao Māori and Te Ao Pakeha.

It is also important to recognise that Te Reo Māori and New Zealand Sign Language are both official languages of New Zealand. Their place in our society needs to be acknowledged, respected and supported in the implementation of this Strategy.

We know that non-disabled people are sometimes not sure which words or terms to use in order to be respectful. Our advice is to listen to how we refer to ourselves and use the same language. If you are still not sure, then just ask us what language we prefer.

We are part of diversity and we are diverse ourselves

Disabled people are part of the vast and diverse human experience. Just as we accept and respect differences like gender, ethnicity, language or belief, the difference and diversity of disabled people need to be understood, acknowledged and celebrated.

Just like other communities, the disability community has different groups of people who experience life in different ways. We think it is important to acknowledge the diversity of our community, both because we are proud of it and also because we want to make sure that no one is left behind. The Strategy is for all of us.
The points below describe some of the rich diversity within our community:

- Māori are the tangata whenua of New Zealand and as the indigenous people they have a special relationship with the Crown. This relationship is recorded in the founding document of Aotearoa New Zealand, Te Tiriti o Waitangi.

- Addressing the inequality that Māori disabled people face is important; 26 percent of Māori identified as disabled in 2013. When adjusted for age, the Māori disability rate is 32 percent.\(^3\) A Māori world view needs to be woven into the implementation of this Strategy. This includes the cultural importance of whānau and a whānau-centred approach which differs from Western concepts of family and disability.

- New Zealand Sign Language (NZSL) is an official language of New Zealand used by some 20,000 New Zealanders\(^4\), approximately 4,000 of whom are Deaf people who use NZSL as their first or preferred language\(^5\).

- The demography of our country is changing, and we are increasingly becoming a multicultural society. This is important to the disability community, as people from different ethnic and cultural backgrounds can sometimes understand and experience disability in different ways to others.

- Pacific peoples make up a growing proportion of our country and of the disability community (19 percent of Pacific people identified as disabled in 2013), as do people from Asian backgrounds (13 percent in 2013). Twenty-eight percent of people from Middle Eastern, Latin American and African backgrounds identified as disabled in 2013. Over the coming decades, we will see more cultural and ethnic diversity in the disability community.

- New Zealand has an ageing population which will result over time in an increasing proportion of people experiencing disability. In 2013, 59 percent of people over the age of 65 identified as disabled\(^6\). Disabled people are also living longer, and there will be an increasing number of people with age-related impairments. This is a global trend and one that is drawing greater attention to disability. Meeting the needs and challenges of our ageing population is a significant issue now, and will continue to be over coming decades.

- Gender norming plays out in the disability community, just like it does in society more generally. Disabled women and girls face different barriers to disabled men and boys.

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\(^3\) Statistics New Zealand (2015). He hauā Māori: Findings from the 2013 Disability Survey
\(^4\) Statistics New Zealand Disability Survey: 2013
Disability and sexuality is also important for our community. Some of our members do not identify as part of the gender binary (male or female) or have a predominant sexual orientation. There can also be an incorrect perception that disabled people do not have sexual needs or desires.

The international catch-cry of disabled people is ‘nothing about us, without us’. For our disability community in New Zealand, this also includes those of us who find it hard to, or are not able to, speak for ourselves. We are amongst the most vulnerable and marginalised members of our disability community. While there may be different terms used for our group, such as people with ‘intensive support’, or ‘special’ needs, the thing we have in common is that we often rely on other people to support us to make decisions and to communicate.

Our community will change

This is just a snapshot of the rich diversity of the disability community. Because disability is about the way other people treat us, it is a dynamic concept that will continue to evolve as our society changes over time.

Future economic growth of the country has the potential to be constrained by skill and labour shortages. The low employment rates of disabled people represent a significant loss of potential contribution to New Zealand’s economy.

Disability impacts on many non-disabled people too

Our families, whānau, friends, carers and supporters are an important part of our community. In this way, disability is something that impacts on people without impairments. The disabiling society we experience affects them too.
Principles and approaches

Figure 2 | Principles and approaches

Principles

- Te Tiriti o Waitangi
- Convention on the Rights of Persons with Disabilities
- Ensuring disabled people are involved in decision-making that impacts them
- A whole-of-life and long-term approach to social investment
- Specific and mainstream supports and services — a twin-track approach

Approaches
The principles and approaches that will be used to implement the Strategy are outlined in this section; they are the ‘how’ to complement the outcomes (which are the ‘what’).

The principles and approaches will help make sure all of our community is visible, acknowledged and respected on an equal basis with others, and that we can live a life with dignity and feel valued.

This section has three sets of principles:

1. Principles of Te Tiriti o Waitangi
3. Ensuring disabled people are involved in decision-making that impacts them.

It also has two approaches:

1. Investing in our whole lives – a long-term approach
2. Specific and mainstream services – a twin-track approach.

Figure 2 on the previous page illustrates the connection between the principles and approaches.
Principles

The principles of both Te Tiriti o Waitangi and the Convention will be reflected in the way this Strategy is implemented; they are for everyone and apply to Māori and non-Māori, disabled people and non-disabled people. The principles are a framework for building a positive relationship between disabled people and the Government.

1. Principles of Te Tiriti o Waitangi

The Strategy will be guided by the principles of Te Tiriti o Waitangi as the founding document of our country.

The principles of the Treaty are:

- **Partnership:** Māori and the Crown have a relationship of good faith, mutual respect and understanding, and shared decision-making.

- **Participation:** the Crown and Māori will work together to ensure Māori (including whānau, hapū, iwi and communities) participate at all levels of decision-making. This includes the right to seek opportunities for self-determination and self-management.

- **Protection:** the Crown actively contributes to improving the wellbeing of Māori, including support for independent living and the protection of Māori property and identity, in accordance with Māori values. Māori have the same rights and privileges as other citizens.

The principles of the Convention are:

- Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of disabled people as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of disabled children and respect for the right of disabled children to preserve their identities.

3. Ensuring disabled people are involved in decision-making that impacts them

We are experts in our own lives and making sure we are involved in decision-making on issues that impact us leads to better quality results. The Convention also has a specific obligation on this (Article 4.3):

“In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organisations”.
Approaches

1. A whole-of-life and long-term approach to social investment

It is important that both whole-of-life and long-term approaches are considered when social investment decisions are being made by the Government on things that impact on us. This will help ensure that we are more independent, are able to participate as much as we choose to, and that we are able to contribute to our communities and reach our potential.

Such an approach will help ensure that:

- the silos between different supports and services are removed to provide a coordinated approach to enable us to achieve our potential
- we receive the right supports and services throughout our lives. Early and proactive support, particularly after an impairment has been diagnosed or it changes, will help set us up for a better future
- the contribution we make to our families, whānau and communities is recognised across a broad range of areas including economic, community and social participation
- our families, whānau and carers are also able to access the right supports and services in order to help us reach our potential.

Making sure there is the right evidence at the right time to inform investment decisions is critical. All too often we have been invisible because disability has not been counted, recognised or understood, and therefore our needs have not been considered.

Evidence is both quantitative (data) and qualitative (lived experience, or stories, directly from us and those who care for us). We know that both are equally important and need to be valued alike to ensure there is a good understanding of the problem (before deciding on solutions); what interventions work best for us; and to be able to measure results against the outcomes we are seeking.
2. Specific and mainstream supports and services – a twin-track approach

A twin-track approach is about making sure mainstream services and supports are inclusive of, and accessible to, us and that services and supports that are specific to us as disabled people are also available. This approach is not about having to choose between the specific or mainstream option; rather it is about having the right access to the right high quality support or service, at the right time and in the right place.

Some of us do not need any specialised supports or services, whereas some of us do so that we can access mainstream opportunities. Our needs for either or both can change over time too.

Ensuring that mainstream services and supports are inclusive of us requires the provision of reasonable accommodation and incorporation of universal design.

• Reasonable accommodation is defined in the Convention as:
  – “…necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms” (Article 2).
  – Reasonable accommodation can often cost very little or nothing at all. Because it is specific to a situation, what it looks like in practice can vary significantly.

• Universal design is good design that works for everyone.
  – It is about making sure everything is accessible to, understood by and used to the greatest extent possible by everyone, without adaptation or requiring little adaptation. Incorporating universal design early on is cost-effective.
  – Universal design is often referred to in relation to the built environment, but it applies to services, supports, the curriculum and technologies as well.
  – Universal design is distinct from accessible design. Accessible design represents the minimum accessibility requirements in built design, whereas universal design seeks accessible design outcomes that work for everyone.

A note on terms:

Mainstream refers to services or supports that are not designed to be specific to or only for disabled people. It includes things that are open for everyone to use or participate in (such as public transport) and also things that may still be targeted towards a particular group (such as maternal health services).
Our outcomes - priorities for change

Figure 3 | Interconnections of outcomes

Outcomes
All outcomes are interconnected

- Education
- Employment and economic security
- Leadership
- Health and wellbeing
- Choice and control
- Rights protection and justice
- Attitudes
- Accessibility
The eight outcomes that will contribute towards achieving the vision of the Strategy are outlined in this section.

Each outcome has two parts to it:

1. A description of what our future looks like – this is an aspirational description of what things should look like for disabled people in the future. This will help make sure that everyone has the same understanding about what the future should look like and that all actions are consistent with this.

2. What this means – this describes at a high level what needs to happen to achieve the aspirational description. It also gives direction to what needs to happen in implementation.

• For each outcome, the first bullet point states that disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning the outcome area.

• This language is taken directly from the Convention.

Specific actions to implement the outcomes will be determined through the Disability Action Plan. You can read more about this in the Making it work section from page 40.

All outcomes are interconnected and should not be read in isolation. For example, achieving the employment outcome is dependent upon the education outcome. The outcome on attitudes is also relevant to all other outcomes. Figure 3 on the previous page shows this interconnection.
We get an excellent education and achieve our potential throughout our lives

What our future looks like

Our learning pathway supports us to develop friendships and social skills, as well as resilience, determination and confidence. It gives us a sense of belonging, builds our identity and language skills and prepares us for life beyond compulsory education.

All local schools and education services (including early childhood, primary secondary, tertiary, kohanga reo and kura kaupapa Māori) are welcoming and provide a great inclusive education for us. We have trained teachers and educators who support and believe in our progress and achievement, and value our contribution to the learning environment.

Education is provided in a way that supports our personal, academic and social development, both in and out of the formal schooling system. This includes making sure that those of us who use different languages (in particular New Zealand Sign Language), and other modes or means of communication, have ready access to them to achieve and progress. Information will be made available at the right time to those who support us, both when we are young or for those of us who need on-going support. This will help us succeed – whatever our individual education pathway may look like.

We are treated with respect and dignity by those around us in the education system, including our peers and those who teach and support us. The love and expertise of our families and whānau and their wish to see us succeed in education will be honoured without question.

As we move on to tertiary and life-long learning, the transition periods are smooth, with the right information and supports available at the right time – particularly when our needs or situations change.
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning education, including early childhood, primary, secondary and tertiary education.
- Access to mainstream education is inclusive (including policy, practice and pedagogy).
- Services that are specific to disabled people are high quality, available and accessible.
- Inclusive education is a core competency for all teachers and educators.
- Decision-making on issues regarding education of disabled people is informed by robust data and evidence.
Outcome 2: employment and economic security

We have security in our economic situation and can achieve our potential

What our future looks like

We take pride in the meaningful paid and voluntary work we do, knowing that we are contributing to our families and whānau, communities and the country as a whole.

We are proportionately represented at all levels of employment, we are self-employed, we own businesses, and we are employers, managers and employees. Career progression is an important part of our working life.

Employers are confident and willing to employ us in meaningful jobs that utilise our strengths and make the best use of what we have to offer. They also have access to on-going support, guidance and tools to help support them in their role as a fair and equitable employer. When we apply for jobs, we do not face any barriers in the application process.

We are treated with respect and dignity by our non-disabled peers and we feel that the work we do is meaningful, valued and real.

Those of us who need specialised supports and services have ready access to them to secure and sustain employment. Reasonable accommodation is understood and provided by our employers. We will have the same opportunities to progress our careers as our non-disabled peers. The additional costs of disability are met, so that we are able to enjoy the same standard of living as other workers.

We have an adequate standard of living that enables us to fully participate in society, where necessary through the provision of income support which takes into account the additional cost of disability. This applies to everyone, including those of us who are not able to work, are retired, are unable to work full-time, or work full-time yet are still unable to afford and maintain an adequate standard of living.
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning employment and income support.
- Access to mainstream employment and income support services is barrier-free and inclusive.
- Services that are specific to disabled people are high quality, available and accessible.
- All frontline workers, including case managers and employers, treat disabled people with dignity and respect.
- Decision-making on issues regarding employment and income support of disabled people is informed by robust data and evidence.
Outcome 3: health and wellbeing

We have the highest attainable standards of health and wellbeing

What our future looks like

Healthcare professionals treat us with dignity and respect. We are seen as individuals and receive appropriate and timely support for all of our health needs, not just those related to our impairment. We do not face barriers accessing mainstream health services because of our impairments, in particular sexual and reproductive health services for disabled women and girls. When we need to, we can access services specific to our impairment (including habilitation, rehabilitation and recovery) in a way that provides early diagnosis and ensures our needs as individuals are taken into consideration.

We have choice and control over all the supports and services we receive, and information about these services is available in formats that are accessible to us. We also have access to information about us. Those of us who need support to communicate or make decisions receive it in an appropriate way at the right time, and those decisions are recognised and respected. We are not secluded within services, and not segregated from or isolated within our communities.

Issues of bio-ethics and bodily integrity are treated with sensitivity, with due regard for our rights and informed consent. This includes making sure our families, whānau and those who support us have the right access to the right information when they are involved in supporting us to make decisions. In the rare circumstances when decisions need to be made on our behalf, these are based on the best interpretation of our will and preference, as opposed to just thinking about what is in our best interests.

Access to high quality peer support enables us to recover from periods of being unwell, and flourish with the confidence that we are not alone.

Our identity as members of other communities, such as Māori or Pacific, will be respected and we will have access to services that are culturally appropriate.

The importance of belonging to and participating in our community to reduce social isolation, and increase our overall wellbeing, is recognised and supported. We get involved in sport, recreation and arts activities, and are recognised and valued for this. Those of us who identify as members of other communities do not face barriers participating in and contributing to cultural activities because of our impairments. We are supported to be healthy and well, and can participate in community activities on an equal basis with others.
What this means:

• Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning health and wellbeing, including sport, recreation, arts and culture.

• Access to mainstream health services is barrier-free and inclusive.

• Services that are specific to disabled people, including mental health and aged care services, are high quality, available and accessible.

• All health and well-being professionals treat disabled people with dignity and respect.

• Participation in community activities if we choose (for example, sport, recreation, arts and culture), or just being present and belonging to our community is supported and valued.

• Decision-making on issues regarding the health and well-being of disabled people is informed by robust data and evidence.
Outcome 4: rights protection and justice

Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system

What our future looks like

We will continue to be treated with fairness and respect at all stages of our journey through the justice system, regardless of whether we are victims, perpetrators, witnesses, or fulfilling a civic duty such as jury service.

Those of us who need services or supports specific to our impairment will receive them, wherever possible, the first time we interact with the justice system. We will continue to receive these supports in a way that does not require us to keep telling our story or risk missing out on something we need, unless our needs change. The people we interact with have a good understanding of any impact our impairment may have on our journey, and take this into account as appropriate.

Those of us who need support to communicate or make decisions receive it in an appropriate way at the right time, and those decisions are recognised and respected. We will continue to be recognised as a person before the law. We feel secure exercising our rights as there are appropriate safeguards in place, even if we need support to make decisions and understand what’s happening.

For those of us who end up in the youth or adult justice system, the transition out of it is accompanied by rehabilitation services that recognise and understand our impairment, and help us to find a positive place in society.

If we feel unsafe, vulnerable to or affected by violence and abuse, we will continue to have access to support that recognises our needs and responds effectively and with sensitivity. We also feel confident in speaking up or complaining if we have been discriminated against or hurt, because we are listened to and our concerns are addressed.

Our needs and rights continue to be taken into account in any prevention and response initiatives. This includes making sure there continue to be safeguards in place for those of us who may be at risk of violence and abuse (for example, caring relationships, community awareness).
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning justice, violence and abuse prevention and human rights.

- The justice sector is barrier-free and inclusive of disabled people with supports and services specific to a person’s impairment provided readily when required.

- All justice sector professionals treat disabled people with dignity and respect.

- Supported decision-making will increasingly be recognised and disabled people can use it in practice.

- Decision-making on issues regarding justice, violence and abuse prevention and human rights is informed by robust data and evidence.
Outcome 5: accessibility

We access all places, services and information with ease and dignity

What our future looks like

We have access to warm, safe and affordable housing that meets our needs and enables us to make choices about where we go to school or work and to fully participate as members of our families, whānau and communities.

We can get from one place to another easily and safely, for example from home to school, work or to a friend’s house. We can also access all public buildings, spaces and facilities with dignity and on an equal basis with others.

We feel safe taking public transport to get around and are treated well when we do so. Our needs are also appropriately considered when planning for new transport services. Private transport services are responsive to and inclusive of us. For those of us who need it, there is access to specific transport options that are affordable, readily available and easy to use.

Information and communications are easy for us to access in formats and languages that are right for us, including in our country’s official languages of Te Reo Māori and New Zealand Sign Language. This helps us to be independent because we do not have to rely on other people. We use technology on the same basis as everyone else; those of us who need specific technology solutions will have access to these in a way that is innovative, progressive and helps to eliminate barriers. The evolving opportunities presented by new technology helps us to achieve our goals.

Our accessible communities are free of barriers (for example, access to shops, banks, entertainment, churches, parks, and so on), which enables us to participate and contribute on an equal basis with non-disabled people.
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning housing (home ownership, social housing and private rentals), transport (public and private), public buildings and spaces and information, communication and technology.
- Universal design is understood, recognised and widely used.
- All professionals involved in accessibility have a good understanding of the principles of universal design and the needs of disabled people and take these into account in their work.
- We enjoy and are fully included in artistic, cultural, sporting and recreation events whether as spectators or as performers.
- Decision-making on issues regarding housing, transport, public buildings and spaces and information, communication and technology are informed by robust data and evidence.
Outcome 6: attitudes

We are treated with dignity and respect

What our future looks like

Disability is understood and accepted as a part of the diversity of the human experience and we are treated with dignity and respect by those around us and society more broadly.

There is a willingness to explore attitudes towards disability, in particular those that negatively stereotype, stigmatise and discriminate. There is an appetite for seeking out ways to change attitudes and ensure that basic human rights are upheld for all people. These changes are made in a way that is safe and that upholds our views and diverse voices.

We are able to choose how we want to be identified and this is acknowledged and respected by society. This is particularly important for those of us who identify first within, for example, our ethnicity or culture and not with disability.

We will be encouraged to speak out in whatever language we use, and our views will be listened to. This includes those of us who may communicate differently, use technology to communicate, and/or have support to communicate or express our preferences. As a result, we are confident demonstrating the value we bring to our families, whānau, community and the country as a whole.

Our views, either as an individual or as part of a group, will be listened to without being diminished, and society will not seek to take this away, either by accident or design.
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning attitude change, stigma and discrimination, in particular where they are specific to disabled people.

- The rich diversity of the disability community will be included and represented in initiatives to change attitudes and behaviours, which will also ensure that disabled people are seen as part of other communities or groups.

- There is a particular focus on making sure all frontline service providers and professionals treat disabled people with dignity and respect.

- Decision-making on issues regarding attitude change, stigma and discrimination, is informed by robust data and evidence.
Outcome 7: choice and control

We have choice and control over our lives

What our future looks like

When we are young, our families, whānau and carers will be supported to help us grow up. Our views as children and those of our families, whānau and carers will be considered when choices are made about what supports and services we receive and what things work best for us. There will also be respect for the evolving capacities of disabled children, and ensuring their input into decisions that affect them.

As we get older we will make our own choices and decisions on things that affect how we live our lives, including where we live. Some of us may need support some of the time or all of the time. Plans or decisions that affect, or have implications for us, will not be developed without our involvement or consent. We have access to information in ways that help us understand what is happening so that we give consent in an informed way.

Those of us who need support to communicate or make decisions receive it in an appropriate way at the right time and those decisions are recognised and respected. The way this support is provided will be empowering and will help build our confidence. In the rare circumstances when decisions need to be made on our behalf, they are based on the best interpretation of our will and preferences, as opposed to just thinking about what is in our best interests. Needing support does not diminish our independence or our ability to have choice and control over our lives.

We will make informed choices based on what is available, rather than settling for a less desirable option because that is all that is offered to us. We are able to change our mind about our decisions.

Sometimes the decisions we take may expose us to risk. Taking risks is part of the human experience, and it is our right to take risks, learn from our mistakes and live our lives as we see fit. If we need support to understand risks and make decisions, this will be provided in a way that helps us understand all the options and consequences. The times when we are prevented from taking risks will be the exception rather than the rule.
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning supports and services that are both specific to them and for the mainstream.

- Those who support disabled people to make choices or decisions will have a good understanding of their role and access to information and support to help them do this in an informed way.

- Decision-making on issues regarding choice and control over supports and services, in particular those specific to disabled people, is informed by robust data and evidence.
Outcome 8: 
leadership

We have great opportunities to demonstrate our leadership

What our future looks like

We have opportunities and are supported to be leaders or role models in whatever field or level we may choose. Leadership for us includes doing great things on behalf of our country or at a national level, and also doing everyday ordinary things for ourselves, our families, whānau or communities. For example, we can be leaders in employment, through voluntary work or at a political level, both locally and nationally.

We are on a level playing field with others and are recognised for our skills, talents and leadership potential. We are supported to develop our leadership potential, and take responsibility for the pursuit and achievement of our goals. When we are young or have an emerging leadership role, we are supported and mentored.

When there are discussions and decisions on things that are important to disabled people, we have strong leaders who represent our views around the table. Our experience of disability is recognised as expertise, and we are acknowledged as experts in our own lives. This representation includes the diversity of the disability community, including the groups within our community who often have not had a voice.

When there are non-disabled people in leadership roles that are important to our community, in the public, private and not-for-profit sectors, they will act as our allies and work closely with us. In this way they can use their influence to help break down the barriers that we experience and that disable us.
What this means:

- Disabled people are consulted on and actively involved in the development and implementation of legislation and policies concerning leadership, in particular where this is specific to them.
- Disabled people are recognised as experts in their own lives.
- People in leadership roles in the public, private and not-for-profit sectors will be supported to see themselves as allies to the disability community. They will work in partnership with disabled people on things that are important to them.
- Decision-making on issues regarding leadership, in particular those specific to disabled people, is informed by robust data and evidence.
Making it work

Figure 4 Governance and Monitoring

**Governance**
- Cabinet
- Chief Executives Group on Disability Issues
- Senior Officials Group on Disability Issues
- Disabled People’s Organisations

**New Zealand Disability Strategy**

**Convention on the Rights of Persons with Disabilities**

**Strategy Outcomes Framework**

**Independent monitoring**
- Human Rights Commission
- Ombudsman
- Convention Coalition Monitoring Group
This section outlines how the Strategy will be implemented.

It has two parts:

1. Keeping on track with progress
2. Achieving practical action
   - Disability Action Plan
   - Governance
   - Monitoring implementation
   - Convention on the Rights of Persons with Disabilities – making rights a reality
   - Making sure the priorities are right – how consultation will work.

An area of strength for the disability community and sector is that it is diverse, with a range of perspectives. This includes different experiences, areas of expertise and representation (either being representative of a particular group or more formally representing an organisation/group) and advocacy. This is sometimes referred to as wearing many different ‘hats’. We are also recognised as experts in our own lives and making sure we are involved in decision-making on issues that impact on us leads to better quality results.

All of these perspectives are important in different ways for the governance and independent monitoring mechanisms, as well as the consultation processes that will support the effective implementation of this Strategy. These mechanisms and processes should aim to reflect the diversity and the changing nature of the disability community.

Figure 4 on the previous page reflects the governance and monitoring of the Strategy.
Keeping on track with progress

It is a priority for the Government that progress toward implementing the Strategy remains on track. To monitor this, an Outcomes Framework will be developed with public consultation in 2017. The Outcomes Framework will outline how we will monitor progress against the Strategy. The framework will specify:

- the targets and indicators (including for each outcome and the principles and approaches where appropriate)
- where the information comes from
- how often it will be collected
- who is responsible for collecting it
- where proxies are needed and how information gaps will be addressed. (Note: ‘proxy’ or ‘proxies’ means ‘something similar’. Proxy indicators are used when the required data is not available, so a similar indicator is used instead.)

The Outcomes Framework will also help make sure there is continuous learning and improvement prior to a final evaluation of the Strategy in 2026.

Every year, the Minister for Disability Issues will report publicly to Parliament on the progress made to implement the Strategy against the Outcomes Framework. This will meet the requirement for the Minister to report under the New Zealand Public Health and Disability Act 2000. The reports will also be submitted to Cabinet to ensure they inform the development and update of Disability Action Plans.
Achieving practical action

Disability Action Plan

The Disability Action Plan (the Plan) will be the primary vehicle for implementation of this Strategy. Future plans will:

- focus on high priority and significant actions for one or more government agencies (this will help make sure the Plan is manageable and easy to understand)
- present a complete picture of the priorities in implementing the Strategy
- support effective learning across government agencies, particularly in the application of the principles and approaches that are applied throughout the Strategy.

Future Plans will continue to cover a four-year period and they will be updated at the mid-point to ensure priorities remain relevant (that is after two years). Issues like funding or legislation need to be considered in the context of actions in the Plans rather than in this Strategy.

There are other strategies and plans that are also relevant to the Disability Strategy. A description of some of these links can be found on the Office for Disability Issues website.

Governance

As a Government Strategy, decisions on implementation will be made by Cabinet.

These will be informed by the existing governance mechanisms for the Disability Action Plan: the Chief Executives’ Group on Disability Issues (and associated Senior Officials Group) and Disabled People’s Organisations.
Monitoring implementation

The Independent Monitoring Mechanism (IMM) will help provide an independent perspective on progress toward achieving the outcomes and goals of the Disability Strategy.

The IMM was established by the Government in 2011. It fulfils an obligation for the Government under the Convention to have an independent mechanism to promote, protect and monitor implementation under Article 33 of the Convention. It is made up of the Human Rights Commission, Office of the Ombudsman and the Convention Coalition Monitoring Group (a group of Disabled People’s Organisations).

The Strategy is the primary vehicle for progressive realisation of the Convention. Therefore it is appropriate for the IMM to provide an independent perspective on implementation of the Strategy. This will not however, be seen to limit in any way, the IMM’s mandate to monitor the Convention.

Convention on the Rights of Persons with Disabilities – making rights a reality

Every four years, the Government reports to and receives Concluding Observations from the United Nations Committee on the Rights of Persons with Disabilities. Concluding Observations recognise areas of good progress but also include recommendations on things that need to be improved.

The Concluding Observations will be included as part of the public consultation process to develop and update the Disability Action Plans. Recommendations from the IMM will also be considered as part of this consultation alongside those from the Committee.

Making the Concluding Observations and recommendations an integral part of implementation of the Disability Strategy will help make the rights of disabled people a reality.
Consultation

Every two years there will be public consultation to inform the development or update of the Disability Action Plans. There is a lot that needs to be done to make this Strategy work, and it is important that priorities for action are informed by what disabled people and the community says is most important to them.

The process for public consultation will reflect the diversity of the disability community as well as the principles of Te Tiriti o Waitangi and the Convention (including Articles 4.3).
### Making it work – a schedule of implementation

<table>
<thead>
<tr>
<th>Year</th>
<th>What happens</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>• New Disability Strategy 2016–2026 agreed by Cabinet</td>
</tr>
</tbody>
</table>
| 2017 | • Public consultation process to develop the Outcomes Framework for the Strategy  
      • Outcomes Framework for the Strategy agreed by Cabinet  
      • Update of the Disability Action Plan – to align with the new Strategy  
      • Annual report from Minister for Disability Issues, including baseline information against the Outcomes Framework where possible |
| 2018 | • Government reports to and receives Concluding Observations from the United Nations Committee on the Rights of Persons with Disabilities  
      • Government receives recommendations from the Independent Monitoring Mechanism  
      • Annual report from Minister for Disability Issues against Outcomes Framework |
| 2019 | • Public consultation process to develop new Disability Action Plan (to include recommendations from the United Nations Committee/Independent Monitoring Mechanism)  
      • New Disability Action Plan (2019–2022) agreed by Cabinet  
      • Annual report from Minister for Disability Issues against Outcomes Framework |
| 2020 | • Annual report from Minister for Disability Issues against Outcomes Framework |
| 2021 | • Public consultation process for mid-point update of Disability Action Plan  
      • Updated Disability Action Plan to be agreed by Cabinet  
      • Annual report from Minister for Disability Issues against Outcomes Framework |
<table>
<thead>
<tr>
<th>Year</th>
<th>What happens</th>
</tr>
</thead>
</table>
| 2022 | • Government reports to and receives recommendations from the United Nations Committee  
      • Government receives report from the Independent Monitoring Mechanism  
      • Annual report from Minister for Disability Issues against Outcomes Framework |
| 2023 | • Public consultation process to develop new Disability Action Plan (to include recommendations from the United Nations Committee/Independent Monitoring Mechanism)  
      • New Disability Action Plan (2023–2026) agreed by Cabinet  
      • Annual update report from Minister for Disability Issues against Outcomes Framework |
| 2024 | • Annual report from Minister for Disability Issues against Disability Outcomes Framework |
| 2025 | • Public consultation process for mid-point update of Disability Action Plan  
      • Annual report from Minister for Disability Issues against Outcomes Framework |
| 2026 | • Government reports to and receives recommendations from the United Nations Committee  
      • Government receives report from the Independent Monitoring Mechanism  
      • Evaluation of the Strategy (and Disability Action Plans)  
      • Annual report from Minister for Disability Issues against Outcomes Framework  
      • End of current Disability Strategy 2016–2026. Next steps to be confirmed |
Getting it going – who is involved

Achieving the vision and outcomes of the Strategy will take all New Zealanders working together. With rights there also come responsibilities, for everyone. There are also some key groups who have particular responsibilities under the Strategy. They are:

- **Disabled people, families, whānau, allies and the disability community and sector** – providing input through governance, independent perspectives and public consultation.

- **Cabinet** – responsible for considering regular reports and making decisions on implementation of the Strategy through the Disability Action Plan.

- **Ministerial Committee on Disability Issues** – supports co-ordination of implementation across government.

- **Independent Monitoring Mechanism** – responsible for providing an independent perspective on implementation of the Strategy.

- **Chief Executives’ Group on Disability Issues (and Senior Officials Group) and Disabled People’s Organisations** – responsible for governance and coordination of the Disability Action Plans.

- **Government agencies** – responsible for implementing the Strategy according to the priorities agreed in the Disability Action Plan.

- **All New Zealanders** – breaking down the barriers of a disabling society and supporting implementation of the Strategy.

- **Local Territorial Authorities (City, District and Regional Councils)** – consider their responsibility for disabled people in the space they oversee, in line with the Strategy and the Convention.

- **Private sector, businesses and Non-Governmental Organisations** – ensure their business as usual is inclusive and responsive to disabled people on an equal basis with others.
Glossary

**Barrier** is something that makes it difficult or impossible for people to do something

**Demography** is statistics about people, such as age and ethnicity

**Disability** is something that happens when people with impairments face barriers in society that limit their movements, senses or activities

**Disabled people** are people who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. This is the understanding of disability in the Convention

**Enabling** is to provide with the ability or means to do something

**Equality** means that everyone gets the same opportunities

**Equity** is recognising that sometimes people need different things in order to be equal

**Impairment** is a problem with the functioning of, or the structure of someone's body

**Investing** is about spending time, energy or money on something

**Mainstream** means things including activities, services, supports, attitudes or ideas, that are open to everyone to use or participate in (for more detail of the disability context, see page 21)

**Non-disabling** is about removing the barriers in society that disable people with impairments

**Pedagogy** is the theory of teaching

**Proxy** means something similar.

**Reasonable Accommodation** is making necessary and appropriate modifications and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms

**Twin-track approach** is making sure that mainstream activities and opportunities are inclusive of, and accessible to, all people and that specific activities and opportunities that are required by some people are also made available to those people (for more detail of the disability context, see page 21)

**Universal design** is good design that works for everyone (for more detail of the disability context, see page 21)
Appendix 1 – The Reference Group

Members of the New Zealand Disability Strategy Revision Reference Group (for further details on each member of the group please refer to the Office for Disability Issues website): www.odi.govt.nz

Colleen Brown MNZM, from Auckland, brings a families perspective.

Robbie Francis, from Hamilton, brings the perspective of young people and lived experience of disability.

Lance Girling-Butcher QSM, from New Plymouth is a nominated Disabled People’s Organisations (DPOs) representative. Lance became blind as an adult.

Peggy Koopman-Boyden CNZM, from Hamilton brings an older person’s perspective from research and personal experience.

Clive Lansink, from Auckland, is a nominated DPOs representative. Clive is blind and is a strong advocate for disabled people speaking for themselves.

Victoria Manning (Co-Chair) MNZM, from Wellington is also the Chair of the NZSL Board. Victoria is Deaf and also brings 20 years’ experience in disability policy.

David Matthews, from Christchurch and Wellington, brings a service provider’s perspective.

Papaalii Seiuli Johnny Siaosi, from Auckland, brings a perspective from mental health and addictions consumers, their families and Pasefika communities.

Dr Martin Sullivan QSO, from Palmerston North, brings his perspective as a disabled person.

Hamish Taverner, from Palmerston North, speaks up for the rights of people with learning disabilities. He brings the perspective of lived experience of this disability.

Jonny Wilkinson, from Whangarei, brings the perspective of a person with lived experience of disability.

Gary Williams MNZM, from Christchurch, is a self-employed disability consultant bringing over 40 years of expertise in the disability sector. Gary also brings a perspective of a Māori disabled person.

Government agencies had two representatives on the group. During the development of the Strategy, these representatives were Brian Coffey (Ministry of Education), Kathy Brightwell (Ministry of Health) and Sacha O’Dea (Ministry of Social Development).

Paul Brown from the Office of the Ombudsman was an observer.

Megan McCoy, Director of the Office for Disability Issues, Co-Chaired the reference group meetings.
Waitemata & Auckland District Health Board’s Disability Strategy Implementation Plan 2016-2026

Waitemata and Auckland District Health Boards have a shared vision of being fully inclusive.

Being fully inclusive means ensuring the rights of disabled people, eliminating barriers so that people can get to, into and around our physical spaces; and everyone can access information and services that they need and enabling full participation.

The New Zealand Disability Strategy 2016-2026 provides a framework for organisations to focus on enabling the full participation of disabled people. It has a vision of New Zealand as a non-disabling society – a place where disabled people have an opportunity to achieve their goals and aspirations and all of New Zealand works together to make this happen.

The Vision, principles and approach of the NZ Disability Strategy 2016-2026, with input from the disability sector and disability community, have shaped our joint District Health Board (DHB)’s’ Disability Strategy Implementation Plan 2016-2026.

Our ten year implementation plan aligns with the timeline of the NZ Disability Strategy 2016-2026. There will be two reviews of our Disability Strategy Implementation Plan during the ten year period – one in 2020 and one in 2023. These are an opportunity to ensure that the work being done is making a positive difference to disabled people and is supporting our goal of being fully inclusive and non-disabling.
New Zealand Disability Strategy 2016-2026

Figure 1 | Disability Strategy Framework

Vision
New Zealand is a non-disabling society – a place where disabled people have an equal opportunity to achieve their goals and aspirations, and all of New Zealand works together to make this happen.
The Disability Strategy identifies eight outcome areas -

The outcome areas that will contribute to achieving the vision of the Strategy are:

**Outcome 1 – Education**
We get an excellent education and achieve our potential throughout our lives

**Outcome 2 – Employment and economic security**
We have security in our economic situation and can achieve our full potential

**Outcome 3 – Health and wellbeing**
We have the highest attainable standards of health and wellbeing

**Outcome 4 – Rights protection and justice**
Our rights are protected; we feel safe, understood and are treated fairly and equitably by the justice system

**Outcome 5 – Accessibility**
We access all places, services and information with ease and dignity

**Outcome 6 – Attitudes**
We are treated with dignity and respect

**Outcome 7 – Choice and control**
We have choice and control over our lives

**Outcome 8 – Leadership**
We have great opportunities to demonstrate our leadership

All eight outcomes are relevant to the work of the District Health Boards and will drive our core work over the next ten years. Our work will have a particular focus on five outcomes – Employment & economic security, Health & wellbeing, Accessibility, Attitudes and Choice & control.

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**Influences**

There are a number of other principles, disability strategies and action plans that influence the DHB’s Implementation Plan. These include:

- Te Tiriti o Waitangi
- Disability Action Plan 2014-2018
- United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- Faiva Ora: National Pasifika Disability Plan 2016–2021
- Auckland DHB & Waitemata DHB Annual Plans
Disability Action Plan 2014-2018

This is a key document in the implementation of the Disability Strategy. The Disability Action Plan presents priorities set by the Ministerial Committee on Disability Issues for actions that advance the implementation of the UN Convention on the Rights of Persons with Disabilities and the New Zealand Disability Strategy 2016-2026. These priorities emphasise actions requiring government agencies to work together, as well as with disability sector organisations and others.

Five Person Directed outcomes:
- Safety/autonomy
- Wellbeing
- Self-determination
- Community
- Representation

Four main areas of focus:
- Increase employment opportunities
- Ensure personal safety (includes decision making and consent)
- Transform Disability Support system
- Promote access in the community

‘Promote access in the Community’ includes 11c – Access to health services and improve health outcomes for disabled people with a focus on people with learning disabilities.

Values

The Values of Auckland and Waitemata DHBs reflect a shared vision for equity and inclusion of disabled people in their care and in the design of patient facilities and services.
Monitoring and Reporting

Work is underway at the Office for Disability Issues to ensure that progress toward achieving the outcomes of the New Zealand Disability Strategy can be measured. This will involve the development of an Outcomes Framework which will specify targets and indicators that will be regularly reported on. Work on this will include getting advice from disabled people, the disability sector and other government agencies.

The Auckland and Waitemata DHBs’ New Zealand Disability Strategy Implementation Plan 2016-2026 will be monitored internally and progress of actions will be reported to the Disability Support Advisory Committee (DSAC) on a quarterly basis.

We will ensure that the DHB Disability Strategy Implementation Plan continues to align with the NZ Disability Strategy, as well as other government strategies and action plans.

There will be two reviews of our Disability Strategy Implementation Plan during the ten year period – one in 2020 and one in 2023. These are an opportunity to ensure that the work being done is making a positive difference to disabled people and is supporting our goal of being fully inclusive and non-disabling.

Current Priorities

Both Auckland and Waitemata DHBs are committed to the vision of being fully inclusive and non-disabling. Current work that will continue across both DHBs as part of the Disability Strategy Action Plan includes improving health literacy and enhancing the patient experience.

Health Literacy

Waitemata and Auckland District Health Boards have made a commitment to improve health literacy across both organisations. Health Literacy means that "people can obtain, understand and use the health information and services they need to enable them to make the best decisions about their own health or the health of a dependant family member/friend”

This work focusses on two areas:

• improving health literacy of both organisations and their staff
• enabling communities to become more health literate

Patient Experience

There is a focus on Patient Experience and Community Engagement across both DHBs. This has led to greater inclusion of disabled people in design and planning of both facilities and services. Examples of this are the Public Spaces work at Auckland DHB and the Waitemata 2025 commitment to universal design as a core design principle.
## Outcomes

Of the eight outcome areas of the New Zealand Disability Strategy 2016-2026, there are five key outcome areas that align with the work of District Health Boards.

<table>
<thead>
<tr>
<th>Outcome 2: employment &amp; economic security</th>
<th>Outcome 3: health &amp; wellbeing</th>
<th>Outcome 5: accessibility</th>
<th>Outcome 6: attitudes</th>
<th>Outcome 7: choice &amp; control</th>
</tr>
</thead>
<tbody>
<tr>
<td>We have security in our economic situation and can achieve our potential</td>
<td>We have the highest attainable standards of health and wellbeing.</td>
<td>We access all places, services and information with ease and dignity.</td>
<td>We are treated with dignity and respect.</td>
<td>We have choice and control over our lives.</td>
</tr>
<tr>
<td>Increase the number of disabled people into paid employment. Record the number of staff with impairments working for the DHB. Increase the confidence of Hiring Managers to recruit disabled people.</td>
<td>Robust data and evidence inform decision making. Barrier free and inclusive access to health services. Improve the health outcomes of disabled people, with a specific focus on people with learning disabilities.</td>
<td>Barrier free and inclusive access to health services. The principles of universal design and the needs of disabled people are understood and taken into account. Improve &amp; increase accessible information across the DHB. Ensure physical access to DHB buildings and services.</td>
<td>All health and wellbeing professionals treat disabled people with dignity and respect. Provide a range of disability responsiveness training. Disabled people are able to access supports that they need in hospital.</td>
<td>Engage regularly with the disability sector and community. Ensure a diverse range of disabled people are identified as stake-holders. Supported decision making and informed consent. Ensure services are responsive to disabled people and provide choice and flexibility.</td>
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</table>
Recommendation

It is recommended that the Disability Support Advisory Group:

Receive the update on Improving NZ Disability Data from Stats NZ

Prepared and submitted by: Doone Winnard, Clinical Director, Population Health

Background

Concerns have been expressed in previous DISAC meetings, both district and regional, about the limited population data available about people with disabilities to support service planning and improvement. In June 2017, Stats NZ released an information paper on the new use of a short set of questions about disability in two of NZ’s household surveys (attached as Appendix 1).

The Stats NZ paper reports how the ‘Washington Group Short Set’ (WGSS)\(^1\) of questions is now being incorporated into the NZ General Social Survey (NZGSS) and the Household Labour Force Survey (HLFS). This will allow us to get greater value from those surveys by enabling information already collected to be broken down by disability status. The NZGSS is collected over a 12-month period and is carried out every two years. Interviews for the 2016/17 survey year have included questions from which disability status can be derived. The HLFS is collected continuously and published every quarter and the disability questions will be included in each June quarter.

The Stats NZ report noted the WGSS questions have also been tested for use in the 2018 Census; the decision has now been made to include them in the 2018 Census. These questions will replace the questions in the previous censuses that helped to identify a sample for the post-censal NZ Disability Survey; those questions were identified as not suitable to publish as an indicator of disability.

The NZ Disability Survey (NZ DS) has previously been undertaken after each of the last four Censuses. It is not being undertaken after Census 2018; the next NZDS is planned for 2023.

Important expectations to note regarding the new disability questions being used

It is expected that the population identified as disabled using the WGSS of questions will be considerably smaller than the population identified by past and future disability-specific surveys – likely a prevalence of disability of about 10% compared with 24% for all people in the 2013 NZDS. People with low levels of functional difficulty are counted in the NZDS disabled population but not in the WGSS population, and there are also less domains of disability covered by the WGSS.

The [WGSS] questions are intended to identify the population with functional limitations that have the potential to limit independent participation in society. This aims to understand social inclusion; for example to compare levels of participation in employment, education, or family life for those with

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\(^1\) The Washington Group on Disability Statistics promotes international co-operation in the area of health statistics focusing on disability data collection tools suitable for censuses.
disability versus those without disability. The Washington Group selected equalisation of opportunities as the primary purpose for an internationally comparable short set of disability questions.

Stats NZ acknowledge that the rationale for the WGSS means that the WGSS questions are not designed for estimating prevalence of disability, nor for use in understanding need for services or interventions that can improve the lives of disabled people. That information needs a disability-specific survey that allows for the use of more extended question sets.

The questions being included in the NZGSS, HLFS and Census 2018

The excerpt below shows the disability questions that will be included in NZGSS, HLFS and Census 2018 (page 9 of the attached Stats NZ report):

We have made slight wording adjustments to the questions to accommodate differences in the delivery mode of our household surveys and to be consistent with the rest of the survey. The NZGSS uses face-to-face interviews, while the HLFS is carried out largely by telephone. We have also dropped the optional words shown in brackets.

Washington Group Short Set of questions on disability

1. Do you have difficulty seeing, even if wearing glasses?
2. Do you have difficulty hearing, even if using a hearing aid?
3. Do you have difficulty walking or climbing steps?
4. Do you have difficulty remembering or concentrating?
5. Do you have difficulty (with self-care such as) washing all over or dressing?
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

Response options

a) No — no difficulty
b) Yes — some difficulty
c) Yes — a lot of difficulty
d) Cannot do at all

Different thresholds can be set for deriving disability status from these questions. The Washington Group recommends a threshold that requires people to have at least ‘a lot of difficulty’ with at least one of the activities to be counted at disabled.

Also attached is a copy of a recent report from Auckland Council about indicators of well-being for older adults. It is regional rather than Counties specific data and is also provided today for discussion (Appendix 2).

On 8 August, Stats NZ published an article entitled ‘Supporting disabled people:2013’ which presents findings on support received by disabled people in some aspects of their personal lives. A copy of attached as Appendix 3.

Disability can be measured for a variety of purposes. Each purpose can be related to different dimensions of disability or different concepts about components of disability. This means there needs to be a clear link between the purpose of measurement and how we define indicators of disability.
Improving New Zealand disability data
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Purpose and summary

Purpose

Improving New Zealand disability data outlines Stats NZ’s plans to publish new data about disabled people. The paper provides information about the way in which the new data has been produced and why it is needed. Understanding this will help to ensure that the data is interpreted correctly and used effectively.

An increasing need for information about disabled people is driven by the Government’s commitment to the New Zealand Disability Strategy 2016–2026 and to international conventions. These commitments require the monitoring of change across a range of socio-economic measures, to ensure that any disadvantage faced by disabled people is being reduced or eliminated.

Data is also needed to inform planning and funding for programmes that facilitate this goal. These include services, equipment, and environmental change required to ensure that disabled people can achieve at the same level as the rest of the population.

Summary

The 2016/17 New Zealand General Social Survey (NZGSS) and the June 2017 quarter of the Household Labour Force Survey (HLFS) have new questions that allow us to produce findings for disabled and non-disabled people separately. We aim to publish findings from the new questions with the first release of data from both surveys.

The specific measure we are using to identify disabled people in these surveys is known as the Washington Group Short Set (WGSS). The same questions have been tested for inclusion in the 2018 Census, and a decision on this will be made in June or July 2017.

We expect the inclusion of the relevant questions to be a long-term change to the core content of the NZGSS (run every two years) and the June quarter of the HLFS. Census content decisions are made independently each time the census is run.

The decision to use the WGSS is based on a number of factors, including:

- the considerable expertise that has been involved in the development of the questions
- the intended use of the WGSS matches our needs
- the results will be internationally comparable
- the question set is short enough to include in our existing surveys.

The WGSS will be used to produce estimates of key socio-economic measures by disability status. It will not be used to produce estimates of disability prevalence or to investigate levels of need for services or environmental change. To meet these and other data needs, a disability-specific survey, with a more extensive question set, will be required.

Agreed funding for post-censal surveys means that the next disability-specific survey is expected to take place in 2023. This will result in a 10-year gap between disability-specific surveys in New Zealand. We looked into whether a short question set could be added to existing surveys, to
generate regular and timely information about disabled people. The inclusion of the WGSS will also help to maximize the value of data that we are already collecting.

We expect that the population identified as disabled using the WGSS will be considerably smaller than the population identified by past and future disability-specific surveys. We also anticipate some differences in the size of the disabled populations identified in the surveys to which the WGSS has been added.
New disability data from Stats NZ’s household surveys

In order to produce information about a population group, such as disabled people, we must be able to identify who is in the group of interest. A disability status measure is based on a set of questions that allows disabled people to be identified in data collections and surveys. We can then analyse the data for disabled people and compare them with other groups.

How to best construct disability status measures continues to be the subject of debate internationally, and there is currently little consistency in the way developed nations identify disabled people in national surveys. There has, however, been some movement towards a shared understanding of concepts and methods in this area.

Deriving disability status in surveys that are not disability-specific requires survey designers to find a short set of suitable questions. One such set is the Washington Group Short Set (WGSS) and this has been chosen as the most suitable available for our purposes. See The Washington Group on Disability Statistics for more information about this question set.

Both the NZGSS and the HLFS (and potentially the 2018 Census) will include the WGSS questions. Disability status will be derived from answers to the questions in this set.

Including disability status in these surveys addresses, in part, a strongly expressed need for more comprehensive and more frequent data about disabled people in New Zealand. We can obtain greater value from the investment in the NZGSS and HLFS by enabling information already collected to be broken down by disability status. This will help to support decision makers in government and across the disability sector by providing timely and comparable data about this vulnerable population group.

New Zealand General Social Survey

The NZGSS provides information about the well-being of New Zealanders aged 15 years and over. It covers a wide range of social and economic outcomes and shows how people are faring in these aspects of their lives. In particular, the survey provides a view of how well-being outcomes are distributed across different groups of the population.

The NZGSS is collected over a 12-month period and is carried out every two years. Interviews for the 2016/17 survey year have, for the first time, included questions from which disability status can be derived. This will allow analysts and researchers to examine how well disabled people are faring compared with other groups across the range of well-being outcomes covered by the survey.

Disability status will be available on NZGSS datasets, and tables will be published on the Stats NZ website. The new questions will be included in the NZGSS every time it is run so that results can be compared over time.
Household Labour Force Survey

The HLFS is collected continuously and published every quarter. The purpose of the HLFS is to produce a timely, relevant, and comprehensive range of statistics relating to the employed, unemployed, and those not in the labour force, using international standards and guidelines.

Disability status will be derived from questions in the HLFS for the June 2017 quarter and in every June quarter from then on. Results by disability status will be published as part of the June quarter Labour Market release on the Stats NZ website and variables will be included in HLFS datasets.

Census of Population and Dwellings

The next Census of Population and Dwellings will be run in 2018. Testing has been carried out on the inclusion of the same questions to derive disability status in this census as we have included in the two household surveys. Decisions about the content of the 2018 Census are due to be released in June or July 2017.
The Washington Group on Disability Statistics

We have chosen to use the Washington Group Short Set of questions to identify disabled people in Stats NZ’s existing surveys.

The Washington Group on Disability Statistics is a UN city group, established to create robust measures of disability status and promote international comparability in disability data.

The Washington Group question sets for identifying disabled people are gaining acceptance and seeing increased use around the world. Considerable work has been carried out on the design and testing of the question sets, and extensive documentation of the processes used can be found on the Washington Group website.

The Washington Group question sets have been developed to enable member states to fulfil the monitoring obligations established by ratification of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD). They are also recommended by the UN Economic and Social Commission for Asia and the Pacific (ESCAP) for use in monitoring progress against the Incheon Strategy. In a joint statement in November 2016, the inter-agency expert group on SDG indicators (IAEG-SDG) endorsed the use of Washington Group question sets by national statistical offices for the disaggregation of data on adults and children. The Washington Group provides information on international monitoring recommendations on its website.

The Washington Group question sets are based on the International Classification of Functioning, Disability and Health (ICF).

The Washington Group Short Set

The Washington Group Short Set (WGSS) is a set of six questions on functioning difficulties and activity limitations. It was developed for inclusion in population censuses and in surveys where only a small number of questions can be used. It is based on the ICF and was designed with a specific purpose in mind.

Read the statement of rationale for the Washington Group general measure on disability.

Two important paragraphs from that document are:

Equalization of opportunities was agreed upon and selected as the purpose for the development of an internationally comparable general disability measure. This purpose was chosen because:
1) It was relevant (of high importance across countries with respect to policy), and;
2) It was feasible (it is possible to collect the proposed information using a comparable general disability measure that includes a small set of 6 census-like questions).

...The [WGSS] questions identify the population with functional limitations that have the potential to limit independent participation in society. The intended use of this data would compare levels of participation in employment, education, or family life for those with disability versus those without disability to see if persons with disability have achieved social inclusion. In addition the data could be used to monitor prevalence trends for persons with limitations in the particular basic activity domains. It would not represent the total population with limitations nor would it necessarily represent the ‘true’ population
with disability which would require measuring limitation in all domains and which would require a much more extensive set of questions.

The rationale makes it very clear that the WGSS is not designed for estimating prevalence of disability, nor for use in understanding need for services or interventions that can improve the lives of disabled people. These information needs must be met using a disability-specific survey that allows for the use of more extended question sets.

We have made slight wording adjustments to the questions to accommodate differences in the delivery mode of our household surveys and to be consistent with the rest of the survey. The NZGSS uses face-to-face interviews, while the HLFS is carried out largely by telephone. We have also dropped the optional words shown in brackets.

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Response options

a) No — no difficulty  
b) Yes — some difficulty  
c) Yes — a lot of difficulty  
d) Cannot do at all

Different thresholds can be set for deriving disability status from these questions. The Washington Group recommends a threshold that requires people to have at least ‘a lot of difficulty’ with at least one of the activities to be counted as disabled.

Expectations about the disabled population

The population identified as disabled by the WGSS will be smaller than the one derived from a more extensive question set, such as that used in the New Zealand Disability Survey (NZDS). Examples from five countries (across several years) give overall disability prevalence rates between 6 and 10 percent (Loeb, 2016) when the WGSS questions are used as intended.

In 2016, the Australian Bureau of Statistics (ABS) ran a Supplementary Disability Survey using the WGSS and released an estimated disability rate of 6.7 percent for their national population. Note that the ABS uses their Survey of Disability, Ageing and Carers to generate the official Australian national disability prevalence rate, which was 18.3 percent in 2015.

In New Zealand, the disability prevalence rate from the 2013 NZDS was 24 percent for all people and 23 percent for people living in private dwellings. We are anticipating that the disabled
population identified by WGSS will be about 10 percent. We also expect that the disabled populations identified by different surveys using the WGSS will not be identical. Differences in method and purpose of the surveys will affect the results.

Important reasons for a finding a smaller population using the WGSS compared with the NZDS are:

- the population coverage is smaller
- the threshold for ‘disabled’ is higher
- fewer domains are included.

Population coverage

HLFS and the NZGSS are household surveys. Only people who live in private dwellings are in the sample. The NZDS included a sample of residential care facilities, as well as some group homes. The smaller coverage of dwelling types will result in a smaller disabled population, as the dwelling types that are not in these surveys can have large proportions of disabled people.

Threshold for disability

A survey respondent is required to indicate ‘a lot of difficulty’ or ‘cannot do at all’ for at least one of the six WGSS questions in order to be counted as disabled. This is a higher threshold than used in the NZDS where the response option ‘with difficulty’ did not allow for the separation of people with some difficulty from those with a lot of difficulty. People with low levels of difficulty are counted in the NZDS disabled population but not in the WGSS population.

Disability domains

When designing measures to identify disabled people in surveys, a decision must be made about how many ‘domains’ to include. A domain is usually associated with a particular impairment type or regular activity.

The NZDS identified disabled people across 10 domains:

- hearing
- vision
- mobility
- agility
- intellectual
- psychological/psychiatric
- speaking
- learning
- memory (for adults)
- developmental delay (for children).

The NZDS also had more than one question for some of these domains. The result was 23 questions for identifying disabled adults and 14 for identifying disabled children. A question set of this length is not suitable for use in surveys that are not disability-specific, however, it will identify
a disabled population that is larger than one identified by only six questions. The six domains included in the WGSS were chosen because they were found to be the ones that identified a majority of people at risk of being restricted in their independent participation in society.

Stats NZ will not use the WGSS to estimate official disability prevalence rates, as this is not the intended purpose of the questions. We also advise against comparing findings from surveys using the WGSS with those from the NZDS. Only a disability-specific survey can produce good estimates of the size of the disabled population, by including a more extensive question set covering more domains, and possibly more dwelling types. A disability-specific survey will allow investigation of the use of assistive devices, services, and environmental changes, and will look more closely at reasons for disparities found in other data sources.
Background to New Zealand disability data

The New Zealand Disability Survey

The New Zealand Disability Survey (NZDS) has been carried out by Stats NZ in the same year as the census since 1996, however, it will not be conducted in 2018. To date, this disability-specific sample survey has been the main source of official statistics about disabled people in New Zealand.

The primary purpose of the NZDS is the estimation of disability prevalence rates for key demographic groups. The survey provides information on socio-demographic characteristics of disabled people. It also collects data on met and unmet need for support and assistive equipment, and on outcomes and barriers to participation across a range of social and economic activities.

In 2012, funding for future provision of social statistics was approved by Cabinet. The funding allows for one post-censal survey in the same year as each population census. Te Kupenga (a survey of Māori well-being) will be the 2018 post-censal survey. We expect to conduct the next disability-specific survey in 2023.

The growing need for disability data

Since the first NZDS was run in 1996, the field of disability rights, both nationally and internationally, has advanced considerably.

The New Zealand Disability Strategy 2001 was heralded as internationally significant in its approach to identifying and addressing inequities faced by disabled people across the full range of rights and entitlements. The recent launch of the New Zealand Disability Strategy 2016–2026 sets out a course for the next 10 years. Monitoring how well we are progressing against the goals of the Strategy requires regular and high quality data.

Ratification of the CRPD by the New Zealand Government in 2008 meant a new set of obligations for New Zealand to demonstrate that opportunities for disabled people do not differ from the rest of society, that people’s rights under the CRPD are upheld, and their dignity respected in all aspects of life. Regular reports to the UN Committee on the Rights of Persons with Disabilities are required in which New Zealand must show that we are meeting our obligations under the CRPD or, if not, what we are doing about it.

Other important international initiatives include the UN Sustainable Development Goals (SDGs), which came out of the Rio+20 Conference held in 2012. New Zealand is working out how to prioritise and progress domestic action relating to the SDGs, and timely data will be needed to report progress for vulnerable population groups, including disabled people.

International agreement is growing on the need for more data, and specifically more internationally comparable data, about disabled people, in order for countries to demonstrate their commitment to specified goals.
Conceptualising disability

In recent years, considerable work has been carried out in national statistical offices and by international agencies to develop and standardise methods for identifying disabled people in population surveys.

Since its publication in 2001, the ICF has seen growing acceptance as a common language and framework for use in disability measurement. In this framework, disability is seen as a dynamic process that involves the interaction of a person’s functional status with their physical, cultural, and policy environments. The focus is on a person’s ability to function within an environment, not on the presence of disease or on self-identity. The ICF approach is described as being a ‘bio-psycho-social’ model. It takes into account impairments in body function and structure, difficulties in daily activities, and restrictions in participation in a range of life domains.

The ICF is the underlying model of disability adopted by the UN in the CRPD. It was used in the first World Report on Disability published by WHO in 2011. The ABS and Statistics Canada both use the ICF as the basis for their national disability surveys, and Stats NZ has endorsed this idea of disability. The changes made to the disability status indicator for children in our 2013 survey were specifically aimed at bringing the measure into line with ICF concepts that were reflected in the adult indicator.

A shared conceptual basis for understanding disability, while a good start, is only part of the picture. In the detailed specification of a disability status measure, a number of other issues must be resolved. These include:

- For what purpose are disabled people being identified?
- Which aspects of body function or structure, activity limitations, or participation restrictions should be made explicit?
- What question wording, order, format, and collection method will elicit the best answers?
- How should thresholds for assigning disability status be set?

Even when there is agreement on the concept under investigation, any variation in addressing these issues will result in different measures and different, albeit overlapping, groups of people being identified as disabled.

There is increased international consensus on the idea of disability and its place in social data. However, differences remain in the specific methods used to identify disabled people in surveys.

From an operational perspective, there have been long-standing reservations in New Zealand about publishing statistics from surveys that use different disability status measures, due to concerns about confusing users.

Survey designers have been unwilling to add extensive question sets to existing surveys when response rates are generally declining and respondent burden is of concern. This has certainly been the case in New Zealand, where the NZDS module for identifying disabled people includes 23 questions for adults and 14 for children.

Resistance to adding large question sets to existing surveys, combined with a desire to have one standard approach to identifying disabled people in official statistics, has meant that Stats NZ has shied away from mainstreaming disability measurement. The development of the WGSS and its growing endorsement internationally have been important drivers of change in this area. A greater
strategic focus within Stats NZ on maximising the value of our data collections to meet customer needs has also underpinned the changes.
Conclusion

There are considerable advantages to mainstreaming disability data by including a measure of disability status as a standard demographic characteristic in relevant official data collections. The ability to disaggregate existing, high-quality data collections by disability status can add substantially to available information about disabled people.

The inclusion of the WGSS in household surveys does not remove the need for a comprehensive disability-specific population survey. It does mean that a range of new information about disabled people will be available, and the continuous inclusion of the measure in these surveys will allow trends over time to be monitored in a way that has not been possible before.

Providing robust disability statistics is both complex and controversial, and having more than one disability status measure is new territory for data users in New Zealand. We are sure, however, that adopting the WGSS to provide more information about this vulnerable population group will be of great value in the ongoing quest to improve the lives of disabled people.
Improving New Zealand disability data

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Older Aucklanders: A quality of life status report

June 2017

Technical Report 2017/014

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The project team are indebted to those external groups and agencies that provided feedback on early versions of the reporting framework, and to the independent reviewers for their helpful comments with this report.

We would also like to thank all those who took part in the 2016 Survey of Older Aucklanders commissioned by Auckland Council and administered by Gravitas Research Ltd, an independent research company. The findings from that survey are a vital component of this report.
Mihi

Give me breath, give me life and, let my expectations seek worthy resolve. Allow my spirit to take wing, and my heart resound with joy.

Where ambition having scaled to the highest of peaks can boast from heaven itself with pride; “Now I can indeed feast with the brave and the best.”

I have walked life’s byways, I have seen the world and all its majesty through the eye of an eagle, soaring in the skies above.

I have heard the very heartbeat of the earth beneath my feet.

I have delved into the meaning of life itself.

It leaves me to conclude; Life with all its challenges, at eventide when journey’s end is close, and all is said and done – let it rest, for life will still go on!

Tihewa mauriora!
Older Aucklanders: A quality of life status report

Alison Reid
Research and Evaluation Unit
Auckland Council
Foreword

If there is one constant in life, it's that we all age. It's equally true that when we are older, we should expect to feel no less significant or worthy than we did in our younger years. With this understood, it's a given that both cities and societies must be built with older people in mind.

To do that properly means understanding – really understanding – the challenges that older people face alongside their aspirations and their capacity to contribute.

We have an ageing population in New Zealand and in Auckland around one in 10 people are over the age of 65. Within the next few decades Auckland will be home to significantly more older people than ever before as our large population of ‘Baby Boomers’ enter their senior years.

The Auckland Plan, a 30-year vision for Auckland, includes a clear directive to ‘Recognise and value the contribution of older people to the community’.

This report tackles that head on by taking issues relevant to all us, from housing and transport to culture and identity, and looking at each from the perspective of older Aucklanders. It explores the importance of inclusiveness and positive imaging of older people, the realities of social isolation and the impact of that on mental, emotional and spiritual well-being. And it considers the significant contribution that older Aucklanders can and do make to our region’s economy and society.

As you read the report you will find that Auckland’s over 65 population is as diverse as any other age group. There is no precise definition of ‘old age’. The age at which a person is considered, and considers themselves, old differs from person to person and group to group. This report highlights the importance of not assuming that older Aucklanders are all the same.

As the title suggests, this report documents the quality of life of older Aucklanders at a moment in time and, importantly, it provides Auckland Council with a vital baseline to help frame future research, strategy and policy.

By better understanding the experience and insights that an ageing population can offer, we can create an age-friendly environment where older Aucklanders are visible, valued and respected.

Liaison Councillor, Seniors Advisory Panel
Linda Cooper
Executive summary

Background and purpose of this report

The intention of this report is to trace the multiple dimensions of social and economic well-being among older Aucklanders. It represents an important step in Auckland Council’s response to the implications of population ageing, now and into the future. In 2013, a quarter of all older people in New Zealand (defined here as those aged 65 and over) lived in Auckland, and this group made up just over one in ten Aucklanders. These proportions will increase in the next few decades, and the diversity that characterises older Aucklanders will become more pronounced.

The report outlines findings across eight broad domains, or themes, that contribute to high quality of life and well-being. These domains are as follows: housing; neighbourhood; transport; social connectedness; health and care; status in society; culture and identity; and economic standard of living. These domains complement the goals of the New Zealand Positive Ageing Strategy, but are focused on Auckland, which is unique in the New Zealand setting due to its large, multi-cultural and predominantly urban population.

This executive summary presents a brief overview of the findings from each domain.

Housing

Older Aucklanders live in a range of housing situations. In 2013, a quarter (25%) lived on their own, and 44 per cent were in a household that was defined as ‘couple-only’. A small proportion (5%) lived in crowded situations (e.g. requiring extra bedrooms). Levels of home ownership among older Aucklanders are higher than the rest of the adult population, although they are gradually decreasing over time. In 2013, over two-thirds (67%) owned or partly owned the dwelling they lived in, compared with a third (39%) of those aged 15 to 64. Around one in five told us that they did not think their housing costs were affordable, and about one in ten agreed that their home had an issue with damp and mould in winter.

Neighbourhood

Neighbourhoods can provide older Aucklanders with a healthy and supportive living environment. This includes the physical environment, as well as the socio-cultural aspects of community engagement and support. We asked respondents to the survey of Older Aucklanders a few questions about their neighbourhood - in general, most (79%) agreed that it was easy to access amenities such as shops and parks (79%), public facilities such as the library or community hall (74%) and services such as the dentist or doctor (77%) in their local area. Over half (60%) felt there was a sense of community in their local area and 60 per cent felt safe or very safe in their local area after dark.
Transport

Mobility and being able to get around the city easily is vital to an active and healthy life. Most older Aucklanders are eligible to use the SuperGold card for free travel on public transport services, which is particularly beneficial for those on fixed incomes as well as those who do not wish to, or can no longer drive. Most (83%) of respondents to the survey of Older Aucklanders who had used public transport in the previous 12 months agreed that public transport is safe, and 75 per cent felt it was affordable, however a slightly lower proportion agreed it is easy to use (69%).

Social connectedness

Mental, emotional and spiritual well-being among older Aucklanders is enhanced by meaningful social connections. Just over three quarters (77%) of respondents to the survey of Older Aucklanders agreed that they were visited by family or friends as often as they would like, and a majority (80%) stated that they belonged to one or more social networks or groups. One in five (20%) said they did not belong to any of the options that were provided – across all age groups, however those aged 85 and over were slightly over-represented.

High proportions (70%) trusted people they dealt with regularly and most (72%) of those who had access to the internet said they used it every day. However a quarter of respondents to the survey said they had ‘sometimes’ felt lonely and isolated in the previous year, and Age Concern (as well as other agencies working with older people) report that this is a very real issue for some older members of society, leading to depression and anxiety.

Health and care

As people age, health needs can become more immediate and there tends to be a greater reliance on the health care system. The majority (80%) of respondents to our survey rated their level of health as good or excellent, however 7 per cent had experienced stress that had a negative effect on them in the previous 12 months, and a sizeable proportion (17%) had postponed or put off a visit to the doctor or their GP in the previous year in order to keep costs down.

In 2015, there were over 3000 public hospital discharges among people aged 65 and over in Auckland related to falls, and 102 deaths – over half of which were among people aged 85 and over. One in ten older Aucklanders are regular smokers (down from 14 per cent in 2006).
Status in society

The expression of positive attitudes and behaviours towards ageing, and the aged, within broader New Zealand society underpins a sense of belonging and inclusion. Over half (56%) of respondents to the survey of Older Aucklanders agreed that they had the opportunity to play a role as an elder in their family or wider community, however only 41 per cent felt that older people are valued in Auckland, and 14 per cent felt they had been discriminated against in the previous 12 months due to their age.

Large proportions (83%) of older people eligible to vote did so at the 2014 central government elections. Data on voting is not available for local elections; however, Auckland Council data suggests that at the 2016 local government elections older people were over-represented among those who stood for elected roles, compared to other age groups.

Culture and identity

Diversity among older Aucklanders must be recognised and responded to appropriately, starting with recognition of the benefits for older Māori to engage with Te Ao Māori (including te reo, tikanga, wahi tapu and access to whanau and hapū). Te Kupenga survey of Māori in Auckland found that over a quarter (28%) of older Māori (those aged 55 and over) felt that it was very important to be engaged in Māori culture, over half (54%) had been to a marae in the previous 12 months, with a further 41 per cent reporting they had been to their ancestral marae during that time, and 21 per cent had undertaken voluntary work for a marae, hapū or iwi. Levels of conversational te reo are relatively low among this group, at 9 per cent in 2013.

Auckland is also a multi-cultural society which is reflected in the older age groups (albeit not to such a large extent as the younger age groups). Samoan, Yue, Northern Chinese and Hindi languages are the most commonly spoken languages among older Aucklanders after English (approximately 3000 in each language group).

Almost half (48%) of respondents to the survey of Older Aucklanders agreed that their culture was an important part of their identity, particularly those who identified with an Asian ethnicity (72%). A majority (83%) of those who strongly identified with a religion or spiritual group agreed that they were able to regularly participate in spiritual events, activities and traditions that were meaningful to them.

Many older Aucklanders have lived through a time when diversity and difference from predominantly western and heteronormative European values was not recognised or celebrated. This may have had deep and lasting impacts on how they view themselves and others, and can impact on their experience in health care and support systems.
Economic standard of living

Older Aucklanders are also diverse with regard to their economic standard of living, and sources of income.

At the 2013 Census, 22 per cent were working in paid employment. The number and proportion of older Aucklanders who were employed had increased since 2006 (17% in 2006 to 22% in 2013). Over half of this group (58%) were paid employees, 27 per cent were self-employed and 10 per cent were employers.

The median personal income among those aged 65 and over was $20,900 in 2013, compared to a median of $29,600 for the overall population aged 15 and over. Over half (58%) of older Aucklanders who stated an income source on their Census form listed more than one source. The majority reported that they received an income from NZ Superannuation or a veteran’s pension (85%). Almost 35,000 older people (22%) lived in areas rated 8, 9 or 10 (most deprived) on the NZ Deprivation Index.

Older Aucklanders contribute significantly to Auckland’s economy and society through their unpaid labour and volunteer work, including caring for family members. At the 2013 Census eight in ten Aucklanders aged 65 years or over (79%) said they partook in unpaid activities such as household work or childcare in the four weeks prior to census day. While this can keep people connected it is also essential that they are supported adequately.

Discussion and conclusion

Auckland is a great place to live for many people, and there is much to celebrate. However, this report also touches on some areas of concern, and highlights the importance of not assuming that older Aucklanders are a cohesive and homogenous group.

This baseline report provides a useful foundation upon which Auckland Council can continue to trace the quality of life of older Aucklanders, as Auckland responds to what will be several substantial demographic changes over the next few decades. Auckland will be home to substantially larger numbers, and greater proportions, of older people over the next few decades, and this group will be ethnically and culturally diverse. These trends will bring specific challenges and opportunities across Auckland’s housing, transport, employment, healthcare, service and support systems.

Auckland Council will continue to work with its stakeholders to create an age-friendly environment where older Aucklanders are visible, valued and respected.
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Introduction

This report presents an overview of the social and economic status of ‘older Aucklanders’, defined as people aged 65 years and over and living in Auckland. At the 2013 Census, a quarter of all older people in New Zealand lived in Auckland, and this group made up just over one in ten Aucklanders.

Demographic trends mean that Auckland will be home to significantly more older people than ever before in the next few decades, and that older people will represent a greater proportion of the overall population. Furthermore, it is projected that about a third of New Zealand’s overall growth in this age group will occur in Auckland.

The contributions and challenges that an ageing population brings are recognised by Auckland Council. In line with this, Auckland Council has established a Seniors Advisory Panel, who provide knowledge on issues that are important to older Aucklanders in relation to the council’s regional strategies, policies, plans and bylaws; and advising the council on how to engage effectively with older Aucklanders.

The Auckland Plan, a 30 year vision for Auckland, includes a clear directive to ‘Recognise and value the contribution of older people to the community’ and an action to ‘Develop an annual report on the status of older people in Auckland, including indicators from the New Zealand Positive Ageing Strategy, and their overall contribution to New Zealand’.

This report is an initial step in addressing this directive. It has been prepared by the Research and Evaluation Unit (RIMU) at the request of the Community and Social Policy Department within Auckland Council, and is a baseline report upon which future research, policy and monitoring activities can expand.

Old age is no place for sissies.
Bette Davis

Grow old along with me! The best is yet to be.
Robert Browning
Demographic context

Overview

In 2013, there were 163,161 people aged 65 and over living in Auckland, accounting for 11 per cent of the total Auckland population, and a quarter (27%) of the national count of older people.

This broad age group spans several life stages: just over half (58%) were aged 65 to 74 ('young-old'), while 30 per cent were aged 75 to 84 ('old'), and 12 per cent were aged 85 and over ('older-old'). Auckland was home to 165 people aged 100 and over.

The number of older Aucklanders has been increasing over the last few decades.

As Figure 1 illustrates, this growth has been particularly large in the 65-74 year age group, jumping from 62,820 in 2006 to 95,190 in 2013. This is related to the ‘baby boom’ cohort (often referred to as those born between 1946 and 1964)\(^3\) reaching age 65, and will also be a result of net in-migration from other parts of New Zealand and from overseas.

Future population growth and ageing

Over the next 20 years, not only will there be more people living in Auckland in general, but there will be increasing numbers of older people (numerical ageing) and they will make up a greater proportion of Auckland's population (structural ageing).\(^4\) The demographic phenomenon of population ageing is occurring across New Zealand, as well as many other countries. It has several drivers including improvements in life expectancy and longevity, combined with a decline in birth rates, which decreases the proportion of the population that is young and thereby increases the proportion that is old.\(^5\)

Statistics New Zealand population projections (medium series) suggest that the number of older Aucklanders will more than double in the two decades between 2013 and 2033, reaching a total of 353,600.\(^6\) Such significant proportionate growth is not anticipated in any other age group and is unprecedented in New Zealand history.

Figure 1: Actual and projected numbers of Aucklanders aged 65 and over, by age group, 2013 to 2043

Data source: Statistics New Zealand, Census and Statistics New Zealand, subnational population projections 2013(base)-2043 (updated) (medium series projections)
Birthplace

In 2013, over half (57%) of older Aucklanders were born in New Zealand.

The proportion of New Zealand-born was particularly high among those aged 85 years and over (64%). Of the 65,724 older Aucklanders who were born overseas, the largest number were born in the United Kingdom or Ireland (38%), followed by the Pacific Islands (19%), and almost two thirds (60%) had been living in New Zealand for 30 years or longer.

A small group (4116 people, or 7% of older Aucklanders) were born overseas and had lived in New Zealand for less than five years. This group could be referred to as 'new migrants'. The majority of older 'new migrants' were aged 65 to 74 years (73%). Just under half (49%) were born in an Asian country (this includes China and India as well as the countries of South-East Asia). The second largest group were born in the Pacific Islands (15%), followed by the United Kingdom and Ireland (14%).

Ethnic diversity

Older Aucklanders are an ethnically and culturally diverse group, albeit predominantly European. In 2013, just over three quarters (78%) of older Aucklanders identified with a European ethnicity. The next largest group were those classified under the broad Asian category (12%), followed by Pacific peoples (6%), and Māori (4%).

Those in the 'older-old' age group were less ethnically diverse than others. For example, in 2013, 90 per cent of Aucklanders aged 85 years and older identified as European, compared to 74 per cent of those aged 65 to 74 years.

There has been a significant increase in the numbers of older Aucklanders who identified with an Asian ethnicity, from 6060 in 2001 (6% of all older Aucklanders) to 18,927 in 2013 (12%). This is the result of rapid increases in immigration, especially in the mid-1990s and then again in the early 2000s from Asian countries.

Geographic distribution

As the map on the next page shows, large numbers of older Aucklanders live in areas on the edges of the isthmus, as well as on the northern coast, and on the edge of the urban area including Whangaparaoa Peninsula and Waiheke Island. This will be a result of a few factors, including past settlement patterns during their lifetime, and availability of suitable housing.

Male to female ratio

There are more older females than older males in Auckland – an overall ratio of 120 females to 100 males in 2013. There were also significant differences in sex ratios between the three age groups, with nearly twice as many females as males in the 85 years and over age group (ratio of 100:188), compared to an almost 1:1 ratio for people aged 65-74 years (100:108). This is related to longer life expectancy among females than among males.

*For more details on the demographic profile of Aucklanders aged 65 and over, please refer to the report on older Aucklanders prepared by Auckland Council following the release of 2013 Census data.*
Figure 2: Distribution of older Aucklanders by census area unit (2013)

Map prepared by Research and Evaluation Unit (RIMU), Auckland Council.
Data source: Statistics New Zealand, Census of Population and Dwellings.
Framework overview

There are obvious challenges in our ability to adequately discuss the complexities and nuances of the social and economic well-being of a large and diverse group such as older Aucklanders in a single report. We therefore offer an overview in this report, and have used over 40 indicators of well-being, within a broad framework of eight domains. We encourage the reader to refer to more detailed reporting undertaken by other agencies and groups on any areas of interest. References are included at the end of this report.

How is the framework arranged?

This report presents information on the social and economic well-being of older Aucklanders, arranged across eight broad inter-connected domains. Each domain is broken down further into several indicators, and an accompanying measure, or measures. These are further described below.

**Domains:** These are the broad themes, or groupings of factors, that contribute to high-level quality of life and well-being, e.g. ‘Housing’.

**Indicators:** These are summary in nature. They act as flags or signals. They represent an area of focus or concern that measures change or progress toward achieving a desired outcome or objective, e.g. ‘Affordability’.

**Measures:** Each indicator is accompanied by one or more measures. These can be quantitative data (such as personal income) or qualitative /subjective information (such as people’s perceptions of their quality of life) e.g. ‘Perceptions that housing costs are affordable’.
How were they selected?

The domains, indicators and measures used in this report were selected through a multi-stage iterative process:

- A literature review was undertaken to explore the determinants of well-being among older people. This included literature from overseas and well as New Zealand.8

- The domains and indicators in the New Zealand government’s Positive Ageing Strategy9 and the World Health Organisation’s Age-friendly Cities10 materials were reviewed for measurability and relevance to the Auckland context. This included ascertaining whether data at the Auckland level was robust enough to report on.

- A range of external stakeholders who work with, study and/or advocate on behalf of older Aucklanders were invited to provide feedback on a draft set of domains and indicators. The Auckland Council’s Seniors Advisory Panel was also invited to provide feedback. Some responses were more detailed than others, and responses tended to reflect the submitter’s particular field or sector. All feedback was collated, considered and, where appropriate, incorporated into the final set of domains and indicators.
### The framework

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing</strong></td>
<td>Older Aucklanders’ ability to access quality affordable housing solutions is crucial to their ongoing health and sense of well-being. There needs to be a range of appropriate housing solutions available, including options for long-term rental tenure, in which older people feel safe and secure.</td>
<td>-Housing type and tenure&lt;br&gt;-Household composition&lt;br&gt;-Crowding&lt;br&gt;-Perceptions of safety&lt;br&gt;-Affordability&lt;br&gt;-Housing quality&lt;br&gt;-Suitability</td>
</tr>
<tr>
<td><strong>Neighbourhood</strong></td>
<td>A healthy and supportive living environment for older Aucklanders includes not only the physical built environment in which they live, but also socio-cultural aspects such as opportunities to meaningfully engage in their wider community, and to feel supported by those around them.</td>
<td>-Perceptions of safety&lt;br&gt;-Accessibility&lt;br&gt;-Community strength and spirit</td>
</tr>
<tr>
<td><strong>Transport</strong></td>
<td>In a large urban area such as Auckland, it can be a challenge to get around. This is due to a range of factors including the adequacy of local infrastructure such as roads, footpaths, and public transport for the needs of older people; the ability of older Aucklanders to pay for transport; and their perceptions of safety.</td>
<td>-Walkability&lt;br&gt;-Licensed drivers&lt;br&gt;-Public transport&lt;br&gt;-Accessibility</td>
</tr>
<tr>
<td><strong>Social connectedness</strong></td>
<td>Emotional and spiritual well-being of older Aucklanders is enhanced by meaningful connection to others, and has links to positive health outcomes. Opportunities to connect exist through social institutions such as marae, churches, temples, mosques, gurudwara, clubs, and associations as well as inter-personal relationships within whānau, family, neighbours and friends. The ability to connect is enhanced by access to communication technologies.</td>
<td>-Contact with others&lt;br&gt;-Unpaid work / volunteering&lt;br&gt;-Access to telecommunications&lt;br&gt;-Social isolation&lt;br&gt;-Trust in others</td>
</tr>
<tr>
<td>Domain</td>
<td>Description</td>
<td>Indicators</td>
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<td>------------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| **Health and care**           | To reach a state of complete health (conceived as physical, mental and social well-being), older Aucklanders must be able to identify and to realise their aspirations, satisfy their needs, and be able to change or cope with their environment. As people age, the likelihood of disability and impairment increases, and it is vital that older Aucklanders have equitable access to adequate and affordable health and care services. | -Life expectancy  
-Smoking rates  
-Self-rated health status  
-Emotional health  
-Accidental injuries  
-Access to support and services  
-Levels of physical activity |
| **Status within society**     | The expression of positive attitudes and behaviours towards ageing, and the aged, within broader New Zealand society underpins a sense of belonging and the active inclusion of older Aucklanders in contributing to Auckland’s future. This includes engagement in Auckland’s social, economic and political realms, and the absence of elder abuse. | -Civic participation  
-Valued contribution  
-Discrimination by age  
-Victims of crime  
-Elder abuse |
| **Culture and identity**      | Older Aucklanders embody a range of traditions and cultures that bring diversity and vibrancy to the city. Māori – tangata whenua and matawaaka – have a unique cultural identity that is recognised through Te Tiriti o Waitangi/The Treaty of Waitangi and the Auckland Plan. It is also important that the human rights of all older Aucklanders to participate in their own cultural practices and traditions are guaranteed. | -Te Ao Māori  
-Participation and expression  
-Acceptance  
-Culturally appropriate services |
| **Economic standard of living** | It is important that all older citizens of Auckland have an adequate standard of income, whether through continued employment, income, or through receiving the financial benefits to which they are entitled. Socioeconomic status is a determining factor in health outcomes and subjective well-being. | -Socio-economic status  
-Paid employment  
-Income  
-Living standards |
Data sources used in this report

When preparing this reporting framework, a commitment was made to developing indicators that could be measured, and broken down by sub-group within Auckland. This included age, ethnicity and household income, where possible. To that end, we also reviewed the available sources of data (surveys, Census, official statistics etc.) that would allow us to develop measures of progress for each indicator.

Some of the indicators are able to be measured using publically available data such as the New Zealand Census of Population and Dwellings. Many are based on the subjective perceptions of older Aucklanders, for example their sense of safety in their home at night. Currently available surveys such as the biennial local government-funded Quality of Life survey\(^\text{11}\) and the New Zealand General Social Survey\(^\text{12}\) provide data for older people living in Auckland. However the sub-sample sizes are small and findings are subject to a high margin of error.

As a result, Auckland Council commissioned a survey of Older Aucklanders. The fieldwork was carried out by Gravitas Research, an independent research company, in August 2016. A total of 846 Aucklanders aged 65 and over took part in the survey. Efforts were made to ensure a representative sample, however there is a slight under-representation by persons of non-European ethnicity in the final sample. Numbers of Pacific and Asian respondents in particular were relatively small and therefore comparisons across ethnic groups are indicative only. A full report outlining the results from that survey will be available separately as an Auckland Council technical report in due course.

In a few instances, we have included indicators that cannot easily be quantified (that is, it cannot be easily ‘counted’), such as accessibility to facilities, and culturally appropriate services). These were highlighted as important during our consultation with stakeholders, and the literature indicates they are important contributors to the health and well-being of older Aucklanders.

All data reported in this document is for Auckland only, unless stated otherwise.
How does this relate to New Zealand’s Positive Ageing Strategy?

The New Zealand Positive Ageing Strategy, initially developed in 2001, articulates the New Zealand Government’s commitment to enabling a society where people can age positively throughout their lives, and where older people are highly valued and recognised as an integral part of families and communities. It includes 10 overarching goals, and aims to provide ‘a common platform from which central and local government agencies and communities can develop strategies and initiatives for positive ageing’.

A recent report outlining progress towards the goals noted that many councils, including Auckland, do not have specific policies for older people. This report represents an important step in addressing that gap. The eight domains presented in this report reflect and complement the general goals outlined in the Positive Ageing Strategy, and provide an Auckland-specific perspective.

“Other than herding into retirement villages (usually not the best long term economic option) there is very, very little - in fact no other option - or incentive for the older age group to stay in Auckland.”
- respondent to the survey of Older Aucklanders
  Female, 65-69

“Really enjoy the dynamics of a thriving, growing city. That’s probably easy to say when we’ve achieved (through a lot of hard work) owning a debt-free home of our own in a location we value and appreciate. We’re dyed in the wool Aucklanders and wouldn’t want to live anywhere else.”
- respondent to the survey of Older Aucklanders
  Male, 70-74
Domain 1  Housing

Why is this important?

Housing is a key determinant of health and well-being, and is a fundamental component of quality of life. Without appropriate shelter, people cannot meet their basic needs and participate adequately in society.

Residential dwellings provide a sense of ‘home’. They are places of private activity, as opposed to the public sphere outside the front door. They are spaces in society where individuals, families and households can retreat from the world and engage in the day-to-day rituals and activities that create a sense of safety and security.

The ability to find and to afford adequate and suitable housing in Auckland is not always straightforward for older Aucklanders. The housing stock is predominantly stand-alone three bedroom dwellings, and the costs of housing are increasing – this includes costs to buy, rent, and living costs. In addition the overall quality of Auckland’s housing stock is poor, particularly the quality of rental stock, which has impacts on health as well as safety.

What are the indicators related to this?

- Housing type and tenure
- Household composition
- Crowding
- Perceptions of safety
- Affordability
- Housing quality
- Suitability
Housing type and tenure

Older Aucklanders live in a variety of housing circumstances. The commonly-held notion that by aged 65 a person or a couple own their own home and are mortgage free, and asset-rich, does not match the reality for many people.

The type of dwellings older people live in

In 2013, 9016 older Aucklanders (6%) lived in 'non-private' dwellings. The majority of this group lived in residential care for older people (87%) but some lived in private hospitals, residential and community care facilities, and hotel, motel or guest accommodation.

As can perhaps be expected the proportion in non-private dwellings was comparatively high among the 'older-old'. Almost a quarter (24%) of all those aged 85 years and over lived in non-private dwellings and most lived in retirement homes (see Figure 3).

Figure 3: Dwelling type (2013) (%)
Older people living in Housing NZ homes or on waiting lists

The Ministry of Social Development reports a national total of 397 applicants aged 65 and over on the New Zealand Housing Register at September 2016, representing 9 per cent of the total applicants at that time. Numbers for Auckland specifically were not available at the time of writing.

In line with the broader housing crisis, the numbers of people on the Housing Register has increased each quarter since September 2015, including the numbers of older New Zealanders.

“The increasing cost of housing makes it difficult to downsize as does the lack of smaller single level home units.”
- respondent to the survey of Older Aucklanders
  Male, 65-69

[I am...] “Concern[ed] about housing inequality for my children.”
- respondent to the survey of Older Aucklanders
  Male, 70-74
Home ownership among older people

Levels of home ownership among older Aucklanders are higher than the rest of the adult population, although they have been decreasing over time. In 2013, over two-thirds (67%) of older Aucklanders owned or partly owned the dwelling they lived in, compared with a third (39%) of those aged 15 to 64. The overall level of home ownership among Aucklanders aged 65 and over had dropped slightly from 72 per cent in 2001 and 70 percent in 2006.

Home ownership among older Aucklanders was slightly lower compared to the rest of New Zealand. Over three quarters (77%) of those aged 65 years and over living outside of Auckland owned their own home. This means that greater numbers of older Aucklanders are renting, often from private landlords. A recent report exploring tenure security for older tenants in New Zealand reported that older people living in rental housing typically have been resource deprived over their life cycle or have had a significant shock to their personal or financial well-being later in life that has caused them to leave home ownership. 15

There is an age differential in levels of home ownership among older Aucklanders, with slightly lower levels of home ownership among those aged 85 years and over (see Figure 4).

The lower rates of home ownership among those aged 85 years and over is likely to be the result of a range of factors including deteriorating health, disability, loss of partner or social networks, and decreasing mobility, that mean older people relocate to retirement villages, rest homes, hospitals or living with other family members. 16

Figure 4: Proportion who own or partly own the home they live in, by age group (2006 and 2013) (%)

Data source: Statistics New Zealand, Census of Population and Dwellings
Household composition

A household is either one person who usually lives alone, or two or more people who usually live together and share facilities (such as for eating or cooking) in a private dwelling. A household may contain one or more families, other people in addition to a family, or no families at all, such as unrelated people living together.17

Household composition

In 2013, 25 per cent of older people in Auckland lived on their own, and 44 per cent were in a household that was defined as ‘couple-only’.

There were differences by broad age group. As Table 1 shows, a large proportion of those aged 85 and over were living on their own, compared to others aged 65 and over (49% compared to 18% of those aged 65 to 74). This will include older people living in retirement villages as well as in their own dwelling.

A report prepared by Statistics New Zealand investigating housing trends in Auckland from 1991 to 2013 found that Aucklanders were more likely to live in a ‘complex’ household (30%) than people living elsewhere in New Zealand (19%).18 Complex households are defined here as those containing a family and other people; more than one family; a group of unrelated people; or a group of related people who did not form a family, such as siblings. Many older Aucklanders live in such households. For example one in ten Aucklanders aged 65 to 74 lived in two-family households.

Table 1: Proportion of people in each age group living in different household types (2013) (%)

<table>
<thead>
<tr>
<th>Household type</th>
<th>65-74 years</th>
<th>75-84 years</th>
<th>85 years and over</th>
<th>65 years and over total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-person household</td>
<td>18</td>
<td>29</td>
<td>49</td>
<td>25</td>
</tr>
<tr>
<td>Couple only</td>
<td>47</td>
<td>42</td>
<td>27</td>
<td>44</td>
</tr>
<tr>
<td>Couple only and other person(s)</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Couple with child(ren)</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Couple with child(ren) and other person(s)</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>One parent with child(ren)</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>One parent with child(ren) and other person(s)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Two-family household (with or without other people)</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Three or more family household (with or without other people)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other multi-person household</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number stated</td>
<td>89,622</td>
<td>44,046</td>
<td>14,343</td>
<td>148,011</td>
</tr>
</tbody>
</table>

Data source: Statistics New Zealand Census of Population and Dwellings
Crowding

Household crowding can be thought of in two ways – functional and structural. Functional crowding is when there are enough bedrooms, but everyone sleeps together, e.g. in the lounge because it’s too expensive to heat the whole house. Structural crowding is when there are more people living in the dwelling than it was designed for. Exposure to household crowding has been found to be related to a number of poorer health outcomes.19

Older people living in households defined as crowded

In 2013, 7617 older Aucklanders lived in households that were categorised as structurally crowded (e.g. requiring extra bedrooms), according to the Canadian National Occupancy Standard.20 This number constituted 5 per cent of all older Aucklanders (Fig. 5).

In line with more general trends of population ageing and housing unaffordability in Auckland, the number of older people living in such situations had increased by 1341 since 2006. By 2013, proportionately more people in all age groups over 50 were living in crowded households than had been the case in 2006.

National and international research has shown that non-European populations, such as Māori and Pacific peoples in New Zealand, live in the most crowded housing.21 However, this is not just a product of poverty and it is likely that a combination of factors contribute. These include larger household size (including a higher proportion of households involving multiple families or extended families), affordability issues (the household cannot afford a dwelling large enough to accommodate its members), living arrangements and lack of housing stock.22

Figure 5: Proportion of each age group living in crowded situations (2013) (%)

[Data source: Statistics New Zealand, customised data]
Perceptions of safety

Perceptions of safety can be as important as actual instances of crime. An individual’s perception of their personal safety in their home and neighbourhood, during the day as well as after dark, will have an effect on their sense of well-being and their engagement in the broader community.

Perception of safety in own home

Our survey of 846 older Aucklanders found that the majority (92%) of respondents felt safe or very safe in their home during the day, and 85 per cent felt safe at night. There were differences across the geographic parts of Auckland, with slightly lower rating of perceived safety after dark among respondents living in southern local board areas (for example, 73% compared with 92% in eastern suburbs). Very few respondents stated they felt unsafe in their own home.

Figure 6: Perceptions of safety in own home (%)

Data source: Auckland Council, Survey of Older Aucklanders
Affordability

Access to quality affordable housing is fundamentally important to good health and social outcomes. The ability to meet ongoing housing costs including power, heating, mortgage repayments or rent, rates and attending to repairs can be extremely challenging for many particularly those on limited and fixed incomes. The ability to ‘downsize’ into smaller and more economical housing is not always straightforward either.

Perception that housing costs are affordable

Over half (59%) of respondents in the survey of older Aucklanders strongly agreed or agreed that their housing costs were ‘affordable’ (this included rent, mortgages, rates and maintenance). Almost one in five (17%) disagreed with this statement.

Perhaps not unsurprisingly, those on lower household incomes were more likely than others to disagree or strongly disagree that their housing costs were affordable (29% of those who reported an income of $20,000 or less, compared to 8% of those on $100,000 or more).

A higher proportion of those living in the southern local board areas disagreed with this statement – 24% compared with 17% overall.

Respondents were also asked whether they agreed that they could afford to heat their home properly during winter. Two thirds (67%) agreed, 13 per cent were neutral and 18 per cent disagreed.

Figure 7: Perception that housing costs are affordable (n=806) (%)

Data source: Auckland Council, Survey of Older Aucklanders
Housing quality

Poor quality housing – for example housing that is damp, uninsulated, insecure or in need of repair – can have serious implications for older people’s health and personal safety.

Problems with damp and mould in the home

Dampness, mould and mildew in Auckland’s dwelling stock is a frequent occurrence due to a combination of local climate, and inappropriate housing materials and typologies. A damp dwelling is more difficult to heat and a poorly heated dwelling more susceptible to damp. Damp and mould can have adverse health effects if not dealt with adequately.

Overall, about one in ten (12%) respondents to the survey agreed or strongly agreed that their home had a problem with damp and mould in winter – a relatively large proportion of people living in western parts of Auckland stated that this was the case (19%).

Figure 8: Perceptions of damp and mould in home during winter (n=797) (%)
Suitability of dwelling and neighbourhood

Housing needs to meet a range of physical and emotional needs at the individual and household level. These needs will change over time, for example as physical ability becomes compromised, a household’s financial status changes, or when a partner dies.

Perception of the suitability of their current housing situation

The majority of respondents to the survey of Older Aucklanders agreed or strongly agreed that the general area or neighbourhood their home was in suited their needs and the needs of others in their household (82%). Three quarters (76%) agreed that the type of home they lived in suited their needs, and the needs of others in their household. Refer to Figure 9.

Those on lower household incomes were less likely than others to agree that the type of home they lived in suited their needs (65% of those who reported an income of $20,000 or less, compared to 85% of those on $100,000 or more). The same pattern was observed with regard to the general area or neighbourhood in which they lived.

Figure 9: Perception of suitability for own needs and the needs of others in household (%)

Data source: Auckland Council, Survey of Older Aucklanders
Domain 2  Neighbourhood

Why is this important?

Neighbourhoods can provide older Aucklanders with a healthy and supportive living environment. This includes the physical environment, as well as the socio-cultural aspects of community engagement and support.

The international literature reveals a broad consensus for the benefits of older adults to age ‘in place’ – that is, to continue living in their neighbourhoods for as long as possible. Doing so helps to combat loneliness and social isolation, as well as sustain older people’s autonomy and control over their living arrangements and day-to-day activities.

Positive interactions between neighbours are important for social support, well-being and can increase older people’s feelings of general trust and safety. Older people who are in frequent contact with family, close friends, and neighbourhoods tend to have better physical health than those who are less involved.

What are the indicators related to this?

- Perceptions of safety
- Accessibility
- Community strength and spirit
Perceptions of safety

*Perceptions of safety in the local neighbourhood impact on the health and well-being of older people. If people feel unsafe they are less likely to talk to their neighbours, go out in the evening, use public amenities and generally participate in their communities.*

Perception of safety after dark

Almost two thirds (60%) of respondents to the survey of Older Aucklanders reported that they felt safe or very safe in their neighbourhood after dark.

Males were more likely than females to feel safe after dark (66% compared with 55%), and the ‘young-old’ (those aged 65 to 74) were more likely than respondents in other age groups to feel safe (63%) (Figure 10).

Those on lower incomes were less likely to report feeling safe in their neighbourhood after dark, compared to those on higher incomes. For example, just over half (53%) of those on incomes of $20,000 or less reported feeling safe compared to 68 per cent of those on incomes of $100,000 or more.

Figure 10: Perceptions of safety in neighbourhood after dark by age group (%)

![Bar chart showing perceptions of safety in neighbourhood after dark by age group.](chart)

Data source: Auckland Council, Survey of Older Aucklanders
Accessibility to local facilities and services

The ability to access local facilities and services is important for older people, particularly those with limited mobility and/or financial resources.

Ability to access facilities and services

In general, most respondents to the survey of Older Aucklanders agreed that it was easy to access amenities such as shops and parks (79%), public facilities such as the library or community hall (74%) and services such as the dentist or doctor (77%) in their local area.

There was a difference in results by household income, with higher proportions of those on higher incomes agreeing that it was easy to access amenities and services compared with those on lower incomes. Results were fairly even across household income groups for ease of access to public facilities.

There was a geographic effect as well - respondents living in Rodney and Franklin (these are both situated outside the main urban area) were less likely than others to agree with all three statements. For example, just over half (53%) of those living in Rodney and Franklin local board areas agreed that it’s easy to access amenities, compared with 85 per cent of those living in central local board areas.

Figure 11: Rating of ease of access to amenities, services and facilities in local neighbourhood (n=830) (%)

Data source: Auckland Council, Survey of Older Aucklanders
Community strength and spirit

*The presence of formal and informal relationships between people living in the same local area encourages a sense of belonging and can provide practical and emotional support.*

Sense of community with others in local neighbourhood

Overall, 70 per cent of respondents to the survey of Older Aucklanders agreed or strongly agreed that it was important to feel a sense of community in their local neighbourhood. A smaller proportion (60%) agreed that they actually felt a sense of community in their local neighbourhood (see Figure 12).

Respondents aged 85 and over were more likely than other respondents to agree with both statements, and Pacific respondents were also more likely than other respondents to agree that they felt a sense of community, at 79 per cent.

It is interesting to note that in the broader 2016 Quality of Life survey, which also includes these questions, respondents aged 65 and over were more likely than any other age group to agree that a sense of community is important (83%), and that they feel this in their local area (69%). This may be related to the amount of time that they spend in their local community.

In addition, the majority (78%) of respondents to the survey agreed or strongly agreed that they get on with people in their neighbourhood.

![Figure 12: Proportion who ‘strongly agree’ or ‘agree’ with each statement, by age group (n=830) (%)](image)

Data source: Auckland Council, Survey of Older Aucklanders
Domain 3  Transport

Why is this important?

The ability to get around Auckland efficiently and safely is of particular importance when considering the quality of life of older Aucklanders. Access to good transport options is vital for older people to connect with their family, friends and communities, to access services and to complete everyday tasks.

Maintaining mobility can be an especially acute challenge in later years. Ageing is often accompanied by increased physical challenges, as well as decreased income. This can limit transport options, such as access to a private vehicle, and increase reliance on subsidised transport or public transport.

Older people may face several challenges to using public transport such as physical access (e.g. getting on and off), negotiating interchanges between routes, delays in services and the cost of fares. This is especially the case for those with reduced physical abilities.

What are the indicators related to this?

- Walkability
- Licensed drivers
- Accessibility
- Public transport
Walkability

*Walkability is a measure of how friendly an area is to walking. Walking has clear health, environmental, and economic benefits.*\(^7\) For many older Aucklanders who are not willing or able to drive or take public transport, the ability to walk safely to local amenities and facilities, or for recreational purposes, is crucial.

**Perception that local footpaths are suitable for getting around on**

Just over two thirds (67%) of respondents to the survey of Older Aucklanders agreed that footpaths in their local area were suitable for getting around on. There were differences by ethnicity with a relatively high proportion of Pacific and Asian older people stating they agreed (82% of both groups).

It is perhaps worth noting that the extent to which respondents had used the footpaths to walk on was not explored.

**Figure 13: Perceptions of footpaths in local area (n=829) (%)**

![Bar graph showing perceptions of footpaths](image)

Data source: Auckland Council, Survey of Older Aucklanders

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Domain 3: Transport
Licensed drivers

The New Zealand Positive Ageing Strategy notes that the ability to carry on driving is an important indicator of well-being, as it allows older people to remain independent.

The proportion of people aged 75 years and over who have a driver’s licence.

The subject population for this indicator is those aged 75 years and over as New Zealand legislation imposes special procedures for keeping a driver’s licence from 75 years.28

As at January 2017, 43,951 people aged 75 and over in Auckland had a current driver’s licence.29 This represents approximately 64 per cent of the population in this age group. The Positive Ageing Strategy Indicators report 2007 notes that men were more likely than women to hold a driver’s licence.

“Failing eye sight restricts my ability to drive at night. Reduced walking already means I can’t walk as far, or as often as I would like. I prefer to not drive in/through Auckland unless it is absolutely necessary. Traffic density is off-putting.”

- respondent to the survey of Older Aucklanders

Female, 80-84
Accessibility

Affordable and accessible transport options for older people is one of the ten goals of the New Zealand Positive Ageing Strategy. Maintaining mobility for older people is crucial to their well-being, their ability to access services and their continued connection to their families, friends and communities.

Accessible transport options

A 2015 report on the Positive Ageing Strategy prepared by the Office for Senior Citizens notes that the New Zealand government and local councils support older people’s mobility through a variety of mechanisms such as driver licence renewals, accessible parking options and education on the safe use of vehicles and mobility scooters. Those who do not have a licence can access public transport and alternative transport schemes. The importance of the SuperGold Card in making public transport accessible for older people is highlighted in that report. This concession entitles the holder to free off-peak public transport after 9am weekdays, all day weekends and public holidays, as well as a range of other concessions. From 1 July 2016, SuperGold cardholders in Auckland can only access their concession using an Auckland Transport HOP Card (cards cost $15 each and are required to carry a minimum $5 credit). At January 2017, there were 121,918 AT HOP cards with a SuperGold concession.

"It is extremely important to me to be able to continue using the SuperGold card/hop card, especially for travel after 3pm for medical appointments and community activities. Due to times of appointments and meetings and distances of travel required around Auckland, if the times of use for the SuperGold card/hop card changed this would have a significant impact on my life, health and finances."

-respondent to survey of Older Aucklanders
Female, 65-69

"Why no bus service on city side of Te Atatu Peninsula?
West Harbour ferries only run Mon-Friday - why not in weekends."

-respondent to survey of Older Aucklanders
Male, 70-74
Public transport

Public transport is a lifeline for many older people who need to get around, but who might not drive or have access to a private vehicle. Public transport includes bus, train, and ferry services. Older Aucklanders are eligible to use the SuperGold card for free travel on most public transport services.31

Use of public transport by older people

Almost two thirds (61%) of respondents to the survey of Older Aucklanders had used public transport in the previous 12 months at least, while 37 per cent never used it during that time. Among those who had used public transport, the largest group had used it ‘less often than once or twice a month’.

There was an age difference in results, with only around a third (36%) of those aged 85 and over stating they had used public transport at least once in the previous year. There was also an interesting difference by household income levels. While just over half (54%) of those on a reported income of less than $20,000 had used public transport in the previous year, the result for those on a household income of $100,000 was 70 per cent. This may reflect the generally higher reported incomes among the ‘young-old’ (those aged 65 to 74), and might reflect the levels of public transport provision in low income versus higher income areas.
Perceptions of public transport

While 83 per cent of all respondents who had used public transport in the previous 12 months agreed or strongly agreed that public transport is safe, and 75 per cent that it is affordable, a slightly lower proportion agreed it is easy to use (69%) (see Figure 14).

Auckland Transport notes that the majority of safety concerns among potential and new public transport customers in Auckland relates to the walk to and from the stop, while existing users have fewer concerns, which also relate to waiting at stations. 32

Figure 14: Perceptions of public transport (n=509) (%)
Domain 4  Social Connectedness

Why is this important?

Mental, emotional and spiritual well-being among older Aucklanders is enhanced by meaningful social connections. Social connectedness has proven links to positive outcomes, including decreased risk of social isolation, enhanced self-esteem and well-being. Social isolation, on the other hand, has been linked to negative health and well-being outcomes, including loneliness, anxiety and depression.33

Connectedness occurs through inter-personal relationships with family, whānau, neighbours and friends, as well as engagement in social institutions such as churches, sports clubs and marae, as well as volunteering.

Auckland is a multi-cultural society. It is important that older Aucklanders from all ethnic, cultural and religious backgrounds can remain connected to their traditions and culture in a positive way.

What are the indicators related to this?

- Contact with others
- Access to telecommunications
- Social isolation
- Trust in others
Contact with others

Ongoing and positive interactions with family members, friends and/or people with similar interests and passions help to sustain positive mental and physical health. International research has consistently shown that the type, quality and character of personal and social relationships are important determinants of well-being for older people.34

Visits by friends and family

This indicator measures the extent to which respondents agreed that they were visited by friends, family or whānau as often as they would like. Over three quarters (77%) agreed that this was the case, while a small proportion (6%) disagreed. Those with a relatively high household income were more likely to agree with this statement than those on lower household incomes (88% of those on $100,000 or over compared with 71% of those on less than $20,000).

Figure 15: Visited as often as they would like by friends and family (n=824)

Data source: Auckland Council, Survey of Older Aucklanders

[I have...] “a very good and happy family who visit often and phone me every day, having good friends, and a wonderful church community”
- respondent to the survey of Older Aucklanders
female, 80-84
Belonging to a social network or group

The majority (80%) of respondents to the survey of Older Aucklanders stated that they belonged to one or more social networks or groups. One in five (20%) said they did not belong to any of the options that were provided. These respondents were from all age groups, however those aged 85 and over were slightly over-represented.

Of those respondents who did nominate at least one group, the largest proportion (39%) stated they belonged to a hobby or interest group. Females were more likely than males to state they were part of a hobby group (48% of females respondents compared to 27% of males).

Other popular choices were a sports club or recreational class (35%) and a church or spiritual group (32%).

When asked to tell us what ‘other networks or groups they belonged to, responses varied, for example:

‘A Red Hat club for fun-loving ladies!’
‘A walking group’
‘Elected representative and company director’
‘A network of friends who live nearby’
‘Just shopping’
‘Volunteer local fire brigade’
‘JP’
‘Probus’

Figure 16: Proportion who belonged to social networks and groups* (n=679)

Data source: Auckland Council, Survey of Older Aucklanders

*Of those who nominated at least one social group or network.
Access to telecommunications

Older Aucklanders have lived through a technological revolution, which has transformed inter-personal communications and the delivery of services. The ability to access, and utilise, telecommunication channels such as the internet and mobile technologies deepens the extent to which older Aucklanders can stay connected and informed.

The proportion of older adults living in a dwelling with internet access

Almost one in five respondents to the survey of Older Aucklanders (18%) stated they did not have access to the internet. This group were more likely to be aged 85 and over (44% of those in this age group, compared with 11% of those aged 65-74).

Of those 680 respondents who did have access to the internet, the majority (72%) said they used it every day. One in ten did not use it - again this tended to be those aged 85 and over.

Figure 17: Use of internet among those who stated they had access to it (n=680)

Data source: Auckland Council, Survey of Older Aucklanders
Social isolation

Many older people experience loneliness and depression, either as a result of living alone or due to lack of close family ties and reduced connections which results in an inability to actively participate in community activities and to form new networks. Social isolation can lead to loneliness, depression and poor health.35

Feeling lonely or isolated

A third (33%) of respondents stated they had ‘never’ felt lonely or isolated in the previous 12 months, 42 per cent stating this had happened ‘rarely’ and a quarter (25%) stating this had occurred ‘sometimes’ (see Figure 18).

The broader 2016 Quality of Life survey results for Auckland found that respondents aged 65 and over were more likely than others to report that they had ‘never’ or ‘rarely’ felt lonely or isolated (77% compared with 52% for those aged 18 to 24 years).

Figure 18: Frequency of feeling lonely or isolated in previous 12 months (n=840)

Data source: Auckland Council, Survey of Older Aucklanders
Trust in others

Trust in others is an important indicator of how older people feel about members of their community. This is associated with their sense of security and social connectedness.36

Levels of trust in others

Results of the survey of Older Aucklanders indicate relatively high levels of trust among older Aucklanders. Seventy per cent stated they ‘completely’ trusted people they dealt with regularly (including family, friends, colleagues or other people) and a similar proportion (69%) stating they ‘neither trust nor distrust’ people they have not met before. Very low proportions stated they did not trust others.

Figure 19: Levels of trust in others (n=845)

Data source: Auckland Council, Survey of Older Aucklanders
Domain 5  Health and Care

Why is this important?

It is widely accepted that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. This is reflected in the Māori concept of hauora which includes tinana (physical), wairua (spiritual), whānau (family) and hinengaro (mental) aspects of well-being, as well as important cultural elements such as land, environment, language and extended family.

Issues of health and well-being, and the need for care and support services, become more acute among older people as the physical ageing process accelerates, and as people’s economic and social environments change.

It is important to consider the ability of older people to access medical and healthcare services, and the ability of those services to adequately respond to their older clients.

What are the indicators related to this?

- Life expectancy
- Smoking rates
- Self-rated health status
- Accidental injuries
- Emotional health
- Access to support and services
- Levels of physical activity
Life expectancy

Life expectancy is a key indicator of the general health of the population. Improvements in overall life expectancy in New Zealand reflect improvements in social and economic conditions, general lifestyle, access to health services and advances in medical treatment and care.

Life expectancy at age 65 indicates the additional number of years a person could expect to live, on average, having reached age 65, based on the mortality rates of the population at each age in a given year.

The latest cohort life tables available from Statistics New Zealand indicate that the average length of life for New Zealanders born in 1951 (therefore 65 years in 2016) is 86.2 years for males and 88.9 for females (assuming medium mortality rates). It is well-evidenced that males tend to have lower life expectancy than females and that Māori have lower life expectancy than non-Māori – although Statistics New Zealand report that life expectancy is increasing in New Zealand overall, and that the difference between Māori and non-Māori life expectancy has decreased over recent decades.
Smoking rates

Cigarette smoking is a key risk factor associated with chronic respiratory disorders and heart disease among older adults, especially Māori. Respiratory conditions are a major cause of both hospital admissions and mortality amongst older people.41

Proportion of older people who smoke regularly

At the 2013 Census, 10 per cent of usual residents in Auckland aged 65 and over stated they were regular smokers (defined as smoking one or more tobacco cigarettes per day). This proportion had decreased since 2006 when it was 14 per cent.

Most were aged 65 to 74 (70% of all smokers aged 65 and over).

Among the five main ethnic categories, Māori reported the highest rates of smoking (15% of Māori aged 65 and over, compared with 10% Pacific, 6% European and 4% Asian) (see Figure 20).

Again, rates of smoking had decreased slightly across all ethnic groups from 2006.

Figure 20: Proportion of Auckland residents aged 65 and over within each broad ethnic group who were regular smokers (2006, 2013) (%)
Self-rated health status

Personal health is a subjective experience and will differ from person to person. Self-rating of health status by individuals is a commonly used measure in frameworks of well-being in New Zealand and overseas.42

Perceptions of health

Respondents to the survey of Older Aucklanders were asked ‘Thinking about whether your health affects your ability to do day-to-day activities, in general, how would you rate your health?’ The majority (80%) provided a positive rating, of either ‘good’ (35%), very good (33%) or excellent (12%). Very few rated their health as poor.

Perhaps not surprisingly, a relatively large proportion of those aged 65 to 74 years rated their health as very good (39%) or excellent (15%) compared to the older age groups (see Figure 21).

Figure 21: Rating of general health, by age group (%)

Data source: Auckland Council, Survey of Older Aucklanders
Emotional health

As well as the typical life stressors common to all people, older adults can lose their ability to live independently because of limited mobility, chronic pain, frailty or other mental or physical problems, and may require some form of long-term care. In addition, older people are more likely to experience events such as bereavement, a drop in socioeconomic status with retirement, or a disability. All of these factors can result in isolation, loss of independence, loneliness and psychological distress in older people.43

Perception of experiencing stress that has a negative effect

It is not possible to definitely measure emotional health among older Aucklanders as it is highly subjective and will change over time from person to person. By way of proxy we have included a measure of the extent to which older Aucklanders experienced stress that has a negative effect, and the next section includes a measure of the extent to which people felt lonely.

Almost half (44%) of the respondents to the survey of Older Aucklanders stated they had ‘sometimes’ experienced stress that had a negative effect on them in the previous year. A similar proportion (40%) felt this had happened only ‘rarely’, and almost one in ten (9%) said it had never happened.

It is interesting to note that the 2016 Quality of Life survey found that Auckland respondents aged 65 plus were less likely than others to report that they had ‘always’ or ‘most of the time’ experienced stress (e.g. 6% compared with 27% for those aged 18 to 24 years).44

Figure 22: Rating of stress that has had a negative effect in previous 12 months (%)
Accidental injuries

An accidental injury refers to a range of scenarios including falls, burns, poisoning, and airway obstruction, either inside the home or in other locations. Accidental falls are a major cause of injury resulting in hospitalisation or death among older people in New Zealand.

Fatal and serious non-fatal injuries from falls

A fall can be life-changing for an older person, impacting on their independence and well-being, with implications for their family or whānau and significant others. Falls in older people are most frequently categorised as being an ‘accident’ caused by an identified hazard in the environment. However, often it’s the interaction between the hazard and the person’s accumulated age-related changes in functioning and disease processes that causes the fall, not the hazard by itself.45

The most serious injuries resulting from falls are fractures and head injuries, and in some cases death.

The Australian and New Zealand Falls Prevention Society report that the most common injuries that require hospitalisation comprise fractures of the leg, arm or fractures of the neck and trunk. The most serious of these fall-related injuries is fracture of the hip.

In 2015, over 3800 public hospital discharges in Auckland among people aged 65 and over were related to falls. This was the most common cause and accounted for 60 per cent of all discharges in that time period. Most recent data available on deaths from falls in shows that in 2013 there were 102 deaths, over half of which were among people aged 85 and over (Table 2).

Table 2: Fatalities and public hospital discharges from falls, 65 years and over, Auckland

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Data source: University of Otago, Injury Prevention Research Unit

Domain 5: Health and care
Access to support and services

With older age often comes the need for support and more frequent visits to medical and care services. It is vital that older Aucklanders know who they can contact for advice and help, particularly those who may be new migrants or have limited English communication skills. It is also important that they can financially and physically access appropriate quality support services and care.46

Knowing who to contact for health advice

The survey of Older Aucklanders asked respondents if they knew who to contact if they needed information about their health concerns and relevant services in their community. The majority of respondents (93%) agreed or strongly agreed that they knew who to contact if they needed advice on their health.

There appear to be some differences by ethnicity, with a slightly lower proportion of those in the broad Asian category agreeing with this statement (55% strongly agreed and 28% agreed). This may reflect the increasing numbers of older immigrants from the broad Asian region, many of whom will be unfamiliar of the New Zealand health system, or who may encounter language barriers.

Figure 23: I know who to contact if I need advice on my health (%)

Data source: Auckland Council, Survey of Older Aucklanders
Going to see the doctor

The Ministry of Health recommend that if a person is sick and it's not an emergency, they should visit a General Practitioner (GP). If it's free to register or enrol with a GP, but they often charge a consultation fee for each visit, and it can cost extra to visit a GP with whom you are not enrolled. Older people who need to see their GP frequently are sometimes also eligible for a high use health card (valid for a year and entitles frequent health service users to reduced costs for some doctor visits and some prescriptions), and/or Care Plus (aimed at people with chronic health conditions, serious medical or mental health needs, or terminal illness).

Our survey of Older Aucklanders found that 17 per cent of respondents had postponed or put off a visit to the doctor or their GP in the previous 12 months to keep costs down 'a little' or 'a lot', particularly those who identified with an Asian ethnicity (29%) and those on lower household incomes (37% of those with household income of less than $20,000).

According to the Positive Ageing Indicators report 2007, this is a measure of an unmet need associated with access to, and the costs of, health care.

"The biggest thing which impacts on my happiness, … is that my husband has dementia. I know there is a lot of support and help out there which I wouldn't have in a small place. So that's another plus for living in Auckland and being 75 yrs old."
-respondent to the survey of Older Aucklanders, female, 75-79

As someone who is perfectly healthy, fit and active I would like to be referred to as 'retired' or as a 'senior' maybe even 'middle aged'? but definitely NOT 'elderly'. Although I am 67 I go to the gym 4 days a week, play tennis 4 times a week, swim and cycle too. “ male
Levels of physical activity

The New Zealand Positive Ageing Strategy notes that regular physical activity is associated with good mental and physical health, functional capacity and self-worth.48

Levels of physical activity

Over half (56%) of respondents to the survey of Older Aucklanders had engaged in physical activity of moderate intensity (such as gardening, stretching/tai chi/ yoga, or walking to the shops) in the previous week, and a third had undertaken light intensity activity (day to day activities such as carrying shopping or doing the housework).

Perhaps not surprisingly there was a difference in results by broad age groups with one in five (22%) of those aged 85 and over stating they had undertaken none, or very little, physical activity in the previous week, compared to only 4 per cent of those aged 65 to 74, and 9 per cent of those aged 75 to 84.

Walking is a very popular activity among New Zealanders, particularly those in this age group. A recent study undertaken by Sport NZ into levels of physical participation among New Zealand adults found that 91 per cent of Aucklanders aged 65 to 74, and 81 per cent of older Aucklanders aged 75 and over, had participated in sport or recreation activities in the previous week, and that walking was the most common type of activity.49
Domain 6  Status in Society

Why is this important?

Underpinning the concept of ‘positive ageing’ is the premise that the years of ‘older age’ should be viewed and experienced positively in our society. This includes the attitudes and experience of older people themselves, as well as the attitudes, expectations, behaviours and actions towards ageing and older people by younger generations.

Broad attitudes towards ageing in New Zealand, and stereotyping of what it means to be older member of society, as expressed in mainstream media for example, can have a strong influence on how older people feel about themselves, and their contribution to society. It also influences how others respond to ageing and the aged. Mainstream media often celebrates western ideals of youth over ageing, and conforms to two stereotypes: the frail and dependent old person, or the sprightly, independent third-ager fighting the physical signs of ageing. These are of course oversimplifications. They do not reflect the diversity and complexity of older people’s lived experience.

This domain also reflects the importance of engagement by older Aucklanders in Auckland’s social, economic and political realms, and the ability to adequately represent, and be represented in civic society.

What are the indicators related to this?

- Civic participation
- Valued contribution
- Perceived age discrimination
- Victims of crime
- Elder abuse
Civic participation

Civic participation refers to participation in the democratic processes that underpin New Zealand society. This includes not only exercising the right to vote at central and local elections, but standing for office itself.

Voting

Voter turnout at elections is recognised as both a measure of public participation and the strength of a democracy. At the 2014 New Zealand central government election, 83 per cent of eligible voters aged 65 and over in the 22 general electorates within the Auckland region (excluding Northland) exercised their vote, and 80 per cent of those on the Māori descent roll voted within the three Māori electorates. Unfortunately, data by local government elections in Auckland is not available.\(^{51}\)

Standing for office

Information on the age of candidates standing for election is not routinely collected by Auckland Council. However, it is known that a total of 432 candidates stood for Auckland’s 2016 local government elections (mayor, local boards, and ward positions). Three hundred, or 69 per cent, of those people responded to Auckland Council’s Candidate Demographic survey. Of these 300 people, 64 (21%) were aged 65 or over (see Figure 24).

Figure 24: Candidates for Auckland council elections, by age (2016)

![Bar chart showing candidates for Auckland council elections by age (2016).](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAIgAAAD2CAIAAAD0q77YAAAABGd发达

Data source: Auckland Council Candidate Demographic Survey
Valued contribution

The extent to which the individual and collective experience, knowledge and contribution of its older members is actively recognised and valued has a direct influence on feelings of self-esteem and well-being among older Aucklanders.

Ability to play a role as elder in the family and/or wider community

Over half (56%) of the respondents to the survey of Older Aucklanders agreed or strongly agreed that they had the opportunity to play a role as an elder in their family or wider community. Just over one in ten (12%) felt that this was not applicable or didn’t know – this proportion was particularly high among people aged 85 and over (19%).

Those of Māori, Pacific and Asian ethnicity were more likely than those of European ethnicity to agree with this statement (69%, 73% and 72% respectively agreed compared with 54% for European).

Figure 25: I have the opportunity to play a role as an elder in my family and/or community (n=810)

Data source: Auckland Council, Survey of Older Aucklanders
Proportion of older adults who believe that older people are valued

Respondents were also asked the extent to which they agreed that people aged 65 and over are valued in Auckland. Responses were generally positive – 41 per cent agreed or strongly agreed with this statement, but it must be noted that 20 per cent disagreed (see Figure 26).

Again, although numbers are small, relatively large proportions of those who identified with an Asian (62%) or Pacific (59%) ethnicity agreed with this statement, compared with other ethnicities.

Figure 26: Overall, people aged 65 and over are valued in Auckland (n=815)

Data source: Auckland Council, Survey of Older Aucklanders

“I would really like to see older people portrayed more positively in the community. Am concerned about the growing divide between younger and older people exacerbated by the housing shortage in Auckland. Don't feel personally to blame for this but envy and lack of respect for elders suggest we are blamed by young people”. (respondent to the Older Aucklanders survey - female, 70-74)
Discrimination by age

The New Zealand Human Rights Commission defines discrimination as occurring when ‘a person is treated unfairly or less favorably than another person in the same or similar circumstances’. The New Zealand Human Rights Act 1993 denies the ability for anyone to discriminate against someone because of their age, as well as several other characteristics such as gender, sexual orientation, political opinion, colour or race. However, discrimination can and does occur, and it may be multi-dimensional. That is, people may experience discrimination (throughout their life as well as in older age) not only due to their age, but on other grounds such as race, sexual orientation and/or religious beliefs.

Perceptions of discrimination

We asked respondents in the survey of Older Aucklanders whether they felt they had been discriminated against in the previous 12 months by age, and also by ethnicity. Over one in ten (14%) felt they had been discriminated against due to their age, 4 per cent by ethnicity, and 21 people (2%) felt they had been discriminated against for other reasons (most of these were female). It is interesting to note that almost two thirds of those who felt they had been discriminated against by ethnicity were New Zealand European.

Victims of crime

Being a victim of a criminal action such as assault or burglary can have a devastating effect on people’s sense of safety and trust in others, and on their sense of worth in society.

Crimes against older people

In the 24 month period from Dec 2014 to Dec 2016, New Zealand Police recorded 4800 instances of crimes against people aged 65 and over in Auckland, out of a total of 126,933. The bulk of these offences were ‘theft and related offences’ (87%), followed by ‘acts intended to cause injury’ (10%). The age of victims is not available for all recorded crimes in New Zealand; however it would appear that older people are less likely to be a victim of crime than people in younger age groups, particularly those aged 20 to 39 years.
Elder abuse

The physical, financial and social vulnerability of older people can sometimes lead to what is referred to as elder abuse. There are several types of elder abuse, including financial, psychological, physical, sexual and institutional abuse as well as neglect. Abuse and neglect are contraventions of a person’s human rights, and can have devastating effects on the individual, their family/whanau and their wider community.

Elder Abuse is recognised as a serious issue in New Zealand. Age Concern state that they receive more than 2,000 referrals of elder abuse every year across New Zealand, with the most common types being financial, physical and psychological. They report that often the abuse experienced by an older person involves more than one type of abuse.

In cases seen by Age Concern’s Elder Abuse and Neglect Prevention Services over the last three years:

- 75% involved psychological abuse
- over 50% involved financial abuse
- 15-20% involved physical abuse
- 10-15% involved neglect
- 10-15% involved self-neglect

Abuse is also identified by other agencies including health providers, the Police, lawyers, community support organisations, and dedicated Elder Abuse and Neglect Prevention services.

Abuse and neglect in institutional settings such as care facilities and rest homes can result from inadequate staff training, support and resourcing. A substantial inquiry into the equal employment opportunities for workers in New Zealand’s aged care sector, published in 2012, noted that the increased dependence of clients, and staff shortages also increases mental stress among workers, which can lead to mistakes, elder abuse and burnout. The investigation found that psychological pressures are especially high in dementia care and night shifts. Home care staff, working in isolation, may face different, but also high rates of stress.
Domain 7  Culture and Identity

Why is this important?

Culture is a fundamental aspect of a person’s identity. People’s values, customs, practices, languages and world views all contribute to their cultural identity, how they see themselves and how they engage with the world. Social groups such as those based on ethnicity, nationality, religion or common interests have a shared sense of cultural identity. Beliefs and practice of these groups link people to their history and heritage. Cultural identity creates a sense of belonging and is an essential contributor to well-being.

Auckland is the most diverse, multi-lingual city in New Zealand. The cultural diversity among Auckland’s older people is growing. Older Aucklanders increasingly have complex identities and identify with more than one ethnic or cultural group as a result of mixed-family heritage, migration and personal biographical experience.

Additionally, cultural identity is not static and does not have clear fixed boundaries. It is fluid; building, changing and deepening over time.

Older Aucklanders well-being is influenced by how they are able to access culturally appropriate services, participate in cultural traditions and express their cultural identity.

What are the indicators related to this?

- Te Ao Māori
- Participation and expression
- Acceptance
- Culturally appropriate services.
Te Ao Māori

Te Ao Māori literally means the Māori world. Te Ao Māori underpins holistic models of health such as Whare Tapa Whā, developed by Sir Mason Durie. Within that frame, one of the key tasks of health promotion is to facilitate access by Māori to te Ao Māori. This includes access to te reo, the language and dialects; tikanga, the processes and practices; marae, the community focal point; wāhi tapu, sites of importance; and access to whānau, hapū and iwi. This is particularly salient for many older Māori living in Auckland who may live far away from their whānau and turangawaewae (place to stand).

Engagement with Te Ao Māori

Engagement in te Ao Māori includes identifying with Māori ethnicity, fluency with te reo Māori, interactions with whānau, the ability to trace whakapapa (genealogy), contact with marae, contact with other Māori and can include holding financial interest in Māori land.

Results from the 2014 Te Kupenga survey, undertaken among a sample of approximately 1400 Māori in Auckland indicate that engagement with te Ao Māori among older Māori (those aged 55 and over) living in Auckland is relatively strong. For example, just over a quarter (28%) felt that it was very important to be engaged in Māori culture, over half (54%) had been to a marae in the previous 12 months, with a further 41 per cent reporting they had been to their ancestral marae during that time, and 21 per cent had undertaken voluntary work for a marae, hapū or iwi. The majority (83%) had watched a Māori television programme, listened to a Māori radio station, or read a Māori magazine in the previous 12 months.

Proportion of older Māori who can korero (converse) in te reo Māori

Many older Māori were raised in New Zealand at a time when the Māori language declined, due to a combination of cultural alienation through increased Māori urbanisation after World War Two and active discouragement of te reo in schools. As a result, levels of te reo among older Māori are relatively low. For example, at the 2013 Census, 9 per cent of older Aucklanders who identified as Māori indicated that they spoke Māori at conversational level, compared with 25 per cent of Māori aged 0 to 14 years.
Participation and expression

In a multi-cultural society such as Auckland it is important that people from diverse cultures and traditions can meaningfully participate in a range of activities and customs that give expression to their culture. An environment where older people are able to express their cultural identity builds and maintains older people’s well-being.

Regular participation in events

Almost half (48%) of respondents to the survey of Older Aucklanders agreed that their culture was an important part of their identity (see Figure 27), particularly those who identified with an Asian ethnicity (72%). A smaller proportion (38%) agreed that they were able to regularly participate in events, activities and traditions from their culture – again, this proportion was relatively high among those who were Asian (53%). It’s worth noting that almost a quarter (24%) didn’t know or felt this question was not applicable.

Figure 27: My culture is an important part of my identity (n=793)

Data source: Auckland Council, Survey of Older Aucklanders
Religion and spirituality

For many people, faith and spirituality offers meaning and life purpose, and is an important element in their sense of well-being. Spirituality can be accessed through organised religion or groups, or in a less structured and more personal way.

At the 2013 Census, 75 per cent of older Aucklanders stated they had at least one religious affiliation. Of that group, two thirds (64%) identified with a Christian religion (mostly Anglican and Catholic).

Our survey found that almost a third (32%) agreed that they 'strongly identified' with a religion or a spiritual group, while 42 per cent disagreed and almost a fifth (17%) stated they did not know if this was the case or felt it was not applicable. Of those who agreed that they strongly identified with a religion or spiritual group, 83 per cent agreed that they were able to regularly participate in spiritual events, activities and traditions that were meaningful to them (see Figure 28).

Figure 28: I strongly identify with a religion and/or a spiritual group (n=805)

Data source: Auckland Council, Survey of Older Aucklanders
Diversity of languages spoken by older people

The diversity of older Aucklanders is apparent in the numbers who speak languages other than English. At the 2013 Census, 17 per cent of Aucklanders aged 65 and over spoke more than one language (defined as able to “hold a conversation about a lot of everyday things”). This proportion was highest among the 65 to 74 year old group, at 19 per cent.

After English (91% of older Aucklanders), Samoan was the second most common language (4494 speakers, or 3% of older Aucklanders), followed by Yue and Northern Chinese (2%) (see Table 3).

Due to the concentration of some ethnic groups in Auckland, there are also concentrations of certain languages in Auckland, as the table below indicates. For example, in 2013 Auckland was home to 87 per cent of all older people in New Zealand who spoke Tongan, and 81 per cent of all older people in New Zealand who spoke a Northern Chinese language.

Comparatively, the proportion of those aged 65 and over who spoke te reo (Māori) was relatively low at 2 per cent.

### Table 3 : Top 10 languages spoken among those aged 65 years and over (2013)

<table>
<thead>
<tr>
<th>Language</th>
<th>Number</th>
<th>%</th>
<th>As % of total 65 yrs and over in New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>139,656</td>
<td>91</td>
<td>25</td>
</tr>
<tr>
<td>Samoan</td>
<td>4494</td>
<td>3</td>
<td>63</td>
</tr>
<tr>
<td>Yue</td>
<td>3741</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>Northern Chinese</td>
<td>3462</td>
<td>2</td>
<td>81</td>
</tr>
<tr>
<td>Hindi</td>
<td>3042</td>
<td>2</td>
<td>79</td>
</tr>
<tr>
<td>Māori</td>
<td>2976</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Sinitic not further defined</td>
<td>2871</td>
<td>2</td>
<td>76</td>
</tr>
<tr>
<td>French</td>
<td>2772</td>
<td>2</td>
<td>31</td>
</tr>
<tr>
<td>Tongan</td>
<td>1893</td>
<td>1</td>
<td>87</td>
</tr>
<tr>
<td>German</td>
<td>1761</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>13,290</td>
<td>9</td>
<td>46</td>
</tr>
<tr>
<td>Total people stated</td>
<td>152,943</td>
<td>120</td>
<td>27</td>
</tr>
</tbody>
</table>

Data source: Statistics New Zealand, Census of Population and Dwellings. People could choose more than one language so percentages will not add to 100. Percentages exclude ‘not elsewhere included’ responses.

Notes:
- 1) Includes Cantonese
- 2) Includes Mandarin
- 3) Includes Chinese languages not further defined
Acceptance

This indicator refers to the principle that acceptance of older people and the differences between them, (e.g. language, sexuality or race) underpins a healthy functioning society. This of course, includes acceptance of difference by others as well as within this group themselves.

Proportion of older people who believe that their culture or ethnicity is valued

The survey of Older Aucklanders also asked respondents the extent to which they agreed that their ethnic and/or religious culture is valued in Auckland. A third (33%) agreed or strongly agreed with this statement and a similar proportion (30%) said they didn’t know, or felt it was not applicable (Figure 29).

Although numbers are small, relatively large proportions of those who identified with an Asian (64%) or Pacific (74%) ethnicity agreed that their ethnic and/or religious culture is valued in Auckland.63

Figure 29: My ethnic and/or religious culture is valued in Auckland (n=796)

Data source: Auckland Council, Survey of Older Aucklanders
Culturally appropriate services

Responding to cultural diversity is one of the key goals of the Positive Ageing Strategy. Older people in New Zealand are increasingly diverse and it is recognised that the cultural make-up of this group is changing – particularly in Auckland. However, a 2014 progress report on the Positive Ageing Strategy found that most services for older people focus on needs of New Zealand European, as they are currently the dominant ethnicity.64

Respect for cultural and ethnic diversity by service providers

The workforce supporting older people living in their own home or in community residential facilities is critically important. These workers not only support the health and well-being of the older members of our community, they also enable the family of older people to stay in the workforce or remain connected to their communities.65

It is important to note that the health and care service workforce in Auckland is itself characterised by ethnic and cultural diversity. Migrant workers make up a significant proportion of the aged care workforce and it seems ‘both likely and necessary’ that this trend will continue, due to the rapidly ageing population here and in many other countries, and a global shortfall of health workers.

In 2012 the Human Rights Commission undertook a comprehensive inquiry into equal employment opportunities in the aged care sector.66

The Commission found that there is a need for culturally appropriate aged care, and that cultural sensitivity is particularly important when working with people with dementia and cognitive impairment. For example, a combination of less tolerance, impaired hearing and speed of speech all contribute to language difficulties between carers and clients, and some older people may have difficulty understanding migrant carers.
Respect for diversity of sexual orientation and gender identity

Diversity and cultural appropriateness also refers to issues of sexual orientation and gender identity. These are essential elements of identity and inform how people plan, organise and generally live their lives. People who are heterosexual often take for granted the ‘normalcy’ of their sexuality and gender identities and the world in which they can openly live. In contrast people who are not heterosexual and who do not ‘fit’ within a heteronormative world have historically been characterised as ‘unnatural’ and ‘deviant’. This can have important implications for some older people’s engagement with the medical system and in residential care facilities.

A report commissioned by the Auckland District Health Board in 2013 provides an excellent overview of the diversity of the Rainbow community (Lesbian, Gay, Bisexual, Takatāpui, Transgender and Intersex) in Auckland and the complexities of their interactions with the public health system. The report notes that many older Aucklanders have grown up in an era where being themselves could be a criminal offence, and discovery could result in a diagnosis of being mentally unwell resulting in forced medical treatment, imprisonment, public shame and family rejection. While some have been involved in fighting for change and acceptance, some may still hide their identity.

While there have been many advances in the rights and legal status of people from Rainbow communities in recent years, societal prejudices continue to exist and to exert a negative effect on the health of these communities.

As the baby-boom generation has aged there has been a surge in demand for services that provide care for senior populations and a growing awareness of the specific health needs of the aged and how their health has been affected by stigma and minority stress.

For optimal support and care, people working within health and support services need to be aware of and sensitive to the needs of this group.
Domain 8  Economic standard of living

Why is this important?

Movement into older age can be a challenging time financially, for example due to lowered income in retirement, additional costs of housing, healthcare or support, or the requirement to financially support other family members. Many older people engage in unpaid work including volunteering.

The socio-economic circumstances of an individual or a household have clear links to their ability to secure material well-being, access services and meet living costs. Consistent with international findings, socio-economic status is found to be a determining factor in health outcomes in New Zealand and helps in part to explain the different mortality rates across ethnic groups.71 In addition, indicators of living standards are found to be associated with higher reported subjective well-being in older adults. A five year study into well-being and ageing in New Zealand found that a higher personal income was linked with higher levels of subjective well-being.72

What are the indicators related to this?

- Socio-economic status
- Paid employment
- Income
- Unpaid work/volunteering
- Living standards.
Socio-economic status

Socio-economic status broadly refers to a person or household’s educational, employment and economic position in relation to others. Lower socio-economic status is often linked to poor subjective well-being and health outcomes.

Proportion of older people living in areas rated 8, 9 or 10 on the NZ Deprivation Index scale

The New Zealand Deprivation Index (NZDep) provides an indication of relative disadvantage extends beyond solely investigating income. It is a combination of a range of socio-economic variables and is measured at the household level. In 2013, 22 per cent of older Aucklanders, or almost 35,000 persons, lived in areas rated 8, 9 or 10 (most deprived).

This is a substantial number, however it should be noted that slightly lower proportions of older people lived in these areas compared to people in other age groups (22% compared with 29% for those aged up to 64 years), and slightly higher proportions lived in areas 1, 2 or 3 (39% compared with 33%) (Figure 30).

Figure 30: Distribution of population across Auckland, by NZ Dep decile (2013)

Data source: University of Otago: Wellington School of Medicine and Health Sciences
Paid employment

There is no official retirement age in New Zealand, however most New Zealand citizens are eligible to receive the universal New Zealand Superannuation once they turn 65. Many people continue working in paid and unpaid employment long after they have turned 65, by choice or financial need.

Proportion of older people in paid employment

In 2013, 22 per cent of older Aucklanders were in paid employment, compared with 61 per cent across all Auckland adults aged 15 and over. This includes full and part-time employment. The largest group of older Aucklanders were ‘not in the labour force’ (78%). The number and proportion of older Aucklanders who were employed had increased since 2006 (17% in 2006 to 22% in 2013).

This will be in part a cohort effect, as the large ‘baby boom’ age cohort have arrived at the age of retirement (65 years in New Zealand), and many are continuing to work.

Employment among older Aucklanders is driven by those aged 65 to 74 years (93% of older Aucklanders employed full-time, and 78% of those employed part-time, were in this age group).

Figure 31: Work and labour force status of those aged 65 and over (2006 and 2013)

Data source: Statistics New Zealand, Census
**Employment status**

In 2013, over half of those aged 65 and over in the labour force were paid employees (58%). However substantial proportions of older people were self-employed (27%) or employers (10%). A small group stated that they were unpaid family workers (5%).

It is interesting to note that older people made up 18 per cent of all unpaid family workers in Auckland – almost one in five.

**Figure 32: Employment status of those aged 65 and over and in the labour force (2013)**

![Employment status chart]

Data source: Statistics New Zealand, Census

**Occupations**

At the 2013 Census, older Aucklanders represented 5 per cent of all people aged 15 and over employed in Auckland, and were employed across all broad occupational categories.

The largest number were in the ‘chief executives, general managers and legislators’ category (2328, constituting 7% of all those aged 65 and over employed in Auckland), followed by specialist managers (7%) and education professionals (6%).

Older workers made up relatively large proportions of all Aucklanders aged 15 and over occupied in the following categories: farmers and farm managers (23% compared to 5% overall), farm, forestry, and garden workers (10%) road and rail drivers (9%).
Income

Ensuring that older people have secure and adequate income is one of the goals in the New Zealand Positive Ageing Strategy, as it is a fundamental element in the ability to live well. Income levels indicate the ability of people to purchase essential and nonessential goods and services including food, housing, health services and transport. While the New Zealand Superannuation Scheme provides universal income support, the amount received is fixed and for many who rely on this solely, it can be a life "on the edge of poverty.

Income sources

In 2013, over half (58%) of older Aucklanders who stated an income source on their Census form listed more than one source. The majority reported that they received an income from NZ Superannuation or a veteran’s pension (85%) (Table 4).

Over a third (39%) received an income from interest, dividends, rent, or other investment. It’s interesting to note that older Aucklanders accounted for 30 per cent of all those who stated they received an income from this source.

| Table 4: Top five income sources among those aged 65 and over (2013) |
|---------------------------------|------|
| Income source                  | %    |
| NZ Super or Veterans pension   | 85   |
| Interest, rent, dividends, other investments | 39 |
| Wages, salary, commissions, bonuses | 16 |
| Other super, pensions, annuities | 12 |
| Self-employment or business    | 9    |

Data source: Statistics NZ, Census
Note: People could receive more than one income from more than one source and categories are not mutually exclusive.

Reported personal income levels

Results from the 2013 Census indicate a variance in reported personal income levels, and a general trend for those aged 65 to 74 to report slightly higher incomes than people in older age groups. Overall, the largest proportion (38%) had a personal income of between $10,001 and $20,000 per annum.

Relatively large proportions of those identifying with Asian and Pacific ethnicities reported a personal income of less than $10,000 per annum compared to other groups.

The median personal income among those aged 65 and over was $20,900 in 2013, compared to a median of $29,600 for the overall population aged 15 and over.
Unpaid work/volunteering

Older Aucklanders contribute significantly to Auckland’s economy and society through their unpaid labour and volunteer work, including caring for family members. This can be an enjoyable way for older people to remain connected with others, however it is also important that people undertaking such activities are valued and adequately supported.

The proportion of older people who engage in unpaid work

At the 2013 Census eight in ten Aucklanders aged 65 years or over (80%) said they partook in at least one unpaid activity, such as household work or childcare, in the four weeks prior to census day. Two thirds (66%) of this group were aged 65 to 74 years.

As Table 5 shows, sizeable proportions of people aged 65 years and over who were participating in unpaid work were looking after a child who is a member of their household (9%) or a child who does not live in their household (14%). Relatively large proportions of people who identified with a Pacific (22%) or Asian (19%) ethnicity provided childcare for children in their household. This suggests that larger proportions of people in these ethnic groups may have been living in multi-generational households compared to other ethnic groups.

A quarter of those older Aucklanders who stated they had not undertaken any unpaid activities were aged 85 years and over (26%). This is likely to be related to general levels of health and physical capability among this ‘older-old’ group.

Table 5: Unpaid activities in previous four weeks by age group (2013) (%)

<table>
<thead>
<tr>
<th>Activity</th>
<th>65-74 years (n=)</th>
<th>75-84 years</th>
<th>85 years and over</th>
<th>Total 65 years and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household work, cooking, repairs, gardening, etc, for own household</td>
<td>84</td>
<td>72</td>
<td>49</td>
<td>76</td>
</tr>
<tr>
<td>Looking after a member of own household who is ill or has a disability</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Helping someone who is ill or has a disability who does not live in own household</td>
<td>9</td>
<td>7</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Looking after a child who is a member of own household</td>
<td>11</td>
<td>5</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Looking after a child who does not live in own household</td>
<td>19</td>
<td>8</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Other helping or voluntary work for or through any organisation, group or marae</td>
<td>17</td>
<td>15</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>No activities</td>
<td>13</td>
<td>25</td>
<td>49</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total stated</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Data source: Statistics New Zealand, Census of Population and Dwellings

Note: Percentages are column based. Activities were those undertaken in the four weeks prior to census day. The total is more than 100% as people could have engaged in more than one activity.
Living standards

Some older Aucklanders, especially those living on fixed incomes, are struggling to meet their living costs. They may be living in extreme financial and material hardship and will be vulnerable to price rises or changes. This has a direct impact on levels of personal health and well-being.

Enough money to meet every day needs

Almost three quarters (72%) of respondents to the survey of Older Aucklanders stated that in the previous 12 months they had enough, or more than enough, money available for necessities – defined as everyday goods such as accommodation, food and clothing. A small proportion (4%) felt that they had ‘not enough’ income.

There was a difference by age, with those aged 65 to 74 more likely than others to state that they had ‘more than enough’ money for necessities (32% compared with 19% of those aged 85 and over).

Table 6: Income available for necessities and non-necessities in previous 12 months (%)

<table>
<thead>
<tr>
<th></th>
<th>65-74 yrs</th>
<th>75-84 yrs</th>
<th>85+ yrs</th>
<th>Total sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=477</td>
<td>n=276</td>
<td>n=85</td>
<td>n=839</td>
</tr>
<tr>
<td>Not enough to pay for my everyday necessities</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Just enough to pay for necessities (with none left for non-necessities)</td>
<td>16</td>
<td>14</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Enough money to pay for necessities (with some left for non-necessities)</td>
<td>39</td>
<td>50</td>
<td>54</td>
<td>44</td>
</tr>
<tr>
<td>More than enough money for necessities (with enough left for non-necessities)</td>
<td>32</td>
<td>23</td>
<td>19</td>
<td>28</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>9</td>
<td>9</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Data source: Auckland Council, Survey of Older Aucklanders

“I feel lucky to be financially secure, living in a comfortable apartment, when so many people live in poverty and cannot afford things like visits to the doctor or dentist.”
- respondent to the survey of Older Aucklanders
Female, 65-69

“Concerned that rates and water bills continue to escalate beyond pension increases with little opportunity to trade down property for releasing capital (unless move away from Auckland where medical support services are available)”
- respondent to the survey of Older Aucklanders
Male, 65-69
Discussion

The findings presented in this report highlight the diversity of the lived experience of Auckland’s older population, and provide useful evidence to strengthen Auckland Council’s commitment to creating a strong, inclusive and equitable society that ensures opportunities for all Aucklanders.

As stated in the introduction, there are obvious challenges in our ability to adequately discuss the complexities and nuances of the social and economic well-being of a large and diverse group such as older Aucklanders in a single report. However, by bringing together available data in a framework such as this, including the results from our own recent survey of over 800 older Auckland residents, across a broad range of economic and social domains we are able to trace broad themes and to identify areas for ongoing attention.

Auckland is a great place to live for many people, and there is much to celebrate. For example, the survey of Older Aucklanders found that the majority of respondents rated their health as being good or excellent; belonged to one or more social groups; had not felt lonely or isolated in the previous 12 months; agreed that they got on with the people in their neighbourhood; and felt safe in their home at night, and had enough money to meet their everyday needs.

Many Aucklanders aged 65 and over continue to participate and contribute through paid employment, others though unpaid employment and volunteering.

However, this report also touches on some areas of concern, and highlights the importance of not assuming that older Aucklanders are a cohesive and homogenous group. There are important differences for example by age and socio-economic status.

The ability to afford basic costs of living in Auckland, and to absorb increases in those costs, is an issue. In 2013, 22 per cent of those aged 65 and over in Auckland lived in areas of relative socio-economic disadvantage, as measured by the NZ DeplIndex. One in five survey respondents told us they did not think their housing costs were affordable, and that they could not afford to heat their home properly during winter. Levels of home ownership are decreasing, and over 7000 older Aucklanders are living in crowded situations.

Loneliness and social isolation among older people is a very real issue, as is elder abuse and neglect. Almost one in five survey respondents felt that older people are not valued in our society.
Conclusion

This is a baseline report. It provides a useful foundation upon which Auckland Council can continue to trace the quality of life of older Aucklanders, as Auckland responds to what will be several substantial changes over the next ten years, and beyond.

Demographic trends that have been unfolding over several decades in New Zealand and across many other developed nations means that Auckland will be home to substantially larger numbers, and greater proportions, of older people over the next few decades, and that this group will be more ethnically and culturally diverse than at present. Population ageing will be accelerated in the next couple of decades, to an extent not ever seen before in New Zealand, as the large baby boom cohort move through their 60s and 70s. This will occur in a general context of population growth and change, driven by migration as well as natural increase.

These trends are not particularly unique to Auckland, or to New Zealand. Nonetheless they will bring specific challenges and opportunities across Auckland’s housing, transport, employment, healthcare, service and support systems. These systems will, in turn, be shaped and directed by the broader backdrop of the impacts of shifting global geopolitical alliances, climate change and advances in technology.

Auckland Council will continue to work with its stakeholders including central government, organisations, groups and local communities to understand and respond to these challenges and opportunities. This includes of course working with older Aucklanders, and drawing on the experience and wisdom that an ageing population offers, to create an age-friendly environment where older Aucklanders are visible, valued and respected.
References


Fox, A. (Ed) (2013). *The new social care: Strength-based approaches*. Public Services Hub, United Kingdom


Saville-Smith, K., Rehm, M., James, B and Murphy, L. (2016) *Downsizing and the housing stock – realities for older people*. A report prepared for the Finding the Best Fit. Housing Downsizing and Older People in a Changing Society research programme. Available at
Endnotes

1 There is no precise definition of ‘older age’. The age at which a person is considered, and considers themselves, old depends on the interaction between their individual biological experience and the meaning attached to their age in the wider social context. In other words, what is considered ‘older’ differs from person to person and group to group. In New Zealand, 65 tends to be the age at which older age is officially recognised and at which entitlement to older age social security benefits begins. (Rootham, 2016: iv).

2 Statistics New Zealand sub-national population projections (medium series) indicate that between 2013 (base) and 2033, the number of people aged 65 and over in New Zealand will increase by 556,200 – of which 183,750 will be living in Auckland (33%) (Statistics New Zealand, 2017).

3 The ‘baby boom’ was a period of significantly increased and relatively high fertility which occurred in New Zealand (as well as several other western countries including Australia, Canada and the United States) between the mid-1940s to approx 1964. At its peak in the 1960s, New Zealand’s fertility rate was more than four births per woman, which was high internationally. It must be noted that this was a predominantly Pākehā phenomenon. For further reading, we suggest Pool, Arunachalam, & Sceats, 2007.

4 Population ageing began over a century ago in New Zealand, and in other developed countries, with the onset of transition in fertility from relatively large to relatively small families. At the start of the 20th century, New Zealand was a very young population. Half of the population was below 23 years of age, and children outnumbered the elderly (taken as those aged 65 years and over) by 8 to 1. Over time however, fertility rates have dropped, and people are living a lot longer. In addition, there was a ‘baby boom’ after World War Two, which exacerbated, but did not cause, structural ageing. Ageing means that there will be numerically and proportionately more people in older age groups over the next few decades. Adapted from Statistics New Zealand, 2000.

5 See Jackson, 2011.


7 Auckland Council, 2015.

8 Rootham, 2016.

9 Ministry of Social Development. 2007.

10 World Health Organisation. 2015.

11 The Quality of Life survey is undertaken every two years. In 2016, the participating councils were Auckland, Hamilton, Wellington, Hutt City, Porirua, Christchurch and Dunedin, along with Waikato and Wellington Regional councils. The primary objective of the survey is to measure residents’ perceptions of aspects of living in urban areas. Topics covered in the 2016 survey include the degree to which respondents felt a sense of pride in the way their local area looks and feels; their perceptions of safety; social issues; public transport; and sense of community in their local area, among other questions. A representative sample of 2,712 Aucklanders aged 18 years and over participated in the 2016 Quality of Life survey. To access results for Auckland refer to Auckland Council, 2016.

12 The New Zealand General Social Survey (NZGSS) is undertaken every two years by Statistics New Zealand. It provides information on the well-being of New Zealanders aged 15 years and over. It covers a wide range of social and economic outcomes and shows how people are faring. In particular the survey provides a view of how well-being outcomes are distributed across different groups within the New Zealand population. For more information go to http://www.stats.govt.nz/browse_for_stats/people_and_communities/well-being/nzgss-info-releases.aspx


James and Saville-Smith, 2016:1. The authors go on to state that ‘it is well established that the vast majority of people 65 years and older are reliant mainly on national superannuation for their income. It is also well established that where national superannuitants are mortgage-free owner-occupiers, their living standards tend to be good and there is a high degree of life satisfaction. However, this is not the case for older tenants reliant on national superannuation. Older tenants have lower living standards and lower levels of satisfaction’ (page 2).


Statistics New Zealand define a ‘household’ as either one person who usually resides alone, or two or more people who usually reside together and share facilities (such as eating facilities, cooking facilities, bathroom facilities, and a living area), in a private dwelling. A ‘family’ is defined as a couple, with or without child(ren), or one parent and their child(ren), all of whom have usual residence together in the same household. The children can be of any age and do not have partners or children of their own living in the household. A household can contain one or more families, or can contain no families at all.


Goodyear & Fabian, 2014.


For further reading on the Canadian Crowding Index, refer to Goodyear, Fabian & Hay, 2011.

Baker et al., 2013.


A common measure of housing affordability is whether a household spends less than 30 per cent of their equalized disposable income on housing. This cannot be easily measured at the Auckland level among the population aged 65 and over and has not been included as a measure in this report. However, it is widely observed that housing is becoming unaffordable in Auckland, and Auckland has recently been rated the fourth least affordable city in a global Demographia International Housing Market Assessment, amongst the 92 major cities surveyed (Daly, 2017).

See for example Saville-Smith, Rehm, James, and Murphy, 2016.

Rankine, 2005.

It is also interesting to note that the 2016 Quality of Life survey found that respondents who were renting in Auckland were more likely than those who owned their home to agree that their home had an issue with damp or mould (Auckland Council, 2016)

This definition was taken from Wikipedia. Accessed 24 Feb 2017.

In New Zealand, drivers must renew their licence at age 75, 80 and every second year after that, and must obtain a ‘medical certificate for driver licence’ from their doctor. Refer to New Zealand Transport Authority website: http://nzta.govt.nz/resources/renewing-licence-over-75/

Data source: customised data from New Zealand Transport Agency. Data has been limited to holders of a current Class 1 (Car) and/or Class 6 (Motorcycle) licence as at 15 January 2017.


The SuperGold card is available to all people 65 years or over and legally and ordinarily resident in New Zealand; those aged under 65 years who receive the non-qualified spouse or partner rate of NZ Super or Veteran’s Pension; or those aged under 65 years who currently receive the Veteran’s Pension. It entitles the holder to free off-peak public transport after 9am weekdays, all day weekends and public holidays, as well as a range of other concessions.

Personal communication with Research Manager at Auckland Transport, December 2016.
33 For example, a study in the United Kingdom reported that the impact and cost of loneliness is on par with the impacts of smoking (Fox, 2013).
34 Rootham, 2016:31.
35 For example, researchers at University of Chicago have found that extreme loneliness increases a person’s chances of premature death by 14 per cent. For more information refer to Bergland, 2014.
36 Ministry of Social Development, 2007:70.
38 Durie, 1994.
39 Source: Statistics New Zealand, complete cohort life tables 1876–2014 (updated March 2016) and national population projections 2014(base)–2068, mortality assumptions (published November 2014). Cohort life expectancy is the average length of life remaining at a given age, experienced by people born in the same year. The data is national and is not available by Māori/non-Māori split.
40 Statistics New Zealand, 2015.
42 For example, the *Social Report 2016: Te pūrongo oranga tangata* prepared by Ministry of Social Development includes perceptions of health as a measure of health, using data from the New Zealand Health Survey. A question on perceptions of own health is included in the biennial Quality of Life survey and Statistics New Zealand General Social Survey.
43 Wording taken from World Health Organisation, 2016.
44 The literature suggests that older adults are often likely to compare themselves with those less fortunate to them when considering subjective measures of health and well-being and as a result, tend to report relatively higher levels of well-being compared to other age groups (Rootham, 2016: 6).
46 Refer for example, to Mehta, 2012; Davey, Keeling, and Zodgekar, 2010.
49 Sport NZ and Auckland Council, 2016.
50 Asquith, 2009: 258.
51 Information on age is not collected for local elections in Auckland. The Electoral Commission is responsible for providing the roll data used for the conduct of local body elections, and local Councils are responsible for the conduct of local body elections. The electoral officer for each Council is responsible for producing the roll used for local body elections and a master roll, showing who has voted. However, under the Electoral Act 1993, there are certain regulations and information on age is not provided by the Commission to Election Services, who manage elections on behalf of Auckland Council. (Advice received from Dale Ofsoske, Electoral Officer for Auckland).
52 Human Rights Commission.
54 Refer to Age Concern website for further information: https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ_Public/Elder_Abuse_and_Neglect.aspx#kindsofabuse
55 Cited on Age Concern website, 17 March 2017.
57 Within the Whare Tapa Wha model of health and well-being, health is a four-sided concept representing four basic beliefs of life: Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health), Te Taha Whānau (family health). The Whare Tapa Wha can be applied to any health issue affecting Maori from physical to psychological well-being. For more information refer to Rangitahi Tu Rangatira website: https://www.r2r.org.nz/maori-health/whare-tapa-wha

58 Sourced from: http://maoridictionary.co.nz/search?idiom=&phrase=&proverb=&loan=&keywords=Turangawaewae


60 Te Kupenga is Statistics New Zealand’s first survey of Māori well-being. The survey gives an overall picture of the social, cultural, and economic well-being of Māori in New Zealand. Along with general social and economic well-being measures, Te Kupenga provides information from a Māori cultural perspective. This includes information about the well-being of the Māori language. The target population for Te Kupenga was the usually resident Māori population of New Zealand, living in occupied private dwellings on the 2013 Census night and aged 15 years or older.

The Māori population includes all individuals who identified with Māori ethnicity or Māori descent in the 2013 Census form. The data collection took place from 4 June 2013 to 25 August 2013.

Nationally, the Te Kupenga survey was answered by 5,549 individuals, of which approximately 1410 were based in Auckland. Numbers are small and caution must be exercised in interpreting the results as there could be a large margin of error.


62 This was evidenced also in Te Kupenga – while 14 per cent of those aged 55 and over stated they spoke te reo in day to day conversations ‘well or very well’, 29 per cent felt they did this not very well, and half (50%) could speak no more than a few words or phrases. (unpublished Auckland Council analysis)

63 Open-ended comments made by respondents to the survey of Older Aucklanders suggest however that some older Aucklanders (Pakeha and Māori in particular) are uncomfortable with increased cultural diversity in Auckland in recent decades, for a variety of reasons including perceptions that this is leading to changes in the housing and labour market, or just generally feeling uncomfortable with Auckland becoming a multicultural society.


67 Callahan, 2014.

68 ‘Heteronormativity’ refers to the assumption of universal heterosexuality and resulting beliefs and practices that only value or acknowledge sexual and emotional relations between women and men. Source: http://socialmovements.bridge.ids.ac.uk/glossary

69 Stevens, 2013.


71 Lotoala, Breheny, Alpass, and Henricksen, 2014.


73 The New Zealand Index of Deprivation (NZDep2013) is a combination of a range of key socio-economic variables at the household level. It provides an overall score of deprivation in a particular meshblock, with 10 indicating relatively poor outcomes and 1 indicating relatively positive outcomes. It is a useful mechanism to explore relative socio-economic advantage across Auckland. The
NZDep2013 was calculated using 2013 Census data on a weighted index. It takes into account a range of factors, shown below in order of decreasing weight.

<table>
<thead>
<tr>
<th>Dimension of deprivation</th>
<th>Description of variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>People aged &lt;65 with no access to the Internet at home</td>
</tr>
<tr>
<td>Income</td>
<td>People aged 18-64 receiving a means tested benefit</td>
</tr>
<tr>
<td>Income</td>
<td>People living in equilised* households with income below an income threshold</td>
</tr>
<tr>
<td>Employment</td>
<td>People aged 18-64 unemployed</td>
</tr>
<tr>
<td>Qualifications</td>
<td>People aged 18-64 without any qualifications</td>
</tr>
<tr>
<td>Owned home</td>
<td>People not living in own home</td>
</tr>
<tr>
<td>Support</td>
<td>People aged &lt;65 living in a single parent family</td>
</tr>
<tr>
<td>Living space</td>
<td>People living in equilised* households below a bedroom occupancy threshold</td>
</tr>
<tr>
<td>Transport</td>
<td>People with no access to a car</td>
</tr>
</tbody>
</table>

*Equivalisation: methods used to control for household composition.
Source: Atkinson, Salmond, and Crampton, 2014.

74 To qualify for New Zealand Superannuation, people must be aged 65 years and over and have lived in New Zealand for at least 10 years while over the age of 20 years, including at least five years over the age of 50 years. Payments are fortnightly and are paid at slightly different amounts according to personal circumstances. At the time of writing it ranged from $886 per fortnight (before tax) for people living alone to $636.20 for a married, civil union or de facto couple where only one partner qualified) (before tax). These amounts may be affected by other income received. https://www.workandincome.govt.nz/eligibility/seniors/superannuation/payment-rates.html .

At the time of writing, the New Zealand Prime Minister Bill English signalled a major policy shift to raise the retirement age to 67 by 2040, and to introduce changes to the terms of eligibility for migrants to New Zealand. He will seek mandate for these changes at the next general election. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11812931.

75 See endnote above.

Purpose

Supporting disabled people: 2013 presents findings on support received by disabled people in some aspects of their personal lives, and is based on data from the 2013 Household Disability Survey (2013 HDS).

This article examines the types of support that disabled people received and who provided that support. The 2013 HDS included questions about a range of personal and domestic tasks for which disabled people might receive help. This article also explores unmet need for help with these tasks, along with differences by age, sex, and impairment type where possible.

Please note this article excludes the findings from the Disability Survey of Residential Facilities (DSRF).

About the 2013 Household Disability Survey

The survey used a comprehensive measure of disability that asked respondents whether they had difficulty with a wide range of daily activities. The 2013 HDS found that 23 percent of all people living in private dwellings were disabled. Men and women were equally likely to be disabled, but women were more likely to experience physical impairment and men hearing impairment. For children (those aged under 15 years), boys (at 13 percent) were more likely to be disabled than girls (8 percent). Disability was strongly related to age. People aged 65 years or older had a disability rate of 56 percent compared with 28 percent for those aged 45 to 64 years, 16 percent for those aged 15 to 44 years, and 11 percent for those under 15 years old.

Summary of key points

The 2013 Household Disability Survey’s findings on support received by disabled people showed:

- 33 percent of disabled adults in private households received regular assistance with a range of personal or domestic tasks.
- Disabled people aged 65 years or over were more likely to receive support than younger disabled adults.
- The most commonly received type of support was with heavy work around the home and garden.
- Adults with intellectual impairments were more likely than adults with other impairment types to receive some support with the tasks covered by the survey.
- Family members who disabled people lived with were most likely to be the providers of support.
- Organisations were also important providers of support, particularly for older people.
- 10 percent of disabled adults reported having unmet need for assistance with the tasks covered by the survey.
- Disabled women reported unmet need for support more often than disabled men.
- 12 percent of disabled children received extra help with personal care at least once a month because of their impairment.
- For 10 percent of disabled children, their caregiver reported an unmet need for help around the house because of the child’s impairment.

See also:

- More support needed for disabled people – media release
- Disabilities for more information on the survey, definitions, and other releases.

One-third of disabled adults are regularly supported by others

One-third of disabled adults living in private households (309,000 people aged 15 years and over) reported that they, or their household, received support of some kind at least once a month because of their impairment.

While we are all supported in some way by others, ‘support’ in this article refers specifically to the range of assistance, both personal and domestic, that the 2013 HDS asked about. This support included help with cooking, shopping, and housework; heavy tasks like cleaning windows and mowing lawns; personal finances, filling in forms, decision-making, or communicating with others (such as at medical visits) – categorised as ‘other help’; and personal care including help with washing, dressing, and toileting. The support was needed because of a condition or health problem.

Taking all types of support together, disabled women were more likely than disabled men to receive support – 39 percent of women and 27 percent of men reported receiving support of some kind. This difference was not due to the typically older age structure of the female population – disabled women were more likely than disabled men to receive support across all age groups.

Disabled people aged 65 years or over were more likely to receive support (47 percent) than younger adults (26 percent).

Figure 1
Figure 1 shows that help with heavy work around their property, such as mowing lawns and washing windows, was the most common type of support received by disabled adults – 21 percent reported that they received help with this type of support. For disabled people aged 65 years and over, 32 percent received help of this kind. The next most common form of support was for domestic housework, reported by 15 percent of all disabled adults and 24 percent of disabled people aged 65 years and over.

For all disabled adults, 14 percent were assisted with aspects of their personal finances and banking, filling in forms, decision-making, or communicating with others (such as at medical visits). This type of support is categorised under ‘other help’ in figure 1. There is little evidence of an age difference for this type of support.

Assistance with personal care, which could be washing, dressing and/or toileting, was the type of help that disabled adults reported least. Just 4 percent reported that they received help with this aspect of their lives.

One in five receiving support daily get carer support

Respite and carer support are types of alternative care that allow the person who usually helps a disabled adult to have a break. For disabled adults who were getting at least one type of support daily, 19 percent reported that they had had respite or carer support at some time in the last 12 months. Twelve percent reported that they needed respite or carer support in the last 12 months but were unable to get it. For people who received help weekly, the proportion who had had respite or carer support in the last 12 months was 14 percent, and 8 percent reported that they needed this alternative care but could not get it.

Help every day with personal care and cooking

While the number of disabled adults who received help with personal care was small, 68 percent of those who did received help daily. Support with preparing meals was also received frequently – 77 percent of those who received this type of help reported that they had help daily with their meals.

The frequency of support received by disabled adults reflects the nature of the task for which support was being received. Help with shopping and housework were most often received weekly and support with heavy work less often (by those disabled adults who received it). This pattern reflects the frequency with which people would usually carry out these tasks for themselves.

Adults with intellectual impairments most likely to receive regular help from others

Adults with intellectual impairments were more likely than adults with other impairment types to receive some support with the tasks covered by the survey. Note that the intellectual impairment rate for adults is low (2 percent) while the physical impairment rate is the highest (14 percent). The bottom row of table 1 shows the percentage of all adults with each impairment type. Disabled people may have more than one type of impairment.

Most support comes from family members living in the same house

The most common provider of support for disabled adults was provided by a family member they live with. For about one-fifth (22 percent) of disabled adults, a family member living in the same house provided at least one type of support and for 18 percent a family member living in the same house was the main provider of support (the one who provided the most support).

Fifteen percent of disabled adults received some support from a care organisation and for 8 percent an organisation was their main provider of support. Friends and neighbours (non-family who don’t live in the same house) are more likely to provide some form of support than flatmates (non-family who live in the same house).

Figure 3

Organisations are important providers of help with housework and personal care

For domestic housework and personal care, organisations are as important as family members living in the same house when it comes to providing support. Family living in the same house are far more likely than others to help disabled people with cooking and shopping.

Figure 5
Ten percent of disabled adults need more help than they get

Having unmet need for some form of assistance in the past 12 months was reported by about 89,000 disabled adults – 10 percent of all disabled adults.

An unmet need for help might arise where some assistance was being provided but it was not enough or where the disabled person was not getting any help at all with an aspect of their life.

Figure 6 shows the percentage of disabled adults who reported unmet need for each type of support covered, by sex. For all support types, women reported unmet need more often than men.

Extra help needed in households with disabled children

In the 2013 HDS, 85 percent of disabled children had a female caregiver, and 71 percent had a caregiver aged 25 to 44 years. For 7 percent of disabled children, caregivers reported having an unmet need for help with the personal care of the disabled child they cared for.

Twelve percent of disabled children received extra help with personal care at least once a month. For all children the amount of help they need to manage personal care tasks depends on age and development. The survey asked about support that was over and above what a child would usually get at their age and that was needed because of a condition or health problem.

The percentage of children who received extra help with personal care differed a lot by impairment type. Children with physical impairments were the most likely to receive extra help while those with sensory impairments were the least likely. The survey does not indicate any differences between boys and girls in the proportion receiving extra help with personal care.

For children who received extra help with personal care, 82 percent received this help on a daily basis.

For one-third (34 percent) of children who received extra help because of their impairment, some help was provided by an organisation (such as the district health board) or private business (such as a care service). A
similar proportion (35 percent) received some extra help from a person who did not live in the same house as them but was not associated with an organisation or private business.

A small proportion of disabled children had caregivers who reported that they received help with domestic tasks because of the child's condition or health problem. Just 2 percent reported getting this type of support; however, 10 percent reported having an unmet need for such support.

See More support needed for disabled people — media release.

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For technical enquiries, contact: Michelle Griffin, Wellington 04 931 4600, info@stats.govt.nz

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188
Counties Manukau District Health Board
Disability Support Advisory Group
Deaths of Intellectually Disabled People

Recommendation

It is recommended that the Disability Support Advisory Group:

Receive the Deaths of Intellectually Disabled People paper.

Endorse the DiSAC Chair write to the National Registrar of Deaths and Chair of A/WDHB DiSAC (as noted below).

Prepared and submitted by: Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer

Background

‘The deaths of intellectually disabled people are being incorrectly recorded in Australia, research has found, and the same problem is likely to exist in New Zealand’ – Radio New Zealand 6 March 2017 (Appendix 1).

This is an issue that is worth looking into but really needs a national approach. It would require matching of very different data sets and would probably warrant a formal research project. We don't think we'd learn or achieve much at all from trying to look at it locally.

The death certificate information for the whole population is held and analysed nationally and if any framework were to be developed, as the article recommends, then it should be a national framework.

We only hold in the DHB, the death certificates for the 40% of our population who die in hospital. We would likely get only a subset of the Intellectually disabled community identified in discharge coding as actually having intellectual disability and we'd have to do a manual analysis of the death certificates.

Way Forward

A way forward could be for the DISAC chair to write to the National Registrar of Deaths asking if they have any plans to look at the issue and if not urging them to do so, perhaps in conjunction with one of the university's population health teams. If they subsequently establish that there is a problem with the quality of the death certificate information (as there is with a lot of death certificate information, for various reasons) then that will need to be addressed but preferably as part of wider work to improve recording of causes of death.

The DiSAC Chair will also write to the Chair of A/WDHB DiSAC to share our concerns.
Deaths of intellectually disabled people "misreported"

From Nine To Noon (/national/programmes/ninetonoon), 9:08 am on 6 March 2017

The deaths of intellectually disabled people are being incorrectly recorded in Australia, research has found, and the same problem is likely to exist in New Zealand.

A team from the University of New South Wales found some people with Downs Syndrome who had died of pneumonia or heart failure would have Downs Syndrome written on their death certificate, though the condition did not directly cause their death.

The cause of death of some disabled New Zealanders may be incorrectly recorded. Photo: 123RF

The researchers said 38 percent of deaths of intellectually disabled people were potentially preventable, but without a robust reporting framework it was difficult to work out how to bring that figure down.
Both the Australian researchers and IHC New Zealand - this country's biggest provider of care services for intellectually disabled people - are calling for a national reporting framework for deaths of the intellectually disabled.

Dr Martyn Matthews, a spokesperson for Idea Services, an arm of IHC, did a small scale study of 54 people who died in 2015.

"I found very similar kind of things - that people were often coded wrong, the intellectual disability was coded as the cause of death," he said.

"I've gone through actual death reports to look at the real cause, the underlying condition that's caused the death, and found high rates of respiratory conditions, aspiration pneumonia ... being one of the higher ones."

The author of the University of New South Wales' study, Professor Julian Trollor, said people with intellectual disabilities died prematurely, from causes similar to the general population.

The average age of death was 54 compared to 81 in the general population, the research found. Young and middle-aged people - those aged 20 to 44 - were four times more likely to die than people of that age group without an intellectual disability.

Prof Trollor said as well as being vulnerable due to the specific cause of the intellectual disability, people with intellectual disabilities may struggle to get good health care, including preventative health care.

"We find in Australia, that often preventative health aspects are being under-detected and under applied to this group.

"They continue a life-long pattern of high risk without the risk reduction strategies", he said.

One in three deaths was potentially avoidable by individualised care and treatment through existing primary health or hospital systems.
Counties Manukau District Health Board
Disability Support Advisory Group
Video Remote Interpreting (VRI) Service Trial

Recommendation

It is recommended that the Disability Support Advisory Group:

Receive the Video Remote Interpreting (VRI) Service Trial paper.

Prepared and submitted by: Jenny Parr, Director of Patient Care, Chief Nurse and Allied Health Professions Officer

Background

‘In March 2016, Kim Robinson had a 64 hour wait for a NZLS Interpreter when he entered hospital in an emergency situation’ – Article Deaf Action New Zealand 8 April 2017 (attached as Appendix 1).

The current state is that the organisation is working through Stage II of trials, which is to complete 80 patient appointments outside of MSC i.e. 20 at BSC and 60 at MMH then report on the results in order to plan next steps. The trials are using our on-premise version of Skype for Business as a test video platform, and this system will not be the longer term solution due to various limitations.

This was an agreed scope to further prove the viability of the Video Remote Interpreting concept whilst waiting for healthAlliance and the regional Telehealth team (of which we are part of) to work through EOI and RFP for what will become the production Telehealth video solution longer term.

This testing stage is taking longer than anticipated due to technical issues that we have had (and been working through resolving), as well as a need to increase the network pipe to Botany before testing there.

We have completed about 25-30 trials at MMH so far. We are now focused on Botany with 16 tests in March 2017. Further work is underway to set up testing at MMH. It will probably be another 6-8 weeks before hA have vendors shortlisted for testing the longer term solutions.

August 2017 Update

The VRI project is progressing and we are continuing to refine the readiness of the Interpreting Service for video. This includes testing and the proving of benefits. Henry Mulligan, Senior Project Manager Information Services at healthAlliance will provide a regional stakeholder update, which is also attached for your information.
Medical Interpreting

[Video Report in NZSL](https://www.youtube.com/watch?v=6q1gD4CRN-c&list=PLPX43XaZbMBZOBfyyNJJcE6rEjIMFf61Zw)

Access to DHB Services in Emergency Situations with NZSL Interpreters

A Report from Deaf Action NZ

March 2017

Executive Summary

In March 2016 Kim Robinson had a 64 hour wait for a NZSL Interpreter when he entered hospital in an emergency situation. Other members of the Deaf Community recounted similar
experiences. This prompted Deaf Action to contact each District Health Board to ask for assurance that each DHB could provide access to NZSL Interpreters 24 hours a day, 7 days a week.

Responses were received from 18/20 DHBs. Of those who replied, only seven were able to provide assurance that they could provide interpreters 24 hours 7 days a week. Three identified areas that required attention, one being the provision of a booking system for normal working hours (9am – 5pm) and undertook to make modifications as result of our letter, while the remaining eight did not provide assurance around access to interpreters.

Deaf Action recommends that as a matter of urgency, all DHBs, particularly those who were not able to guarantee full access to an NZSL Interpreter review their policies and procedures to ensure that they have effective services that are accessible to the Deaf community at all times utilising technology if required.

Current research into the experiences Deaf people have within the health systems needs to inform future practice.

REPORT

In May 2016, Deaf Action sent a letter to all District Health Board (DHB) in New Zealand to ask for assurance that their DHB is able to provide access to sign language interpreters 24 hours 7 days a week.

This followed the experience of a patient, Mr. Kim Robinson, at Whangarei Base Hospital who, earlier in 2016, was not able to access a NZSL Interpreter for 64 hours during an emergency situation. When he shared his experience with the Deaf community on Facebook he was overwhelmed by the number of people in New Zealand who said they experienced similar difficulties. It became clear to Deaf Action that this issue required attention.

A forum took place May 2016 in Auckland. Over 30 Deaf people, interpreters and family members shared their experiences. From this, It was clear that the procedures for accessing NZSL interpreters are confusing and inconsistent across DHBs. This creates stress and uncertainty at times when a Deaf person is vulnerable or at risk. Without NZSL Interpreters in place, we Deaf people are unable to provide information about our health, nor are we able to provide informed consent to any treatment or course of action.

Therefore, members of Deaf Action want to know how each DHB can confidently ensure Deaf people across New Zealand are guaranteed access to interpreters in emergency situations.

DHBs will know their obligations under the Health and Disability Consumers’ Code of Rights, in particular to Right 3 Dignity and independence; Right 4 Proper Standards; Right 5 Effective
Communication; Right 6 Information.

We acknowledge that the spread of the Deaf community and the availability of qualified NZSL Interpreters varies throughout New Zealand has an impact on accessibility. We also acknowledge that the Deaf community is often referred to as a ‘low incidence, high need’ community however this does not lessen our need to access health services.

With improved technical developments and service adaptations we know it is realistic to expect this to provide opportunities for 24 hours 7 days a week access and NZSL interpreters.

Methodology:

A letter was sent to twenty DHBs throughout New Zealand in May 2016. Responses were received from 18 DHBs, an 90% response rate. Eight were from DHBs with a population over 300,000 with the remaining ten from those under 300,000.

We also did not hear from Taranaki DHB who we believe has strived to improve their ability to provide access. The remaining non-responder was the Tairawhiti DHB.

Findings:

1. Eight DHBs were able to assure us they are able to provide Deaf people access to NZSL Interpreters 24 hours 7 days a week. These DHBs include Waitemata, Counties Manukau, Waikato, Wairarapa, Hutt Valley, Capital Coast, Canterbury and West Coast.

Five demonstrated this by sharing details of their processes while three have a Disability policy which includes an interpreting policy also. This policy guarantees that a person asking for an interpreter will have access to one. However, this is dependent on the time of the day and the availability of interpreters.

2. Three DHBs asked for guidance or are open to a discussion on how to improve access and services to the Deaf. As result of our letter Auckland and Northland DHBs undertook an immediate review and implemented improvements while welcoming further advice. Lakes DHB also reviewed their policies and asked for advice to strengthen their ability to provide a safe 24 hours 7 days a week service.

3. Seven DHBs demonstrated shortcomings which need to be addressed in order to provide effective 24 hours 7 days a week services.

4. DHB's used a combination of in-house interpreter booking services and external agencies.
5. Three DHBs (Capital Coast, Hutt Valley and Wairapapa) collaboratively committed to improve access to all services for NZSL Users in both emergency and non-emergency situations in order to improve the experience and safety of deaf people using their health services.

Initial research is now complete with the findings informing future development. These DHBs also refer to a Deaf Leadership group which provides guidance. In addition, these DHBs provide training to staff to ‘manage’ the situation safely until an NZSL Interpreter arrives.

6. Not one DHB referred to the Video Remote Interpreting (VRI) service which has been available since 2009. One DHB referred to the use of skype as a useful tool at times when it is not possible to have an interpreter present on site.

7. Several DHBs demonstrated how they access NZSL Interpreters Monday – Friday 9am – 5pm however they did not explain what takes place after hours and where a policy or procedure was provided this was not evident.

8. There is confusion around the role and professional expectations of a qualified NZSL Interpreter leading to the expectation that communicators can fulfil the same role. Several DHBs referred to local interpreters when in fact there are no qualified interpreters living within the region. In some cases using family members or friends as communicators was seen as acceptable.

Several referred to staff members or family members who are brought in to act as interpreters which suggests they are not qualified NZSL Interpreters.

Deaf Action recommends

1. All DHBs make a commitment towards providing effective accessible services to the Deaf community at all times by reviewing their policies and procedures. Some DHBs will benefit from adopting a collaborative approach.

2. DHBs to work with their local Deaf and NZSL Interpreting community to develop local solutions.

3. DHBs to ensure there is access to the Video Interpreting Service via Skype while understanding face to face interpreting is the preference of the community. http://www.nzvis.co.nz (http://www.nzvis.co.nz)

4. DHBs to implement an alert system (potentially on their NHS number) to indicate where an NZSL Interpreter is required.
5. Deaf community to be encouraged to provide feedback when services have gone well and not so well. Feedback mechanisms to be clarified.

6. NZSL Interpreter community to consider how national interpreting services may be provided to all DHBs between 8pm and 8am.


We also want to acknowledge that Northland DHB has taken positive steps to ensure Kim Robinson’s experience does not occur again.

**New Initiatives**

Deaf Action also wants to make you aware of the following initiatives currently taking place as these will help inform good practice.

1. Capital Coast, Hutt Valley and the Wairapapa DHBs undertook a research project on the experiences Deaf people using New Zealand Sign Language have when accessing Health Services. This is overseen by the Director of Disability Strategy and Performance, Strategy, Innovation and Performance Directorate Capital Coast DHB and will be published in 2017. For further information call 0800 DISABILITY

2. Auckland University of Technology Sign Language Section was funded by the NZSL Board for their project: Negotiating healthcare through NZSL: Experiences of Deaf New Zealanders.

The aim of this project is to create a corpus of authentic stories from Deaf people discussing their experiences of understanding health information. This will be available in 2017.

**Deaf Action NZ**

Deaf Action began in July 2015 as a voluntary organisation to advance the human rights and to represent the interests of Deaf, deaf and hard of hearing people in Aotearoa New Zealand. It is a growing group of Deaf community members who, together, provide leadership for the human rights of Deaf people. We want to make sure that the services Deaf people use are accessible and accountable as well as ensuring Deaf people can achieve their goals in education and employment. Citizenship is important to us as is New Zealand Sign Language (NZSL) which we hope will be an ordinary language in New Zealand in the future.

Deaf people are primarily visual beings, whose eyes are their portal to the world of information and knowledge. Thus, sign language and visual strategies must be made available to Deaf people as a birth right.
Copy of Report:

Deaf Action Report March 2017 PDF

Deaf Action Report March 2017
(https://deafactionnz.files.wordpress.com/2017/03/deaf-action-report-march-20172.doc) (.doc)

BLOG AT WORDPRESS.COM.
REGIONAL TELEHEALTH VIDEO CONSULTING CAPABILITY
Stakeholder Update:

1. What does Telehealth video consultation include?
2. What’s been happening?
3. What happens next?
4. What are the usability evaluations?
5. How does this improve the patient experience?
6. How does this improve the clinician experience?
7. When will this happen?
8. How do I gain access to Telehealth VC?
1. What does Telehealth video consultation include?

Telehealth is the ability to deliver healthcare at a distance by remote transmission of audio, video and clinical data. This project has been created to support:

- The delivery of an improved experience for patients and their whaanau
- Support the delivery of clinical care remotely
- Professional development and continuing education remotely

The solution/s provided will allow for real-time consultations with an ability to record these for later use.”
The Northern Region DHB’s agreed that a range of Telehealth Video Consulting capabilities were needed, to better support the delivery of clinical services, from the DHB’s to other hospitals, medical centres, patient homes.

High level requirements, for the Telehealth Video Consulting capability, were agreed upon:

- Northern Reg Telehealth Forum provided functional requirements
- The hA domain architect (networks & security) provided technical requirements
- The MoH National Telehealth Forum, ProCare and other DHB’s quality checked the requirements

The Northern Region DHB’s asked for Expressions of Interest, from the market for the provision of a Regional Telehealth Video Consulting solution, to meet these requirements.

22 responses were received. A shortlist of 12 candidate solutions was agreed.

Detailed requirements have been given to the 12 shortlisted candidates. Responses are due at the end of July 2017.
3. What happens next?

• A reduced shortlist of candidate solutions will be agreed upon, on the basis of the RFP responses

• A procurement will engage with the shortlisted vendors to qualify the affordability of the candidate solutions

• The project will evaluate the usability of the candidate solutions, with the clinical champions for selected Telehealth service opportunities

• The project will then make a recommendation on the final set of Telehealth Video Consulting solutions which should be made available to the Northern Region

• The project will seek approval and funding to make the recommended solutions available

• The project will make the approved solutions available

• The DHB’s will be able to establish new Telehealth services to consume the new Telehealth Video Consulting capability
4. What are the usability evaluations?

One of the most important criteria for candidate Telehealth Video conferencing solutions is that they are easily usable by both patients and clinicians.

The project will assess this in a range of scenarios using the Telehealth service opportunities below:

<table>
<thead>
<tr>
<th>Generic Tele-health scenario (RFP)</th>
<th>DHB</th>
<th>Specific tele-health service to be used in usability evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/base consultation to GP/clinic/remote hospital</td>
<td>CMH</td>
<td>Virtual interpretation service</td>
</tr>
<tr>
<td>Acute remote assessment of an urgent situation</td>
<td>NDHB</td>
<td>Acute assessment of patients at remote sites by specialists using VC to help determine care plan and retrieval strategy @ Dargaville and the Bay of Islands regional hospitals</td>
</tr>
<tr>
<td>Specialist/GP/therapist consultation to patient in their home</td>
<td>WDHB</td>
<td>WDHB to confirm the service prior to SteerCo</td>
</tr>
<tr>
<td>Multidisciplinary and/or multi-organisation patient discussion regardless of locations</td>
<td>CMH</td>
<td>MDM and specialist support to Waiuku GP’s and Franklin hospital</td>
</tr>
<tr>
<td></td>
<td>NDHB</td>
<td>Specialist support for midwifery, specialist and MDT support for virtual home visits to Dargaville and Bay of Islands regional hospitals</td>
</tr>
<tr>
<td>Store, forward &amp; remote monitoring capability</td>
<td>ADHB</td>
<td>Wound Management &amp; the TELEDOT service</td>
</tr>
</tbody>
</table>
5. How does this improve the patient experience?

• More equitable access to health care, particularly for remote communities and those who struggle to leave the home such as older or disabled people

• Improved management of long-term conditions and decreased hospital admissions

• Reduced commuting hours, stress and family disruption, especially where supporting family members need to accompany a patient

• Reduced travel and accommodation costs, as well as less time off work

• Reduced travel related accidents and fatalities for patients
6. How does this improve the clinician experience?

- Ability to deliver health services without being in the same room as the person receiving care
- Opportunity to deliver of health care-related education, research and evaluation remotely
- Reduced commuting hours, travel accidents and travel costs for those delivering services
- Diminished need for DHB funding of patient travel / accommodation grants and shuttle services
- Lesser need for DHB building capacity such as outpatient clinics and parking
7. When will this happen?

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul</td>
<td>RFP responses</td>
</tr>
<tr>
<td>Aug</td>
<td>RFP shortlist</td>
</tr>
<tr>
<td>Sep</td>
<td>Affordability checks</td>
</tr>
<tr>
<td>Sep - Nov</td>
<td>Usability evaluations</td>
</tr>
<tr>
<td>Dec</td>
<td>Secure funding and contract the vendors</td>
</tr>
<tr>
<td>Dec - Feb</td>
<td>Make Telehealth Video Conferencing solutions available to the DHB’s</td>
</tr>
</tbody>
</table>
8. How do I gain access to Telehealth VC?

- Each DHB has a list of Telehealth service opportunities for this new technology.
- The DHB’s will prioritise the roll-out of Telehealth Video conferencing to these services in 2018.
- If you have a service that would benefit from Telehealth Video conferencing, or want to know more, please contact your DHB Telehealth rep.

<table>
<thead>
<tr>
<th>WDHB</th>
<th>ADHB</th>
<th>CMH</th>
<th>NDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robyn Whittaker</td>
<td>Lucy Westbrooke</td>
<td>Leanne Elder</td>
<td>Roy Davidson</td>
</tr>
</tbody>
</table>
Counties Manukau District Health Board
Disability Support Advisory Group
Disability Friendly Hospital Maps

Recommendation

It is recommended that the Disability Support Advisory Group:

Receive the Disability Friendly Hospital Maps paper.

Prepared and submitted by: Colleen Brown, DiSAC Chair

Background

At CM Health, wayfinding maps are available for consumers and visitors to use to find their way around the large hospital campus.

However, what about those in the disability community who need to have a different set of information in order to make their access to hospital services easy.

Attached is a comparison between CM Health and Mid Central DHB for discussion.
Parking at Middlemore Hospital

Middlemore Hospital. Please consider using public transport. The main entrance to the Middlemore Hospital site is on Hospital Road. The bus stop and train station are located outside Galbraith Building entrance which is on Hospital Road. Once in the main entrance check the wayfinding board for directions to different services within the hospital.

Vehicle access for parking at Middlemore Hospital is through the Main Gate 1 on Hospital Road. There are 6 car park zones and signs will direct you to the one closest to your destination.

- Rehabilitation patients use car park 6
- Birthing (in Galbraith Building) have dedicated car park spaces on Hospital Road

Kidz First Hospital entrance is through South Gate 2. Parking sites outside the Kidz First Hospital entrance is specially provided for caregivers/parents who have patients in Kidz First. You do need to display a parking permit to use this carpark or risk your car being towed. However, you will not be guaranteed a place if parking spaces have all been taken.

Click here for the updated wayfinding map.

Mobility Parking spaces can be located near most of the entrances around the hospital. Please ensure you display an authorised mobility parking pass at all times. Click here for more information about mobility parking at Counties Manukau DHB locations. Patients may be dropped off or picked up from outside the Hospital main entrance, which has a small number of free short-term parks reserved for this purpose only. Please consider others and remove cars as soon as possible.

Parking for all other visitors is available in designated paid visitor parking spaces around the Middlemore Campus. There is a new public designated parking area beside the new Edmund Hillary Block. Please follow the signs and to enter the visitor car park insert your ticket barcode up. Remove the ticket and the barrier will rise.
Autopay stations are located throughout the carpark and Hospital main entrance. After validating your ticket you have 15 minutes to exit the carpark otherwise extra payment is required. Parking prices will be updated soon.

**Visitors car parking rates**

Hours of operation: 24 hours per day / 7 days a week.

<table>
<thead>
<tr>
<th>Time</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 15 minutes</td>
<td>No charge</td>
</tr>
<tr>
<td>15 minutes to 1 hour</td>
<td>$4.00</td>
</tr>
<tr>
<td>1 hour to 2 hours</td>
<td>$8.20</td>
</tr>
<tr>
<td>2 hours to 3 hours</td>
<td>$12.20</td>
</tr>
<tr>
<td>3 hours to 4 hours</td>
<td>$16.40</td>
</tr>
<tr>
<td>4 hours plus</td>
<td>$20.40</td>
</tr>
<tr>
<td>Lost ticket</td>
<td>$40.80</td>
</tr>
<tr>
<td>Between hours of 2pm to 8pm</td>
<td>30 minutes free parking available but visitors must be in and out of car park within the 30 minutes other normal rates apply.</td>
</tr>
</tbody>
</table>

**Free Parking is available at:**

- Manukau SuperClinic
- Auckland Spinal Rehabilitation Unit
- Pukekohe Hospital
- Botany SuperClinic
Counties Manukau Health Disability Services

PUBLIC SERVICE

Disability Support Services is here to support those who have a health condition or impairment who live within the Counties Manukau community.

One in five New Zealanders has a long-term impairment. Many are unable to reach their potential or participate fully in the community because of barriers they face doing things that most New Zealanders take for granted. The barriers range from the purely physical, such as access to facilities, to the attitudinal, due to poor awareness of disability issues.

Counties Manukau Health is committed to ensuring the services it funds support the NZ Disability Strategy vision:

“The vision of this Strategy is a fully inclusive society. New Zealand will be inclusive when people with impairments can say they live in: ‘A society that highly values our lives and continually enhances our full participation’.”

Disability Services provided by Counties Manukau Health:
Auckland Spinal Rehabilitation Unit (Inpatient)
Auckland Spinal Rehabilitation Unit (Outpatient)
Dual Disability (Regional Mental Health Service)
Home Health Care
Interpreting and Translation Services
Adult Mental Health
Mental Health Services
Services

- EMS - Equipment and Modification Services Prioritisation Tool from the Ministry of Health
  To access the tool from a connected health location click here.... More

Travel Directions

Please see maps provided below under Parking.

Public Transport

If you require Total Mobility transport you can contact:

SUPERCARE4U.COM
Phone: (09) 630 2060
Web: supercare4u.com

Transport Services Available:

- Shopping Mobility
- Employment Mobility
- Airport Transfer Mobility
- Medical Appointment Mobility
- Tours and Sightseeing Mobility
- Church Mobility
- Education Mobility
- Non Medical Emergency Mobility
- Rehabilitation Mobility
- Culture Mobility
- Prescription/Medical Equipment Deliveries
- Group Transport Mobility
- House/Flat Relocation Mobility

https://www.healthpoint.co.nz/public/other/counties-manukau-health-disability-services/#_parking
# Parking

## Mobility Parking

Below is a list of mobility car parks around CMDHB locations:

<table>
<thead>
<tr>
<th>MIDDLEMORE HOSPITAL</th>
<th>NO. OF PARKS</th>
<th>WESTERN CAMPUS</th>
<th>NO. OF PARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Car Park</td>
<td>11</td>
<td>Staff Parking Building</td>
<td>12 (4 x 3 Level)</td>
</tr>
<tr>
<td>Building 1 Front</td>
<td>2</td>
<td>Building 38</td>
<td>1</td>
</tr>
<tr>
<td>Building 2 CIU</td>
<td>3</td>
<td>Building 39</td>
<td>2</td>
</tr>
<tr>
<td>Building 5 Dialysis Unit</td>
<td>3</td>
<td>Building 43</td>
<td>4</td>
</tr>
<tr>
<td>Staff Afternoon Parking</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building 12 Emergency</td>
<td>2</td>
<td>17 LAMBIE DRIVE</td>
<td></td>
</tr>
<tr>
<td>Buildings 14/15</td>
<td>5</td>
<td>Front Entrance</td>
<td>2</td>
</tr>
<tr>
<td>Visitor car park</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building 21</td>
<td>5</td>
<td>19 LAMBIE DRIVE</td>
<td></td>
</tr>
<tr>
<td>Building 31 (Ward 22)</td>
<td>2</td>
<td>Front Entrance</td>
<td>2</td>
</tr>
<tr>
<td>Building 31 Front (Ward 24)</td>
<td>4</td>
<td>Back Entrance</td>
<td>2</td>
</tr>
<tr>
<td>Building 31 Back</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### AUCKLAND SPINAL UNIT

| MANUKAU SUPERCLINIC         | Visitor’s Parking | 7 |
| Visitor’s Parking           | 13               |   |

### BOTANY SUPERCLINIC

| MANUKAU SURGERY CENTRE      | Main Entrance     | 2 |
| Visitor’s Main Entrance     | 10               |   |
| Side Parking                | 1                |   |
| Rear Parking                | 1                |   |
| Diagnostic Medlab           | 1                |   |

For more information please view the following maps:

- Middlemore Hospital
- Botany SuperClinic
- Manukau SuperClinic and Surgery Centre

For information about Mobility Parking Permits or to apply for one, visit the Mobility Parking Website

https://www.healthpoint.co.nz/public/other/counties-manukau-health-disability-services/#_parking
Contact Details

MIDDLMORE HOSPITAL
South Auckland

WEBSITE
www.countiesmanukau.health.nz

Information about this location
View on Google Maps
Get directions

STREET ADDRESS
Middlemore Hospital
Hospital Road
Otahuhu
Auckland

POSTAL ADDRESS
Private Bag 93311
Otahuhu
Auckland 1640
New Zealand

https://www.healthpoint.co.nz/public/other/counties-manukau-health-disability-services/#_parking
General information

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**Middlemore Guide**

**Rainbow Corridor**

**Car parks**

**PARKING FEES**

- 2pm - 8pm first 30 minutes are FREE
- Other times first 15 minutes are FREE
- If you stay longer, the following fees apply:
  - < 1 hour: $4.00
  - 1 - 2 hours: $8.20
  - 2 - 3 hours: $12.20
  - 3 - 4 hours: $16.40
  - > 4 hours: $20.40

**Main Reception**

- Cashier
- Spiritual Centre
- *Main Gate 1*

**Emergency**

- Emergency
- all ages
- *on Hospital Road*

**Kidz First**

- Children’s Hospital
- *South Gate 2*

**Building Services**

**SERVICES**

- **Galbraith**
  - Radiology*
  - Birthing
  - Maternity
  - GynaeCare
  - Early Pregnancy
  - Wound Care
  - Manchester Suite

- **Bray**
  - Bereavement Care
  - Middlemore Foundation

- **Scott**
  - Wards 1 - 11
  - Coronary Care
  - Cardiac Catheter Laboratory
  - Cardiac Step-down
  - Oral Health

- **McIndoe via Scott**
  - National Burn Centre
  - Middlemore Central
  - Staff Centre

- **Harley Gray**
  - Critical Care
  - Neonatal Care
  - Operating Theatres
  - Medical Assessment

- **Edmund Hillary**
  - Wards 31 - 35
  - Koropiko
  - Haematology
  - Gastroenterology
  - Cardiac Investigation
  - Discharge Lounge

- **Poutasi Link**
  - Eligibility
  - Car parking

- **Ko Awatea**
  - Ko Awatea Centre

- **Esmé Green**
  - Middlemore Clinical Trials
  - University of Auckland
  - M.I.T.
  - A.U.T.

- **Colvin Complex**
  - Wards 22|Tui, 23, 24
  - Rehabilitation

- **Titan Mai**
  - Huia
  - Kuaka

- **Building 38**
  - Whittora
  - Home Health Care
  - Renal Self Care

- **Building 58**
  - MRI + CT scans*

* Radiology services are in two buildings. Please check your destination.
Partners in Care

MidCentral DHB is developing a disability-friendly hospital map

7 Jul 2015 | Partners in Care

MidCentral DHB media release, 25 June 2015

People with disabilities will benefit from a new Palmerston North Hospital campus map soon to be available showing as many disability-friendly features as possible, making access to health services simpler.

The map – a one-stop map – shows the location of 40 mobility car parks; ramp and lift access to buildings, disability toilets; low counters for people in wheelchairs; hearing loops; Braille on lifts; 19 taxi cab spots for easy pick-up, and many more.

Until now the hospital has had a number of maps with some disability features on each. This has meant people with disabilities have had to check all of the maps to see things like where are the closest mobility car parks; does the building have steps or ramp or lift access; where can a taxi drop them off and pick them up from; and does the building they go to have wheelchair access to counters and disability toilets.

Soon, it will be made easier for all our patients, including those with a disability, to check out/copy the map to make sure they will be more easily able to attend appointments.

Director Patient Safety and Clinical Effectiveness Muriel Hancock welcomes the initiative. “For people with disabilities this new map should make accessing all our services much easier. We hope our efforts in producing one map with all disability-friendly features will be welcomed. We are also keen to hear about other disability-friendly features we could consider adding to the map in future.”

If anyone has any other ideas to make it simpler for people with disabilities that we could include in the map please telephone (06) 350 8945, or email communications@midcentraldhb.govt.nz (mailto:communications@midcentraldhb.govt.nz).

Last updated 07/07/2015

Page tags
midcentral   disability   map   consumer