

# **Ageing New Zealand and Health and Disability Services 2001–2021**

Background Information  
International Responses  
to Ageing Populations

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# Introduction

All countries will be faced with an increasing, and proportionately older, population with different health and disability issues over the next 10 to 20 years. Many Western countries have recognised that the post World War II baby boomers will retire from work during this period and that this could have a significant impact on the delivery of health and disability services.

This background paper seeks to outline some of the international discussion and suggestions for responding to the increased demand for services for ageing populations. The paper focuses mainly on the United States, Canada, Australia and the United Kingdom.

The international discussion demonstrates that comprehensive responses and strategies are not yet well developed. This is possibly because of the immediate pressures in recruiting and retaining staff to meet the demands of the current environment, with budget constraints and an internationally competitive health practitioners labour market.

The United Kingdom does in fact have a well developed strategy for increasing and diversifying its health workforce, but this has occurred as a result of a decision to significantly upgrade the National Health Service rather than in response to the impacts of an ageing population. Nonetheless, it may provide a useful case study for New Zealand, and an outline of the strategy is included at the end of this paper.

# The Issues

The literature highlights four potential areas that will need to change if health systems are to cope with the increasing demand for health services for ageing populations. More specifically, the changes relate to a need for:

1. more practitioners to complement increasing population sizes
2. more specialist services to deal with specific conditions associated with age, such as, cataracts and hip replacements
3. more expertise in older people's health because of the prevalence of chronic and multiple conditions
4. more support services for older people, who often need assistance with daily living.

The literature about these four areas is summarised below.

## 1. Need for more practitioners

The increased size in the labour market that will accompany an increase in the overall population size cannot be relied on to provide the additional health practitioners needed.

In discussing the matching of supply and demand for the services of physicians and nurses, the OECD (Simeons and Hurst 2004) reaches the following key conclusions.

- There are very different ratios of physicians and nurses to population across the OECD countries. (New Zealand has relatively low numbers of physicians but relatively high numbers of nurses per head of population.)
- Countries that have left the domestic supply of physicians mainly to the market have higher levels of staffing than countries that have planned and controlled entry into physician training for many years. (New Zealand has had capped entry to its medical schools for many years but not to its nursing courses.)
- Controlling the numbers can contain costs, but there is evidence to suggest that this will also constrain outcomes and responsiveness.
- In the medium to long term, the most effective way a country can adjust the supply of physician and nursing services to meet demand will be to adjust medical and nursing school intakes, particularly if self-sufficiency is the long-term goal.
- Better information and forecasting techniques are needed to reduce cyclical fluctuations.
- International migration of doctors and nurses can increase the flexibility of the relevant labour markets, especially in the short run, by speeding up the process of reaching equilibrium. (Forty percent of registered doctors in New Zealand were trained overseas in 2003.)
- However, international migration of the health workforces can lead to net outflows of staff from poorer countries with low and, sometimes declining, health status to richer countries with high and rising health status.

- The services delivered by physicians and nurses depend on these workers' productivity as well as numbers. Fee-for-service methods raise productivity per physician compared with salaries or capitation, but it is not clear what impact, if any, higher activity levels per physician have on the quality of care they deliver.
- Nurses are motivated more by non-pecuniary factors and conditions of service than by pay, but relative pay levels do play an important part in attracting nurses into the profession and raising their participation rates once they are qualified.
- There is evidence that some hospitals have used the power of their monopoly in the local labour markets to drive down the wages offered to nurses and this has led to lower employment levels.
- Research in the United States suggests that the workplace strategies adopted by 'Magnet' hospitals, which include influential nurse executives, flat organisational structures and investment in nurse skills, have favourable effects not only for retaining nurses but also for patient outcomes and satisfaction. (The Magnet system is being piloted in New Zealand by Hutt Valley District Health Board.)
- A review of the evidence on skill mix changes between physicians and nurses in primary care and hospital settings in the United States and United Kingdom suggests that nurses performing certain extended roles, relating to pre-diagnosed patients, can provide care that is equivalent to that provided by doctors and that patients prefer such care. However, the cost-effectiveness of different arrangements remains unclear.
- Although there is a range of policy instruments for influencing the supply of health services, there is a lack of systematic evidence about the relative effectiveness and cost-effectiveness of the different policy instruments.
- Much remains to be discovered about the best way to plan and regulate entry to the medical and nursing professions, given the tendency for training programmes to experience fluctuation mainly as a result of the lags inherent in completing professional training courses.

The OECD has examined the potential contribution to the efficient use of the health workforce and the possibility of 'skill mix' changes (Buchan and Calman 2004). Skill mix changes may involve a variety of developments including enhancing skills among a particular group of staff, substituting between different groups, delegating up and down a uni-disciplinary ladder and innovating in roles.

Much of the focus had been on the mix between physicians and nurses. Buchan and Calman's 2004 study examines skill mix changes between physicians and nurses both in primary care and in hospital settings.

A number of previous literature reviews of the role of advanced practice nurses in primary care settings have suggested the following points.

- Nurses can provide care equivalent to that provided by doctors in these settings.
- Patients are generally more satisfied with nurse consultations than doctor consultations.
- Nurses order more tests than doctors and have longer consultations with patients.

However, a review of the use of nurse practitioners in hospital emergency departments suggested that nurse practitioners were neither better nor worse than house officers in treating minor injuries.

A randomised controlled trial of an innovative nurse telephone consultation service in out-of-hours primary care suggested that the service would pay for itself in terms of reduced emergency admissions to hospitals. In contrast, an assessment of NHS Direct – a telephone consultation service introduced throughout England in 2000 – suggests that the service was offsetting only about half its costs by more appropriate use of NHS services – although patient satisfaction with the service was high.

The OECD survey relates to 16 countries and offers the following information.

- Eight countries reported some current use of nurses in advanced practice roles.
- Three countries reported that piloting is underway or being considered.
- Eight countries reported that nurses had been given limited capacity to prescribe, and one country is piloting such a role for nurses.
- Six countries reported that nurses in some advanced practice or specific roles had been granted capacity to bill patients for their services.
- Seven countries reported that nurses in advanced practice roles could refer patients to specialists in a ‘gatekeeper’ system, and one country is investigating the possibility.

The case studies of drivers, facilitators and constraints for the use of advanced nurse practitioners in the United States and the United Kingdom showed the following results.

- Some of the leading drivers were common to both countries, including staff shortages and substitution.
- In the United States, the pursuit of value-for-money was seen as a leading driver, and nurses led the spread of advanced nurse practitioners.
- In the United Kingdom, the development of new services was seen as a leading driver, and the spread of advanced nurses practitioners was led by government policy with more positive support from the medical profession than was reported in the United States.
- Major constraints included the opposition of some of the medical profession in the United States and lack of funding and shortages of nurses with appropriate training in the United Kingdom.
- One of the most striking differences between the two countries was the attitude of the medical profession – relatively hostile in the United States and supportive in the United Kingdom. This may be partly because of the predominance of fee-for-service payment of doctors in the States and the predominance of capitation and salary payment systems for doctors in the United Kingdom.
- A key issue is the extent to which advanced practice roles for nurses have been recognised under legislation, provided for in educational and training programmes, given access to direct reimbursement and specified in career ladders.

Fooks et al (2002) provides a comprehensive analysis of issues relating to the physician and nursing workforces in Canada. Appendix A of the report contains a literature review organised into three sections: forecasting and data issues; education and training issues and professional practice and system issues.

The situation in Canada went from a perception in the early 1990s that there would be a future oversupply of physicians to a concern in the late 1990s that the country was facing a severe undersupply. The report concludes that four key shifts in thinking will be required that will take enormous effort and will need new ways of engagement. Health human resource planning:

- must become integrated into overall health system design issues
- must be done from the perspective of population health needs and not on the basis of numbers of personnel
- should be on the basis of teams of providers and not on the basis of individual professions
- requires national co-operation.

In 2004, the Canadian Policy Research Networks undertook an environmental policy scan of activities relating to physicians, nurses and pharmacists and included three areas of review:

- education and training
- recruitment, retention and workplace initiatives
- capacity for health human resource planning to occur at a national level.

(Fooks and Maslove 2004)

## **2. Need for more specialist services**

Population ageing will increase the demand for health practitioners who have the specialist skills to treat conditions more likely to affect the older population.

### **Surgery**

Dvali et al (2003) identified a significant decline in the number of medical students interested in surgery. There are many reasons for this decline in interest. Medical students favour 'controllable lifestyle' specialties such as radiology, anaesthesiology, dermatology and pathology and are less willing to accept the rigors of a surgical career.

Of particular concern is the increasing number of women entering medical schools who are disinclined to choose surgery as their specialty. Studies cite the lack of female role models, male bias and concerns about balancing career and family as the main reasons for this downward participation trend.

### **Care of the critically ill and patients with pulmonary disease**

Two areas of medicine, care of the critically ill and management of pulmonary disease, are likely to be influenced by the ageing of the United States population (Angus et al 2000). Angus et al forecast that the proportion of care provided by intensivists and pulmonologists in the States will decrease below current standards in less than 10 years.

The shortfall is troubling because the current provision of intensivists care is arguably already low and the ageing population is likely to create similar shortfalls in other areas of medicine.

### **Cataracts**

The number of people with cataracts will increase at a proportionately greater rate than the total population. The supply of cataract services could be augmented by increasing the number of ophthalmologists, increasing the efficiency with which cataract surgical services are delivered, or advances in technology. The demand for cataract surgery could be decreased by implementing effective primary prevention strategies, although successful strategies are currently unknown and/or untested (McCarty 2002).

### **Laboratories**

The demand for qualified laboratory professionals will increase with the increased health-care and laboratory testing needs of an ageing population (Best 2002). Best makes a case for changing the staffing mix in laboratories.

Current enrolment levels in laboratory science programmes will be insufficient to replace current laboratory professionals. One strategy to consider is the proper deployment of medical technologists (MTs) and medical laboratory technicians (MLTs) based on the skill level required for the job. MTs are more suitable for the higher level technical and leadership roles in the laboratory. MLTs are trained and competent to assume 80 percent to 90 percent of the testing functions in most laboratories. Hospital laboratories need to move to a more appropriate technologist-to-technician ratio for many reasons, including decreasing costs, increasing efficiency, providing adequate and appropriate staffing and improving recruitment and retention.

## **3. Need for more expertise in older people's health**

Several articles express concern about the current teaching, or lack of teaching, of gerontology in all the health professions in the United States.

- a) The older patient has unique characteristics (Fleming et al 2003). Care of the aged population requires knowledge of atypical presentation of disease, frailty, multiple co-morbidities, chronic diseases and inappropriate medication use, combined with an awareness of social needs and threats to physical function. To provide medical care for the elderly population in the year 2030, it is estimated that the number of physicians will need to double or triple from current levels, and currently the majority of physicians have had little or no geriatric training.

The geriatrician must:

- design and implement special health programmes
- administer systems of geriatric care delivery
- establish liaisons with other clinical and business services
- serve as an educator for medical students, residents, fellows and staff
- serve on formulary committees for hospitals/health care systems

- develop and manage protocols for falls, restraints, pressure ulcers, delirium and so on
- serve as clinical experts in geriatric clinics, hospital consult services, postacute care, long-term care and home health care.

Geriatric fellowship programmes last one year, and training sites are found in:

- specialised geriatric clinics
- nursing homes, home care agencies
- rehabilitation units, inpatient geriatric units
- inpatient multidisciplinary geriatric consultation teams
- outpatient primary care clinics
- hospice programmes
- senior citizen centres, adult day care centres.

Non-physician clinicians include:

- advanced practice geriatric nurses – nurse practitioners and clinical specialists who work predominantly in nursing homes
- physician assistants – specialists who practise mostly in primary care but who can specialise in orthopaedics, cardiovascular surgery, hospital care and dermatology.

- b) Geriatrics needs to join paediatrics as a required element of training for the next generation of health care professionals (Kovner et al 2002).

“... In 2002 [in the United States] more than thirty-five million people were age sixty-five and older, and 23 percent of them reported poor or fair health. Older adults use 23 percent of ambulatory care services and 48 percent of hospital days, and they represent 83 percent of nursing facility residents. Yet 58 percent of baccalaureate nursing programs have no full-time faculty certified in geriatric nursing. Only three of the nation’s 145 medical schools require a geriatrics course.”

There is some evidence that care of older adults by health care professionals prepared in geriatrics improves outcomes for such patients, resulting in better physical, functional and psychosocial status, without increasing costs. Older patients cared for by nurses trained in geriatrics are less likely to be restrained, have fewer admissions to hospital and are less likely to be transferred inappropriately from nursing facilities to hospitals.

The Alliance for Aging Research estimates that, in contrast to the existing 9000 geriatricians, [in the United States] 20,000 geriatricians are needed to meet current demand, and at least 36,000 will be needed to treat older adults by 2030. This would be 0.55 geriatricians per 1000 population, compared with the current ratio of 0.97 paediatricians per 1000 population (0–14 year olds).

How many is enough?

- Does every older adult need a geriatric nurse practitioner, geriatrician or pharmacist certified in geriatrics? – No
- Does every older adult need a provider who has some education and training in geriatrics? – Yes

- Do these providers need access in person, by phone or via electronic communication to a geriatric nurse practitioner, geriatrician, pharmacist certified in geriatrics or other health care worker with advanced education in geriatrics? – Yes

The John A Hartford Foundation; the Geriatric Research, Education, and Clinical Centres (GRECC) programme of the VA; the Donald W Reynolds Foundation and the Hearst Foundation have provided support to attract additional students to careers in geriatrics and to the introduction of programmes to ensure geriatrics competence among practising nurses and physicians. In nursing, a programme is underway to improve the geriatrics competence of the 20 percent of practising nurses who belong to specialty associations that take care of large numbers of older adults, such as oncology, neurology, rehabilitation and critical care.

Ongoing initiatives include specialised and comprehensive geriatrics education modules, which can be completed either during specialty training or through continuing education, and the development of websites that specifically address the needs of specialty physicians for geriatric content.

Clinical settings need to change – two objectives are to get more provider organisations to employ practitioners with training in geriatrics and to get more of them to provide geriatric-specific care.

More health services research is needed to assess the effectiveness of different models of training, staffing and organisation of care and the relationship to health outcomes and quality of care.

- c) The present health care system will need to change from one that focuses on diagnosis and treatment of disease to a system that attends to the major issues affecting quality of life of older adults and their families (Bennett and Flaherty-Robb 2003). Bennett and Flaherty-Robb identify four critical areas that will influence the quality of life of older citizens.
1. Individuals need resources to help manage chronic medical conditions.
    - Chronic conditions can cause limitations in daily activities, hospitalisation, transition to a nursing home and poor quality of life, but many people who have chronic conditions lead active productive lives.
    - While medical help for treatment of chronic disease conditions is readily available, the care resources needed to manage chronic conditions in day-to-day life are not so readily available.
    - In order to balance behavioural changes, medications and system relief strategies, older adults need knowledge about what to do, the belief that they can achieve success and family (or other assistance) to help.
  2. Too few primary health care providers are educated to provide geriatric-focused care.
    - The decline in nurse numbers in the United States during the next 20 years will occur just as 78 million baby boomers retire and enrol in Medicare.
    - To prevent, or at least mitigate, the expected shortage of gerontological nurses in the United States, increased recruitment of nurses to gerontological specialties must be initiated now.
    - Most registered nurses have little or no training in gerontological nursing.

- The number of nurses who specialise in care of older adults is even more acute in advanced practice nursing.
  - Other disciplines have a similar shortage of geriatrics-educated professionals:
    - Only 14 of the 145 medical schools require a course in geriatrics for medical students.
    - Less than 5 percent of medical schools faculty are geriatric specialists.
    - Only 720 of 200,000 pharmacists have geriatric certification.
    - While it is estimated 5000 geriatric psychiatrists are needed to meet today’s mental health care needs of older adults, there are currently about 2400 geriatric psychiatrists practising in the United States.
  - New policies that could improve the geriatric knowledge of the health care workforce include:
    - mandating a specified number of credits as a condition of license renewal
    - initiating new continuing education programmes in academic institutions to attract professionals without geriatric training
    - working with state licensing boards to implement requirements for geriatric course content in nursing, medical and pharmacy education.
3. Financial issues drive health care choices for many older adults.
- Financial resources may be drained by having to pay for multiple prescriptions for chronic conditions, more visits to physicians and mental health care and by the lost work and productivity of unpaid family caregivers.
  - Help is needed for daily activities such as cleaning, cooking and personal care in order for older adults to remain in their own homes.
4. Cultural values do not give priority to providing services and support for older adults.
- Ageing is still viewed by many Americans with fear and trepidation, and many are not prepared for the natural ageing process of physical decline, loss and grief.
  - Life course planning is common in financial planning but has not been applied to improving self-care competency and learning the skills of relationships, care giving and care receiving.
  - The focus of current care design is on urgent and emergent conditions rather than preventive services or support for management of chronic conditions.

## 4. Need for more support services

“The paraprofessional long-term care workforce – nursing assistants, home health and home care aides, personal care workers, and personal care attendants – forms the centrepiece of the formal long-term care system ... Low wages and benefits, hard working conditions, heavy workloads, and a job that has been stigmatised by society make worker recruitment and retention difficult.” (Stone and Wiener 2001).

The following are some factors that affect the supply and quality of workers.

- How society values the job – the public views frontline worker jobs as low-wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people.
- Labour market conditions – several studies have identified the strength of the economy as a major predictor of turnover rates in long-term care. Many trained nurse assistants leave to work in higher-wage jobs.
- Health and long-term care policies – the amount spent by funders plays a substantial role in determining provider wages, benefits and training opportunities.
- Regulatory policy – policy focuses on protecting consumers rather than responding to workers’ concerns. Regulation tends to emphasise entry training and disregards continued career growth or developments.
- A major policy issue is the extent to which nursing assistants are allowed to perform certain tasks currently performed by nurses (for example, administering medication or providing wound care). Giving frontline workers added responsibility and autonomy may motivate them to remain in the job or encourage others to enter such positions.
- Programme design features can affect the size of the labour force by making it easy or hard for relatives and friends to be paid for care.
- Labour policies – governments invest in programmes to prepare primarily low-income and unemployed individuals for new and better jobs, sometimes to the detriment of the long-term care industry by requiring that the programme graduates secure wages that are higher than typical frontline salary workers.

State initiatives to recruit and retain frontline long-term care workers have become a priority in many states and include:

- establishing ‘wage pass-throughs’ in which a state designates some proportion of a public long-term care programme’s reimbursement increase to be used specifically to increase wages and/or benefits for frontline workers
- increasing worker fringe benefits, such as health insurance and payment for transportation time
- developing career ladders by establishing additional job levels in public programmes, training requirements or reimbursement decisions
- increasing and improving training requirements

- developing new worker pools, including former welfare recipients
- establishing public authorities to provide independent workers and consumers with ways to address issues about wages and benefits, job quality and security.

Providers in the United States are experimenting with a range of interventions, such as programmes in nursing homes and home care settings, although few have been evaluated. For example:

- Pioneer Homes tries to link the facility to the outside world and create a community – plants and animals abound, children interact with residents and workers are respected as an essential part of the care team
- the Wellspring model has a three-pronged approach that includes intensive clinical training, periodic analysis of outcomes data to monitor quality and management/job redesign efforts, in which nursing assistants become essential members of care teams and are empowered to make certain decisions
- Co-operative Home Care Associates, a worker-owned company, is staffed largely by former welfare recipients. After three months' employment, a worker can purchase shares in the company. Wages are higher than average for home care aides, and workers receive fringe benefits as well as guaranteed hours. Workers are encouraged to advance their careers and earn higher pay and status as associate trainers or by assuming administrative positions
- many frontline workers have developed their own initiatives to improve their status, compensation and job opportunities. Unions have made major inroads in organising both nursing home and home care workers in selected states across the country.

## The Australian Approach

In April 2000, the Minister for Aged Care, the Hon Bronwyn Bishop, published a comprehensive discussion paper, *The National Strategy for an Ageing Australia*, which dealt with the current and future directions for the health and aged care system in that country.

The paper identifies that “healthier lifestyles, better coordinated services, higher retirement incomes, more appropriate housing and transport and other improvements to social infrastructure have the capacity to keep older people healthier, independent and in their homes for longer. This is in the best interests of both older people and the community”.

A range of strategies have been introduced to encourage healthier lifestyles and improve population health, including Active Australia and the Food and Nutrition Policy and a framework for the prevention of chronic disease.

In 2004, the Commonwealth Department of Health and Ageing commissioned a comprehensive review of the aged care workforce. The review (Richardson and Martin 2004) concludes that there are few signs that the labour market is in crisis, or even under serious stress, but that there are some indications of stress in the aged care labour market.

- The nurses, especially registered nurses, are substantially older than the typical female worker.
- Nurses are less content in their jobs in aged care than personal carers and allied health workers.
- A relatively high level of vacancies for registered nurses suggests some recruitment difficulties.
- There is a relatively high turnover of direct care staff, especially personal carers.
- However, the short training period for personal care workers means that the supply of workers for these jobs is quite responsive to changes in pay and conditions.
- Recruitment and retention of staff in aged care facilities would rise substantially if the overall Australian labour market became tighter.

## The United Kingdom Approach

*The NHS Plan: a plan for investment, a plan for reform*, published in 2000, provided a blueprint for a radical new approach to developing the health workforce in the United Kingdom. It led to the establishment of the Changing Workforce Programme within the NHS Modernisation Agency.

The impetus behind the reforms was the need to upgrade health services in the United Kingdom and, in respect of the workforce, the impact of the European Working Time Directive (that limits the number of hours that junior doctors may work) rather than a serious regard for the implications of an ageing population on health services. However, the approach is similar to that required to develop policies to meet the needs of an ageing population – an assessment of the needs of patients, the health services that will be needed and the workforce needed to deliver the services.

The Changing Workforce Programme set up a flexible career framework to help redesign the roles of the health workforce and supported a series of pilot projects in different provider locations throughout the United Kingdom.

Much of the new approach is based on a research project that produced three reports in a series entitled *The Future Health Workforce*. The third in the series specifically covers new roles in services for older people and takes a service-needs, patient-focused approach (Cochrane et al 2002).

The report identifies an urgent need for changes to address the problems of a fragmented service and workforce – the lack of continuity of care, the delays and confusion for patients and the waste of resources. It proposes the development of new professional roles designed specifically for older people's services: a practitioner for older people (Appendix 1) and an assistant practitioner (Appendix 2). It describes how the roles should work in practice across existing professional boundaries and across health and social care.

A more comprehensive description of the roles and current status of the assistant practitioner for older people is included in the *Changing Workforce Programme Pilot Sites Progress Report* available on the NHS Modernisation Agency website ([www.modern.uk/cwp](http://www.modern.uk/cwp)).

The role of assistant practitioner encompasses:

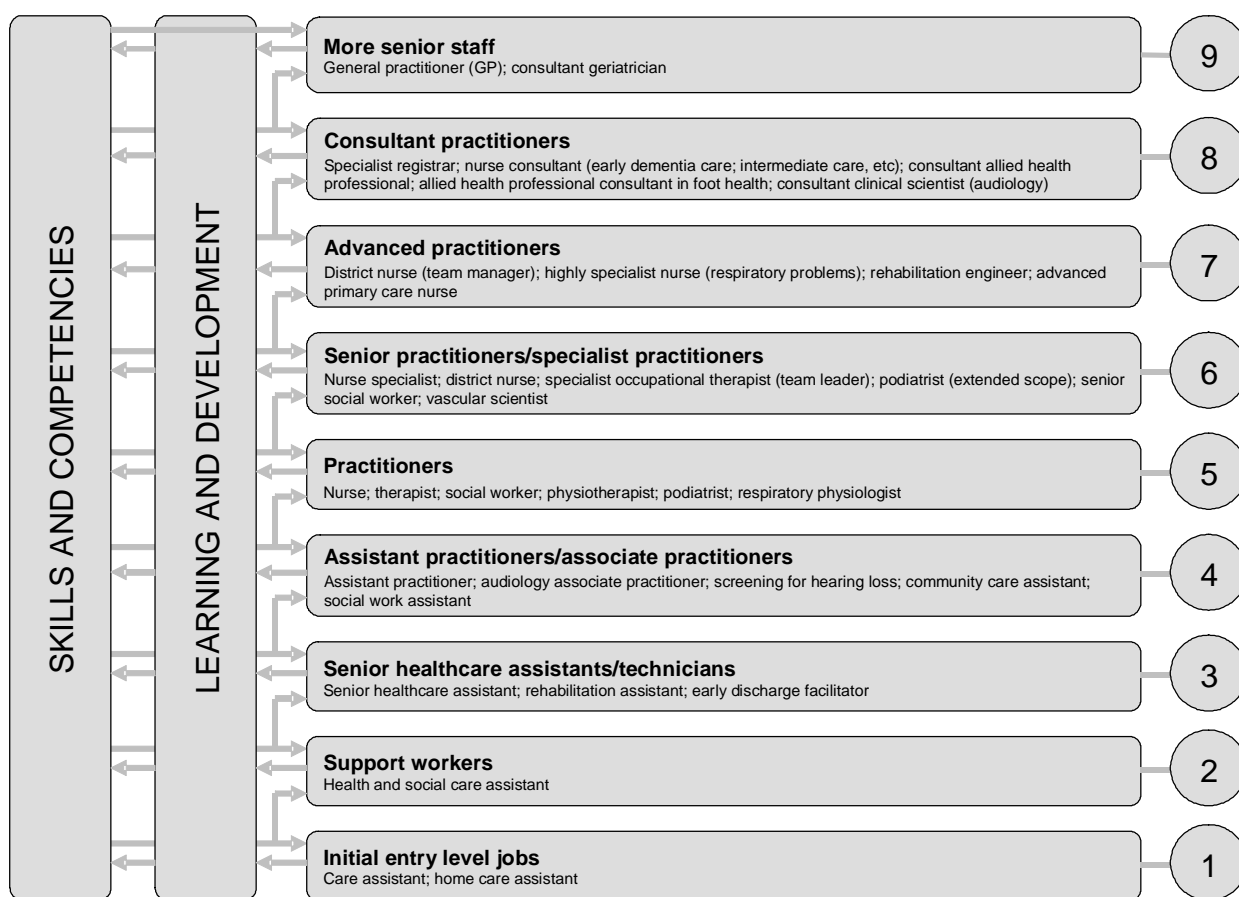
- home helpers
- supervision of administration of medication by home helpers
- clinical care co-ordinators
- nurse consultants in early dementia care
- stroke support workers
- patient/carer support nurses
- nurse specialists for older people in primary care
- occupational therapy information workers
- community pharmacists linking in with home help managers and district nurses for medication.

The latest version of the NHS Modernisation Agency's *Career Framework for the NHS* (June 2004) includes illustrative examples of career frameworks for practitioners working in the areas of Older People, Stroke Units, Cardiology and Mental Health. The framework for older people from that report is set out in Figure 1.

Two other initiatives are being implemented at the University of Southampton, Common Learning, in conjunction with the University of Portsmouth, and a Foundation Degree in Health Care.

The Common Learning programme ([www.commonlearning.net](http://www.commonlearning.net)) recognises that in order to deliver services specifically around the needs of patients/clients, it is vital to improve communication and working relationships between young professionals.

**Figure 1:** A career framework for practitioners (older people)



From *Career Framework for the NHS* (NHS Modernisation Agency 2004)

Foundation Degrees developed from an initiative of the Department of Education and Skills in the United Kingdom to improve the skill levels of young people and adults. They are intermediate level, vocational higher-education qualifications that will integrate academic and work-based learning through close collaboration between employers and universities/colleges ([www.foundationdegree.org.uk](http://www.foundationdegree.org.uk)).

# Appendix 1: Role Outline: The Practitioner for Older People in the United Kingdom

This role integrates primary, community and intermediate care across health and social services. It has been designed to improve the quality of patient care – to increase continuity of care, reduce confusion for patients and eliminate the overlaps and fragmentation of the current service. It also aims to improve workforce supply by improving the status of staff who work with older people.

The main elements of the role are:

- developing comprehensive health and social histories:
  - evaluating developmental maturation
  - physiological and functional status
  - psychosocial status
  - risk factors for illness
  - activities of daily living (instrumental and functional)
- conducting physical examinations, including:
  - observation of the patient’s condition
  - palpation
  - auscultation
  - percussion
- ordering and performing diagnostic tests and interpreting test results
- diagnosing and making decisions:
  - drawing together and analysing all relevant data
  - discriminating between normal findings/normal changes of ageing and pathological findings
  - developing a differential diagnosis and prescribing in line with care pathways
  - admitting and discharging in line with care pathways
- developing a care plan to promote, maintain and restore health and also to meet social needs; arranging a contract of care with the patient/carer
- implementing a care plan, including, for example:
  - re-ablement and rehabilitation including, for example, mobilisation, positioning, orientation and cognitive and memory problems
  - nutritional review and advice and feeding – including swallowing difficulties
  - skin integrity
- co-ordinating all services that are required across the health and social care settings
- evaluating the client’s response to the care plan and modifying as required
- promoting health and education to the patient, carer, colleagues and assistants
- confirming death and care of relatives
- researching and auditing: applying research findings to practices and the development of care pathways.

Adapted from *Cochrane et al. 2002. The Future Health Workforce: The Third Report*. London: Chamberlain Dunn Associates

## Appendix 2: Role Outline: The Assistant Practitioner for Older People in the United Kingdom

This role integrates primary, community and intermediate care across health and social services. The assistant practitioner will work in support of the practitioner and will play a key role in implementing the care plan. The aim is to reduce the overlaps and lack of continuity associated with current roles.

The main elements of the role are:

- monitoring the patient's condition and outcomes and reporting to the practitioner
- conducting diagnostic tests:
  - venepuncture
  - ECG
- conducting clinical observations and providing treatment in the following areas:
  - observations: temperature, pulse, blood pressure, weight, blood glucose
  - tissue damage: monitor and treat
  - wound management
  - urinalysis
  - catheter care: including insertion
  - bowel movements: monitor and treat
  - nutrition: monitor food intake and advise
  - set up naso-gastric feeds and gastrostomy tubes
  - collect specimens
  - anti-embolic stockings
- assisting with rehabilitation:
  - assistance and support in daily activities: dressing, washing, oral care, toileting, feeding, kitchen and so on
  - mobilisation
  - positioning
  - exercises: passive and muscle relaxing
  - swallowing difficulties
  - orientation, memory and cognitive problems
- co-ordinating the patient's personal hygiene
- promoting health and education to the patient and carer on the aims of the care plan, exercises, walking aids and so on
- health education and promotion
- co-ordinating formal documentation: assisting with benefit claims and so on.

Adapted from *Cochrane et al. 2002. The Future Health Workforce: The Third Report*. London: Chamberlain Dunn Associates

## References

- Angus DC, Kelley MA, Schmitz RJ, et al. 2000. Current and projected workforce requirements for care of the critically ill and patients with pulmonary disease. *Journal of the American Medical Association* 284(21): 2762–70.
- Bennett JA, Flaherty-Robb MK. 2003. Issues affecting the health of older citizens; meeting the challenge. *Online Journal of Issues in Nursing* 8(2). Accessed 6/7/04, from [www.nursingworld.org/ojin/topic21/tpc21\\_1.htm](http://www.nursingworld.org/ojin/topic21/tpc21_1.htm)
- Best ML. 2002. Avoiding crisis: right-sizing staffing for the future. *Clinical Leadership and Management Review* 16(6): 428–32.
- Buchan J, Calman L. 2004. *Skill-mix and Policy Change in the Health Workforce: Nurses in Advanced Roles*. OECD Health Working Papers. Paris: OECD.
- Cochrane D, Conroy M, Crilly T, et al. 2002. *The Future Health Workforce: The third report*. London: Chamberlain Dunn Associates.
- United Kingdom Department for Education and Skills. 2001. *Foundation Degree*. Accessed 30/11/04 from [www.foundationdegree.org.uk](http://www.foundationdegree.org.uk).
- Dvali L, Brenner MJ, Mackinnon SE. 2003. The surgical workforce crisis: rising to the challenge for an aging America. *Plastic and Reconstructive Surgery* 113(3): 893–902.
- Fleming KC, Evans JM, Chutka DS. 2003. Caregiver and clinician shortages in an aging nation. *Mayo Clinic Proceedings* 78: 1026–40.
- Fooks C, Canadian Policy Research Networks Inc. 2002. *Health Human Resource Planning in Canada: Physician and Nursing Work Force Issues*. [Saskatoon]: Commission on the Future of Health Care in Canada.
- Fooks C, Maslove L. 2004. *Health Human Resources Policy Initiatives for Physicians, Nurses and Pharmacists*. Ottawa: Canadian Policy Research Networks Inc. Accessed 1/12/04 from <http://www.cprn.org/en/doc.cfm?doc=1112>.
- Kovner CT, Mezey M, Harrington C. 2002. Who cares for older adults?: workforce implications of an aging society. *Health Affairs* 21(5): 78–89.
- McCarty CA. 2002. Cataract in the 21st century: lessons from previous epidemiologic research. *Clinical and Experimental Optometry* 85(2): 91–6.
- NHS Modernisation Agency. 2003. *Changing Workforce Programme: Pilot sites progress report: Spring 2003*. Manchester: NHS Modernisation Agency. Accessed 1/12/04 from [http://www.modern.nhs.uk/cwp/21135/Pilot\\_Sites\\_Progress\\_Report.pdf](http://www.modern.nhs.uk/cwp/21135/Pilot_Sites_Progress_Report.pdf).
- NHS Modernisation Agency. 2004. *A Career Framework for the NHS: Discussion document: version 2, June 2004*. London: NHS Modernisation Agency.
- Richardson S, Martin B. 2004. *The Care of Older Australians: A picture of the residential aged care workforce*. Adelaide: National Institute of Labour Studies, Flinders University. Accessed 8/10/04 from [www.ssn.flinders.edu.au/nils/research/recent\\_reports/Agedcareworkforce.php](http://www.ssn.flinders.edu.au/nils/research/recent_reports/Agedcareworkforce.php).
- United Kingdom Department of Health. 2000. *The NHS Plan: A plan for investment, a plan for reform*. London: Department of Health.

Simoens S, Hurst J. 2004. Matching supply and demand for the services of physicians and nurses. In: *Towards High-Performing Health Systems: Policy studies*. Paris: OECD.

Stone RI, Wiener JM. 2001. *Who Will Care for Us? Addressing the long-term care workforce crisis*. Washington, DC: The Urban Institute and the American Association of Homes and Services for the Aging.

**THE NEW ZEALAND DISABILITY STRATEGY**

**MAKING A WORLD OF DIFFERENCE  
WHAKANUI ORANGA**

**Minister for Disability Issues**

**April 2001**

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## FOREWORD FROM THE MINISTER FOR DISABILITY ISSUES

E ngā iwi, e ngā reo, e ngā karangatanga maha o ngā hau e whā, tēnei te mihi atu ki a koutou katoa. Tēnā koutou, tēnā koutou, ā, tēnā koutou katoa.  
Tihei mauriora.

To all people, all voices, all the many relations from the four winds, I greet you all.

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.

The aim of the New Zealand Disability Strategy: Making a World of Difference – Whakanui Oranga is to eliminate these barriers wherever they exist.

The Strategy will guide Government action to promote a more inclusive society. It is an enduring framework which will ensure that government departments and other government agencies consider disabled people before making decisions. It will sit alongside other government programmes such as the Positive Ageing Strategy, the New Zealand Health Strategy and the Re-evaluation of Human Rights Protections in New Zealand.

The Government will take the lead – but we will also be doing everything we can to influence the attitudes and behaviour of society as a whole. All New Zealanders need to consider issues for disabled people and their aspirations as individuals. We must also consider the families and whānau of disabled people, and others who support them.

The New Zealand Disability Strategy has been developed with extensive input from the disability sector. During the consultation period, 700 submissions were received, including feedback from 68 meetings around the country. A summary of consultation findings is available from the Ministry of Health.

Thank you to all those who attended meetings, made submissions and promoted the Strategy. In particular, I want to thank the members of the sector reference group, whose tireless work has played a major part in its successful development.

The Government is committed to the New Zealand Disability Strategy. Each year government departments will develop work plans which set out specific steps to implement the Strategy. These plans will be monitored annually, and a review of overall progress will occur after five and ten years.

I have appreciated the opportunity to be Minister for Disability Issues during one of the most exciting periods of developmental work on disability issues. In the five years since I was Labour's disability spokesperson, there has been an exponential change of attitude, including changes in

language and understanding. I am grateful to all those who helped bring me up to speed during this challenging time.

I also want to acknowledge my colleague Ruth Dyson, the first Minister for Disability Issues, who has raised the profile of disability issues both inside and outside Government and who laid the strong foundations on which the Strategy is built.

I am keen to shepherd the New Zealand Disability Strategy through the next stage of implementation, in an active and collaborative way with disabled people. Working together, I am confident that we can, indeed, make a world of difference.

Hon Lianne Dalziel  
Minister for Disability Issues

## **ACKNOWLEDGEMENTS**

The development of the New Zealand Disability Strategy has involved valued input from a wide range of individuals, groups and organisations. The advice and assistance from the following contributors is particularly acknowledged:

- New Zealand Disability Strategy sector reference group
- Disabled Persons Assembly (New Zealand) Inc, especially those local representatives who hosted consultation meetings
- workshop, hui, fono and focus group participants and everyone who made a submission on the New Zealand Disability Strategy discussion document
- the Auckland Disability Providers Network
- organisations that helped with accessible versions of the New Zealand Disability Strategy discussion document, especially the Royal New Zealand Foundation for the Blind and IHC
- New Zealand Sign Language interpreters who provided their services at consultation meetings.

## **Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi**

The Treaty of Waitangi is New Zealand's founding document and the Government is committed to fulfilling its obligations as a Treaty partner. This special relationship is ongoing and is based on the underlying premise that Māori should continue to live in Aotearoa as Māori.

Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in developing and implementing disability strategies for Māori and that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.

Māori should be able to define and provide for their own priorities for participation and be encouraged to develop the capacity for delivery of services to their communities. This needs to be balanced by the Crown's duty to govern on behalf of the total population.

To date, the relationship between Māori and the Crown in the disability sector has been based on three key principles:

- participation at all levels
- partnership in service delivery
- protection and improvement of Māori wellbeing.

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## SUMMARY

The New Zealand Disability Strategy presents a long-term plan for changing New Zealand from a disabling to an inclusive society. It has been developed in consultation with disabled people and the wider disability sector, and reflects many individuals' experiences of disability.

Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments. Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have.

Along with other New Zealanders, disabled people aspire to a good life. However, they also face huge barriers to achieving the life that so many take for granted. These barriers are created when we build a society that takes no account of the impairments other people have. Our society is built in a way that assumes we can all see signs, read directions, hear announcements, reach buttons, have the strength to open heavy doors and have stable moods and perceptions.

Underpinning the New Zealand Disability Strategy is a vision of 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.’

Achieving this vision will involve ensuring that disabled people have a meaningful partnership with Government, communities and support agencies, based on respect and equality. Disabled people will be integrated into community life on their own terms, their abilities will be valued, their diversity and interdependence will be recognised, and their human rights will be protected. Achieving this vision will also involve recognising the principles of the Treaty of Waitangi.

To advance New Zealand towards a fully inclusive society, the Strategy includes fifteen Objectives, underpinned by detailed Actions. The Objectives are to:

1. encourage and educate for a non-disabling society
2. ensure rights for disabled people
3. provide the best education for disabled people
4. provide opportunities in employment and economic development for disabled people
5. foster leadership by disabled people
6. foster an aware and responsive public service
7. create long-term support systems centred on the individual
8. support quality living in the community for disabled people
9. support lifestyle choices, recreation and culture for disabled people
10. collect and use relevant information about disabled people and disability issues
11. promote participation of disabled Māori
12. promote participation of disabled Pacific peoples
13. enable disabled children and youth to lead full and active lives
14. promote participation of disabled women in order to improve their quality of life
15. value families, whānau and people providing ongoing support.

Key government departments will produce an implementation work plan for the 2001/02 year showing what they are doing towards implementation of the Strategy. This annual planning process will then be rolled out to other departments in 2002/03. The Minister for Disability Issues will report to Parliament annually on progress in implementing the Strategy and full reviews of progress will be conducted after five and ten years.

## **INTRODUCTION**

**‘Disability is in society, not in me.’**

**‘I have the right to dignity, to develop my potential, to use my qualities and skills.’**

– Consultation comments

We live in a disabling society. The New Zealand Disability Strategy presents a plan for changing this.

Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual or other impairments.

Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have. Our society is built in a way that assumes that we can all move quickly from one side of the road to the other; that we can all see signs, read directions, hear announcements, reach buttons, have the strength to open heavy doors and have stable moods and perceptions.

Although New Zealand has standards for accessibility, schools, workplaces, supermarkets, banks, movie theatres, marae, churches and houses are, in the main, designed and built by non-disabled people for non-disabled users. This is our history of disability in New Zealand.

Disability relates to the interaction between the person with the impairment and the environment. It has a lot to do with discrimination, and has a lot in common with other attitudes and behaviours such as racism and sexism that are not acceptable in our society.

People and groups of people should not be judged by one particular aspect of their lives – whether it’s their race, gender, age or impairment. Individual beliefs and assumptions, as well as the practices of institutions, mean that many disabled people are not able to access things that many non-disabled people take for granted.

The desire to break down the barriers that cause disability is also closely linked to ideas about the human rights of people with impairments. Without human rights we cannot live as full human beings.

Human rights include political, civil, social, cultural and economic rights. Human rights are described by international instruments – such as the Universal Declaration on Human Rights and core treaties such as the International Covenant on Civil and Political Rights, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (UNCROC). In New Zealand we have legislation such as the Bill of Rights Act, the Human Rights Act and the Privacy Act.

In the New Zealand Disability Strategy discussion document, the term ‘people experiencing disability’ was used throughout the document. There was a mixed reaction to this term – some people liked it and thought it was a good way of expressing that disability is something that happens to people who have impairments. Other people thought it was over-complicated.

The New Zealand Disability Strategy sector reference group has recommended that this final Strategy should use the term ‘disabled people’ to refer to the people at the heart of this Strategy.

## VISION OF A NON-DISABLING SOCIETY

Along with other New Zealanders, disabled people aspire to a good life.

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.’

This will happen in a country where:

- disabled people have a meaningful partnership with Government, communities and support agencies, based on respect and equality
- we have moved forward from exclusion, tolerance and accommodation of disabled people to a fully inclusive and mutually supportive society
- disabled people are integrated into community life on their own terms. This means that equal opportunities are assured but individual choices are available and respected
- the abilities of disabled people are valued and not questioned
- interdependence is recognised and valued, especially the important relationships between disabled people and their families, friends, whānau and other people who provide support
- human rights are protected as a fundamental cornerstone of government policy and practice
- the diversity of disabled people, including their cultural backgrounds, is recognised, and there is flexibility to support their differing aspirations and goals
- disabled people are treated equitably, regardless of gender, age, cultural background, type of impairment or when and how the impairment was acquired
- community-based services ensure that disabled people are supported to live in their own communities, and institutionalisation is eliminated
- the idea that society imposes many of the disabling barriers faced by people with impairments is widely understood and, therefore, legislation, policy and other activities enhance rather than disable the lives of people with impairments
- the principles of the Treaty of Waitangi are recognised.

## **BARRIERS**

**‘More often than not, barriers are made out of peoples’ ignorance towards something different.’**

– Consultation comment

One in five people in New Zealand reports having a long-term impairment. Because everyone comes from different backgrounds, holds different beliefs and has different needs, there is a great diversity of people who have impairments.

The key common factor among people with impairments is that they face many lifelong barriers to their full participation in New Zealand society.

Attitudes have been identified, through consultation, as the major barrier that operates at all levels of daily life in the general population. Attitudes and ignorance make their presence felt as stigma, prejudice and discrimination. In the year to June 1999, disability discrimination was the largest category of complaints to the Human Rights Commission.

Stigma, prejudice and discrimination affect our behaviours. Sometimes the combination of attitudes and behaviours can seem to create almost insurmountable barriers, for example, whole systems or organisations can become a barrier much in the way that institutionalised racism operates.

### **When I’m a child ...**

- For disabled children, it is hard to get the best start to their life ahead. Children’s needs can put big demands, including financial pressure, on their families and whānau.

### **When I’m a youth ...**

- Disabled people are much less likely to have educational qualifications than non-disabled people.

### **When I’m an adult ...**

- Disabled people are much less likely to be employed. For instance, the unemployment rate for people with ongoing mental illness is very high. Half of recent complaints to the Human Rights Commission in regard to disability related to employment.
- The public service employs a far lower proportion of disabled people than exist in the general working age population, despite equal employment opportunity policies.
- Disabled people often have reduced housing options through poverty or factors such as discrimination when neighbours object to supported houses being established in their area.

### **When I’m older ...**

- Older people experience difficulties when their problems are seen as an inevitable part of ageing. Faced with this attitude, they may miss the opportunity to remain able and

independent through rehabilitation, correction of health problems or provision of support services.

- For older disabled people, one of the biggest problems can be being denied the opportunity to remain in their familiar surroundings and ‘age in place’. Even in their own homes, some can feel isolated and insecure if they have limited contact with families, friends and their community.

### **My whole life ...**

- Despite New Zealand having strong standards for physical accessibility, access to public facilities and other buildings such as marae is poor. On top of that, most public transport is not independently accessible, and car modifications are expensive.
- People in higher socio-economic areas are more likely to access and receive support services than people in low socio-economic areas. Reflecting this situation, Māori as well as Pacific peoples are typically low users of support services.
- Forty-four percent of Māori with a long-term impairment report that they have an unmet need for some kind of service or assistance. Twenty-nine percent of non-Māori with a long-term impairment report an unmet need. The majority of support for everyday activities comes from families.
- Poor literacy is a problem for many and is a cause of communication barriers. This problem extends to Braille and sign language literacy.
- Disabled people, especially those with psychiatric or intellectual impairments, are often shut out of social networks and full participation in community activities, because people are ignorant or fearful of behaviour they perceive as different.
- As a group, disabled people are likely to have lower incomes and fewer financial and family resources than the general population. This economic disadvantage is compounded by the financial cost of disability. The earning potential of families with disabled children can be curtailed by their need to provide support for their children or live and work in areas where they can access family or professional support.
- Disabled women are more likely to have low incomes than men or non-disabled women. Seventy-one percent of women with long-term impairments report an annual personal income of less than \$15,000.
- Disabled people are almost three times as likely to get income from a government benefit than non-disabled people (excluding superannuation from this calculation).

Although the Government provides a range of services, the experience of accessing these services can be very disabling because sometimes they are not flexible enough to meet individual needs. To get a benefit, a piece of equipment, or maybe some help at home you might have to tell your story to three or four different people — just to get what you need at that particular time. Next year those three or four people may have moved on, with a new lot of assessors in their place.

These kind of arrangements and turnover of staff are disabling because the person, their families and whānau spend a lot of time fighting the system, in order to get access to the same opportunities other New Zealanders have.

The Government needs to help open the way into community life for disabled people — by removing the barriers to their participation.

## **DELIVERING THE STRATEGY**

Under the New Zealand Public Health and Disability Act 2000, the Minister for Disability Issues is required to have a New Zealand Disability Strategy. The Government recognises that a lot of work is required to remove the barriers to participation faced by disabled people and create a fully inclusive society. As part of the New Zealand Disability Strategy, 15 Objectives and detailed Actions to achieve this have been developed.

Government departments are expected to develop annual New Zealand Disability Strategy implementation work plans that spell out what work they are doing to implement the Strategy. Key departments will develop their initial implementation work plans for the period 1 July 2001 to 30 June 2002. This annual planning process will then be rolled out to other departments in 2002/03.

Government initiatives that will benefit disabled people, such as the New Zealand Positive Ageing Strategy, the New Zealand Health Strategy, the Māori Health Strategy and the Pacific Health and Disability Action Plan, will complement the New Zealand Disability Strategy.

The decisions that territorial authorities and non-departmental public bodies make also have a significant impact on the lives of disabled people. It is important that territorial authorities and other public bodies support and assist with implementing the New Zealand Disability Strategy, and ways of making this happen need to be considered in discussion with them.

The Minister for Disability Issues will report to Parliament annually on progress in implementing the Strategy and full reviews of progress will be conducted after five and ten years.

## **THE GOVERNMENT'S OBJECTIVES**

Fifteen Objectives have been developed for the New Zealand Disability Strategy.

Objective 1: Encourage and educate for a non-disabling society

- Encourage the emergence of a non-disabling society that respects and highly values the lives of disabled people and supports inclusive communities.

Objective 2: Ensure rights for disabled people

- Uphold and promote the rights of disabled people.

Objective 3: Provide the best education for disabled people

- Improve education so that all children, youth and adult learners will have equal opportunities to learn and develop in their local, regular educational centres.

Objective 4: Provide opportunities in employment and economic development for disabled people

- Enable disabled people to work in the open labour market (in accordance with human rights principles) and maintain an adequate income.

Objective 5: Foster leadership by disabled people

- Acknowledge the experience of disability as a form of specialised knowledge and strengthen the leadership of disabled people.

Objective 6: Foster an aware and responsive public service

- Ensure that government agencies, publicly funded services and publicly accountable bodies (such as territorial authorities) are aware of and responsive to disabled people.

Objective 7: Create long-term support systems centred on the individual

- Create a quality assessment and service delivery system that is centred on disabled people, ensures their participation in assessment and service delivery, has invisible borders and is easy to access.

Objective 8: Support quality living in the community for disabled people

- Provide opportunities for disabled people to have their own homes and lives in the community.

Objective 9: Support lifestyle choices, recreation and culture for disabled people

- Create and support lifestyle choices for disabled people within the community and promote access to recreation and cultural opportunities.

Objective 10: Collect and use relevant information about disabled people and disability issues

- Improve the quality of relevant disability information collected, analysed and used, including regular national surveys of activity limitation.

Objective 11: Promote participation of disabled Māori

- Promote opportunities for disabled Māori to participate in their communities and access disability services. Disabled Māori should receive an equitable level of resource that is delivered in a culturally appropriate way.

Objective 12: Promote participation of disabled Pacific peoples

- Promote opportunities for disabled Pacific peoples to participate in their communities and access disability services. Disabled Pacific peoples should receive an equitable level of resource that is delivered in a culturally appropriate way.

Objective 13: Enable disabled children and youth to lead full and active lives

- Disabled children and youth should enjoy full and active lives, in conditions that prepare them for adulthood and which:
  - ensure their dignity
  - affirm their right to a good future and to participate in education, relationships, leisure, work and political processes
  - recognise their emerging identities as individuals and reinforce their sense of self
  - promote self-reliance
  - recognise their important links with family, friends and school
  - facilitate their active participation in the community.<sup>1</sup>

Objective 14: Promote participation of disabled women in order to improve their quality of life

- Improve opportunities for disabled women to participate in their communities, access appropriate disability services, and improve their quality of life.

Objective 15: Value families, whānau and people providing ongoing support

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<sup>1</sup> Developed from Article 23 of the United Nations Convention on the Rights of the Child.

- Acknowledge and support the roles, responsibilities and issues facing family, whānau and those who support disabled people.

## **ACTIONS**

These Actions will inform the annual New Zealand Disability Strategy implementation work plans to be developed by government departments.

### **Objective 1: Encourage and educate for a non-disabling society**

#### Actions

- 1.1 Develop national and locally-based anti-discrimination programmes.
- 1.2 Recognise that it is disabled people who are experts on their own experience.
- 1.3 Recognise and honour the achievements of disabled people.
- 1.4 Include the perspectives of disabled people in ethical and bioethical debates.
- 1.5 Encourage ongoing debate on disability issues.

## **Objective 2: Ensure rights for disabled people**

### Actions

- 2.1 Provide information for everyone about the rights of disabled people.
- 2.2 Provide education to ensure that disabled people understand their rights, recognise discrimination and are able to be self-advocates.
- 2.3 Educate agencies responsible for supporting children and families about the rights and abilities of disabled parents.
- 2.4 Review Human Rights legislation to ensure the ongoing enhancement and strengthening of the rights of disabled people.
- 2.5 Investigate, and if appropriate, support, development of a United Nations convention on the rights of disabled people.
- 2.6 Investigate the level of access that disabled people have to independent advocacy, and address any shortfall in service provision.
- 2.7 Evaluate New Zealand's performance on the rights of disabled people.
- 2.8 Consider disabled people whenever New Zealand's performance is being evaluated against international human rights obligations, for example, the Convention on the Elimination of All Forms of Discrimination Against Women, and United Nations Convention on the Rights of the Child.

### **Objective 3: Provide the best education for disabled people**

#### **Actions**

- 3.1 Ensure that no child is denied access to their local, regular school because of their impairment.
- 3.2 Support the development of effective communication by providing access to education in New Zealand Sign Language, communication technologies and human aids.
- 3.3 Ensure that teachers and other educators understand the learning needs of disabled people.
- 3.4 Ensure that disabled students, families, teachers and other educators have equitable access to the resources available to meet their needs.
- 3.5 Facilitate opportunities for disabled students to make contact with their disabled peers in other schools.
- 3.6 Improve schools' responsiveness to and accountability for the needs of disabled students.
- 3.7 Promote appropriate and effective inclusive educational settings that will meet individual educational needs.
- 3.8 Improve post-compulsory education options for disabled people, including: promoting best practice, providing career guidance, increasing lifelong opportunities for learning and better aligning financial support with educational opportunities.

## **Objective 4: Provide opportunities in employment and economic development for disabled people**

### **Actions**

#### Planning and training for entering employment

- 4.1 Provide education and training opportunities to increase the individual capacity of disabled people to move into employment.
- 4.2 Enable disabled people to lead the development of their own training and employment goals, and to participate in the development of support options to achieve those goals.
- 4.3 Educate employers about the abilities of disabled people.
- 4.4 Provide information about career options, ways to generate income, and assistance available for disabled people.
- 4.5 Investigate longer-term incentives to increase training, employment and development opportunities for disabled people.
- 4.6 Ensure a smooth transition from school to work.
- 4.7 Investigate the requirements of the International Labour Organisation Convention on Vocational Rehabilitation and Employment, with a view to ratification.

#### Employment and economic development

- 4.8 Encourage the development of a range of employment options recognising the diverse needs of disabled people.
- 4.9 Ensure disabled people have the same employment conditions, rights and entitlements as everyone else has, including minimum wage provisions for work of comparable productivity.
- 4.10 Make communication services, resources and flexible workplace options available.
- 4.11 Operate equal employment opportunity and affirmative action policies in the public sector.
- 4.12 Investigate a legislative framework for equal employment opportunities across the public and private sectors.
- 4.13 Ensure disabled people have access to economic development initiatives.

4.14 Encourage staff and service organisations (for example, unions) to appoint or elect disabled people as delegates and members of their executives.

4.15 Ensure that the needs of disabled people are taken into account in developing more flexible income support benefits, to make access to work and training easier.

4.16 Review income support provisions to ensure they provide an adequate standard of living.

## **Objective 5: Foster leadership by disabled people**

### **Actions**

- 5.1 Encourage disabled people to take part in decision-making as service users, as staff in the delivery of services, and in the governance, management, planning and evaluation within all services that disabled people access.
- 5.2 Assist self-help initiatives, service provision and advocacy organisations run by disabled people for disabled people.
- 5.3 Model the inclusion of disabled people in leadership roles within government departments, in order to encourage leadership by disabled people within all organisations.
- 5.4 Support the establishment of a leadership development and mentoring programme for disabled people.
- 5.5 Establish a register of disabled people for government appointments.
- 5.6 Make information available to disabled people and their advocacy organisations about how to influence government policy.

## **Objective 6: Foster an aware and responsive public service**

### **Actions**

- 6.1 Develop mechanisms to ensure that all government policy and legislation is consistent with the objectives of the New Zealand Disability Strategy.
- 6.2 Adapt public sector training to ensure that service development and service delivery are consistent with the New Zealand Disability Strategy.
- 6.3 Ensure that all government agencies treat disabled people with dignity and respect.
- 6.4 Improve the quality of information available, including where to go for more information, the services available and how to access them.
- 6.5 Make all information and communication methods offered to the general public available in formats appropriate to the different needs of disabled people.
- 6.6 Ensure the locations and buildings of all government agencies and public services are accessible.
- 6.7 Work with territorial authorities to develop ways they can support the New Zealand Disability Strategy.

## **Objective 7: Create long-term support systems centred on the individual**

### **Actions**

- 7.1 Ensure that overarching processes, eligibility criteria and allocation of resources are nationally consistent, but that individual needs are treated flexibly.
- 7.2 Ensure that government agencies, publicly funded services and publicly accountable bodies co-operate to ensure that the disabled person is at the centre of service delivery.
- 7.3 Investigate the development of a holistic approach to assessment and service provision, that applies across agencies and funding sources.
- 7.4 Develop and maintain effective rehabilitation services.
- 7.5 Encourage equity of funding and service provision for people with similar needs, regardless of the cause of their impairment.
- 7.6 Identify unmet need and develop affordable solutions to fill these gaps.
- 7.7 Improve timeliness of service provision.
- 7.8 Develop a highly skilled workforce to support disabled people.
- 7.9 Ensure that disability services do not perpetuate the myth that disabled people are ill, while recognising that disabled people do need access to health services without discrimination.

## **Objective 8: Support quality living in the community for disabled people**

### Actions

#### Living in the community

8.1 Increase opportunities for disabled people to live in the community with choice of affordable, quality housing.

8.2 Support disabled people living in rural areas to remain in their own communities by improving their access to services.

8.3 Support the development of independent communication for disabled people.

8.4 Ensure disabled people are able to access appropriate health services within their community.

#### Moving around the community

8.5 Require all new scheduled public transport to be accessible in order to phase out inaccessible public transport.

8.6 Encourage the development of accessible routes to connect buildings, public spaces and transport systems.

8.7 Develop nationally consistent access to passenger services where there is no accessible public transport.

## **Objective 9: Support lifestyle choices, recreation and culture for disabled people**

### **Actions**

9.1 Support disabled people in making their own choices about their relationships, sexuality and reproductive potential.

9.2 Provide opportunities for disabled people to create, perform and develop their own arts, and to access arts activities.

9.3 Educate arts administrators/organisations and other recreational and sporting organisations about disability issues and inclusion.

9.4 Support the development of arts, recreational and sports projects, including those run by and for disabled people.

## **Objective 10: Collect and use relevant information about disabled people and disability issues**

### Actions

10.1 Ensure that guidelines for research funding take into account the need for research on disability issues, include disabled people in the development and monitoring of the disability research agenda, and enable disabled people to put forward their own experiences in the context of the research.

10.2 Collect relevant and useful information about disability through all relevant surveys to inform the research programme.

10.3 Use disability research, and analyse disability data, including that from the 1996 and 2001 Disability Surveys, to contribute to policy work, service development and monitoring.

10.4 Undertake research focusing on disability issues for Māori and Pacific peoples.

10.5 Make disability research information available to disabled people in culturally appropriate and accessible formats.

10.6 Adopt ethical and procedural standards for disability research projects.

10.7 Appoint disabled people as members of ethics committees.

## **Objective 11: Promote participation of disabled Māori**

### **Actions**

11.1 Build the capacity of disabled Māori through the equitable allocation of resources within the context of Māori development frameworks.

11.2 Establish more disability support services designed and provided by Māori for Māori.

11.3 Ensure mainstream providers of disability services are accessible to and culturally appropriate for disabled Māori and their whānau.

11.4 Train more Māori disability service provider professionals and increase the advisory capacity of Māori.

11.5 Ensure that Government funded or sponsored marae-based initiatives meet the access requirements of disabled people (and encourage all other marae-based initiatives to also meet those requirements).

11.6 Support training and development of trilingual interpreters for Deaf people.

11.7 Ensure Te Puni Kōkiri undertakes a leadership role in promoting the participation of disabled Māori.

## **Objective 12: Promote participation of disabled Pacific peoples**

### **Actions**

12.1 Increase access to, and quality of, both Pacific and mainstream service providers that deliver disability services to disabled Pacific peoples, their families and communities.

12.2 Support disability workforce development and training for Pacific peoples, by training Pacific peoples as providers of disability information and services for their local communities.

12.3 Encourage Pacific communities to consider disability issues and perspectives and further their own understanding of disability through the development of community-based plans for disability issues.

12.4 Support training and development of trilingual interpreters for Deaf people.

12.5 Ensure the Ministry of Pacific Island Affairs undertakes a leadership role in promoting the participation of disabled Pacific peoples.

## **Objective 13: Enable disabled children and youth to lead full and active lives**

### **Actions**

13.1 Ensure all agencies that support children, youth and families work collaboratively to ensure that their services are accessible, appropriate and welcoming to disabled children, youth and their families.

13.2 Ensure that the Youth Development Strategy recognises the needs of disabled children and youth.

13.3 Conduct anti-discrimination and education campaigns that are age-appropriate and effective.

13.4 Establish a process for including advice from disabled people on disability issues for children and youth within relevant government agencies and Commissioners' offices.

13.5 Provide access for disabled children, youth and their families to child, youth and family-focused support, education, health care services, rehabilitation services, recreation opportunities and training.

13.6 Improve support for disabled children and youth during transition between early childhood education, primary school, secondary school, tertiary education and employment.

13.7 Introduce ways of involving disabled children and youth in decision-making and giving them greater control over their lives.

13.8 Develop a range of accommodation options so that disabled young people can live independently.

13.9 Provide and evaluate educational initiatives about sexuality, safety and relationships for disabled children and youth.

13.10 Ensure the Ministry of Youth Affairs and Ministry of Social Policy undertake a leadership role in promoting the participation of disabled children and youth.

**Objective 14: Promote participation of disabled women in order to improve their quality of life**

Actions

14.1 Promote women's rights and provide opportunities for disabled women to achieve the same level of economic wellbeing and educational attainment as men.

14.2 Provide equitable, appropriate and welcoming access to services.

14.3 Support disabled women to live independent and secure lives in the environment and with the people of their choosing.

14.4 Ensure that criteria and considerations for the health and reproduction-related treatment of disabled women are the same as for non-disabled women.

14.5 Include the perspectives of disabled women in the development of all strategies.

14.6 Ensure the Ministry of Women's Affairs undertakes a leadership role in promoting the participation of disabled women, to improve their quality of life.

## **Objective 15: Value families, whānau and people providing ongoing support**

### **Actions**

15.1 Ensure needs assessment processes are holistic and take account of the needs of families/whānau as well as the disabled person.

15.2 Improve the support and choices for those who support disabled people.

15.3 Provide education and information for families with disabled family members.

15.4 Ensure that, where appropriate, the family, whānau and those who support disabled people are given an opportunity to have input into decisions affecting their disabled family member.

15.5 Develop a resource kit for professionals on when and how to interact with families/whānau of disabled people.

15.6 Work actively to ensure that families, whānau and those who support disabled people can be involved in policy and service development and delivery, and in monitoring and evaluation processes where appropriate.

15.7 Encourage debate around responsibility for caring, payment for caring and how to further recognise and value the caring role.

15.8 Provide families and those who support disabled people with information that is accurate, accessible and easily found.

## **APPENDIX : MEMBERSHIP OF THE NEW ZEALAND DISABILITY STRATEGY SECTOR REFERENCE GROUP**

Ms Robyn Hunt (Co-chair)  
Dr Jan Scown (Co-chair)  
Ms Jennifer Brain  
Mr Paul Gibson  
Mr Les Gilsenan  
Mr Mike Gourley  
Mr Mark Lau Young (May-July 2000)  
Ms Judith Lunny  
Dr Nigel Millar  
Ms Missy Morton  
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Mr Graham Stairmand  
Ms Lorna Sullivan  
Mr Patrick Thompson  
Mr Maaka Tibble