Grey Power
NEW ZEALAND FEDERATION INCORPORATED

REPORT ON THE ADVOCACY VISIT TO WELLINGTON MAY 26TH – 28TH 2015 AND TO THE MINISTRY OF HEALTH ON JULY 21ST 2015

Full report for web-site publication

"What can be asserted without proof can be dismissed without proof".
Christopher Hitchens

Author - Jan Pentecost –Advocacy Standing Committee Chair

Disclaimer: Although every effort has been made to provide accurate information in this report the author takes no responsibility for unintended inaccuracies

From May 26th to 28th 2015 the Grey Power advocacy team met with decision-makers in Wellington.

These lobby visits are very important because advocacy, in all its forms, is Grey Power's reason for existing.

Who did the advocacy team meet?
In no particular order - Age Concern – Robyn Scott-CEO, MSD – Office of Senior Citizens, NZ Post – Holden Hohaia, Opposition Leader - A. Little, Maori Party Co-Leader – Marama Fox, NZ First – Fletcher Tabuteau, Dept. of Internal Affairs, Act Leader – David Seymour, Director-General of Health – Chai Chauh, Pharmac, Minister of Senior Citizens – Hon Maggie Barry, and the Ministry of Health.

What was the Objective of the Meetings?
- To advocate and to access information on behalf of Grey Power members and others regarding appropriate issues which have been received by the Federation Board since the last advocacy trip or which are on-going;

- To request politicians and others to follow up on promised action from the previous advocacy visit.

Who were the core advocacy team?
The core team consisted of Terry King, (Grey Power President) and Jan Pentecost, (Grey Power Advocacy Standing Committee chair & National secretary).
With the exception of Miles Jackson (Election Strategy NAG chair) who attended all meetings, the following - Lew Rohloff (Superannuation and Taxation NAG chair), Jo Millar (Health NAG chair), Trevor Daniell (Local Govt. & Housing NAG chair), and Violet McCowatt (Social Services NAG chair) led meetings relevant to their NAG. Pete Matcham (Research Standing Committee chair) was also present as an observer at the majority of the meetings.

What were the gains, maybes and shortfalls for Grey Power?

1. MEETING WITH AGE CONCERN:
Helen Keller wrote "alone we can do so little; together we can do so much." Therefore if Grey Power works with other NGOs such as Age Concern perhaps both organisations can effect change?

In the past Grey Power has petitioned the Office of Senior Citizens and others to appoint an aged care commissioner and support from Age Concern would assist in this endeavour. It was our intention to discuss this during the visit especially since Elder Abuse and Neglect Prevention Service (EANPS) national advisor, for Age Concern, Louise Collins has been reported as saying that there is no one agency that covers all types of abuse – the system is fragmented (it includes MOH, DHBs, Health & Disability Commissioner etc.) and "*a watchdog in the form of an aged care commissioner … would help fill this vacuum.*" However we did not have enough time to hear Age Concern's views on this issue.

Nevertheless Grey Power's gain was learnings about:
'World Elder Abuse Day',
Social isolation,
The Commissioner for Older People for Northern Ireland's 'Appreciating Age, Valuing the positive contributions made by Older People for Northern Ireland (www.copni.org) which contains a model which might be useful for NZ,
Some useful tips on publicity pamphlets, including using case studies i.e. a national story and media information.
** Action: It was agreed that M .Jackson would peruse the publications provided by Age Concern.

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2. **SOCIAL SERVICES**
MEETING WITH THE MINISTRY OF SOCIAL DEVELOPMENT – SENIOR CITIZENS
2.1 Purchase of spectacles – Grey Power has been requested to ask about MSD policy regarding an eye examination and the purchase of spectacles - the concern is that choice has been taken away from individuals

who are advanced funds (their own money which they must pay back). It seems that in effect the MSD is telling their "clients" where they can spend their own money and they are restricted to purchasing low value product.
Q. How does this system of advancing superannuation payments to permit people to purchase necessary items actually work –e.g. who can access them, what do they cover, is it for essential goods, how they are paid back, how do people manage on a reduced superannuation while they pay back their loans, what are the conditions which are attached to advancing superannuation payments etc.?
A. The advance payment was seen as early payment of NZS rather than a loan.
Work and Income are well placed to negotiate a good deal and ensure the taxpayer receives value for money
The preferred supplier arrangement for clients in financial hardship meant that the latter receive quality products and supporting services at very competitive prices which means lower levels of debt repayment.
An important point was that the advance is interest free

It is interesting to note that if the advance for glasses is early payment of NZS and not a loan, why are we talking about 'lower levels of debt to pay back to Work & Income and interest-free?

Grey Power's **gain** was learnings about MSD's view on advancing superannuation to purchase glasses – the **shortfall** was very little knowledge was provided on how the system works.

2.2 Abatement of unqualified spouse, other income – this is a request arising from the 2014 AGM
Q. How does the abatement system work?
A. The Government has no plans to change the income test for New Zealand Superannuation (NZS) where a non-qualified partner (NQP) is included or to change the income test for social security benefits.

Where a person who is eligible for NZS has a partner who is not eligible for NZS (either they are under 65 years or do not meet the residential qualifications) there is a concession to allow them to be included in the NZS payment. An income test ensures that this concession is targeted to low income households. It is advantageous to include a NQP only if a couple's total income before tax income (excluding NZS) is less than $26,875.

An important point is that the NQP inclusion is a concession. In most cases it is the expectation that people will work up until age 65. This concession is unique to the New Zealand pension system. While the Netherlands had a similar provision, it has recently been removed.

As at 1 May 2015, there were 12,733 NQPs included in their qualifying partner's NZS payment. The majority of NQPs are aged 60 to 64 years – approaching the age of eligibility for NZS.

When the lower NQP rate was introduced in October 1991[1]it was set to equate to the single adult rate of the Unemployment Benefit and the married person rate of NZS (i.e. the payment was equivalent to what an unemployed person would receive).
Grey Power's **gain** was information on how the NQP abatement issue is perceived by MSD.

2.3 Phones with GPS to assist older people:
Q. = Whether phones with this capability could be subsidised for older people who would benefit from them.
A. The Ministry of Health is already able to provide, for older people who are at risk of wandering more effective and specialised tools via their Equipment Management Service than can generally be delivered via a phone GPS.

Current technology and manufacturing trade-offs mean that phone-based GPS technology is not as robust as specialist GPS products. Phone GPS signals are often easily lost, particularly in urban areas or indoors. It should not be relied on to help ensure safety of older people.

For people who require on-going GPS monitoring (primarily for those at risk of wandering), assistance with monitoring costs is available if they are for the disability allowance.
Grey Power's **gain** was the information that phone-based GPS was not the ultimate answer and that those at risk of wandering and on a low income may receive income support for a device from MSD

2.4 A Housing Strategy for Older people:

[1] Prior to October 1991, when a NQP was included the maximum amount payable to the couple was the same as that payable to a couple who both qualified.

Grey Power's aim: to request the Office for Senior Citizens to carry out co-ordinated and on-going research into the housing needs of older people with a view to producing a comprehensive strategy to improve the housing options available to older people.

Grey Power housing policy is to maintain and improve housing options for older persons.

Government policy is to support the NZ Positive Ageing Strategy (PAS); its housing goal is affordable and appropriate housing options for older people and to do this income-related rents policy for state housing will be maintained, adequate assistance will be provided towards the cost of local authority rates, the government will work with local government to increase the supply of universal design and energy-efficient low-rental housing, including supported pensioner housing complexes and investigate options for government assistance to enable low-income families to purchase homes.

Background: in 2005 the then Labour Govt. launched the New Zealand Housing Strategy which set out a long term vision for housing and identified seven priorities for the next decade. They were sustainable housing supply; assistance and affordability; home ownership; private rental sector; housing quality; sector capability and meeting diverse needs[2].

These coincide more or less with Grey Power policy and the Positive Ageing Strategy (PAS) but a cursory google search has failed to find a copy of the actual strategy and the 2013 Housing NZ briefing for the incoming Minister of Housing makes no mention of such a strategy. Therefore, with no apparent base-line housing strategy, in an effort to further support the housing goals of the PAS, the Grey Power Local Body and Housing NAG has provided the following direction for Federation advocacy efforts:

- The provision for an adequate housing supply for older persons.
- Better regulation of the private rental sector to ensure healthy homes and sustainable tenancies.
- Provision of a range of housing services to assist older people to make informed choices.
- Provision of a range of options to suit the diverse housing and aged care needs of older people reaching retirement.
- Consideration of new ways of funding housing projects e.g. Social housing bonds, Betterment taxes, Inclusionary zoning, Public Private Partnerships.
- The requirement that all special housing area developments be required to provide a percentage of affordable and specially designed housing for older people. (Auckland Council and appropriate central government agency).

Q. Is it possible for MSD to draw up a comprehensive strategy for improving the housing options available for older people which coincide with Grey Power's housing policy?
A. focussed on social housing down-sizing rather than a specific answer to the question:

There is no specific initiative on downsizing social housing for older clients; however there are a number of ways a client can end up moving into a smaller property.

If a social housing provider notices a change in the housing needs of a client i.e. they need an extra room or they are under-utilising a property they can request that MSD completes a housing needs assessment on the client. The outcome of the review will give the provider confirmation of the client's needs and they will take this into account when allocating a property to a client

Once a client has been allocated a property, a social housing provider may review a client's requirements to be or continue to be allocated, or let a particular house. They may require a client to transfer to a different house belonging to that provider if they consider the transfer is necessary or desirable for any reason and the other housing is appropriate for the tenant's housing need. This process can be completed by the social housing provider without any review of the client's housing needs by MSD.

Grey Power's **gain** was information re down-sizing of social housing based on individual needs – the **shortfall** was that no discussion occurred on a Grey Power recommended housing strategy

[2] (www.hnzc.co.nz/.../annual-report/2004...annual-report/annual-report-20)

2.5 Security locks on pensioner housing:
Grey Power policy is to work to ensure the security and safety of all New Zealanders and their assets with particular emphasis on the 50 plus age group and policy goal #6 is to work with appropriate agencies to encourage the use of efficient home security devices including effective security doors and alarms in social housing. Consequently V. McCowatt (Grey Power Social Services NAG Chair) requests, and has done so in the past, that the MSD ensure every council provides security locks for pensioner housing.

Q. Is it possible for MSD to ensure every council provides its pensioner housing with security locks?

A. Local Authorities are independent of MSD who have no ability to force any local council to provide security locks. Nevertheless there are minimum legal requirements under section 46 of the Residential Tenancies Act 1986, which requires that landlords "shall provide and maintain such locks and other similar devices as are necessary to ensure that the premises are reasonably secure." This requirement applies to council provided social housing.
Grey Power's **gain** was that information was provided which clarified whose responsibility pensioner housing security was and the also that legislation exists re this.

2.6. Age-Friendly Cities
Grey Power is very interested in Age Friendly Cities and it was noted that an age-friendly community benefits people of all ages and aligns with the goals of the PAS. The meeting confirmed that:

The Office of Senior Citizens (OSC) is looking for ways to raise awareness of the value of Age Friendly Cities, and it aligns well with work underway on addressing social isolation.

OSC is developing a webpage which can act as an information hub, and promotes material via its Facebook.

OSC is also seeking to identify opportunities to promote the concept with local councils as they travel and discuss the Positive Ageing Strategy.

OSC is keen to work collaboratively with groups such as Grey Power on this issue.

Grey Power's **gain** was the valuable information that OSC are working to raise awareness of both the Positive Ageing Strategy and Age-Friendly cities at local council level.

The Advocacy Team thank MSD/OSC for their time to provide the above information some of which is supplied verbatim in this report.

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3. **GENERAL**
MEETING WITH DEPARTMENT OF INTERNAL AFFAIRS (DIA):
We asked the DIA team:
Q. 1. Can the SuperGold card have a photo added to provide identification especially for people who can no longer drive or do not own a passport?
A. Membership was the purpose of the SuperGold card – it was never intended as ID and the banks etc. choose what they will accept as I.D.
Grey Power was informed that Government Departments are working with an on-line identity product called RealMe. It works as your online ID; it was created by the Department of Internal Affairs and New Zealand Post and is backed by the government.
The Department of Internal Affairs said this could perhaps be used externally.
They also asked Grey Power to find out how big this issue is; i.e. is there a demand for this type of ID?

Q.2. Rotorua Grey Power has asked is there a possibility that the rates rebate income eligibility threshold be at least the gross married rate of national superannuation and is it possible that an application protocol be established so that people with community services cards automatically qualify for the rebate.
A. Was focussed more on the operational review of the rates rebate process such as:
Promotional publications,
Ways that eligible older people would feel more comfortable accepting the rebate

Improvement to the system to make it easier for the end user
Easier ways to obtain earnings evidence
Integrated on-line services
Incorrect information from the rebate calculator – Grey Power pointed out that some members were receiving wrong amounts for their rebates when using the calculator - DIA replied that it is likely the wrong data is being entered into the computer.

Q.3. Zone 3 has asked is it possible to record the names of deceased children on death certificates?
A. The details that appear on death certificates are governed by regulations set by Parliament. Go to http://www.legislation.govt.nz/regulation/public/1995/0183/latest/DLM204054.html?search=qs_act%40bill%40regulation%40deemedreg_death+certificate_resel_25_h&p=1.

These regulations specify in clause 7 (1) (a) (xiid) the sex and age of the person's children when the person died (if still living at that time). It appears that the purpose of recording the children is to assist those seeking to apportion the estate of the deceased.

It is possible to change legislation however there would be practical problems in listing children's names because the certificate is already very full and this may mean it runs to two pages. Also, children change their names which may mean that certificates become 'out of date' or contain errors. Currently our computer system does not automatically link names of parents to children.

Q.4. It is difficult for some older people to see passport form boxes on the form
A. The reason for this size is that the boxes need to be read by a digital scanner.
Grey Power's **gains** from the meeting with the DIA were:
Information on the issues discussed and a request from DIA that a Grey Power member be appointed to the rates rebate operational review team – Trevor Daniell, Chair, Local Body & Housing National Advisory Group will fill that position.

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3. MAORI PARTY CO-LEADER – MARAMA FOX –
Marama provided Grey Power with the following information:
Her main interests are energy, superannuation and housing
The party superannuation policy is that the age of entitlement should be 60 yrs because Maori have a shorter life span and therefore many do not benefit fully from superannuation – in 2013, Statistics NZ reported that Maori life expectancy is more than seven years less than other New Zealanders.
People have earned the right to superannuation and it should not be means-tested
Maori value their older people
The Maori Party are looking at subsidised conversion to solar energy
She is very concerned about the housing conditions of many vulnerable people
Grey Power's **gain** was that it has renewed contact with the Maori Party and that when making policy Grey Power should also consider the Maori perspective

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4. MEETING WITH NZ POST - Holden Hohaia, Government and Community Relations Manager briefed Grey Power, as part of the stake-holder engagement process, on postal operations changes:

NZ Post are to reduce street receivers if they are only getting low volumes of letters – volumes will be reviewed and the receivers will be removed if the mail volume falls below the accepted threshold;
Communities will be advised of the removal of street receivers and Holden will contact local Grey Power associations if there are to be postal changes in specific areas;
We asked Holden about the necessity for receivers outside rest-homes, especially at Christmas time – he will pass on information to necessary Post Office personnel
NZ Post has a legislative requirement to maintain a postal network
There is the expectation that NZ Post will return a dividend;

Where post shops close NZ Post has to find a host business to do post business
Three levels of service = full post shop, franchise only stores and transaction franchise only;
Holden will talk to Grey Power associations, if requested, when he is specific regions and will also bring specialists to talk about banking etc.
Grey Power's **gain** was that members' are now aware of changes to the New Zealand mail system.

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5. TPPA

At the May 12th 2014 Grey Power Federation executive committee meeting it was resolved that 'due to the possible impact on Pharmac and the cost of prescription medicine a special project TPPA sub-committee be formed to include, Miles Jackson (Chair) Pete Matcham, Jo Millar, Les Howard (media spokesperson) and Jan Pentecost.'

The Trans- Pacific Partnership agreement has the potential for numerous negative outcomes and is being negotiated in secret even though the Minister of Foreign Affairs and Trade, Tim Groser, appears to believe he has been open about the issues under negotiation and that '*the consultation process has been the most extensive any New Zealand Government has undertaken for any trade negotiation*' [3]

Regardless of these assertions several Grey Power Associations have joined protests and Les Howard has released a media statement recently which was reported by Yahoo News: "*Grey Power has joined calls for the Government to release more information about the TPPA. The organisation is worried about a potential impact on the drug agency Pharmac, and the potential for higher health costs…"*

If the New Zealand government signs this treaty, then according to Eric Monasterio and Philip Pattemore[4] Pharmac will lose its ability to use market competition to drive down the cost of medications.

Also a statement from Wikileaks suggests that there are provisions in the agreement which will permit corporate investors to sue governments to ensure the former maintain their profits through the creation of a supra-national court or tribunal. In other words foreign pharmaceutical firms and others could sue our government, through the investor-state settlement tribunals (ISDS) to obtain taxpayer compensation for loss of expected future profits[5].

However the Hon Todd McClay, Associate Minister of Trade, has asserted that New Zealand has already concluded free-trade agreements with balanced ISDS provisions and that the government is taking the same balanced approach with the TPPA [6]. He has said: "*the Government has been clear from the start that it will strongly resist proposals that would increase the price New Zealanders pay for their medicine. We are taking a careful approach to pharmaceutical patent issues to ensure that the agreed outcome does not affect the fundamentals of medicine access in New Zealand"*[7].

Although Grey Power has focussed on Pharmac and the possibility of New Zealanders' reduced access to affordable and life-saving drugs there is much more at stake. Prof Jane Kelsey, from the University of Auckland, says the leaked text shows that the negotiators have completely failed to protect the interests of New Zealanders because this agreement has the potential to undermine Kiwi sovereignty and its right to self-governance[8]

Nevertheless Trade Minister Groser has said that there is a clear bottom line and until the negotiation settles down "*if it ever does – and we can see exactly what we are expected to do and exactly what we will get in return - unless it clearly is in our view in the net national interest and we are confident we can carry the debate, we*

[3] A response by MP Jo Goodhew, quoting Tim Groser, to a letter to the Timaru Herald editor by Les Howard? date and page #.
[4] Eric Monasterio and Philip Pattemore (*Academics condemn secrecy over Trans-Pacific Partnership Agreement*, 24/02/2015, Stuff.co.nz; Fairfax NZ)
[5] T. Shaohui, *Opposition mounts to New Zealand's "undemocratic" foreign trade pacts,* Xinhua, 26.03/2015
[6] Parliamentary Questions for oral answer, 2. Trans-Pacific Partnership –Vote, 30 October 2015, Vol 704, page 2)

[7] Parliamentary Questions for oral answer, 12. Trans-Pacific Partnership – Release of Information, 28 October 2015 Vol 704, page 14
[8] J. Olsen, *Govt. secrecy over TPPA a major threat to NZ,* Otago Daily Times, online edition | Friday, 8 May 2015 | - Opinion - Jen Olsen is a member of TTP Action Dunedin.

will not be party to the agreement... we will not sign agreements that do not allow legitimate public policy regulation in the public interest in the future"[9].

To summarise, because of secrecy, the only knowledge available is through leaked documents, not open consultation; Grey Power and many others are deeply concerned that if this agreement is signed, notwithstanding lack of support from President Obama's Democrats, quickly followed by support for it from the US Senate, our members and many other New Zealanders may be severely disadvantaged.

Post script: the Prime Minister has now confirmed that it will cost tax payers more for medicines if the agreement is signed –see Hansard- Sitting date: 29 July 2015. Volume: 707; Page: 5417.

LABOUR PARTY LEADER – ANDREW LITTLE –

5.1. We asked Andrew Little to ensure that the government and opposition were aware that many Grey Power members want much more public information and consultation before the TPP treaty, which may have negative repercussions for them on a variety of issues including a dramatic price rise for prescription medications provided by Pharmac is signed.

A. Little provided the following response to Grey Power's concerns:

Labour is disappointed that their demands for more openness and transparency from the Government have not been heeded

New Zealand must not sacrifice Pharmac or give up its sovereign right to regulate and legislate in areas such as health, economic policy, the environment etc.

New Zealand negotiators should be arguing strongly for New Zealand's interests including the right to control who buys its houses.

Labour supports trade deals that genuinely benefit our country (from notes supplied by A. Little)

5.2. NZ FIRST TPPA SPOKESPERSON FLETCHER TABUTEAU:

We asked the following questions:

Q.1. Because it has been reported that Tim Groser has said that the Ministry has been open and consulted about issues under negotiation, what is your understanding of openness and do you know who has been consulted?

A. There were four open MFAT briefings two of which were public – they not well organised with selective invites – there is lack of consultation and transparency

Q.2. Do you think the public will have the opportunity to make submissions before the agreement is signed?

A. There will be no discussion with NZ or Parliament before signing and it will be difficult for the Government to withdraw from a signed treaty – once the agreement is signed there will be a 4 year code of silence

Other comments:

Fletcher provided a copy of his draft 'Fighting Foreign Corporate Control Bill,' which aims to protect the public interest by prohibiting New Zealand from entering international agreements that include provisions for investor-state dispute settlement (ISD)

He believes that the ISD provisions are not good enough to cover negative interaction between nations.

Grey Power's **gain** is that more information was supplied and its concern re TPPA was noted. The **shortfall** is that the Government appears not to be listening to country-wide protest

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6. SUPERANNUATION

Grey Power policy: To maintain a state-funded universal superannuation scheme payable at age 65 years

6.1. ACT LEADER-DAVID SEYMOUR

Q. Can we discuss differences between Act policy and Grey Power's policy on the age of eligibility for receipt of superannuation payments?

This question arose because Grey Power responded thus to a media release by Mr Seymour:

[9] Parliamentary (Questions for oral answer, 7. Trans-Pacific Partnership – Scope of Negotiations, 30 October 2014, Vol 701, page 6

'*Calls by the ACT Party for a national referendum on the age of eligibility for national superannuation have been labelled a desperate publicity stunt by Grey Power.*
ACT leader David Seymour has claimed that a public vote would end the dispute over the issue and has called for a binding public referendum.
Grey Power national president Terry King said last year's general election was a clear indication that the majority of the public would not support an increase in the age of entitlement and it was only extreme right wing politicians who wanted the Government to abandon the longstanding commitment to retired New Zealanders… There is a moral contract between the Crown and the community to manage that pension scheme efficiently and fairly and a referendum would be a costly waste of time," he added.'

A. There was no definitive answer – in fact Mr Seymour and Grey Power policy are poles apart on this issue – Grey Power pointed out that although there is a concerted campaign from some financial sector interests to convince us that the current 'pay as you go' scheme with its age eligibility of 65 years is not sustainable our research disclosed that NZ's universal superannuation scheme is sustainable – see the Allianz International Pension Paper, 1/2014 = '2014 Pension Sustainability Index' which shows that NZ ranks as the third most sustainable country on a list of 50 other countries including the UK, US and Australia. Also Peter Harris, a former CTU economist and economic advisor to Michael Cullen has written at least 3 articles stating that the present system is sustainable and the KASPANZ web-site is also interesting. These sites along with many others also point out the fiscal cost of NZS is low compared to overseas countries.

Discussion also occurred on local bodies and their core business and although Grey Power had no specific questions on this subject the meeting ended more cordially than it began.

6.2. LABOUR LEADER – ANDREW LITTLE clarified Labour's policy on superannuation:
They are committed to protecting the universal NZ Super scheme not just for now but for future generations,
They are not considering means-testing
They will not raise the age of eligibility
They are strongly committed to restarting contributions to the NZ Super fund as soon as possible
Grey Power's **gain** is that more information was supplied and **the Leader of the Opposition invited Grey Power to provide (promptly) its suggestions for Labour Party election issues policy.**

7. MINISTER OF SENIOR CITIZENS – HON. MAGGIE BARRY also clarified the Government's position on superannuation. She said that "there should always be state-funded superannuation – sufficient to keep older people above the poverty line."

She discussed the issue of those who will miss out on KiwiSaver and offered to provide Grey Power with the figures of those who might be in this category and commented re the discussion on affordable housing that '*a rent to buy was a future prospect.'* She believes that people should start planning earlier.

An Aged Care Commissioner was discussed but no definitive support for this was forthcoming. This a pity because the Greens support the appointment of an aged care commissioner[10] and Labour would investigate funding the Commissioner out of the $5.7 million annual budget of the Retirement Commissioner."[11]

Following the 2010 Green Party, Labour Party and Grey Power investigation into the treatment of the older people which found deep-seated problems in the aged care sector in New Zealand that affects the quality of care our elderly receive Grey Power and the NZ Aged Care Assn (NZAC), in 2013, produced a discussion paper on the subject of financial abuse of older people; its objective was to develop a policy paper as the basis for discussion and consultation on the need for an aged care commissioner.
It states that each year, EANPS receive over 1,000 referrals about people who may be facing elder abuse or neglect.[12] This is about 4 referrals every day. However we are also aware that reported abuse does not reflect the whole size of the problem. International research shows that only a small proportion of the elder abuse incidents

[10] See more at: https://home.greens.org.nz/press-releases/green-co-leader-addresses-grey-power-agm#sthash.djC2XgKy.dpuf)
[11] *Campaign.labour.org.nz/aged care*
[12] Age Concern New Zealand, World Elder Abuse Awareness Day, 15 June 2012

come to the attention of an agency that can be of assistance.[13] In the UK it is reported that 2.6% of older people experience abuse each year.[14] In New Zealand this would equate to approximately 50 people per day.

The major type of abuse recognised in our society is psychological abuse, which accounts for 62% of cases, material financial abuse = 50% of cases, physical abuse = 20% of cases and neglect accounts for 20% of cases and while significant attention is paid to physical abuse, a review of the literature shows that many people experience multiple types of abuse. Financial abuse may be the second most frequently reported form of abuse, with up to 50% of cases involving financial abuse, either as the main form of abuse or occurring with another form of abuse. For instance research has disclosed that where financial abuse is the main form of abuse, over half these cases (54%) also include psychological abuse, where psychological abuse was the main form of abuse, 31% of these cases also included financial abuse, where physical abuse was identified as the main form of abuse, 22% also included financial abuse. And where active neglect was identified as the main form of abuse, 11% also included financial abuse.[15]

Recent research by Age Concern identifies which groups of older people are being abused. It notes that many are women, 40% live alone, 80% of abuse is committed by members of family or whanau, over 40% of abusers are adult children and up to 35% of abusers are primary care givers, including community carers.

Age Concern state that two out of every five people abused experience a significant reduction in their independence, loss of confidence and self-esteem. Victims of abuse feel very frightened or anxious and emotionally distressed. In turn, this diminishes health and wellbeing.
The problem is increasing as the table below shows:

Reported Cases of Abuse in NZ (source: Age Concern)			
Year	**Financial Abuse Cases (Main form of Abuse)**	**Total Cases**	**Percent**
2006/07	138	515	27%
2007/08	134	518	26%
2008/09	200	517	39%
2009/10	194	576	34%
2010/11	202	583	35%

As the New Zealand population ages, the problem of elder abuse will continue to grow significantly. As highlighted in the Age Residential Care Services Review in 2010, the population over 65 years is estimated to increase by 84% from 512,000 to 944,000 in 2026.[16] Particularly important is the growth in people aged 85 or over, as this group is likely to be less independent and therefore more vulnerable. The report highlights that between 2006 and 2026, this population will more than double, from 58,000 to 116,500.[17]

Compounding this issue is the increased prevalence of dementia. Loss of cognitive function leads to greater vulnerability as people age, and consequently their increased reliance on others to manage their affairs. An Australian report on the Review of Aged Care projected that the prevalence of dementia doubles every five years after age 65. At ages 60-64 the prevalence of dementia is just 0.6% for women and 1.2% for men. By the age of 90 the prevalence is 35% for women, and 32.6% for men.[18]

[13] National Centre on Elder Abuse USA, Iceberg Theory of Elder Abuse: The National Elder Abuse Incidence Study, 1998
[14] National Centre for Social Research, Kings College London, UK Study of Abuse and Neglect of Older People: Prevalence Survey Report, 2007
[15] Davey J, and McKendry J, Financial Abuse of Older People in New Zealand, A Working Paper, November 2011, p8
[16] Grant Thornton, Age Residential Care Review, 2010, P78. Based on 2006 data.
[17] Ibid
[18] Alzheimer's New Zealand, Dementia Economic Impact Report, 2008, p9

In summary, if the prevalence of financial elder abuse continues, the real numbers of victims will increase due to demographic changes and increased dementia rates. And although New Zealand has a range of Commissioners and an Office for Senior Citizens, none has the responsibility for investigating allegations of financial and psychological abuse. Nor do they have the skills and expertise to compile evidence and make applications to the family court. Hence NZACA & Grey Power envisage that an aged care commissioner would work in a similar way to other commissioners, such as the Children's Commissioner or Health and Disability Commissioner, but have the powers to investigate allegations of abuse. She/he would not be able to award compensation and is more likely to have a lesser volume of work than the Office of the Retirement Commissioner.

The Commissioner would be appointed by the Governor-General on the advice of the government of the day.

Given that the expected increase of New Zealanders over 65 years and a prevalence of abuse rates at 1-2%, this request is seen as reasonable and should not be ignored.[19]

Please note the information above is sourced from a discussion paper prepared by the NZ Aged Care Assn and Grey Power NZ Inc. Oct. 2013

Grey Power would like the Minister to note, following the 2014 Report on the Positive Ageing Strategy, under Goal Five = the underlying causes of elder abuse which asked how this issue should be addressed, that:

- Whilst noting positive government action in providing funding for elder abuse and neglect prevention services, it now investigates the appointment of an aged care commissioner whose responsibilities would include independent advice to the minister and advocacy support for vulnerable people, the management of a complaints process into matters of elder abuse that would not normally be investigated by the police and jurisdiction to investigate matters involving elder abuse where an individual was deemed vulnerable.

  The aged care commissioner could also be part of a strategy to address a key underlying cause of elder abuse which is deeply ingrained stigma and discrimination. Ageism can manifest itself in abuse, violence and neglect (a violation of human rights) which many older people are subjected to.[20] All this may require new or amended legislation.

- The Government supports calls for a UN legally binding human rights treaty that can facilitate efforts to respect, protect and fulfil the human rights, including the safety and security, of older persons.

Other areas of interest mentioned were that people should keep working if they want to or are able to; the Minister is encouraging the Napier Connects model to reduce social isolation of older people in communities, is supportive of Age Friendly cities policy and is interested in Grey Power's work on age-friendly cities.

The Minister asked that she meet with Grey Power Federation Board regularly

Grey Power's **gains** were the opportunity to expand on its superannuation policy, it ideas on age-friendly cities and the Minister's request to have continuing contact with her. The **shortfall** was Grey Power's inability to move forward with its request for an aged care commissioner

Of note: the Minister of Senior Citizens is responsible for '*a whole of government advocacy role on behalf of older people, particularly in relation to policy development and decision-making.* [21] This includes many policy areas such

[19] *From the nzaca.org.nz/publication/.../The**AgedCareCommissioner**inNewZealand.*
[20] The statement from the Eighteenth Session of the UN Human Rights Council panel discussion on the realization of health of older persons, Geneva, 16 September 2011
[21] MSD 2013 Briefing paper to the Minister of Senior Citizens

as retirement income, employment, housing, transport, ageing in the community, disability support, community and voluntary sector involvement, and protection of older persons' rights and interests.

8. HEALTH

8.1. DIRECTOR-GENERAL OF HEALTH – CHAI CHAUH

The general topic was the allocation of funding for DHB's and cataract surgery

Q.1. What is the effect of salary increases on the current year's funding allocation?

A. The State Services Commission sets salary bands and the increases come out of the current available monies; however this has no impact on services – front line services would never be compromised.

Q.2. Is it common practice for cataract patients to receive treatment for only one eye?

A. G.Ps should engage with the Ophthalmology College re the need to remove cataracts from both eyes. Consideration is needed re the cost/benefit of providing home help as opposed to receiving a prompt operation.

The Director- General also said that the whole health system was required to save dollars and that there are funding and capability reviews in process

Grey Power's **gains** were information on funding of DHB salaries and the appointment of Roy Reid to represent stakeholders at the NZ Health Strategy Review workshops plus the appointment of the Health NAG Chair Jo Millar and K. de Lacy a Health NAG member to various other health related groups

8.2. PHARMAC

The topics covered were free shingles vaccine for superannuitants who are CSC holders and modern cancer drugs.

Q.1. Is there any likelihood of this vaccine being provided free, or subsidised, to community service card holders especially those over 50 years old?

A. This has been discussed with the advisory committee and there is a will to provide the vaccine but it is a balancing act within Pharmac's budget – it is on their radar

Q.2. Do people need or have a choice regarding drugs used to treat cancer?

A. Pharmac is very active in this very complex area. They believe that NZ is well served by cancer drugs and they have a high-powered committee that looks at this. However there are always some problems e.g. optimal use of medications often is enhanced with early diagnosis.

Pharmac is working with the Ministry of Health to decide how some of these gaps can be plugged.

Discussion also occurred on the difficulty some older people have with medication packages and ear droppers. Pharmac pointed out that they work closely with pharmacists and if people find packaging or medical devices difficult to use they should tell their pharmacist – if there is no help forthcoming Pharmac's advice is to shop around and find a pharmacist who will assist older people. The Chair of the Grey Power Federation Health NAG, Jo Millar, may also be able to assist. Her contact is: Phone 03 453 0700 - Email d.j.millar@xtra.co.nz

For further information on Pharmac and how it works please visit http://www.pharmac.health.nz/

Grey Power's **gains** were clear answers to questions and a positive result from President Terry King's invitation for Pharmac to address the 2016 AGM about the Pharmac process.

8.3. MINISTRY OF HEALTH (MoH)

The topics covered were elective surgery, screening and travel costs.

8.3.1. Elective Surgery

New Zealand has always rationed public health through the use of waiting lists/booking systems to constrain elective surgery and diagnostic tests[22]. And priority criteria to decide who will and who won't receive treatment in the public health system are part of the patient pathway process which is utilised to assist the rationing process.

[22] D. Jenkins & S. Birks; *An Economic Assessment of the Priority Criteria for Elective Surgery in New Zealand,* p 3. July 1998 & Health Projections and Policy Options for the 2013 Long-term Fiscal Statement – Draft Paper for the Long- Term Fiscal External Panel New Zealand Treasury, November 2012

But whether the assessment tool is used consistently and results in equitable decisions has been questioned by the Auditor- General[23] even though the New Zealand Health Strategy (p.21; 2000) set out objectives for access to elective services which included national equity of access and maximum waiting times for a first specialist assessment and for elective procedures.

Information received from Grey Power members does not coincide with these objectives; we are aware that many older people consider they are suffering from severe ill health, incapacity and distress (see Arthur's story below as an example).

Arthur's story

'I'm sorry I'm not the only person in the cart, but here goes.

I injured my knee ten years ago and made an ACC claim… the specialist … recorded it as arthritis. I didn't find out for 18 mths. I complained to him, and told him ACC would dump me--and they did. I appealed, and won, but after minor keyhole surgery, they dumped me again… Meantime a different surgeon got me on the waiting list, so I gave up on ACC.

I waited for a total of ten years of serious pain and NO SLEEP for surgery due on Feb 2nd past but two weeks before surgery at a pre-op. meeting the surgeon wrenched my injured knee reducing me to a crying heap and announced that it wasn't my knee causing the pain and cancelled the operation.

In the following six weeks, in an effort to find some other cause for the pain he inflicted and the cancelled op. he has arranged six X-rays, a bone scan, a cat scan and several blood tests and EVERY WEEK some-one has phoned to book me in for an MRI Scan (which I have explained to them ad nauseam that I cannot have because of a metal implant. And now a back specialist (who has never contacted me)

None of these scrambling efforts to cover his careless handling found any other problems except that he claims I have almost NO ARTHRITIS for a man of my age (81yrs)…

I'm, although drugged up, in constant pain, some of it serious enough to put me into spasms and I haven't slept a night through in bed for about five years and have pretty well decided I must go to my grave in pain.

Apart from my knee pain I'm in good health and my marbles are mostly intact still do the cryptic.

Hope at least that you can start some help for others, think it's too late for me.' Arthur.

Because Grey Power has heard similar stories (with some variation) it is interested to start its research process by finding out how patients presenting for elective procedures are treated.

N.B: prioritization tools are questions that permit the clinician to decide whether a person qualifies for an elective process or not at any given time. Therefore we asked the MoH the following questions:

Q.1. Are the current national prioritisation tools used across all DHBs or do some utilise local tools?

A. We have a mixture of local and national tools in use.

Where surgery is the best option for the patient, it is a requirement that all patients put forward for elective surgery are prioritised on either an approved national tool or a nationally approved local tool. The Ministry is working with clinical groups to update to modern clinical prioritisation tools (currently general surgery, ophthalmology and plastic surgery tools).

Modern nationwide tools in use are for bariatric (obesity) surgery, gynaecological surgery and ear, nose and throat surgery. Also being rolled out nationally is the modern tool for cataract surgery and orthopaedic surgery. We are reducing the reliance on local tools as we transition to the national tools.

Q.2. Who, within the DHB allocates scores?

[23] see Delivering scheduled services to patients; the Auditor- General's recommendations, 2013, *www.oag.govt.nz › 2013 publications*

A. All patients are scored by clinicians. In some specialties, this is a surgeon, but it can be another clinician with appropriate skills, training and experience, for example a Clinical Nurse Specialist. Where the scoring of a patient is not done by a surgeon the Clinical Director for that service remains responsible for the prioritisation.

Q.3. Are the tools used to decide priority such that they permit consistent and equitable access to public elective service? For instance how do DHB personnel define what a health need is? What the benefits of treatment will be to a patient's quality of life? What is a state of unreasonable distress, ill-health and/or incapacity?
A. Consistent use of national tools promotes equity of access. As described above, this is not yet universal. Health need in terms of prioritisation is a combination of the impact of the condition on the patient, and the clinician's assessment of the patient.
It is impossible to gauge in an objective way how much a particular treatment or procedure will improve the quality of life for an individual patient. The highs and lows of any particular episode of care cannot be known in advance. However, clinicians make an assessment of the potential of an individual to benefit based on the efficacy of the type of operation proposed and the individual characteristics of the patient, including things like frailty and any other illnesses. Benefit has three dimensions, likelihood, quantum and duration and forms part of the informed consent conversation with the patient.

Q.4. Is age part of the criteria?
A. Age is not an acceptable stand-alone criterion for prioritisation tools as this is prohibited under the Human Rights Act 1993, 21(1) (i). However, where there is good evidence that age affects the patient's ability to benefit in some way this may be an acceptable criterion on an ethical basis. For example, refusing diagnostic surgery, as a pre-cursor to fertility treatment to a woman aged 60, even where there might be the capacity to provide it, is ethical and non-discriminatory because there is no possibility of a beneficial outcome.
More people are receiving access to surgery and this includes people over 65 years.

Q.5. What are the incentives for DHBs to carry out a certain number of elective services?
A. District Health Boards and the Ministry agree expectations such as service provision (volumes), patient flow management (timeliness for the patient), and other indicators of service delivery at the beginning of the financial year. Performance is actively managed, with results against the Electives health target, and patient flow indicators, reported publicly. Funding is also used as a lever for performance. A proportion of funding for electives is centrally held and targeted to service areas that need it most. DHBs are paid based on delivery, and access to funding is linked to other quality measures such as waiting times. Generally, DHBs have consistently exceeded expectations in the volume of surgery delivered in recent years.

Q.6. Are the national priority tools patient-centred – do individuals & families have a part to play in health delivery decision making?
A. All of the modern national tools have a patient derived component. Patients are encouraged to accurately represent their condition and its impact on their life. Patients have an absolute right to give and withhold consent at any time, and are strongly encouraged to ask questions and seek information from any health provider.
In addition to individual decision making, patients and their families can take part in health care decision making on many levels, by participation in DHB advisory committees and consultation processes, by submissions to the health select committee and by participation in local and national election processes.
Patients may also wish to join specialty or condition specific advocacy groups, for example, The Heart Foundation, Breast Cancer Aotearoa or Diabetes NZ. These groups provide information and support to patients and their families.

Q.7. Are there any conditions that DHBs do not treat?
A. DHBs treat a wide variety of conditions across a number of specialties. However, not all conditions are treated at all DHBs e.g. neuro surgery, transplant surgery, cardiac surgery. Some services are delivered at regional centres and some are managed as National Services. There are a few services that are not provided in New Zealand and

access to these is managed centrally through the Ministry of Health, with services being provided overseas where appropriate.

Post Script: In a statement on 11th August 2015 Health Minister Coleman said the Government had lifted elective surgeries by 42 per cent from 117,954 in 2007/08, to 167,188 in 2014/15. However Surgeon and Canterbury Charity Hospital founder Phil Bagshaw has responded that the annual increases were not nearly enough to keep up with need spurred by an aging population and a huge backlog.
http://www.stuff.co.nz/national/health/71058864/elective-surgery-claims-pure-spin-surgeon-phil-bagshaw-says

8.3.2. Screening
In the last several years members have requested that Grey Power advocate for screening for prostate cancer, bowel cancer and for free mammograms to be provided for women over 70 years old therefore we asked the MoH the following questions:

Prostate Cancer Programme
Q.1. What is in place now to ensure that the aims of the AQIP have been implemented?
A. The Ministry has established the Prostate Cancer Working Group and a number of sub-groups made up of health professionals, consumer representatives (including the Prostate Cancer Foundation) and academics who, together with the Ministry, are working on implementing the actions of the Prostate Cancer Awareness and Quality Improvement Programme (AQIP). The AQIP is a four-year programme that started in July 2013. Actions completed or in development include: publishing brochures and other information for the public about prostate cancer, released guidance on using active surveillance to manage men with low-risk prostate cancer, developing management and referral guidance for primary care, design of an online decision support tool to help men to make informed decisions about prostate cancer testing and treatment, and improvements to the grading of prostate cancer specimens.

Q.2. Is there a possibility now that NZ would implement a national prostate cancer screening programme?
A. Based on existing evidence on the harms and benefits of prostate cancer testing, the Ministry does not have any plans to implement a national prostate cancer screening programme. However, the Ministry continues to monitor the research and evidence around screening for prostate cancer. The Ministry is committed to improving the quality and consistency of prostate cancer testing and treatment through the actions of the AQIP, so that men will have improved prostate cancer outcomes. This is in line with the findings of the 2011 Health Select Committee Inquiry and the 2012 Prostate Cancer Taskforce findings.

Bowel Cancer Programme
Q.1. Are there any preliminary results from the current pilot?
A. The Ministry publishes quarterly results of the pilot against the monitoring criteria on the website. You can find these results here: http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/bowel-cancer-programme/bowel-screening-pilot/bowel-screening-pilot-results
In addition, there is an external evaluation of the pilot taking place. Several reports, including an interim evaluation of Round one (the first two years) of the pilot can be found here: http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/bowel-cancer-programme/bowel-cancer-publications.

Breast Screening
Notwithstanding the contradictory stance in the current BreastScreen Aotearoa pamphlet 'Information for Women aged 70 years and over,' which states firstly that there is little evidence of benefit of screening for this group then immediately below this states 'the risk of cancer increase as you get older' a cursory google search on the benefits and disadvantages of screening for 70-74 year old women or older women found evidence of its considerable value to this cohort. For instance a study conducted in the UK and reported in the May 2010 issue of the British Journal of Cancer [24] found that as medical research advances and women are living longer and more

[24] http://www.nature.com/bjc/

healthy lives, early detection of breast cancer via mammograms mean an increased chance of early less invasive treatment and survival.

These benefits are implicit in the 2009 US Preventative Services Task Force's revised guidelines recommending biennial screening for women aged 50 to 74 years[25], the Canadian Taskforce recommendation of routine screening for women aged 70-74 years every two to three years because the benefits of mammography are likely to be similar to those seen among women aged 50-69 years [26]and in Australia where extended screening now includes women aged 70-74 years[27].

Another Australian study has found that including mammograms for women 70-79 years is relatively cost-effective similarly to screening women 40-49 years[28]. On the strength of these findings therefore it is difficult for lay people to understand why 70-74 year old women miss out on free mammograms; if risk increases with age, the assumption is that mammograms would expose cancer earlier in its development and save lives more readily.

The MoH were asked:

Q.1. What criteria are used in NZ with regard to screening to balance the costs against the benefits that it provides as it applies to 70-74 year old women

A. All screening programmes need to ensure benefits are greater than the harms before they are introduced. Any consideration given to changing the eligibility criteria (e.g. enabling women aged 70 -74 to have access to the programme) will need to examine benefits and harms of extending the age range (as the amount of over diagnosis increases as women get older), the effect on the workforce capacity, impact on coverage, as well as an analysis of the cost and benefits.

Q.2. Is age a consideration

A. Age is a key consideration when deciding to offer breast screening. Organised screening mammography has been shown to work best in women between the ages of 50 and 69, with some benefit in women aged 45-49 years.

The risk of harms from participation in a national breast screening programme increase with age, with the likelihood that a screening programme would detect cancers that would not have caused death, as older women tend to have slower growing tumours compared to younger women. Complications from treatment also increase with age. This is why at the current time the breast screening programme does not screen women over 70 years of age. As new evidence becomes available this position will continue to be reviewed.

In New Zealand, women (including those over 70 years of age) who are at high risk for breast cancer, or who have breast cancer symptoms, are eligible for publicly funded mammograms by their DHB, following a GP referral.

Q. 3. Apart from BreastScreen Aotearoa (BSA) pamplet and taking into account research by the NZ Breast Cancer Foundation that found that many older women believe that when their free mammograms cease as they are "past breast cancer" is there any other means to inform them that they are more at risk?

A. BSA is curently reviewing all resources and website information to evaluate how messages can be better communicated in relation to the benefits and harms of screening for different age groups. BSA also encourages women to talk with their GP or practice nurse about breast awareness and the risk of developing breast cancer at any age but in particular when outside of the current BSA age range.

Q.4. Various countries taskforces etc. have recommended or implemented mammograms for women 70-74, is that a possibility in NZ?

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[25] (http://pubs.rsna.org/doi/full/10.1148/radiol. RSNA Radiology – July 2010, Vol 256, Issue 1

[26] http://canadiantaskforce.ca/ctfphc-guidelines/2011-breats-cancer/?lang+en-CA/ = CMAJ, November22, 2011, 183 (17)

[27] (http://www.researchgate.net/publication/259270788_Breast_cancer_screening_of_women_aged_70-74_years_results_from_a_natural_experiment_across_Australia.

[28] Benefits, harms and costs of screening mammography in women 70 years and over: a systematic review; Barratt. A, Irwig. L, Glasziou. P, Salkeld. G and N. Houssami, MJA, Vol 176, 18 March 2002.

A. The NSU is aware of other countries working towards or actively introducing screening for women 70-74. The World Health Organisation has recently undertaken an assessment of the cancer-preventive and adverse effects (benefits and harms) of different methods of screening for breast cancer including the 70-74 year old age group. The full report will be published in November 2015. The National Screening Unit will evalulate this new evidence as it becomes available.

Q.5. What is the procedure for breast reconstruction
A. Once a woman is diagnosed with breast cancer she will be referred to a specialist for treatment. She should discuss breast reconstruction with her surgeon.

Home help:
Over the past few years Grey Power has heard stories of older people being unaware that visits from the provider of their home/personal cares were re-assessments with a subsequent cut in their assistance hours.

One such person has informed Grey Power that she believes that "the questions were couched in such a way that an unsuspecting client might wrongly give the impression that the time allotted to housework was not necessary at all." And she commented that if a person's needs are unchanged why should cuts be made with a subsequent impact on their quality of life?

This situation is unfortunate because a study on the well-being (quality of life) of older people in 2009 indicated that living in one's own home and the receipt of home-based care were part of the main-stay of well-being. [29]

Grey Power is interested in MoH comments on why some older people were unaware that they were taking part in a re-assessment visit for their home care/help.
Q.1. Does re-assessment using the formal InterRai assessment tool mean that older people's needs are consistently evaluated and that services as required by seniors are allocated fairly across the country?
A. Yes, an older person's interRAI re-assessment information is consistently evaluated; however support services available depend on where a person lives. DHBs have different arrangements for the type of support services provided, often targeting resources to meet the needs of people with high and complex needs providing both personal care and household management as opposed to providing services for household management only. Some DHBs no longer provide any support service for household management unless there accompanying need for support for personal care needs.

Q.2. Does the assessment tool include self-assessment of well-being?
A. Yes, self- assessment is a feature with a focus in the areas of self-reported health, mood and potential for physical improvement.

Q.3. Is there a standardised complaints system which includes the right to request another re-assessment?

A. Yes, the complaints management systems for needs assessment and service coordination services (NASCs) and other agencies that do assessments include the 'request a review' in the form of a face to face reassessment with a family member or support person at a time convenient. NASC processes require information to be given to older people at the original assessment about how to request a review. Older people also have the right to access all information arising from their assessment and care plan. Privacy and confidentiality is respected at all times. If these steps don't resolve concerns, then people should be encouraged to contact either the NASC manager or DHB portfolio manager or the Health and Disability Commissioner.

Q. 4. Is information on the assessment process readily available to older people?
A. It is a requirement for the Ministry of Health's booklet 'Needs Assessment and Support Services for Older People – what you need to know' is provided to people either at the time of making an appointment or with the appointment confirmation. A copy is attached; it is also available via

[29] www.familycentre.org.nz/Publications/index.html - ***Koopman-Boyden***, P and ***Waldegrave***, C (Eds) (***2009***) "Enhancing Wellbeing in an Ageing Society: 65 - 84 year old New Zealanders in 2007" EWAS Monograph)

http://www.health.govt.nz/publication/needs-assessment-and-support-services-older-people-what-you-need-know

Q. 5. Who carries out reassessments?

A. This is an important role for health professionals, (e.g. registered nurses, social workers, occupational therapist and physiotherapists) trained as interRAI assessors. Assessors can be from either a NASC agency or a home and community support services provider.

Q. 6. If a persons' health situation is unchanged why a re-assessment, in some cases, results in a reduction of home-help/care hours occur?

A. The reasons for a re-assessment should be fully explained to the person before the reassessment takes place and documented in the persons support/care plan at the time of the original assessment.

There are a range of different types of home and community support services for older people, sometimes for example, a support package is provided at a higher level with the intention that it is lowered by a certain time. DHB NASC processes require a review to ensure that support needs have stayed the same and that the supports allocated are appropriate to meet those needs. Again it is important the older person is clear about the purpose of the reassessment and their rights to have its outcome reviewed.

Travel reimbursement of the cost of travelling to hospital was also discussed:
The Guide to the National Travel Assistance (NTA) Policy, provides guidance to the District Health Boards (DHBs), people who are referred long distances and/or frequently for specialist health and disability services, and other interested parties on aspects of the National Travel Assistance (NTA) Policy 2005 that require clarification. The guide is updated from time to time by NTA reference group to ensure that DHBs are involved with the development of claims management business rules, and ongoing management of NTA claims and policy issues. (There is no work occurring at the moment to review the National Travel Assistance policy or guide and yes any change to the policy would need to be authorised by the Minister, however the policy is supported by guidelines and not fixed rules).

The guiding principle behind the NTA scheme is to assist with equitable access to publicly funded specialist health and disability services for all New Zealanders.
It has been recognised that the cost burden of travel is often beyond the means of those who must travel long distances and/or frequently for treatment. The Ministry and the DHBs developed the NTA scheme to provide some financial assistance to those New Zealanders who may find it difficult to access specialist health and disability services without such assistance.
The DHBs fund the NTA, and for claims management purposes, the Ministry's NTA payment team provide the national administration system, which includes registrations and claims payments.
Holding a Super Gold Card does not provide a person with any additional NTA benefits above those they are already entitled to under the Scheme.
Eligibility Criteria for NTA
If a client answers 'yes' to any of the four questions listed below and they have been referred for NTA by a publicly funded health or disability specialist (not their GP or another primary health care provider or a private specialist), they are eligible to claim travel assistance under the NTA scheme.
Do they travel per visit: (child under 18) over 80 kilometres or more one way? (adult) over 350 kilometres or more one way?
Do they (adult or child under 18) attend more than 22 visits in two months?
Do they attend more than five visits in six months, and travel per visit: (child under 18) over 25 kilometres or more one way? (adult) over 50 kilometres or more one way?
Do they hold a Community Services Card and travel per visit: (child under 18) over 25 kilometres or more one way? (adult) over 80 kilometres or more one way.

(Please note that the answers in this section of the report are verbatim from the MoH with grateful thanks to Jill Lane and her team.)