THE FULL REPORT OF THE GREY POWER NEW ZEALAND FEDERATION INC. LOBBY VISIT TO WELLINGTON, MARCH 21ST – 23RD & APRIL 11TH 2017

▶ **The Objective of the Meetings was 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 lobby trip or which are on-going;
- request politicians and others to follow up on promised action from the previous lobby visit where applicable.

▶ **The core lobby team consisted of:** Tom O'Connor, (Grey Power Federation President & Advocacy Standing Committee co-chair), Mac Welch (Grey Power Federation Vice-President) and Jan Pentecost, (Grey Power Advocacy Standing Committee co-chair & National secretary).

Jo Millar (Health National Advisory Group chair), R. Reid (Treasurer & Aged Care/Retirement Villages National Advisory Group chair) and V. McCowatt (Social Services National Advisory Group chair) attended the meetings relevant to their National Advisory Group.

1. **MEETING WITH THE RT HON WINSTON PETERS –** discussion centred on:

▶**Seniors' healthcare** and as a result NZ First MP Barbara Stewart has re-submitted the Affordable Healthcare Bill which includes the SuperGold Health Insurance Rebate policy. The 3 components of the omnibus bill are;

1. SuperGold Health Insurance Rebate
2. Parent Migrants required to take out 10 years' health insurance
3. Abolish fringe benefit tax on health insurance

NZ First's Affordable Healthcare Bill was first read in parliament on 11 November 2015 and voted down by National and its support parties.

▶ **NZ Superannuation** -Grey Power were told that Winston is the only current party leader who has consistently said that superannuation must remain a universal entitlement at age 65 with no means-testing; this is also Grey Power policy. And that NZ First was the first party to advocate for increasing the residency requirement in NZ from the current 10 years to 25 years.

▶**Housing affordability**, Winston is also the only party leader who has consistently promoted restricting the massive increase in immigration and foreign purchase of NZ property and land largely responsible for pricing first home buyers off the property market.

Grey Power's gain was the information that the senior's healthcare bill had been re-submitted and that Grey Power's superannuation policy coincided with NZ First's

2. **MEETING WITH GRANT ROBERTSON – LABOUR FINANCE SPOKESPERSON –**

▶ **Superannuation** - discussion occurred on NZ superannuation as a permanent institution – Labour are concerned that currently there are no contributions to the NZ Super fund – they would re-start this but cannot commit to increasing the rate of contribution – they would invest more of the fund in NZ small businesses and suggested a dedicated percentage of investment – the Singapore system was mentioned as an example to emulate.

▶ **Taxation** – the system required would fund superannuation

– corporation tax – government has proposed interest limitation and Labour agree with this. The problem is that whatever tactics governments come up with to re-coup corporate taxes, people create answers to get around them – part of the story is to have global rules.

▶**KiwiSaver** – Labour have not finalised their policy yet on the kickstart amount but this scheme does create a valuable culture of saving – problems are that people are taking hardship payments holidays and although the default mechanism permits people to get into their own houses superannuation is compromised. KiwiSaver is a barometer of hardship.

▶**Financial Transaction Tax** – if Labour becomes government it will establish a tax working group which will canvass all ideas and explore all options based on finding a tax system that is fair, simple and able to be collected. Collective bargaining needs to be strengthened and the minimum wage will be lifted progressively.

Grey Power's gain was knowledge of possible Labour policy on the above issues.

3. MEETING WITH RUTH DYSON – LABOUR SENIORS SPOKESPERSON – discussion focussed on:
3.1 The closure of MSD offices – Although Grey Power understands that at the present time only a few offices have closed we are concerned for those older people affected by these closures and that this will be the beginning of more closures.

It appears that service agencies are being closed all over New Zealand which causes hardship for many older people. As an example; research undertaken by a Grey Power association found that in one town, 16 service agencies such as Life-Line etc. have been either lost or reduced.

The potential impact of office closures on older people include:

▶ The difficulty, for many senior people, of carrying out MSD business. How can they if they don't own a computer and are unable the internet.

▶ Intermittent cell phone or internet coverage or no coverage at all in various rural areas plus difficulty for older people who do not have either a land line or mobile phone.

▶ Travel to the nearest MSD office following closure may be beyond the capability of older people (they do not drive anymore) and those on low incomes

The combined impact of losses from closures or reduced services e.g. difficulties of access and long waiting times for the MSD office phone to be answered or appointments dates from service agencies is detrimental to the well-being of many older people.

4. **AGED CARE** – Separate meetings with Barry Coates (Greens) Ruth Dyson (Labour Senior spokesperson) & Maggie Barry (Min of Seniors) occurred.

4.1 Issue – Elder abuse and the possibility of an extension of Child, Youth and Family legislation to include abused older people and housing for older people especially for those who need to leave home because of elder abuse

Grey Power policy - To work to ensure the safety and well-being of all older people in care, whether in their own homes or in care facilities. And the housing policy states that there is no emergency housing available for seniors who are being abused, neglected or suffering mental or physical health problems. (Seniors do not qualify for Women's Refuge nor can they gain priority at HNZ and will generally be behind the queue of families waiting for housing);

Background - Elder abuse research commissioned by the Office of Seniors found that the majority of research participants did not experience abuse. However, around one in ten did

report some form of abuse and between 2 and 3 percent reported being forced to do things they didn't want to do, were afraid of someone in their family, and had someone close to them try and hurt or harm them recently. [1]

It is important to note two issues here:

- an ageing population means the numbers of older people being abused will increase exponentially. The projections disclose that abuse numbers will almost double in the next 20 years.
- the projections can be expected to underestimate the actual prevalence of elder abuse because it is often hidden, shameful and older people may wish to avoid jeopardising relationships they depend on.

Age Concern's Elder Abuse and Neglect Prevention Service (EANPS) receive over 1,000 referrals about people who may be facing elder abuse or neglect.[2] This is about 4 referrals every day. They also say that they are aware that reported abuse does not reflect the whole size of the problem as the research above mentioned. International research shows that only a small proportion of the elder abuse incidents come to the attention of an agency that can be of assistance.[3]

Of interest, 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.[4]

Consequently, Grey Power policy exhorts us to ensure the well-being of older people today and in the future and we requested that the Children, Young Persons, and Their Families Act 1989 be amended to include assistance for abused older people. The act runs to some 360 pages but a quick skim discloses that some of the same principles could be applied to elder abuse.

Examples in the Act are:

Part 1 General objects, principles, and duties

General objects

4 Objects

The object of this Act is to promote the well-being of children, young persons, and their families, ~~and~~ family groups, (including older persons) by—

(a) establishing and promoting, and assisting in the establishment and promotion, of services and facilities within the community that will advance the well-being of children, young persons, and their families and family groups (including older persons)

Under Part 2 Part 2 Care and protection of children and young persons:

Definition of child or young person (and older persons) in need of care or protection

[1] http://www.msd.govt.nz/documents/about-msd-and-our-work/about-msd/our-structure/osc/elder-abuse-summary-report.pdf
[2] Age Concern New Zealand, World Elder Abuse Awareness Day, 15 June 2012
[3] National Centre on Elder Abuse USA, Iceberg Theory of Elder Abuse: The National Elder Abuse Incidence Study, 1998
[4] Davey J, and McKendry J, Financial Abuse of Older People in New Zealand, A Working Paper, November 2011, p8

(1) A child or young (and older) person is in need of care or protection within the meaning of this Part if—

(a) the child or young (and older) person is being, or is likely to be, harmed (whether physically or emotionally or sexually), ill-treated, abused, or seriously deprived; or the child's or young person's (or older person's) development or physical or mental or emotional well-being is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable;

Financial matters

387 The Chief executive is empowered to make payments for benefit of children and young persons – no govt. funding that we are aware of, is provided for older people and the act provides safe places for children to live but there appears to be a lack of safe houses for older people.

Recommendation:

Grey Power recommends, as part of its policy re elder abuse by families, caregivers and other responsible persons, and because abuse of older people is predicted to rise exponentially that a first step would be a commitment to amending legislation to provide protection and financial assistance, including provision of safe houses.

Minister Barry informed Grey Power that this will be reconfigured later this year; part of the work being done is to institute a holistic approach across all the govt. departments, NGOs etc. that deal with this based on the 'social investment' approach – further information re this will be announced soon.

4.2 Lack of adequate communication in the Far North – The people of the Far North feel neglected when it comes to communication technology because of:

- Lack of reliable mobile phone coverage with none at all in some areas – this means that older persons' emergency services find it difficult to locate and communicate with people in need – medical alarm systems also need reliable phone connections
- Lack of low cost Broadband internet – many older people in the Far North live in remote communities – the internet would allow them to access G. Ps, counsellors and other specialists on line and telehealth services would allow people to take more control over their own health and well-being.
- Communication barriers mean that people cannot keep in touch with family and friends which lends itself to mental and emotional stress of loneliness (social isolation)

Minister Barry said that this issue falls within MBIE – they will be contacted re this.

5. MEETING WITH HON MAGGIE BARRY (MINISTER OF SENIORS) – the following issues were discussed and responses were supplied to the Grey Power Federation annual general (AGM) meeting:

5.1 SuperGold card off-peak travel = a smartcard – the Minister is still working on this. She said "I've been talking to Tom and Jan and your GP executive for the past 18 months or so about making the card even more useful and transforming it into a smart card with a chip so it can be used all over the country. We've been having productive discussions with NZTA and the regional and city councils and we are making good progress towards a secure smart gold card and I'm confident we will get there soon but the technology is complex and I don't want there to be any hiccups and we have to get it right so we're going through it carefully and I hope to announce it's do-able in the next few months." (AGM speech)

5.2 SuperGold card ID options **–** the Minister has asked banks to find ID options that are simple and straightforward while still being legally secure. She said "I'm pleased to say that four out of the six banks will accept expired passports and drivers licences as evidence of identity for people 65+.

As well, the SGC is generally accepted as secondary ID if it has a photo on it and you can have one added free of charge by going to your nearest AA centre. I have written to the Banking Ombudsman, Nicola Sladden, to ask that the SGC be accepted as a legitimate form of ID." (AGM speech)

The Minister also told the lobby team, that under their code of practice banks must have other options available for customers who can't provide suitable photo ID. If you find yourself in this position talk to your bank manager or personal banker to see how they can help.

Ministry of Social Development have confirmed that Seniors can use their SuperGold Card (with or without a photo) as ID to show Work and Income security guards.

5.3 New Zealand birth certificates can be used as official ID for most things and you can get a new copy of yours for $26.50 by applying online at www.bdmonline.dia.govt.nz/ or over the phone by calling 0800 225 252 within NZ - and you can pay by credit or debit card. You may need a new copy rather than the one you have at home because the newer birth certificates, issued or reprinted after January 1 1998, carry a unique ID number while older one's don't. Some businesses may not accept a birth certificate without that ID number. (Information provided by the Minister's Office).

5.4 The closures of WINZ offices was also discussed with Minister Barry.

The potential impact on older people:

▶ Many senior people can't, (because they don't own a computer) or won't use internet to carry out MSD business

▶ Some rural areas only have intermittent cell phone or internet coverage or no coverage at all and some older people do not have a phone either land line or mobile

▶ Travel to the nearest MSD office may be beyond the capability of older people (they do not drive anymore) and those on low incomes

▶ The combined impact of losses from closures or reduced services e.g. difficulties of access and long waiting times for the MSD office phone to be answered or appointments dates from service agencies is detrimental to the well-being of many older people.

The Minister's response was that this is the responsibility of Minister Anne Tolley. Therefore, she will be approached for information etc.

5.5 Increasing to superannuation receipt eligibility age:

Grey Power asked 3 questions -

Q. 1. New Zealand can afford the cost of NZS so why raise the age of entitlement?
A. From Minister Barry's office "NZS costs are currently relatively affordable by international standards. Last year the NZS scheme cost 4.8 percent of GDP before tax, which compares to an average of 9 percent of GDP across the OECD. However, with the increasing proportion of the population aged over 65, the cost is projected to rise to 8.4 percent of GDP 2060. While this may still be affordable, the ageing population is also

placing pressure on other resources. Assuming that economic growth remains within forecast parameters, meeting the future challenge of NZS and health expenditure would require trade-offs, either restricting spending increases in areas like health and education, increasing taxes or running significant deficits, or some combination of these.

The Government is announcing the change now so that political parties can debate superannuation transparently in the lead-up to the election."

Grey Power's stance is that research discloses that NZ's superannuation scheme is affordable, for example read the file:///E:/Allianz_2016_Pension_Sustainability_Index.pdf

Q.2 People who are 65 and unable to work should not have to go on a benefit. How will the government manage this issue?
A. "Not everyone will be able to work up until 67. The Government has committed to a review in 2030 to look at the expected impact on different groups as a result of a change in the age of eligibility for NZS. (Minister's office)

The review will look at the latest trends in employment and longevity at that time, to ensure the impacts of disadvantaged groups are fully understood and to consider whether any temporary additional support is need for those unable to work beyond 65. As health and life expectancy continue to rise, older people will be better placed to provide for their financial security.

The Government has proposed that the qualifying age for accessing KiwiSaver funds will remain at 65 years, this will provide more options for many people making the transition from work to retirement.

There will always be people who are unable to work (at any age) due to health or other reasons. The Government provides a range of social security benefits and extra financial assistance to those who meet the criteria.

At present, around 9.6 percent of people aged 60-64 (the age group immediately below the current age of eligibility) receive a benefit because their ability to work is affected by a health condition or disability. Many of this group have been on a benefit for a long time. By comparison, 7.8 percent of people aged 55-59 are on a health-related benefit.

Māori and Pacific people have a lower life expectancy than the general population so spend a reduced period in receipt of NZS. The current age of eligibility for NZS already impacts on different ethnic groups in different ways.

Māori and Pacific life expectancy has continued to improve and the gap between Māori and non-Māori life expectancy has narrowed in recent years and is expected to continue to narrow over the next twenty years."

Grey Power's stance is that if the age of superannuation receipt does rise, people who have worked hard in labour intensive employment will be subject to punitive WINZ policies which underpin the benefit system and which have been described in fairly gruesome terms by many.[5]

Q.3 How can Grey Power have a voice in the proposed changes?
A. As a major stakeholder the Grey Power Federation will be consulted as part of the policy development and legislative process. This may include:

- being part of focus groups

[5] http://www.stuff.co.nz/the-press/news/68162272/beneficiaries-scared-stiff-of-work-and-income, https://www.theguardian.com/world/2014/jun/03/dont-copy-our-welfare-cuts-new-zealand-experts-warn-australia plus many personal stories

- being part of reference groups
- discussions with the Grey Power Federation executive through the regular meetings with Ministers and the Ministry of Social Development.
- public consultation meetings
- written and oral submissions.

Grey Power's gain –was information and the knowledge that the Minister was looking at these issues and will keep us informed of progress.

Raising the age of eligibility for receipt of superannuation raises concerns for Grey Power because we want to ensure that universal, non-means tested superannuation payable at age 65 years will be available for coming generations i.e. our children, grandchildren and great-grandchildren

6. **MEETING WITH THE LABOUR HOUSING SPOKESPERSON PHIL TWYFORD** – a briefing paper re possible Labour policy was discussed and Grey Power's gain was, because it agreed substantially with Labour's housing ideas, to receive and accept the opportunity to work with Labour on affordable housing; - more information will be forthcoming.

7. **MEETING WITH BARRY COATES (NZ GREEN PARTY SENIOR CITIZENS SPOKESPERSON)** – the issues discussed were:

7.1 Housing for older people especially for those who need to leave home because of elder abuse – the focus during the meeting was on Grey Power's policy to advocate for an independent aged care commissioner- Barry was interested in the mechanisms to make an aged care commissioner's position work – in other words how would the system work – a reply from Grey Power was sent to him based on the discussion paper commissioned in 2013 by the New Zealand Aged Care Association (NZACA) and Grey Power to initiate discussion with key stakeholders in the Aged Care sector. (see https://nzaca.org.nz/publications/documents/)

7.2 The closure of WINZ offices- Barry offered to produce a parliamentary question on this

Grey Power's gain was the opportunity to supply information on these issues to the Green Party and to receive an undertaking of action on issue 2.

8. MEETING WITH THE MINISTRY OF HEALTH (MoH) – the discussions centred mainly on 2016 Grey Power Federation annual general meeting remits.

8.1 Older people's oral health – the Federation asked that the cost of dental care be included within state-funded provision as directed by AGM remit 2016 '*That the AGM direct the Federation to advocate for the cost of dental care to be included within state funded provision.'*

Explanation

The incidence of necessary on-going dental care in adulthood and old age is increasing as the cohort growing up between the common practice of tooth removal as a prophylactic and the introduction of fluoridation, ages. At the same time, the cost of dental care continues to increase at a rate greater than inflation, making it price prohibitive for an increasing number of people.

Background:
Grey Power has requested politicians to consider state funding of oral health on several occasions – the case we have put is as follows:

Aim: to improve vulnerable older people's oral healthcare by making treatment more affordable.

Objectives:

Long Term Goal: To obtain free dental care for older people (the big idea).

Short Term Goal**:** To obtain subsidised dental care for older people with community service cards. This is considered achievable in the short term

Research from Ministry of Health data and newspaper articles has disclosed that although mobility problems, cognitive decline and the lack of training in geriatric dentistry may be negative factors in older people's access to effective oral health care, unaffordable dental care is a wide-spread problem for many older people. 75% of over 65 - year olds list NZ superannuation as their only source of income; consequently, this makes the costs of dental care prohibitive for many[6].

This is costly economically and socially for the govt. because much existing evidence discloses a strong correlation between poor oral health and other conditions such as respiratory conditions and cardiovascular disease. Hence "Older people's quality of life can ... be substantially affected by poor oral health."[7]

Therefore, there is an urgent need to implement policy aimed at providing affordable and accessible oral health care to vulnerable older people. A 2011 estimate discloses that it would cost approximately $1 billion for a universal free dental care system[8]. However, it should be considerably less expensive to provide subsidised oral health care for older people with community service cards. In fact, it is likely that it costs more for Vote: Health to treat medical conditions associated with poor oral health than to subsidise dental care costs.

Recommendations:

▶ Grey Power recommends that as part of a commitment to improving oral health progressive implementation beginning with subsidised dental care for older people who hold community service cards be initiated by the government as was discussed in the 2006 Strategic Vision for Oral Health in New Zealand which comments that its overall objective was to eliminate oral health inequalities[9]

▶ Grey Power also recommends that primary health care and oral health care should be integrated to reduce the barriers in accessing oral health care faced by older adults from the lower socioeconomic cohort.[10]

▶ Grey Power strongly suggests that the government adopt a national oral health strategy which includes policy aimed at assisting older people maintain good oral health

The MoH supplied the following information

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[6] A Progressive Dental Health Policy 2011
[7] Lynne Giddings, Barbara McKenzie-Green, Linda Buttle & and Keita Tahana; *Oral healthcare for older people 'I can't afford not to go to the dentist, but can I afford it?' NZMJ*
URL: http://www.nzma.org.nz/journal/122-1301:ISSN1175 8716
[8] Scoop; June 22 2011
URL http://www.scoop.co.nz/stories/PA1106/S00376/a_progressive-dental-care-health-policy-for-all-new-zealanders.
[9] Good Oral Health for All, for Life *The Strategic Vision for Oral Health in New Zealand*, Ministry of Health, August 2006.
[10] Santosh Jatrana, Peter Crampton and Sara Filoche, *The case for integrating oral health into primary health care, NZMJ* http://www.nzma.org.nz/journal/122-1301:ISSN1175 8716

The *New Zealand Oral Health Survey* (2009), *New Zealand Older People's Oral Health Survey* (2012), and *New Zealand Health Survey* (2014/15) have found:

- relatively high rates of oral disease and unmet need for dental care amongst older people
- older people who visited dental professionals for regular check-ups had significantly more sound teeth than those who visited a dental professional only for a dental problem
- older adults who had seen a dental professional in the previous 12 months had better oral health over almost all of the survey indicators
- the majority of older adults usually visited a dental professional only when they had a problem, rather than for routine dental check-ups
- significant ethnic, socio-economic, location and dependency-related disparities in oral health and care.

Publicly funded oral health services

Generally, publicly funded dental services are available to children and adolescents up to their 18th birthday, while adults are responsible for meeting the costs of their own dental care. The priority is to improve the oral health of children and adolescents, through prevention, education, early intervention and treatment. There is good evidence to demonstrate that establishing regular dental habits early in life and intervening early to prevent and treat decay have benefits that last a lifetime.

Some emergency dental care is funded by district health boards for low-income adults for relief of pain and treatment of infection, and hospital dental services are available for special needs patients, and hospital inpatients for specific purposes.

DHBs currently spend around $198.5 million each year on oral health services, of which approximately $144 million is for child and adolescent oral health services, $46 million is for hospital dental services, and $8.5 million is spent on emergency dental care for relief of pain and treatment of infection for low income adults (i.e. with Community Services Cards).

Work and Income New Zealand (WINZ) also funds essential dental treatment (a maximum of $300 per person per annum through Special Needs Grants) for low-income adults, also for relief of pain or treatment of infection. These grants do not cover preventive or maintenance oral health care for adults.

There is no current policy to extend additional public funding of dental care to older people or adults generally.

The Government has agreed to the Healthy Ageing Strategy (HAS), released in December 2016. Its vision is that "older people live well, age well, and have a respectful end of life in age-friendly communities", and it seeks to maximise the health and well-being of older people. The priority actions relevant to older people's oral health are as follows:

14(a) Develop clinical pathways for optimal dental care throughout ageing and into the end of life, to maintain independence and minimise pain.

14(b) Identify and promote innovative care arrangements for the oral health care of older people receiving home and community support services and living in aged residential care.

14(c) Disseminate updated information and advice on dental care to older people, family and carers in communities, and aged care organisations.

In relation to the last priority area, it is notable that since 2010, the Ministry has funded the New Zealand Dental Association to deliver a programme of workshops (*Healthy Mouth, Healthy Ageing*) that provides oral health training for older people's carers.

8.2 The following was in response to Grey Power's question asked last year on <u>the number of people who do not turn up for elective surgery procedures</u>

- The Ministry does not collect information on the number of people who do not turn up for elective surgery procedures, or 'Did not Attends' (DNAs)

- DNAs more frequently impact on outpatient appointments rather than the surgical procedures
- Most DHBs capture this information at a local level, and it is widely recognised as an area of focus for reducing wastage from an operational and financial point of view, but also for improving equity of access, with DHBs citing that Maori and Pacific patients are more likely to not attend than other groups
- A number of DHBs have made this an area of priority for local focus. For example, Waitemata DHB completed a service improvement initiative in 2014 called 'Breaking the DNA Cycle' which focused on working with GPs and GP practices associated with high DNA numbers, negotiating dates that suit both patients and staff, enabling patients to book appointments using their own language, reviewing the reminder system, and allowing patients for contact the hospital outside of office hours
- Other DHBs, such as Lakes DHB, have made this an area of priority and are actively focused on plans to reduce DNA rates
- The Ministry and DHBs are implementing a new national collection - National Patient Flow – which, once in fully implemented, will collect information on the number of patients who do not attend their scheduled appointments

8.3 Grey Power requested, because of a 2016 AGM that <u>GST be removed from the costs of elective surgery for those who fund their own procedures because of problems regarding waiting lists</u>

The MoH responded that "*The Ministry has no influence over the cost of elective surgery that is self-funded through private providers.*" However:

- Reducing waiting times for elective services remains a priority
- Between 2011 to 2014 there was a dedicated programme to incrementally reduce the maximum waiting time for first specialist assessment and elective treatment. Since January 2015, the maximum waiting time has been four months, and DHBs remain focused on achieving this goal
- While four months is the maximum, DHBs are focusing on treating patients in line with their clinical need, with more urgent patients having shorter clinically appropriate waiting times
- The average waiting time between a patient being accepted for elective surgery and being treated has reduced from 71.5 days in to 2008 down to 57.7 days in 2016
- New Zealand will always have more patients than our publicly funded non-urgent medical and surgical services can cope with at any one time. This has always been the case, and public health systems internationally face a similar challenge
- The Government's approach to address ongoing demand has been to focus on:
    - Increasing access to elective services (including First Specialist Assessment (FSA) and treatment)
    - Supporting DHBs to provide elective care within expected timeframes
    - Improving equity of access – through consistent implementation of clinical prioritisation tools, and increasing access in line with population share
    - Streamlining pathways and processes
- This approach means that more New Zealanders are accessing elective care, faster. Between 2008 and 2016 the number of FSA provided each year has increased from 404,511 to 552,423 – an increase of 37 percent, and an average increase of over 18,000 additional people receiving an FSA each year
- Similarly, between 2008 and 2016 the number of elective surgical discharges delivered has increased from 122,828 to 172,153, an increase of 40 percent, and an average increase of over 6,000 per year. This increase is keeping ahead of population growth. The greatest increase over this period was for the over 65-year-old group, with delivery increasing 60% between 2008 and 2016
- *Orthopaedics:* The number of patients over 65 years who have received an Orthopaedic procedure has increased by 30% over the same time period to 11,114 in 2016 compared to 8,543 in 2008

- *Major Joints (all admission types):* The number of patients over 65 years who have received a Major Joint procedure has increased by 31% to 3,598 in 2016 up from 2,751 in 2008

8.4 Grey Power also requested during its November lobby visit that the Minister of Health's office provide answers to the following questions:
▶ which measures are in place to ensure the health system makes the best use of the limited health care resources so that those in most need receive the timely, equitable medical treatment they require?
▶ does the cost of delayed elective medical treatment for older people outweigh the costs of the household help, accidents because of physical impairment etc.?
▶ what does the use of nationally recognised priority tools mean in practice? Does their use mean that people are assessed consistently and equitably across New Zealand given that DHBs are required to have nationally recognised priority tools in place to make sure the decision-making process is clear and fair[11]?

So far answers have not been forthcoming.

8.5 The 2016 AGM requested that Grey Power lobby for antibiotic resistance to become a national health priority – MoH responded that they are working on an action plan for release later this year in response to the WHO resolution on AMR. It will cover the key actions of improved prescriber and consumer education, improved surveillance and monitoring, better reporting of resistance and controls over access and use where practical. The action plan will cover human, agricultural and horticultural use of antimicrobials.

8.6 The same as above, this was a 2016 AGM issue re international standards re receipt of specimens at microbiology labs and the possibility of all hospitals maintaining a full, not for profit, laboratory for the protection of diagnostic medicine

The MoH replied that hospitals provide laboratory services, either through an internal laboratory provider or through external contracting arrangements with a private laboratory provider. Regardless of how laboratory services are provided, laboratories are subject to accreditation standards i.e. by International Accreditation New Zealand (IANZ). Any organisation holding IANZ accreditation can have confidence in its processes and thereby provide assurance to its customers and clients that international standards are being met.

IANZ is a full signatory member of the International Laboratory Accreditation Cooperation (ILAC) and the regional body, Asia Pacific Laboratory Accreditation Cooperation (APLAC).

Reports from IANZ accredited laboratories and inspection bodies are recognised throughout the world by regulators in countries where accreditation authorities are signatories to the ILAC or APLAC Mutual
Recognition Arrangements (MRA). Accreditation authorities in over 65 countries currently participate in the Arrangement. The Arrangement ensures test, calibration and inspection reports from IANZ accredited organisations meet the required international standards and avoids the need for expensive re-testing and recertification. In turn, accredited reports from these other countries are recognised in New Zealand.

Accreditation means formal recognition that an organisation has been independently assessed by an authoritative accreditation body in five key areas:

- Competence and experience of staff

[11] (https://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services/questions-andanswers-elective-services#5)

- Integrity and traceability of equipment and materials
- Technical validity of methods
- Validity and suitability of results
- Compliance with appropriate management systems standards and found to be competent to carry out its services in a professional, reliable and efficient manner

Laboratory accreditation

Laboratory accreditation is to the international standard NZS ISO/IEC 17025 General Requirements for the Competence of Testing and Calibration Laboratories or ISO 15189 Medical laboratories — Requirements for quality and competence.

IANZ Accreditation is applicable to all organisations providing medical examinations, including community laboratories and those in the public hospital system. With accreditation, medical laboratories receive formal recognition of the organisation's technical competency after assessment of their processes, resources, facilities, staff and other key factors and skills which relate to, and impact on the quality of the service provided.

Most medical testing laboratories in the private sector and in hospitals around the country are accredited by IANZ, giving assurance that tests essential for human health are carried out accurately and competently.

Bodies engaged in the recognition of the competence of medical laboratories will also be able to use this Standard as the basis for their activities. Demonstrated conformity to this Standard does imply conformity of the quality management system within which the laboratory operates to all the requirements of ISO 9001. This International Standard is not intended to be used for the purposes of certification.

General Accreditation- ISO 15189 Medical laboratories — Requirements for quality and competence. This standard is based upon ISO/IEC 17025 and ISO 9001.

Specific Accreditation- The scopes of accreditation for medical laboratories are, in general, classified according to disciplines of pathology. These general classes include microbiology, as well as other areas such as biochemistry, cytology, haematology and histology.

8.7 Hearing Aids

1. Eligible people may access Ministry of Health funding towards the hearing aid(s) recommended for them by a member of the New Zealand Audiological Society.
2. Funding is allocated through two new funding streams which are set out in the Hearing Aid Services Notice 2011 (issued under Section 88 of the New Zealand Public Health and Disability Act 2000).
3. Under the Hearing Aid Funding Scheme all children who have a hearing loss, adults who have had severe hearing loss since childhood or have a dual disability (such as hearing loss and a severe visual impairment), and adults who hold a Community Services Card and are working (including seeking work), studying or caring for a dependent person, are able to receive fully funded hearing aids once for each ear within a six-year period. This funding covers the cost of the actual hearing aids; it does not include the cost of any audiology services received in the public or private sector.
4. Under the Hearing Aid Subsidy Scheme all adults who have a hearing loss which is not covered by the Hearing Aid Funding Scheme above, or any other government funding schemes, are able to receive a subsidy valued at $511.11 (incl. GST) towards a hearing aid for each ear once in a six year period.
5. There is increasing demand on the subsidy scheme with growing demand from over 65s accessing the subsidy.

6. DSS allocates a budget of $17 million annually to provide funding for both hearing aid schemes and for repairs to hearing aids (for adults) provided through the Hearing Aid Funding Scheme.
7. The Ministry funds an additional $5 million a year under the ACC hearing loss regulations through a joint funding memorandum of understanding with ACC for those eligible adults who have both non-injury related and injury-related hearing loss.

Guide to getting hearing aids subsidy

http://www.health.govt.nz/system/files/documents/publications/guide-to-getting-hearing-aids-hearing-aid-subsidy-scheme.pdf

8.8 Subsidy for Incontinence products?

Information provided on the Continence NZ website - urinary incontinence has recently been identified by the World Health Organisation as a major health issue in developed and developing nations. Based on population estimates from the 2013 Census over 175,000 women have bothersome urinary incontinence. The prevalence is even higher in adult Maori women at 47%. A small proportion of adult men have urinary incontinence but this still represents 47,000 people. The same census also discloses that over 45,000 New Zealanders over the age of 65 have severe urinary incontinence.

The web-site points out that urinary incontinence is not a lethal condition but it is strongly associated with poor quality of life and self- esteem, social isolation and depression.[12]

MoH response:
Incontinence products are considered by a DHB incontinence nurse specialist.

The national guideline provides for up to four pads a day funded through community nursing services. Individual needs and circumstances are considered by DHBs on a case by case basis. That means DHBs are able to provide more if required and agreed with the person. There are no plans for a subsidy at this stage.

8.9 GP referral of patients to private Occupational Therapists to make decisions (instead of the GP making the decision) about the person's ability to continue driving and that it can cost patients $750.00.
MoH response:
We have not heard that this is a broader issue. We do know the guidelines (see below link) which allow the GP to refer to OTs if they are not sure whether their patient is medically fit to drive.
https://www.nzta.govt.nz/driver-licences/getting-a-licence/medical-requirements/occupational-therapy-assessments/
What happens? You have to complete a medical declaration when you complete any driver licence application form. This asks you to declare any conditions that may affect your ability to drive safely, including diabetes, locomotive joint or limb problems, strokes, nervous or mental disorders, high blood pressure, seizures, fits, convulsions, epilepsy, serious injuries (e.g. head or spinal injuries),visual disturbances (e.g. cataracts, double vision, glaucoma), cerebral vascular accidents/disease, cognitive impairment or

[12] http://www.continence.org.nz/pages/Incontinence-Everyones-Problem/57/

any other condition that may affect your ability to drive safely, including fatigue, disabilities and conditions such as dementia.

The certificate must be no more than 60 days old and either state that you are safe to drive, or set out the conditions under which you can drive safely.

Sometimes an occupational therapist check is required where a doctor has concerns over whether you're medically fit to drive the classes or endorsements you're applying for.

This assessment involves an approximately two-hour off-road assessment, which may be followed by a 50–60-minute on-road assessment. The therapist then sends a report back to your doctor.

When issuing your medical certificate, your doctor will take the therapist's report into consideration – for example they may recommend you only drive vehicles with an automatic transmission

You are responsible for the cost of getting your certificate. The cost varies from doctor to doctor.

(Sourced from http://www.nzta.govt.nz/searchresults?section=&licence=&term=renewing+driving+licence+for+over+75+yr+olds)

8.10 Bowel Screening – Grey Power asked why was the national bowel screening roll-out not started in Southland which has the highest bowel cancer rate in NZ?
We were informed that the roll-out of national screening depends on whether a region has adequate workforce, facilities and colonoscopy back-up

8.11 Cataracts and other eye issues– the aim is to up-skill nurses and other back-up staff to do injections etc. which would leave surgeons to only do the surgery.

Grey Power's gain – was that the MoH provided an enormous amount of information (for which we thank them) and that some of the issues such as antibiotic resistance are, or will be, resolved. However, problems such as the unaffordability of dental care for older persons or limited funding for hearing aids are unlikely to be on the Ministry's agenda

9. PHARMAC

9.1 The shingles vaccine,

Grey Power has no specific policy regarding this issue and had also already approached Pharmac re this

Background - Grey Power Rotorua has requested that we lobby Pharmac to provide free shingles vaccine for all CSC holders. Advancing age is the main risk factor. The best defence is vaccination which currently costs about $200 from a doctor and at this time is available to those over 50[13]

For those who are unaware, shingles:

- Is caused by the same virus responsible for chicken pox
- Is reactivated when this virus which has remained dormant in the spinal cord is rejuvenated
- Is reactivated when the immune system is weakened e.g. a result of growing older

[13] Fuatai. T; *shingles risk on the rise,* NZ Herald; Feb 16, 2014

- Is highly unlikely to result in death, however the pain can be so severe that sufferers consider suicide – this pain can last for up to one year after the onset
- Can result in blindness in one eye if you have facial shingles
- Can be treated by anti-viral medication and pain killers
- Manifests itself as a painful rash
- Could affect up to 40% of those aged between 45 and 85 years old

Pharmac's responses to the following questions were:

Q. Can the shingles vaccine be funded by Pharmac?

A. Funding for this vaccine is on the priority list but cannot be funded at present, people need to talk to their G.P about this condition – Pharmac will provide information for the Grey Power quarterly magazine.

9.2 The use of opioids by older people

Research carried out by the ACC Pharmaceutical Advisor and Dr Rob Griffiths has shown that ACC patients over 65 yrs are prescribed stronger opioids, at higher doses and for longer than for younger people – this finding has been extrapolated anecdotally to apply to non-ACC people as well. Their literature reviews disclose that "taking strong opioids especially in combination with other drugs, doubles the risk of hospitalisation, magnifies the risk of falls by up to 6 times and accelerates frailty and loss of independent living[14]

Grey Power asked Pharmac

Q. Is the use of opioids for older people safe? –

A. Opioids are a valid part of the therapeutic paradigm and there is on-going work on falls prevention - the push is for the appropriate use of opioids for the right person at the right time

9.3 Subsidies which are available for medicine prescriptions?

The following information is provided on the MoH web-site:

Many medicines are subsidised by the government. The prescription charge (co-payment) is a small contribution people pay towards the cost of the medicines they receive. For most people, this charge is $5 for each new prescription item. New Zealanders can reduce their medicine costs through the Prescription Subsidy scheme.

A prescription subsidy is aimed at reducing costs for families and people who are prescribed a lot of medicines. You become eligible for the subsidy once you have paid for 20 new prescription medicine items from 1 February each year.

You can reach the 20-item threshold by combining prescription items for your partner and dependent children aged from 13 up to 18. Just tell your regular pharmacist the names of all the people in your family to help them keep track of how many items you've paid for. This information is gathered electronically so you no longer need to keep your receipts.

Please note, as there is no prescription charge on items for children under 13 years, these items can't be counted as part of the 20-item threshold.

To qualify for a prescription subsidy talk to your pharmacist and make sure he or she knows the names and ages of all the people in your family. Your pharmacist will check the electronic records to see how many prescriptions you (and any eligible family members)

[14] Letter to Jo Millar from Dr Rob Griffiths

have paid for since 1 February and if the total is 20 or more you'll qualify for a subsidy. Any pharmacy can check your eligibility.

As not all medicines are funded, discuss any questions you have about prescription charges with your pharmacist.

9.4 The renewal of the contract for Diabetic Meters?

Q. Is Pharmac looking at this?

A. Pharmac are reviewing the contract. They are aware of the problems that arose after the last contract and conducted a survey of a number of people. The result of this survey made it very clear that Pharmac had not conveyed the message clearly about the usage of the new meters. They have undertaken to ensure all are fully informed should there be a change in meters. It is quite possible the current meter contract could be renewed. Grey Power will be copied into all information circulated about anything to do with diabetes.

10. MEETING WITH THE HEALTH AND DISABILITY COMMISSIONER re Right 7 (4) consultation

10.1 Background – Rose Wall (Deputy Health and Disability Commissioner) contacted the president to ask that she meet with him and other executive committee members about the public consultation regarding health and disability research involving adult participants who are unable to provide informed consent to participate in the research.

She is also looking at ways of disseminating information about the consultation process, so she can get feed-back from as many people as possible.

She says that New Zealand law has a strong focus on the rights of consumers of health and disability services. Respect for the autonomy of consumers, and the expectation of transparency from health and disability services providers, are fundamental principles that underlie New Zealand's Code of Health and Disability Services Consumers' Rights (the Code). These principles are deeply engrained within the culture of our health and disability sector, and can be seen most obviously in a consumer's right to make an informed choice and give informed consent before receiving health and disability services.

Recently, it has been argued that New Zealand's laws regarding non-consensual research are too restrictive, and prohibit studies that could lead to significant improvements in health and disability services.

The two fundamental consultation questions: are New Zealand's current laws regarding non-consensual research appropriate and, if not, how should they be amended?

10.2 General information - RIGHT 7 (4) of the HDC Code = the Right to Make an Informed Choice and Give Informed Consent says
4) Where a consumer is not competent to make an informed choice, and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -
a) It is in the best interests of the consumer; and
b) Reasonable steps have been taken to ascertain the views of the consumer; and
c) Either, -
i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

At present in New Zealand, research on a person who is unable to give consent can take place only if participation in the research is in **that person's best interests.** If the purpose of research is to generate generalizable knowledge to benefit people in the future, then consent cannot be given for an incompetent person to participate

The United Kingdom does permit research involving participants who are unable to give consent, but only if the research has the potential to benefit the participant without creating disproportionate risk or is intended to provide knowledge of the causes or treatment of, or care of, people affected by a similar condition. If so, researchers must have good reason to believe that any risks to individual participants are negligible, will not significantly impact their freedom or privacy, and will not be unduly invasive or restrictive.

The Mental Capacity Act 2005 and the Code of Practice provide a number of additional safeguards to protect vulnerable consumers, including requiring that research:

- is part of a project that has received formal approval;
- cannot be carried out in contravention of an advance directive; and
- cannot be carried out (or continued) if a participant objects or appears to object.

In Australia, there is a strong focus on ascertaining and promoting the rights of people to choose whether to participate in research. The National Health and Medical Research Council (NHMRC) has published guidelines for ethical conduct in human research. The guidelines relating to people with a cognitive impairment, intellectual disability or mental illness require that prior to conducting research, researchers should inform Human Research and Ethics Committees how they propose to determine capacity (including how the decision will be made and by whom, criteria used, and process for reviewing capacity during the research).

If it is proposed to conduct research on a person who does not have capacity to consent, researchers must obtain consent from a person who is authorised to consent on the incompetent person's behalf. Consent should be witnessed by a person who has the capacity to understand the merits, risks and procedures of the research and is independent of the research team, and who knows the person and is familiar with his or her condition. Where consent is sought by a proxy, the researcher should still explain to the participant as far as possible what the research is about. Any refusal or reluctance to participate should be respected.

NB: The consultation document and submission form can be found at www.hdc.org.nz. And consultation ends on Sunday 30 April 2017.
Extra information:

An example of valuable knowledge is genomic research in common brain disorders but although it has potential to advance medicine and benefit future individuals, genomic research does not offer direct benefit to participants. The dilemma is the challenge of simultaneously addressing the ethical requirements for "valuable research," "scientific validity," and "respecting persons."

Respecting persons is generally met through the processes of informed consent for individuals having capacity or use of appropriate safeguards for individuals lacking capacity. Acceptable safeguards include excluding these individuals from research if their

participation does not meet the necessity requirement or enrolling them via processes such as EPA authorization, use of research advance directives, and awaiting return of capacity.

Risks of research involvement is another aspect – especially if there is significant risk to participants with no guarantee of benefit, even though the possibility of benefit exists.

11. **MEETING WITH KIWIBANK** - the main gain for Grey Power was that information regarding the flagging of members' accounts will be published in this edition of the Grey Power quarterly magazine. Also concern was expressed by Grey Power over KiwiBank's policy re the removal of dark glasses in their banks; this is a problem for some older people who have to wear them for medical purposes but we were assured that the glasses only need to be removed for the security photo then they can be worn again.

12. MEETING WITH DR ALISTAIR SHAW – EXECUTIVE DIRECTOR OF THE NZ UNION OF STUDENTS' ASSOCIATION – Grey Power's gain was a very useful discussion on intergenerational inequity – e.g. grandparents talking to grandchildren and other issues such as graduates opting out of KiwiSaver to save for their first house. Grey Power agreed whole heartedly with Dr Shaw's statement that we believe in intergenerational solidarity.

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