Supporting Older Māori & Pacific Peoples in the Central Region 2012
Tihei mauri mate!
He mihi ki a rātou ma
Kua wehe atu ki te po.
Hoki wairua atu ra
Ki a rātou mā. haere, moe mai, kāti.

Ka huri te mihi ki a tātou te hunga ora,
Tihei mauri ora ki te whei ao ki te ao mārama

Tihei Mauriora

Ka rere haere te mihi tuatahi ki te ngākau ki tō tātou matua,
a lo nui, a lo roa, a lo te mataaho, a lo taketake, a lo wānanga, ara, a lo i kore i mutu
 te kaipupuri i ngā taonga katoa o te ao wairua, te hurihuri nei,
Kia tau iho tōna manaakitanga ki a tātou katoa e noho nei i te pito ora,

Kia tutuki ai te kupu o te karaipiture e mea ana,
Kia whai koriora ki te Atua i runga rawa,
kia mau te rongo ki te mata o te whenua,
he whakaaro pai ki ngā tāngata

Ki a Ranginui e tu nei, ki a Papatūānuku
e takoto nei, tēnā korua.
He mihi hoki tēnei ki ọu korua uri.
Tēnā ra koutou ngā kāhui atua o ngā mea katoa.

He mihi maioha ki ngā mareikura me ngā whatukura
ngā kauwae rangatira o nga tangatawhenua o Aotearoa
me ngā tipuranga o te Moana-nui-kiwa

Tēnā koutou katoa.

E ki ai te kōrero, a koro mā a kuia ma
Mā to rourou, mā toku rourou, kia ora ai te iwi
Mo te kaupapa o te pukapuka nei
Ka rere ngā mihi ki ngā

Poari Matua o Te Hauora
Ngā ringa raupā, ngā manu tioreore,
i awhina, i tautoko te hanga
o tēnei pūkōrero, o tēnei rautaki hoki
He tino mihi miharo ki a koutou katoa

Mā te io tātou e manāki,
E tāki, koutou i runga te aroha o te runga rawa.
Tēnā koutou, tēna koutou, tēna tātou katoa.
Acknowledgement: Gilbert Taurua, Director Māori Health and Chair (Whanganui DHB), Christine Pihema, Māori Manager Hospital Services (Hutt Valley DHB), Siloma Masina, Manager Pacific Health Unit (Hutt Valley DHB), Folole Fai, Team Leader/Community Clinical Nurse-Long Term Condition, Central PHO (Central PHO), Paddy Jacobs, Advisor, Māori Health Public Health Services (MidCentral DHB), Cheryl Goodyer, Manager Service Delivery Māori Health Group (Capital and Coast DHB), Taima Fagaloa, Director Pacific Health Directorate (Capital and Coast DHB).

Liaison members who provided expertise during the project are Joanne Edwards, HoP Portfolio Manager, Planning and Funding (Wairarapa DHB) and Lisa Jones, Population Health Intelligence, (Hawke’s Bay DHB).

The project group would like to acknowledge the contribution of Siloma Masina who passed away in December 2011. Siloma was part of the Executive Management Team at the Hutt Valley District Health Board and a member of our project working group. She brought a strong community and primary care perspective to this project, and advocated strongly for the interests of Pacific people. We would like to thank her family for sharing her with us and her contribution lives on within this Supporting Older Māori & Pacific Peoples Report.

This photo is courtesy of the Kai Tiaki Nursing Magazine
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Executive Summary

This report examines how older Māori and Pacific Peoples are supported to have their long term care needs met in the Central Region and reflects how older Māori and Pacific people are supported by whānau and communities.

Ministry of Health (2011) report, that as the demographic balance in New Zealand changes, the Government will be required to spend an increasing proportion of the health budget on older New Zealanders. It is therefore becoming increasingly important for the health sector to plan for an ageing population. An increase in health service demand and Māori health service needs is expected, particularly given that Māori over the age of 50 have poorer health outcomes and a higher burden of chronic illness than non-Māori of the same age.

The Central Region’s Pacific population will rapidly grow. This means that not only are the numbers of Pacific people increasing, but also their proportion of the total population is growing.

The Pacific population is much younger than other groups, having considerably more children aged under 15 years, and less elderly people. Within the Central Region, Porirua in particular has a high proportion of Pacific people (approximately 27%).

Although the Region’s Pacific population is relatively young, by middle age most are significantly less healthy than the wider population, and few live beyond 75 years of age. Pacific people have significantly worse health outcomes than other New Zealanders, dying younger and experiencing more ill-health while alive.

Chronic illness and co-morbidities contribute to disability, diminish quality of life, and increase long-term care costs. The Central Region Regional Services Plan 2011/2012 reports that ‘the demand for aged residential care (ARC) services is expected to exceed capacity from 2014 if the current model of care does not change’.

With more people living in the community and utilisation rates to aged residential care reducing it is likely that more complex patients will be supported in the community by informal whānau supports. Consideration needs to be given on how to support whānau caregivers, to improve health and social outcomes for elders and reduce carer burden.

Analysis was undertaken to understand access to the Long Term Conditions (LTC) Fund and funded community supports by Māori and Pacific. To understand the preferences of Māori and Pacific people, six focus groups were held across the Central Region and together these inform the recommendations. Results from this analysis shows Māori and Pacific do access funded community supports from 50 years, but for the majority of Māori and Pacific it is their preference to be supported by whānau in their home.

The Central Region DHBs need to take a regional and targeted approach to Māori and Pacific service planning and delivery which is responsive to individual needs across the continuum of care. This Report identifies 20 quality improvements for the Central Region DHBs, which have been aligned to the Regional Services Plan for 2012/2013.
## Recommendations

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| Improved Māori and Pacifica health and reducing health outcome disparities | Integration of capacity and capability through all work streams | • All health priority workstreams will align to the intent detailed in the regions Māori Health Plan  
• All workstream development will ensure the active participation of Māori and Pacific at all levels (Māori reps on workstream priority areas, GM Māori on Steering Group, Iwi Governance are engaged where appropriate)  
• All workstreams will integrate into their work the targets detailed in the RSP Māori Health Accountability Framework  
• Ensure that all proposed models of care have an integrated Māori Model of Care aligned to their development, that upholds Tikanga Best Practise standards and are committed to appropriate and effective care  
• MOH National Health Indicators will be tracked across the Central Region via the Māori Health Monitoring Framework  
• Māori Health Workforce Strategy developed with a consolidated workforce report | 1. Health providers, community support workers and NGOs need to establish improved communications, better relationships and understanding of each other’s scopes and roles to reduce fragmentation of knowledge and service provision for Māori and Pacific people.  
2. Develop Whānau Ora Navigators. The navigator role could:  
• assist whānau and whānau caregivers in their journey which could include but is not limited to advocacy, brokerage and mentoring  
• promote health literacy  
• support advanced planning by the whānau  
• establish a nominated key contact for whānau  
3. Engagement with Māori, particularly for the purpose of assessment, should always be face to face with the whānau caregiver and support network present.  
4. Consider how to partner with local bodies, government services and non-government services agencies to minimise the impacts of social isolation.  
5. Work alongside MoH and researchers to understand access and utilisation issues for Māori and Pacific. For Pacific people there is a need to understand the use of primary health services. DHBs then need to make provision for and prioritise the implementation of findings.  
6. Support whānau caregivers by providing them with some targeted practical care skills. Training and mentoring in areas such as specific chronic disease management, manual handling such as lifting, medication management and the management of the behavioural and psychological symptoms of dementia.  
7. Work in partnership with NASC agencies to ensure cultural... |
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<td>Embed with HWNZ the Hauora Māori Training scheme</td>
<td>responsiveness training occurs and that it is of high quality, for Māori and Pacific.</td>
<td>8. Support Workforce NZ and other agencies to develop the Māori and Pacific workforce and should also be considered a priority for the Regional Training Hub. For Māori and Pacific ‘right’ care may not be ‘clinical’ but may include navigational support, whānau interaction etc.</td>
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<td>Improved data collection</td>
<td>Accurate data available to make informed decisions and monitor trends</td>
<td>Workstreams will ensure that primary care interface includes active participation and integration with providers. Provide quarterly consolidated regional reporting and analysis of indicators &amp; targets</td>
<td>9. DHB access to the LTC funding eligibility criteria must be monitored and reported on over the next 12 and 24 months.</td>
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<td>10. The Health of Older People Portfolio Managers annually utilise the InterRAI clinical repository data to compare ‘at risk’ categories for the elderly Māori and Pacific populations.</td>
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<td>11. Establish standardised data systems to enable regional benchmarking. At a minimum NASC services and DHBs ought to monitor and report on:</td>
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<td>• Access to services by Māori and Pacific by comparison to its over 65 years population</td>
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<td></td>
<td>• The average time taken between receipt of referral and assessment time</td>
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<td>• The average time from assessment to service allocation</td>
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<td>• Level of care required – both that associated with the carer (respite care) and that associated with physical needs of the elder (personal cares).</td>
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<td>12. Ensure there is a better connection between older persons and disability sectors to ensure a smooth transition between service providers and funding pools.</td>
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<td>13. Ensure aged care services have appropriate Māori and Pacific health plans, cultural policies and appropriate cultural training.</td>
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<td>14. DHBs and NASC agencies need to ensure the data collection systems</td>
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| Strengthen service responsiveness | Improved service integration and collaboration                          | • Improved quality, coordination and integration of care services to older Māori and Pacific  
• Improved access to benefit information and entitlements to older Māori and Pacific  
• Services are provided in accordance with consumer/kiritaki rights legislation                                                                                                                                                                                                                     | enable previous year’s information to be archived to enable service provision trends and needs to be accessible at NHI level.                                                                                                                                                                      |
| 15.                            | Develop models of care which incorporate a Pacific approach to support the elderly person and family to navigate health services. Components of the model of care should include: | • agreement that engagement with Pacific people should always be face to face  
• development of care coordinator type roles that assists families to deal with the complexities of multiple caregivers  
• support from health professionals with the provision of tools and resources to enable informal care in the home  
• facilitate and enhance communication between family members  
• ensuring that respite care can respond with urgency to prevent a crisis  
• Health Navigators to play a key role in the relationship between NASC assessors, care coordination agencies and Pacific elderly                                                                                                                                                              |                                                                                                                                                                                                                                                                                                      |
<p>| 16.                            | NASC assessors and DHB based Social Workers to provide whānau caregivers with information on Ministry of Social Development and Ministry of Health carer support benefits available. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                      |
| 17.                            | The consumer perspective is sought to inform service planning and quality initiatives via patient experience surveys and Māori and Pacific consumer representation on local DHB consumer groups. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                      |
| 18.                            | Undertake a stock take of funded cultural programmes in partnership with other agencies, non government organisations and community providers to understand what programmes are currently funded, how are they funded, what the utilisation levels are and evaluate how the programmes support self management in the community. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                      |
| 19.                            | Extend funded support such as day programmes or home based support services to include those who are vulnerable/at risk of functional |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                      |</p>
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<td>decline through social isolation.</td>
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<td>20. Formalise links with other agencies across health and social care that provide for social inclusion in their policies and ensure that services are well communicated to clients and their whānau.</td>
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Demographics

For their older populations, Hutt Valley and Capital & Coast DHBs have a higher percentage of Pacific people than other DHBs, whilst Whanganui and Hawke’s Bay DHBs have the highest percentage of older people who are Māori than other Central Region DHBs as shown in the table below.

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<th>C&amp;CDHB</th>
<th>HBDHB</th>
<th>HVDHB</th>
<th>MDHB</th>
<th>WaiDHB</th>
<th>WhaDHB</th>
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<tr>
<td>Māori</td>
<td>3.6%</td>
<td>8.2%</td>
<td>5%</td>
<td>5.1%</td>
<td>5%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Pacific</td>
<td>3.6%</td>
<td>0.7%</td>
<td>3%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>92.8%</td>
<td>91.1%</td>
<td>92%</td>
<td>94%</td>
<td>94.5%</td>
<td>90.8%</td>
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Table 1: Percentage of Māori and Pacific Peoples aged 65 and over for 2010/2011

Deprivation Distribution

Differences in health outcomes are due to a combination of factors, including socio-economic inequality, access to and quality of health care, and health risk factors such as diet, and other lifestyle factors.

There is great contrast between the proportions of people in each DHB living in the least deprived quintile (1) and the most deprived quintile (5).

- Capital & Coast has the greatest proportion (35.0%) of people living in quintile 1 while the lowest proportions occur in Hawke’s Bay (9.1%), Whanganui (9.4%) and MidCentral (11.2%).
- Wairarapa has the lowest proportion of people living in quintile 5 (11.7%) and Hawke’s Bay has the highest (34.7%).
- Of the people in quintile 5 in Hawke’s Bay, 41.6% are of Māori ethnicity.
- Across all DHBs the highest proportions for Māori and Pacific People are in the two most deprived quintiles.
- Hutt Valley is the most uniform of the six DHBs and Wairarapa has the highest proportion of people living in quintiles 3 and 4.

Charts 1 & 2 identify the Central Region Population Distribution by DHB, Deprivation Quintile and Ethnicity (Regional Clinical Services Plan 2008)
Māori

The Ministry of Health (2011) Report Tatau Kura Tangata: Health of Older Māori Chart Book 2011 cite a number of demographics, socioeconomic determinants and key indicators of health for Māori:

- It is forecasted that between 2011 and 2026, the Māori population aged 50 years or above will grow by 7.1% by comparison to growth of 3.3% for non-Māori of the same age.
- For those Māori aged 65 years or above, it is predicted the growth will by 12.8% so by 2026, Māori will comprise 9.5% of the older people’s population, up from 6.8% in 2006.
- 25.1% of Māori aged 50 years or above lived in the most deprived areas by comparison to 6.6% for non-Māori.
Māori males aged 50 years were expected to live to 74 years and Māori females aged 50 years were expected to live to 77 years of age. Māori life expectancy at age 50 is at least six years less than that for non-Māori, for both genders.

Approximately 35% of Māori aged 50 years and above live with a disability, approximately 5% more than for non-Māori in the same age group.

’Māori aged 50-65 years have significantly lower skills to obtain, process and understand basic health information in order to make informed and appropriate health decisions compared to non-Māori’ MoH (2011 Key Findings).

Whilst statistics regarding migration of young Māori to Australia were not explored, there is a concern by Māori, that migration of young Māori reduces the extended family and significantly limits the care pool for some elders.

The 2006 Health Literacy Survey reported in Tatau Kura Tangata: Health of Older Māori Chart Book 2011 showed that 80% of Māori aged 50-64 had a poor level of health literacy, meaning they have insufficient skills to cope with the health literacy demands they face.

**Pacific Peoples**

The Medical Council Report Best Health Outcomes for Pacific Peoples: Practice Implications 2010 cite a number of demographics, socioeconomic determinants and key indicators of health for Pacific Peoples:

- ’The Pacific population in New Zealand is expected to grow from nearly 7% to 12% by 2051.
- The majority of Pacific peoples living in New Zealand are born here.
- The health outcomes of Pacific peoples are worse when compared with the general population in New Zealand. These outcomes are reflected in lower life expectancy, higher rates of chronic disease, and premature disability. For example, Pacific peoples:
  - are three times more likely to have diabetes than the general population
  - are more likely to be severely disabled, with a higher proportion of disabled children or young adults
  - have nearly twice the rate of avoidable mortality and ambulatory-sensitive hospitalisations as other New Zealanders
  - have a higher incidence of mental health disease than the general population’.
- Statistics New Zealand and Ministry of Pacific Island Affairs (2011 p.13) identify that ’in 2006, the estimated life expectancy for Pacific men was 73.9 years and 78.9 years for Pacific women, more than four years less than for the total population’
- White et el. (2008) cited by Statistics New Zealand and Ministry of Pacific Island Affairs (2011 p.27) report that ‘on average, Pacific peoples have worse economic circumstances than the overall population, with the majority of Pacific peoples living in areas with the fewest economic resources’.
‘The Adult Literacy and Life Skills Survey 2006 showed that, overall, the literacy of Pacific peoples was lower than other ethnic groups (Statistics NZ and Ministry of Pacific Island Affairs, 2010). Pacific peoples experience other factors that contribute to limited health literacy, such as lower socio-economic status and language difficulties.’ Statistics New Zealand and Ministry of Pacific Island Affairs (2011 p. 38)

Focus Group Themes

Methodology

During November 2011 six focus groups were facilitated by the project team members across the Central Region. Attendance at a focus group was by invitation and included elders, carers and Māori and Pacific service providers.

Both rural and urban focus groups occurred and both Pacific, NZ born and Pacific born elders and carers attended. Some interested consumers were unable to attend focus groups, therefore their perspective was sought through one on one interviews. There were four Māori focus groups and two Pacific focus groups, representing over 40 people in total. Where participants attended a focus group, koha was provided in the form of either petrol or food vouchers.

Participants were provided with information sheets (Appendix 1) and consent forms (Appendix 2).

At a similar time these focus groups occurred, Ministry of Health were undertaking a review of the ‘cultural conversation’ component of the InterRAI comprehensive clinical assessment process. Therefore it was encouraged that participants had experienced a needs assessment within the last year in an attempt to reflect those who may have been interviewed during the roll out of InterRAI. MoH were seeking an understanding of: “does the cultural conversation enable the exploration of what is needed in a culturally relevant manner?”

Guideline question sheets were provided to the facilitators to enable some measure of standardisation across the groups (Appendix 3).

The focus groups sought to understand:

a. The context of whānau in supporting the older Māori and Pacific person
b. How do elderly Māori or Pacific people wish to be supported in the community?

c. When aged residential care is required, are there barriers to access?

Māori Focus Groups Themes

Themes generated from the Māori focus groups can be broadly categorised into:

- The importance of home and family and cultural values
- Preferences for home versus aged residential care
Stress on whānau carers
Knowledge of health services available
Issues associated with assessment or formal care
Deciding on aged residential care
The aged residential care experience.

The importance of home and family and cultural values

- What constitutes whānau is varied, but participants noted that it ranges from three generations in a household to elderly living alone and estranged from their whānau.
- How care was provided for the elder depended on the individual whānau, with elderly staying for periods of a few months to a year with each of their children, while others were looked after in their own homes or in rest homes.
- Families in urban areas have more pressure to go to work so caring for a family member puts more financial pressure on a family. In a rural setting caring for a family member will have less impact on lifestyle, the stress is different (not financial).
- The dynamic of the whānau impacts on how elders are cared for. Some whānau don’t want to know, and don’t want to provide support. Whānau can be busy with their jobs and their own whānau and unavailable to provide any support. It was noted that in a successful community the whānau and neighbours will all provide support.
- Being the primary carer for the elder is often viewed in a positive light.
- Participants noted that older Māori can be private and that the elder’s wishes need to be acknowledged. Sometimes this meant formal services are refused. Conversely other participants noted a sense of pride amongst elders, which can sometimes mean a Kaumatua would rather be cared for by a stranger than their own family.

  “Grandfather won’t let anyone help – if he does let people help (informal or formal) then I have to go over to grandfather’s house and clean up first and then let the person in. I have to wait while they are there. I might as well do it myself” (Wellington)

- Participants reported that elders don’t advocate for themselves and haven’t learnt to navigate the health system. Traditionally they have relied on their own capacity to survive.

  “Our people are proud, too proud to ask, they never ask for anything; they survived by getting out there and doing it. To this day my dad still won’t ask, we offer him heaps and he says no, no, no. It’s not until you actually do it, that he will accept it but you can tell there are a lot of things they would like and want” (Ohakune)

- There is concern that in the current economic times, Māori elders are being burdened with the responsibility of childcare for their grandchildren. Often this reflects the need for a dual household income and impacts on the health of the older person and represents risk to the grandchildren.
Positive impacts for care recipients were associated with enhanced capabilities at home and in the wider community. Caregiving had a positive impact on carers’ personal development and was perceived as strengthening whānau cohesiveness.

“.. Father with dementia did not want his children to bathe him, nor did he want a stranger coming in to do it... Luckily there was a family member who was a trained nurse and offered to come in and do it and the father was ok with this” (Levin)

Preferences for home versus aged residential care

- Older Māori have a preference to live at home and elders want their own whānau to look after them. Therefore whānau will try to keep family member at home for as long as possible.
- There has been a cultural shift in the last 10 years by Māori, as before then Māori were less likely to go to aged care facilities. However there can still be a stigma attached with the perception that you are no longer cared for in your own family and many have the image that you spend days sitting in rocking chairs.

“I won’t let grandfather go into an aged care facility. Putting him into a residential care facility is like putting him into a coffin” (Wellington)

- Where whānau are fragmented and iwi are spread around the country, then aged residential care often becomes necessary.

Stress on whānau caregivers

- Whānau caregiver stress occurred for several reasons:
  a. Stress related to the elder not wanting formal supports
  b. Stress related to the management of behavioural and psychological symptoms of dementia
  c. Whānau not being supportive of main caregiver
  d. Isolation and sacrifice.

- Whānau caregiver stress can be due to the older person not wishing to let other family in to help or refusing formal services to help out the whānau caregiver.
- The whānau caregiver stress related to dementia can be due to a lack of understanding of dementia

“He is stubborn, sits back and expects to be waited on, is refusing showers, hiding pills etc. His wife still works and as he is physically capable of helping they aren’t entitled to any supports. But the issues is that he is refusing to do tasks, and this is causing stress on the wife” (Hutt Valley)

- Whānau not being supportive of the whānau caregiver was often cited as being due to a lack of understanding on the demands on the whānau caregiver as well as the stress of differing opinions.
“Riding this waka with the old man has been one of the most challenging things in all my life and I have had a few challenges in my life, both good and bad, but nothing as challenging as this. When you love someone so much you just can’t give up. No matter what, you keep striving. Little do you realise that it is pulling you so much, down, down, down. You don’t realise, you don’t sleep. The other thing that hurts a lot is the ignorance of your family, because they don’t want to know, they don’t understand” (Ohakune)

‘Whānau opinions can be the biggest barrier “we don’t put our elders into residential care”. Whānau can often have split decisions on what to do and those looking after the elder are stressed, but are stopped by the rest of the family’ (Hutt Valley)

- Whilst being a whānau caregiver can be a positive experience, the impact of caring for whānau members was noted as having a significant impact for those providing care. Many spoke about feelings of isolation and depression as a result of their care giving duties.

  “I feel isolated even though I have four mokopuna living with me. I can’t drive, I don’t have a landline and whānau live away. I am in a prison, but not in prison. Home is a prison because I can’t get out like I would like” (Ohakune)

- Whilst whānau and whānau caregiver stress was also reported, it was noted that whānau and the whānau caregivers are very resilient.

- Strength of Māori and Pacific culture is to look after their whānau, however it comes with risk, when there is expectation on children to be the carer at home.

Knowledge of health services available

- The focus groups identified that whānau don’t know where to go get health information or support and of not knowing who to turn to. Whānau don’t understand the health systems and do not question medical teams. Some providers who participated in the focus groups reported:

  “we advocate to the whānau to use an ambulance to get immediate access to health services for their elder and then will coach the whānau to disagree with discharge until services are put in place” (Hutt Valley)

- Whānau don’t understand the medical conditions of the elder, such as behavioural aspects of dementia which can lead to abuse. Need training for carers so they can understand the needs of the elder.

- A lack of health professionals/support available to assist with assessment and transition into aged residential care facilities created stress on whānau and was evident more where primary care was not engaged with the whānau.

  “You keep continually hitting all these barriers, one day you think you are doing well, the next day another barrier, who can I turn to?” (Ohakune)
• Services vary significantly depending on whether you live rurally or in an urban centre. In rural areas there seem to be more geographical barriers to accessing services and there are fewer providers to choose from.

• Where whānau were engaged with services and knew of respite care, carers voiced positive experiences.

  “Hospice as respite for my mother was great. I could be me for a few hours” (Wellington)

**Issues associated with assessment or formal care**

• There is a lack of recognition of the role of the whānau in understanding the elders’ level of function and not listening to the whānau caregiver or wider whānau during the assessment.

  “I keep in touch with my coordinator, she will get someone to come and do an assessment, but even that can be frustrating because they don’t always listen to you (the carer), they ask you what you think, you tell them and then they go off and do something different. They ring again and ask again what you think but they don’t listen. They do go by whatever the person (older person) they are questioning says, whatever they say they stick to that, whether they are right or wrong rather than also considering what the carer has to say. Sometimes they (the older person) can hold it together and come across good...by not listening to the carer, someone who has been there 4-5 years, they make you feel that they are just not taking any notice” (Ohakune)

• With the NASC process it seemed to be a smoother process if you live in an urban location versus rurally especially where a geriatrician is needed to support a level of decline for those with dementia.

• Providers who participated in the focus groups felt that InteRAI comprehensive clinical assessment has made the process more complex. There are no Māori assessors in one DHB, which has created a huge gap for Māori.

• Many of the participants in the focus groups expressed a wish to have services ‘by Māori for Māori’. This related to cultural values as well as some elders not speaking English.

  “Māori girl comes in to provide services. Is good to have a Māori girl. We fit together, so can be Māori, our way” (Wellington)

  “Need specific Māori support and need a holistic approach that is not perceived in the pakeha world” (Wellington)

• Cultural connections are important – when someone moves into the region the cultural connections need to be made. Services are not necessarily good at helping the elder or their whānau set those connections up (support of the emotional and spiritual health).
Find it unfair that friends or live in caregivers who provide care can’t be paid to provide care and reported that formal caregivers were often inflexible in when care was provided.

“Our would make me feel better (elder) if I could pay my caregiver to help me, but I can’t afford to and there is no government funding” (Wellington)

“Formal caregivers need to fit around the person and not set the schedule (like only having the shower at 9am). Sometimes when they want to shower me, I don’t want to. That is why they should pay the person who already lives in my house to give me a shower, cos’ they can do it when it suits me as a person” (Wellington)

Participants expressed positive experiences with the assessment process and resulting service coordination

“My husband (has dementia) did not understand the need for his assessment, believing there was nothing wrong with his health. From my perspective the health care assessor was very considerate. It was relatively easy to find out what was happening next after the assessment” (Hutt Valley)

Deciding on aged residential care

Proximity to family was important for whānau when deciding on residential care, however sometimes there is no capacity in those facilities or those facilities close to whānau are not always seen as appropriate by the whānau.

“You can’t always get into a residential care facility that is right beside where you live. My aunt wasn’t able to get into the home just across the road. Instead I had to take uncle every day in the car to visit (at least 15 minutes drive each way) instead of being able to cross the road. It added stress to Uncle and to me” (Wellington)

Having other Māori or Pacific elders within the facility or having staff who were Māori or Pacific was seen as an important factor in deciding on a residential care facility.

“But even when we came to terms with doing it, it was finding a specific home that was compatible for him. There aren’t any, like specific to Māori and Pacific Islanders. Places are far and few when it comes to the cultural specifics” (Ohakune)

“One rest home in this area is often picked by Māori is because the Charge Nurse is Pacific Islander” (Wellington)

Whānau can find that health professionals aren’t very helpful or informative when deciding on a residential care facility. Whānau left to make the decision on which rest home they should put their elder into.
• Whānau often don’t understand the financial implications of having their elder going into aged residential care. They don’t understand Enduring Power of Attorney (EPOAs) and don’t realise they may need to contribute funding.

The aged residential care experience

• Māori are going into aged residential care at an earlier age than non-Māori. The age difference between Māori and Pakeha can be 20 or more years and often Māori have different diagnosis.

• Māori often go into hospital level care versus rest home level care, so transition is more difficult for elder and whānau.

  “When the elder goes into aged residential care it is important to encourage the whānau to visit the elder, take them out on the weekends, offer to feed and shower so that keep their cultural and whānau connections. ARC staff can care for the physical needs and whānau can care for the emotional and spiritual needs” (Hutt Valley)

• Participants noted that aged residential care facilities were rarely culturally appropriate. This concern was voiced in relation to aged residential care, respite and day programmes.

  “Lack of culturally appropriate ARC facilities or services” (Ohakune)
  “Traditional Māori medicine – Rongoā helps maintain spiritual wellness and it needs to be recognised within residential facility” (Hutt Valley).
  “In ARC diversion therapy is often not culturally appropriate i.e. crossword puzzles, music” (Hutt Valley)
  “Residential care providers should be proactive – when you move your elder there they should say, you are Māori so here are some options for you. How do you want to care for your elder whānau?” (Wellington)

• Many Māori voiced positive experiences for their whānau within aged residential care facilities.

  “When made the decision to move their father into an ARC facility the staff were very supportive and made it an easy transition. Family members are still able to be very involved and this had helped” (Levin)

Recommendations

1. Whānau Ora navigators could assist whānau members to develop skills and knowledge which will build on their strengths and develop the confidence to proactively engage with community and aged care services. Specifically they could:

   a. assist whānau and whānau caregivers in their journey which could include but is not limited to advocacy, brokerage and mentoring ensuring an early intervention approach
b. promote health literacy for their local populations

c. support advanced planning by the whānau and health professionals to be identified early to NASC agencies so respite or formal support can be activated quickly and before the family is in crisis

d. establish a nominated key contact for whānau

2. Engagement with Māori, particularly for the purpose of assessment, should always be face to face with the whānau caregiver and support network present to ensure that problems and underlying issues are identified, especially when there are language/health literacy issues.

3. Caring for others takes its toll on the whānau caregiver and there is an identified need to support them with some practical care skills. DHBs could facilitate access to training and mentoring in areas of specific chronic disease management, manual handling such as lifting, medication management and the management of the behavioural and psychological symptoms of dementia.

4. Some carers are not aware of Ministry of Social Development and Ministry of Health carer support benefits which are available to financially support their carer role. NASC assessors and DHB based Social Workers need to provide this information to whānau caregivers.

5. Ensure aged care services have appropriate Māori health plans, cultural policies and staff has access to appropriate cultural training. DHBs to ensure that Māori health plans are developed in consultation with local Māori so they are meaningful documents which ensure the care being offered meets the physical, spiritual and cultural needs of Māori, particularly for those who are isolated from whānau.

6. These focus groups provided a rich consumer perspective on issues for Māori. It is important that the consumer perspective is sought and informs service planning and quality initiatives, so Māori can inform future directions. This could be achieved via patient experience surveys and Māori consumer representation on local DHB consumer groups.

7. DHBs undertake a stock take of funded cultural programmes in partnership with other agencies, non government organisations and community providers to understand what programmes are currently funded, how are they funded, what are the utilisation levels and evaluate these against how it supports self management in the community.

8. Māori workforce development needs to occur to ensure people with the right skills are providing care to the right people, at the right time. For Māori and Pacific ‘right’ care may not be ‘clinical’ but may include navigational support, whānau interaction etc. DHBs need to be supporting Workforce NZ and other agencies to develop the Māori workforce and should also be considered a priority for the Regional Training Hub.

9. Māori have poorer health outcomes than non-Māori. DHBs need to work alongside MoH and researchers to understand access and utilisation issues for Māori and ensure there is an opportunity for DHBs to utilise the InterRAI clinical repository to
support such research. DHBs then need to make provision for and prioritise the implementation of any research findings.

Pacific Peoples Focus Groups Themes

Themes generated from the Pacific focus groups can be broadly categorised into:

- The importance of home and family and cultural values
- Preferences for care in the home
- Stress on carers
- Knowledge of health services available
- Issues associated with assessment
- Deciding on aged residential care
- Lack of cultural services available.

The importance of home and family and cultural values

- Carers for Pacific older people in the community are mainly spouses and children of Pacific older people. Numbers of family members in the same dwelling varied between two and ten people. Often the extended family are involved and support the primary caregiver.

  “Mrs X looks after her elderly mother in her home... Mrs X’s sister and husband with their children have their own place but always visit the mother daily and likewise with a married brother who lives in a nearby town.”
  (Palmerston North)

- The care is provided either in the caregivers own home or they are looked after by children or grandchildren at their own home.

- Some participants identified conflicts between family members who were not the principal caregiver, but are occasional visitors. This can often cause conflict and significant stress on the family member.

  ‘They sometimes criticise or disagree with the way their parent is being cared for by their sibling’ (Porirua)

- Whilst it is acknowledged that Pacific elders make a positive contribution to family life, there is concern that in the current economic times, unwell Pacific elders are being burdened with the responsibility of childcare for their grandchildren. Often this reflects the need for a dual household income and impacts on the health of the older person and represents risk to the grandchildren.

- Participants acknowledged that there continues to be a significant sensitivity in relation to gender care issues for Pacific in the delivery of care, ie. Daughter providing physical care for father.
“...found it really hard to provide general hygiene care to her father when it came to bathing and showers. He refuses to let her do these chores due to Cultural values (Le Va) respect between father and daughter” (Porirua)

**Preferences for care in the home**

- There is a preference by Pacific for family to provide assistance first.
  
  “I will decline help if I know I can cope and that my family will provide the support I need” (Porirua)

- It is acknowledged that there can be differences between NZ born Pacific and Island born Pacific Islanders.
  
  “The group had a long discussion about their cultural obligations and parental expectations especially the island born Pacific generations. There is a view that New Zealand born Pacific island generations are more flexible and more accepting if there is a need to place an elderly parent in residential care. The opposing view of the island born Pacific generations tends to regard placing a parent in a home as not fulfilling their obligations and view this as being unkind to ones parent or grandparent” (Porirua)

- Most participants knew of respite care, however there was reluctance to use these services.
  
  “... were reluctant to ask for respite care following a bad experience with the home. E.g. elderly parent had a fall and some came back with bruises following respite care” (Porirua)

- Participants noted that it was a major decision that the family has to make to put their elderly person in an aged residential care and there was concern how this would be perceived by other Pacific families.
  
  “It is a big issue for us as Pacific people to place our parents or grandparents in an aged residential care facility. It is a huge decision that the family has to make” (Porirua)

- When aged residential care was required participants voiced a feeling of neglecting their duties and feeling guilty about leaving the family member with strangers. Language barriers were also noted by one participant.
  
  “Her children did not mind and understood well the decision for aged residential care but she felt that she was neglecting her duties as his wife. There are also language barriers for them both... it will be difficult for staff at the home to understand him and vice versa” (Porirua)
**Stress on carers**

- Participants noted difficulty juggling work, family and church commitments. It was often mentioned that for the main caregiver, their lives were planned around the needs of the elderly family member and there was little opportunity for time out.
  
  “...it is such an effort to get to her to have bloods in the morning, then to the doctor in the morning, before I go to work” (Palmerston North)

  “Sometimes comes home from work really tired knowing that I need to attend to my Mum. We plan our lives around her Mum’s care and needs” (Porirua)

- Participants felt that the system did not acknowledge the option of funding family to care for their family member in their home. Participants felt that this would be a cheaper option for the DHB if family members were resourced better to provide care.

  “...DHBs and the MOH should consider allowing extended family members to provide Respite Care and be recognized as such financially (this is a much cheaper option than ARC) but will need to have quality control measures in place...” (Palmerston North)

- Dealing with challenging behaviour and deterioration in mental status of elderly family member increased carer stress.

  “...He was becoming forgetful, confused, wandered with no recognition of what he was doing and where he was going. Constant monitoring of his behaviour” (Palmerston North)

- A strength of Māori and Pacific culture is to look after their whānau, however it comes with risk, when there is expectation on children to be the carer at home.

**Knowledge of health services available**

- ‘The Adult Literacy and Life Skills Survey 2006 showed that, overall, the literacy of Pacific peoples was lower than other ethnic groups’ (Statistics NZ and Ministry of Pacific Island Affairs, 2010).

- Statistics NZ and Ministry of Pacific Island Affairs (2011 p.38) report ‘Pacific peoples experience other factors that contribute to limited health literacy, such as lower socio-economic status and language difficulties’.

- To access services, Pacific people need to be aware that the services exist and that they are needed. Health professionals have a responsibility in raising awareness and enabling access.

- Whilst many participants were aware of respite care, access to this information had been ad hoc. In one instance a carer only found out about these services after her own health event, in another instance the carer was only made aware of services after elderly family member placed in aged residential care.

- One family said that it was easy to access respite care and get information as it was all organised by the visiting services that assist with care at home.
• Pacific elders and family felt further disadvantaged if information provided was not in the language they spoke.

Issues associated with assessment

• Most of the participants’ elderly family members’ were assessed at home. The needs of the family were included but concern was raised that this did not reflect on the allocated resources or support for caregivers provided.
• There was concern over some areas of the assessments. It was noted that due to language barriers, Pacific were unable to understand the process. There was also concern that phone assessments were undertaken which reduced the level of a person’s care.

  “…a reduction in hours and time allocated for the older person following a phone assessment even though their condition had worsened” (Porirua)

• While most participants were happy with the timeframe for feedback following the assessment some identified a long wait for support or feedback following the assessment, in one case two years for equipment and housing modifications.
• One participant was frustrated at being pushed between systems (ACC and NASC) with no one taking responsibility for her parent.

  “…In the meantime, her mother deteriorated while waiting for support” (Porirua)

Lack of cultural services available

• Pacific participants felt that DHBs needed to invest further in activities that encourage elderly Pacific people out of their homes and into the community for daily/weekly community based services.

  “…provide facilities where there are organised pacific group activities for older Pacific people (cultural activities) like the Kaumatua group …along the lines of prevention and diversion activities” (Porirua)

  “…will be great if there was a facility that is Pacific specific with Pacific caregivers, Pacific food and Pacific programmes” (Porirua)

• It was suggested that rest homes need to have funded day programmes for the elderly so carers get time out.
• In relation to cultural responsiveness, participants felt that there are sometimes fundamental barriers between Pacific people and non-Pacific health professionals which can compromise the quality of communication between them, and consequently, the quality of any service delivered.

  “…suggest that NASC services commit to employing Pacific assessors” (Porirua)
Recommendations

1. Pacific people feel a strong sense of responsibility in caring for their family member even at times when it is not practicable. DHBs need to develop models of care which incorporate a Pacific approach to support the elderly person and family to navigate health services.

Components of the model of care should include:
   a. engagement with Pacific, particularly for the purpose of assessment, should always be face to face with the caregiver and support network present to ensure that problems and underlying issues are identified, especially when there are language/health literacy issues
   b. development of care coordinator type roles that assists families to deal with the complexities of multiple caregivers where more than one family member cares for the Pacific elderly person
   c. support from health professionals with the provision of tools and resources to enable care in the home such as tools for administration of medications
   d. neutral non-family members who can assist in facilitating and enhancing good communication, and assisting with role clarification of family members
   e. acknowledgement of the significant role of the carer in maintaining the elderly Pacific person at home and ensuring that respite care can respond with urgency to prevent a crisis
   f. Health Navigators to play a key role in the relationship between InterRAI assessors, care coordination agencies and Pacific elderly and ensure that Pacific navigate the health system across primary, community and specialist services.

2. DHBs need to work in partnership with NASC agencies and service providers to improve the engagement between service providers and Pacific families. A mechanism to improve engagement would be to ensure cultural responsiveness training occurs and that it is of high quality, sustainable and consistent across the DHBs.

3. Some carers are not aware of Ministry of Social Development and Ministry of Health carer support benefits which are available to financially support their carer role. NASC assessors and DHB based Social Workers need to provide this information to caregivers.

4. The focus groups provided a rich consumer perspective on issues for Pacific people. It is important that the consumer perspective is sought and informs service planning and quality initiatives, so Pacific can inform future directions. This could be achieved via patient experience surveys and Pacific consumer representation on local DHB consumer groups.

5. Pacific workforce development needs to occur to ensure people with the right skills are providing care to the right people, at the right time. For Māori and Pacific ‘right’
care may not be ‘clinical’ but may include navigational support, whānau interaction etc. DHBs need to be supporting Workforce NZ and other agencies to develop the Māori and Pacific workforce and should also be considered a priority for the Regional Training Hub.

6. Poorer health outcomes for Pacific are often the result of poor utilisation and access to primary care, therefore DHBs need to work alongside MoH and researchers to understand access and utilisation issues as they relate to Pacific people’s use of primary health services. There is an opportunity for DHBs to utilise the InterRAI clinical repository to support such research. DHBs then need to make provision for and prioritise the implementation of the research findings.
Access to Services

(i) Long Term Condition Fund (50 – 64 years)

People aged under 65 with chronic health conditions can experience difficulty accessing needed long-term support services because they do not meet the access criteria for either Ministry of Health funded disability support services or District Health Board (DHB) funded long-term support services. In response to this, the Interim Funding Pool (IFP)\(^1\) was set up in November 2006 to address the needs of those aged 50 – 64 years of age.

Administration of the IFP/ LTC Fund sat with Ministry of Health until funding was devolved to DHBs in July 2011.

Generally people are eligible to receive funded support through the LTC Fund if they meet the following criteria:

1. are not eligible for Ministry funded disability support services or DHB funded long-term support services
2. have one or more chronic health condition(s) that is/are expected to continue for six months or more
3. have a very high need for long-term support services
4. do not have an informal support system (family/ whānau) or the caregiver is under considerable pressure and their ability to support the person is compromised
5. are not currently receiving Ministry funded disability support services or long term support services funded by a DHB (regardless of funding source).

Due to poorer health outcomes and earlier onset of chronic health conditions for Māori and Pacific Peoples a data request was made to MoH in September 2011 to understand access to the LTC.

The table below identifies the total number of people in the Central Region accessing the LTC Fund for 2010/2011. This represents an increase of two from the previous year, though there was slight movement by DHB.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Total Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>26</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>31</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>21</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>25</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>22</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>146</strong></td>
</tr>
</tbody>
</table>

Table 2: Total numbers receiving support through the LTC in 2010/2011

\(^1\) During this project, the term IFP was replaced with the Long Term Conditions Fund
Chart 3 shows a comparison of actual accepted numbers within the Central Region against the expected number based on regional population split. For example, Capital and Coast DHB has 33% of the region’s population, whereas they have 18% of the region’s LTC accepted numbers.

Chart 4 demonstrates that in the Central Region, Māori and Pacific Peoples have access to the LTC fund.
Whilst there are overall low volumes in the Central Region, there were five diagnostic groups which made up 75% of the total numbers for all ethnicities. The top (5) are:

1. Brain and nervous system i.e. stroke
2. Dementia
3. Nutrition, hormones and metabolism
4. Respiratory system

These diagnostic groups do not vary significantly from the major causes of death for Māori and Pacific Peoples aged 50 years and over.

The types of services being delivered through the LTC fund are outlined in the chart below. The total number of services is (509) reflecting that most people will receive more than one funded support throughout the year.

**Chart 5: Funded supports received through the LTC**

**Summary**

- Overall Māori and Pacific Peoples in the Central Region are receiving funded support through the LTC.
- Access rates by DHB vary significantly when compared to the regional population split.

**Recommendations**

1. The LTC funding eligibility criteria has been a national standard; however with the devolution of funding to DHBs, the challenge will be to ensure that the eligibility criteria don’t change once DHBs start to manage their own budgets, especially when it changes to Population Based Funding Formula (PBFF) which is expected in 2014. The Health of Older Persons Portfolio Managers have agreed to 30 standardised data
collection for the LTC, however this needs monitoring and reporting on in the next 12 and 24 months.

(ii) NASC (65 years +)

The Ministry of Health and DHBs are supportive of the philosophy which encourages people to make choices about where they live and ensures that there is support in the community when they choose to remain in their own homes.

An older person may require a mix of support services, both informal and formal, to stay in their own home. Even with adequate help and services in place, older people may be alone for long periods and experience loneliness.

Formal support services are accessed through a Needs Assessment and Service Co-ordination (NASC) service. NASCs are organisations contracted to the Disability Support Services, which work with people to help identify their needs and allocate Ministry-funded support services and assist with accessing other supports.

InterRAI is a comprehensive clinical assessment tool used by NASC agencies to evaluate the needs, strengths, and preferences of individuals. All InterRAI assessors have health qualifications and annual practicing certificates. InterRAI was used by all of the Central Region DHBs during 2010/2011, though in Whanganui there may still have been some support needs assessments occurring.

Prior to the New Zealand roll out of InterRAI by Ministry of Health, a Māori Strategy Group was consulted. This group confirmed that the items in InterRAI were acceptable to Māori and endorsed the process of InterRAI. This consultation led to MoH adapting the InterRAI training to ensure assessors trained in having “cultural conversations”.

However MoH did undertake to revisit the cultural acceptability of items in InterRAI during 2011/2012. This work has been led by Dr Brigette Meehan from MoH who consulted with the Project Team during 2011/2012 to seek their views and to be informed by the focus groups held.

To understand access by Māori and Pacific peoples aged 65 years and over to support services, a data request was sent to Health of Older Persons Portfolio Managers and NASC agencies in September 2011. Three years of historical data was sought.

It was recognised that the Central Region DHBs and NASC agencies do not collect data in a standardised way, therefore were required to report any data quality issues. The data quality issues are noted in Appendix 4. In addition to the individual DHB responses the TAS analysts noted:

- Data completeness issues make comparison between years weak
- Given the low numbers, analysis is presented by per 1000 of the population
- The raw numbers for Māori and Pacific are low, so statistically these graphs need to be treated with caution
Due to the way in which Wairarapa stores its data, the 08/09 and 09/10 years information was unavailable and therefore is not represented.

Hutt Valley DHB were unable to classify all service users into Non-Complex and Complex therefore their total volumes are included.

The charts below show service provision across the Central Region. “Service Provision” refers to the total service provision for clients defined as non-complex and complex.

**Chart 6: Service Provision for Māori**

**Chart 7: Service Provision for Pacific People**
**Community versus Aged Residential Care**

The Central Region Health of Older Persons Portfolio Managers undertook regional benchmarking and identified that the average age of entry to residential care in the Central Region is 83 years of age for the 2010/2011 period.

Tables 3 and 4 show the percentage of complex clients who have their needs met in the community and in aged residential care for all DHBs in the Central Region, by ethnic group.

<table>
<thead>
<tr>
<th>% of Complex Clients Supported In The Community for all Central Region DHBs</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008/09</td>
</tr>
<tr>
<td>Māori</td>
<td>56%</td>
</tr>
<tr>
<td>Pacific Peoples</td>
<td>75%</td>
</tr>
<tr>
<td>NZ European/ Other</td>
<td>36%</td>
</tr>
</tbody>
</table>

Table 3: Complex clients supported in the community

<table>
<thead>
<tr>
<th>% of Complex Clients Supported in Aged Residential Care for all Central Region DHBs</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008/09</td>
</tr>
<tr>
<td>Māori</td>
<td>44%</td>
</tr>
<tr>
<td>Pacific Peoples</td>
<td>25%</td>
</tr>
<tr>
<td>NZ European/ Other</td>
<td>64%</td>
</tr>
</tbody>
</table>

Table 4: Complex clients supported in aged residential care

Refer to Appendix 5 for service provision rates by DHB for the last three years.
When considering equity of access to services by Māori and Pacific people, two timeframes along the service continuum were considered. These were:

1. The average time taken between receipt of referral and assessment time
2. The average time from assessment to service allocation.

Two DHBs were unable to identify response times and where timeframes were identified there was significant variation. Where outliers were noted, the DHB reviewed individual cases. Refer Appendix 6.

**Summary**

- Access to services varies significantly by DHB for Māori and Pacific, however despite data quality issues, when viewed as the whole region, access has increased over the last three years.
- Generally access by all ethnic groups to aged residential care has reduced across the region over the last three years reflecting the approach by DHBs to support older adults in the community when they choose to remain in their own homes.
- Data collection systems are not standardised across the DHBs making comparison and benchmarking difficult. Lack of archiving makes trend analysis impossible for some DHBs and NASC agencies.

**Recommendations**

1. In assessing the needs of Māori and Pacific people it is important for DHBs to ensure the needs of the Māori and Pacific people are informed by robust data collection processes. DHBs need to establish standardised systems to enable regional benchmarking to ensure a focus on outcomes for elderly Māori and Pacific people. At a minimum NASC services and DHBs should monitor and report on:
   a. Access to services by Māori and Pacific by comparison to its over 65 years population
   b. The average time taken between receipt of referral and assessment time
   c. The average time from assessment to service allocation
   d. Level of care required – both that associated with the carer (respite care) and that associated with physical needs of the elder (personal cares).
2. DHBs and NASC agencies need to ensure the data collection systems enable previous year’s information to be archived to enable service provision trends to be viewed in the future and needs to be accessible at NHI level.
3. It is recognised that InterRAI as a clinical repository of information offers DHBs the opportunity to better understand their local elderly Māori and Pacific population. It is recommended that annually the Health of Older Persons Portfolio Managers utilise the InterRAI repository to compare ‘at risk’ categories for the elderly Māori and Pacific populations. For example, social isolation is considered within the context of the InterRAI assessment in section E – Mood and Behaviour Patterns and Section F – Social Functioning.
4. With more people living in the community and utilisation rates to aged residential care reducing it is likely that more complex patients are being supported in the community by formal and informal supports. Whānau are looking after elders who are likely to have greater health and social care needs, therefore training/mentoring is required to support informal caregivers. Training and mentoring could be in areas of manual handling, medication management and the management of the behavioural and psychological symptoms of dementia.

5. Mainstream providers need to understand and be familiar with the “Whānau Ora” approach to improve health navigation by elders and whānau. Likewise community support workers and NGOs need to understand and be familiar with mainstream processes and services to improve health navigation by elders and whānau. Overall there is a need to establish improved communications, better relationships and understanding of each other scopes and roles to reduce fragmentation of knowledge and service provision for Māori and Pacific people.

6. As Māori and Pacific people develop chronic conditions younger (50 years +), there must also be a better connection between older persons and disability sectors to ensure a smooth transition between service providers and funding pools.

(iii) Targeted Services for Older Māori and Pacific People

Ashton (2000 p.81) reports that ‘the Māori population is aging faster than the general population is, and the degenerative effects of aging occur at an earlier age. There is therefore an urgent need to examine the service requirements and preferences of Māori people and to develop a style of service that best meets their needs’.

The Health of Older Persons’ Portfolio Manager was requested to provide information on whether there were targeted programmes or services in place locally for older Māori and Pacific Peoples.

There were no targeted programmes for older Pacific people, though Hutt Valley DHB noted Mapusaga O Aiga Trust previously provided a Pacific Island Day Care programme, however the provider decided to cease this service in May 2011.

Table 5 summaries the response from the DHBs for older Māori. Appendix 7 details the full responses from the DHBs.

<table>
<thead>
<tr>
<th>Targeted Service</th>
<th>C&amp;CDHB</th>
<th>HBDHB</th>
<th>HVDHB</th>
<th>MDHB</th>
<th>WaiDHB</th>
<th>WhaDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB supported community services specific to Māori &amp;/or Pacific People</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Are the services above effective?</td>
<td>n/a</td>
<td>Yes</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Yes</td>
</tr>
<tr>
<td>Were DHB supported</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
community services available in the last 5 years, which have been ceased

<table>
<thead>
<tr>
<th>Targeted Service</th>
<th>C&amp;CDHB</th>
<th>HBDHB</th>
<th>HVDHB</th>
<th>MDHB</th>
<th>WaiDHB</th>
<th>WhaDHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged residential care facilities which cater specifically for Māori or Pacific People</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Table 5: Targeted services for Māori by DHB

MidCentral DHB noted that whilst there were no targeted services in 2010/2011, they have developments underway to support older Māori.

Hawke’s Bay DHB has a new Pacific Action plan. Actions include engagement with Pacific communities, programmes related to healthy lifestyles, CVD and cardiovascular disease.

Targeted programmes can be seen as prevention against social isolation, as social isolation can lead to self neglect and health issues and is as important as physical care in maintaining the independence and wellness of older adults.

Hovey (2009 p29) consulted with iwi on social isolation

‘In general discussions with iwi there were good indications that the iwi groups consulted took good care of their own kaumatua and kuia. However, there could be others who do not fall within iwi care or their systems and could be ‘invisible’, and so falling through the cracks... it was stressed that Māori older people can be shy and need encouragement, very private, concerned over who provides their care, independent and want to stay in their own home and retain their dignity...being housed on or near a marae, like Pūtiki and Kaiwhaiki, can help to address loneliness and social isolation as this encourages involvement and there are comings and goings to watch.’

Many DHBs in the Central Region contract with rest homes to provide Day Support Services. Services are funded primarily to provide carer respite, so where carer eligibility criteria are met, it goes some way to addressing social isolation for clients living in the community. The Hovey (2009) review noted that not many older Māori people use day care so more specific programmes for Māori older people would be beneficial.

Summary

- Whanganui and Hawke’s Bay DHB have the highest percentage of older people who are Māori than other Central Region DHBs, which reflects their investment in targeted services is reflective of their population.
- There are no services targeted specifically for Pacific People in the Central Region. This can be provided through:
  - telephone contact


- being visited
- engaging in activities outside the home
- living with others.

**Recommendations**

1. Māori and Pacific families support their elders in the home. Targeted services included the need for education on the health related condition and behaviour (such as dementia) to informal carers to ensure elders are safe in their homes and to reduce carer stress.

2. To address social isolation, support and care needs to be put in place by utilising current Māori social structures and networks, and develop new connections or communities where required. These forums could be whānau orientated in that other whānau members could participate if they choose, providing a support system for both the carer and the older person. Whilst the impacts of social isolation may be reflected in health outcomes, this must be a joint effort with local bodies and government services and non-government services. DHBs need to consider how to partner these agencies to minimise social isolation.

   ‘DHBs explore opportunities with other agencies, to provide community lunches or regular gatherings for lonely older people in venues other than rest homes. There would be merit in targeting specific groups and ensuring cultural appropriateness. ...more specific programmes for Māori older people would be useful – perhaps enabling them to come together for kai, singing, activities and share memories.” Hovey (2009 p.29)

3. DHBs need to formalise links with other agencies across health and social care that provide for social inclusion in their policies and ensure that services are well communicated to clients and their whānau.

4. Funded support such as day programmes or home based support services is extended to include those who are vulnerable/ at risk of functional decline through social isolation.
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>aged residential care</td>
<td>Residential care for older people, including rest-home care, dementia care, hospital care and specialised hospital (psycho-geriatric) care.</td>
</tr>
<tr>
<td>Health literacy</td>
<td>‘Is defined as the ability to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions’ MoH (2011 p.19).</td>
</tr>
<tr>
<td>he mihi mihi</td>
<td>NZ a Māori ceremonial greeting</td>
</tr>
<tr>
<td>iwi</td>
<td>Tribe</td>
</tr>
<tr>
<td>kai</td>
<td>Food</td>
</tr>
<tr>
<td>kaiāwhina</td>
<td>Helper, assistant</td>
</tr>
<tr>
<td>Kaiwhaiki</td>
<td>Marae in Whanganui</td>
</tr>
<tr>
<td>kaumātua</td>
<td>Elder</td>
</tr>
<tr>
<td>koha</td>
<td>Donation, contribution</td>
</tr>
<tr>
<td>koro</td>
<td>Shortened version of “koroua”. Is always a male.</td>
</tr>
<tr>
<td>Kuia</td>
<td>Female elder</td>
</tr>
<tr>
<td>Le Va</td>
<td>New Zealand’s national Pacific health workforce development programme within Te Pou</td>
</tr>
<tr>
<td>marae</td>
<td>Public area in front of a meeting house</td>
</tr>
<tr>
<td>mokopuna</td>
<td>Child, grandchild</td>
</tr>
<tr>
<td>pūtiki</td>
<td>Tie together, to knot</td>
</tr>
<tr>
<td>respite care</td>
<td>Short-term care for people to provide informal carers with a break from providing care. Respite is provided in a variety of settings, including residential care, hospitals or in the home.</td>
</tr>
<tr>
<td>Rongoā</td>
<td>Māori treatments including herbal remedies (rongoā rākau)</td>
</tr>
<tr>
<td>Social isolation</td>
<td>Defined as the lack of meaningful social contacts and can be exacerbated with old age as friends and family members die or move, and health issues increase for the person or their carer.</td>
</tr>
<tr>
<td>Tangi</td>
<td>Funeral service</td>
</tr>
<tr>
<td>Te Ao Māori</td>
<td>The Māori worldview</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>waka</td>
<td>Canoe</td>
</tr>
<tr>
<td>whakapapa</td>
<td>Genealogy</td>
</tr>
<tr>
<td>whānau</td>
<td>Family</td>
</tr>
<tr>
<td>whānau caregiver</td>
<td>‘A whānau caregiver is defined as “a person linked to the person with a</td>
</tr>
<tr>
<td></td>
<td>disability by whakapapa and who has inherited or assumed the role out of</td>
</tr>
<tr>
<td></td>
<td>a sense of duty, obligation and love’ Nikora et al. (2004 p.50)</td>
</tr>
<tr>
<td>Whānau Ora</td>
<td>Whānau Ora is an inclusive approach to providing services and opportunities</td>
</tr>
<tr>
<td></td>
<td>to whānau in need. Whānau Ora is about a transformation of whānau, with</td>
</tr>
<tr>
<td></td>
<td>whānau setting their own direction and has a focus on outcomes</td>
</tr>
</tbody>
</table>
Bibliography


References


Appendix 1: Focus Group Participant Information Sheet

He mihi mahana ki a koe

What?
The Central Regional Supporting Older Māori and Pacific People Project has an inclusive approach to understanding the health needs of Older Māori and Pacific People.

It empowers Older Māori and Pacific People and their whānau to have input into identifying their needs for ongoing wellness.

The purpose of the focus group is to understand peoples’ preferences for support and their views of Aged Residential Care. In particular we wish to know:

- How do elderly Māori and Pacific peoples wish to be supported in the community?
- When Aged Residential Care is required, are there barriers to access?

How?
Facilitators of the groups will be ask you questions about (but not limited to):

The context of family
- Who are the family members that reside in your home?
- Who and how is care provided to the elderly people in your home?

Focus: How do elderly Māori and Pacific peoples wish to be supported in the community?

- What challenges do you experience in caring for your elderly family member in the home?
- What responsibilities do your elderly family members have in the day to day running of your household?
- What role do other non-resident family members play in the care of your elderly?
- How easy or difficult was it to find information about support and financial services to assist your elderly family members?
- If the elderly family member in your home has been recently assessed, how did they find the visit and the experience of being assessed, do you feel the needs of the family and whānau were considered too?
- If the elderly family member in your home has been assessed, how easy or difficult was it to find out what the assessment found and what was happening next.
- If a care worker comes into your home, what works well and what difficulties does the family experience?
• If you felt you needed a break from caring how easy or difficult was it to find information on how to access a break (Respite Care)
• Are there any reasons that you would decline help if it was offered?

**Focus: When Aged Residential Care is required, are there barriers to access?**

• What challenges were you experiencing in caring for your elderly family member that led you to think that they may need aged residential care?
• How easy or difficult was it to find information about aged residential care?
• What concerned you about placing your elderly family member in residential care?
• Now that your family member is in aged residential care, what are the challenges, what is working well or better?

**Who?**

The focus groups will be lead by XXX on behalf of the Central Regional Supporting Older Māori and Pacific People Project.

**What will happen if I take part?**

If you decide to take part in this study, we will discuss the consent process with you and confirm your consent to participate. The Focus groups will be recorded for the purpose of allowing a conversational style of discussion. These audio tapes will be reviewed by Central TAS (DHB Shared Services agency) and once selected quotations and themes have been agreed, these recordings will be deleted.

**What will happen with the results?**

The information sought will be used to inform the Central Region DHBs how best to contribute to whānau needs and aspirations;

• you will not be named in any reports within the Central Regional Supporting Older Māori and Pacific People Project, or in any publications or reports circulated externally;
• any raw data of the project will be retained in secure storage
• participation in the focus group is entirely voluntary; and you are free to withdraw from the focus group at any time without any disadvantage; and
• your participation will not have any negative effect on your current employment and/or relationship with the any health provider participating in the Central Region.
• General themes may be used to inform Ministry of Health projects for Older Adults.
What if you have any questions?

If you have any questions about our project, either now or in the future, please feel free to contact XXX

Kia ora mo to tautoko

On behalf of the Central Regional Supporting Older Māori and Pacific People Project.
Appendix 2: Focus Group Consent Form

I have read and I understand the information sheet for taking part in the Supporting Māori People & Pacific Focus Group.

I have had the opportunity to discuss this study with the facilitators and I am satisfied with the answers I have been given.

I understand that my participation in this forum is entirely voluntary (my choice) and that I can withdraw from the focus group at any time.

I understand that my participation in this focus group is confidential and that no material that could identify me or my whānau will be used in any documents associated with this project.

I have had time to consider whether to take part in this focus group.

I know who to contact if I have any questions about the focus group.

I consent to be interviewed as part of this focus group  
Yes ☐  No ☐

I consent to my korero being audio taped  
Yes ☐  No ☐

I __________________________________________________________ (full name) hereby consent to take part in this focus group.

Signature__________________________  Date________________________

Kia ora mo to tautoko

Name
Title
Address
Phone:
Email:
Appendix 3: Guided Questions for Focus Groups

The context of family

1. Who are the family members that reside in your home?
2. Who and how is care provided to the elderly people in your home?

Focus: How do elderly Māori and Pacific peoples wish to be supported in the community?

1. What challenges do you experience in caring for your elderly family member in the home?
2. What responsibilities do your elderly family members have in the day to day running of your household?
3. What role do other non-resident family members play in the care of your elderly?
4. How easy or difficult was it to find information about support and financial services to assist your elderly family members?
5. If the elderly family member in your home has been recently assessed, how did they find the visit and the experience of being assessed, do you feel the needs of the family and whānau were considered too?
6. If the elderly family member in your home has been assessed, how easy or difficult was it to find out what the assessment found and what was happening next.
7. If a care worker comes into your home, what works well and what difficulties does the family experience?
8. If you felt you needed a break from caring, how easy or difficult was it to find information on how to access a break (Respite Care)?
9. Are there any reasons that you would decline help if it was offered?

Focus: When Aged Residential Care is required, are there barriers to access?

Give examples of what Aged Residential Care is.

1. What challenges were you experiencing in caring for your elderly family member that led you to think that they may need aged residential care?
2. How easy or difficult was it to find information about aged residential care?
3. What concerned you about placing your elderly family member in residential care?
4. Now that your family member is in aged residential care, what are the challenges, what is working well or better?
Appendix 4: Data Quality Issues with NASC Information

DHB and NASC agencies were required to report any data quality issues as part of the response. This was to ensure that quality issues were apparent during analysis being undertaken and summarised in the report. In addition to the individual DHB responses noted below, the analysts noted:

- Data completeness issues make comparison between years weak
- Given the low numbers, analysis is presented by per 1000 of the population
- The raw numbers for Māori and Pacific are low, so statistically these graphs need to be treated with caution
- Due to the way in Wairarapa stores its data, the 08/09 & 09/10 years information was unavailable and therefore is not represented
- Hutt Valley DHB was unable to classify all service users into Non-Complex and Complex therefore total volumes are included, though complexity is inaccurate.

The data quality issues by DHB are noted in table 6 below.

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Data quality issues noted by the DHB/NASC Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>• The number of assessments reported is from the national InterRAI reporting data warehouse and may not include all assessments.</td>
</tr>
<tr>
<td></td>
<td>• Care Levels 1&amp;2 have been classified as Non Complex, Care Levels 3&amp;4&amp;5 have been classified as Complex. However Level 3 contains a mixture of Complex and Non Complex clients which cannot be separated out without a manual review of every client.</td>
</tr>
<tr>
<td></td>
<td>• Due to the transition from HM/PC to Packages of Care (PoCs) and then to PoCs with Care Levels, the split of complex/non complex is not always available before 12/2010 so this has been added to a new section – “Unknown level”. The main transition period for PoCs to PoCs with levels was early 2009 to mid 2010 and the numbers for 2009/2010 will have a number of double counts with clients being counted once with no level and once with a level.</td>
</tr>
<tr>
<td></td>
<td>• Using the Excel feature “remove duplicates” and selecting only ‘NHI’ and ‘Level of care’ will have left one record at each level, but this may have picked up some services (like Personal Cares) where a level is not always recorded and the PoC where a level is more likely to be recorded. Where this occurs, the client will be double counted.</td>
</tr>
<tr>
<td></td>
<td>• A client will be counted each time they appear with a different “Level” – for example if a client has received services and the allocation moves from “no level” recorded to “non-complex” to “complex” they will appear three times in the numbers. In</td>
</tr>
<tr>
<td>DHB Region</td>
<td>Data quality issues noted by the DHB/NASC Agency</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>- None noted</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>- Care Levels 1&amp;2 have been classified as Non Complex, Care Levels 3&amp;4&amp;5 have been classified as Complex. However Level 3 may contain a mixture of Complex and Non Complex clients which cannot be separated out without a manual review of every client.</td>
</tr>
</tbody>
</table>
|                  | - The split of complex/non complex is not always available so this has been added to a new section – “Unknown level”.

- Using the Excel feature “remove duplicates” and selecting only ‘NHI’ and ‘Level of care’ will have left one record at each level, but this may have picked up some services (like Home Management) where a level is not always recorded and Respite where a level of 4 has been added. Where this occurs, the client will be double counted. |

- A client will be counted each time they appear with a different “Level” – for example if a client has received services and the allocation moves from “no level” recorded to “non-complex” to “complex” they will appear three times in the numbers. In addition, if a different level has been recorded on a CS allocation and the HM/PC created at the same time then the client will be counted at each level. |

- The lists of allocations have been split into Community Care and Residential Care and a client moving from receiving services in the Community to Residential Care would be counted twice – once in each list. |

- The time taken for new services to be delivered is not available – This was not recorded in out old system that I am aware of and with a large amount of expensive report development would be only available from our new system for the last 6 months of the required time period. There is also an issue in identifying what is a “new client” when an assessment may be for an existing client changing from Contact to MDS or the client may have been set up for many years for DN or referral processing. |
<p>| MidCentral DHB  | - The quality of the data is questionable to an unknown level of accuracy.                                                                                                                                                                                             |
|                  | - DHB has plans to replace the current NASC database due to data integrity concerns. This is planned for the 2012-13 year.                                                                                                                                             |</p>
<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Data quality issues noted by the DHB/NASC Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wairarapa DHB</td>
<td>• Statistical data is collected as a snapshot and as information is updated it overwrites the previous information, therefore SPA level and whether the person is receiving services in the community or in ARC is not able to be identified for previous years.</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>• All population data provided was based on the 2006 census.</td>
</tr>
<tr>
<td></td>
<td>• No breakdown available for Pacific People in the data sheet provided.</td>
</tr>
<tr>
<td></td>
<td>• During the year people’s needs may change and a re-assessment or review may determine a higher level of SPA. The supports could also change from Community Support to Aged Residential Care during the year.</td>
</tr>
</tbody>
</table>

Table 6: Data quality issues by DHB
Appendix 5: Service Provision Rates for Aged Residential Care and Community Supports

Table 7 shows the percentage of Māori receiving services in the community versus in aged residential care over the 3 year period.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Year</th>
<th>% Māori Receiving Community Services</th>
<th>% Māori in Aged Residential Care</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>2008/09</td>
<td>63%</td>
<td>37%</td>
<td>• On average 71% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC reducing over 3 year period</td>
</tr>
<tr>
<td>Capital and Coast DHB</td>
<td>2009/10</td>
<td>76%</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Capital and Coast DHB</td>
<td>2010/11</td>
<td>73%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>2008/09</td>
<td>46%</td>
<td>54%</td>
<td>• On average 46% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC has remained static over 3 year period</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>2009/10</td>
<td>46%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>2010/11</td>
<td>46%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>2008/09</td>
<td>51%</td>
<td>49%</td>
<td>• On average 50% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC reducing over 3 year period</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>2009/10</td>
<td>39%</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>2010/11</td>
<td>61%</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>2008/09</td>
<td>59%</td>
<td>41%</td>
<td>• On average 57% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC increased over 3 year period</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>2009/10</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>2010/11</td>
<td>51%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>2010/11</td>
<td>50%</td>
<td>50%</td>
<td>• Trend information not available.</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>2008/09</td>
<td>85%</td>
<td>15%</td>
<td>• On average 87% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC reduced over 3 year period</td>
</tr>
</tbody>
</table>

Table 7: The percentage of Māori receiving services in the community versus in aged residential care over the 3 year period
<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Year</th>
<th>% Pacific Peoples Receiving Community Services</th>
<th>% Pacific Peoples in Aged Residential Care</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Coast DHB</td>
<td>2008/09</td>
<td>76%</td>
<td>24%</td>
<td>• On average 78% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC reducing over 3 year period</td>
</tr>
<tr>
<td>Capital Coast DHB</td>
<td>2009/10</td>
<td>79%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Capital Coast DHB</td>
<td>2010/11</td>
<td>80%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>2008/09</td>
<td>13%</td>
<td>88%</td>
<td>• On average 41% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC reducing over 3 year period</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>2009/10</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>2010/11</td>
<td>60%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>2008/09</td>
<td>81%</td>
<td>19%</td>
<td>• On average 78% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC increased over 3 year period</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>2009/10</td>
<td>77%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>2010/11</td>
<td>77%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>2008/09</td>
<td>67%</td>
<td>33%</td>
<td>• On average 27% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC increased over 3 year period</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>2009/10</td>
<td>13%</td>
<td>88%</td>
<td></td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>2010/11</td>
<td>0%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>2010/11</td>
<td>67%</td>
<td>33%</td>
<td>• Trend information not available.</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>2008/09</td>
<td>75%</td>
<td>25%</td>
<td>• On average 76% of clients receive services in the community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Access to ARC reducing over 3 year period</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>2009/10</td>
<td>75%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>2010/11</td>
<td>78%</td>
<td>22%</td>
<td></td>
</tr>
</tbody>
</table>

Table 8: The percentage of Pacific Peoples receiving services in the community versus in aged residential care over the 3 year period
Appendix 6: Time taken for new clients to receive services (aged 65 years and over)

The tables below reflect the information returned from the NASC Agencies by DHB region. The questions sought to understand how long it takes for new clients to receive services by ethnic group to determine if there was significant variation for older Māori and Pacific Peoples.

There were two timeframes along the service continuum that were considered. These were:

1. The average time taken between receipt of referral and assessment time
2. The average time from assessment to service allocation

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Māori</th>
<th>Pacific Peoples</th>
<th>NZ European/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Hawke's Bay DHB</td>
<td>19 days</td>
<td>7 days</td>
<td>17 days</td>
</tr>
<tr>
<td></td>
<td>3 days</td>
<td>5 days</td>
<td>3 days</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>20 days</td>
<td>20 days</td>
<td>18 days</td>
</tr>
<tr>
<td></td>
<td>32 days</td>
<td>80 days</td>
<td>24 days</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>6 weeks</td>
<td>6 weeks</td>
<td>6 weeks</td>
</tr>
<tr>
<td>DHB Region</td>
<td>Māori</td>
<td>Pacific Peoples</td>
<td>NZ European/Other</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------</td>
<td>-----------------</td>
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</tr>
<tr>
<td></td>
<td>time</td>
<td>Average time</td>
<td>Average time</td>
</tr>
<tr>
<td></td>
<td>from assessment</td>
<td>from assessment</td>
<td>from assessment</td>
</tr>
<tr>
<td></td>
<td>to service</td>
<td>to service</td>
<td>to service</td>
</tr>
<tr>
<td></td>
<td>allocation</td>
<td>allocation</td>
<td>allocation</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>5 days</td>
<td>5 days</td>
<td>5 days</td>
</tr>
</tbody>
</table>

| Whanganui DHB    | No waiting time, appointments are determined by a persons availability | No waiting time, appointments are determined by a persons availability | No waiting time, appointments are determined by a persons availability |
| Average Referral to assessment time | No waiting time, appointments are determined by a persons availability | No waiting time, appointments are determined by a persons availability | No waiting time, appointments are determined by a persons availability |
| Average time from assessment to service allocation | No waiting time, appointments are determined by a persons availability | No waiting time, appointments are determined by a persons availability | No waiting time, appointments are determined by a persons availability |

Table 9: Average timeframes for the period 2010-2011

Notes:

Wairarapa DHB – urgent referrals are responded to within 24 hours from referral to assessment time. Non urgent referrals are usually seen within 30 days. The average timeframe is longer than previous years due to downtime associated with InterRAI training, increase in referral numbers in the latter half of the year and reduced staffing resource.

Hawke’s Bay DHB – average time from referral to assessment time for Pacific Peoples is 10-12 days less than for Māori or “other”. When referred, there was no particular reason for this, other than likely to be influenced by the small number of clients or timing of when clients entered the service.

MidCentral DHB – Due to some high averages in MidCentral DHB’s data across the three years, case files were reviewed. For Pacific Peoples (2010/2011) the 80 days average time from assessment to service allocation reflects a case held open pending the outcome of needs assessment for the spouse with the identified health needs. Data is also skewed given the low volumes.

Average time from assessment to service allocation for Māori is reflected as on average longer. Case files were reviewed to understand the discrepancy. One case was held open pending rehabilitation outcomes (6 weeks) and the other awaiting whānau decision making. Other cases reflect data quality issues as noted in Appendix 5.
<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Māori</th>
<th>Pacific Peoples</th>
<th>NZ European/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>12 days</td>
<td>10 days</td>
<td>13 days</td>
</tr>
<tr>
<td></td>
<td>3 days</td>
<td>3 days</td>
<td>3 days</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>29 days</td>
<td>18 days</td>
<td>14 days</td>
</tr>
<tr>
<td></td>
<td>21 days</td>
<td>20 days</td>
<td>17 days</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>4 weeks</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>5 days</td>
<td>5 days</td>
<td>5 days</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
</tr>
<tr>
<td></td>
<td>No waiting time, appointments are determined by a person’s availability</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
</tr>
</tbody>
</table>

Table 10: Average timeframes for the period 2009-2010
<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Māori</th>
<th>Pacific Peoples</th>
<th>NZ European / Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>Average Referral to assessment time</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Average time from assessment to service allocation</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>Average Referral to assessment time</td>
<td>13 days</td>
<td>13 days</td>
</tr>
<tr>
<td></td>
<td>Average time from assessment to service allocation</td>
<td>2 days</td>
<td>2 days</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>Average Referral to assessment time</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td></td>
<td>Average time from assessment to service allocation</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>Average Referral to assessment time</td>
<td>21 days</td>
<td>41 days</td>
</tr>
<tr>
<td></td>
<td>Average time from assessment to service allocation</td>
<td>19 days</td>
<td>66 days</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>Average Referral to assessment time</td>
<td>4 weeks</td>
<td>4 weeks</td>
</tr>
<tr>
<td></td>
<td>Average time from assessment to service allocation</td>
<td>5 days</td>
<td>5 days</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>Average Referral to assessment time</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
</tr>
<tr>
<td></td>
<td>Average time from assessment to service allocation</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
<td>No waiting time, appointments are determined by a person’s availability</td>
</tr>
</tbody>
</table>

Table 11: Average timeframes for the period 2008-2009
Appendix 7: Targeted Services for Older Māori and Pacific Peoples

The Health of Older Persons Portfolio Manager was requested to provide information on whether there were targeted programmes or services in place locally for older Māori and Pacific Peoples.

The tables below summarise the responses from the Health of Older Persons Portfolio Managers and the NASC services in their DHB regions.

*Question 1*: Please identify any services your DHB currently supports which are specifically designed to maintain/support older Māori or Pacific Peoples to remain in the community, such as day programmes, kaumatua housing etc.

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Response provided to the question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>None noted.</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>Two programmes targeting kaumatua with Te Taiwhenua o Heretaunga. Kainga Tautoko $78k per annum and Kaumatua programme $78k. This combines a clinical coordinator providing socialisation for older people and health checks for older people to Hawke’s Bays largest population of older Māori. Several services self fund day activities for older Māori. These include Te Kupenga Hauroa in Napier and Central Hawke’s Bay. Each year services in Hawke’s Bay are required to assess their capability against the Treaty Responsiveness Framework. Options Hawke’s Bay rebranded 3 years ago to include more focus on Māori. Their consumer advisory group membership was refreshed this year to include Māori representatives. Their first task is to review services again and assess their responsiveness to Māori. This includes updating action plans. The DHB has a new Pacific Action plan. Actions include engagement with Pacific communities, programmes related to healthy lifestyles, CVD and Cardiovascular disease. Tu Mai Ra (the Māori Health Plan) focuses on increasing flu vaccination for older people. Internal affairs also funds socialisation programmes in the community.</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>None specific known.</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>Not currently, however a development is underway which will see more kaumatata supported through early identification of supports with a Māori Iwi provider providing Needs Assessments and a supporting Māori provider developing day care supports.</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>No specific Māori/Pacific Peoples services.</td>
</tr>
</tbody>
</table>
### Question 2: How effective are these programmes in supporting older Māori and Pacific Peoples to remain in the community? How is this evidenced?

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Response provided to the question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whanganui DHB</td>
<td>Provide intermediate care. A 4 week respite programme in residential facilities to support people who have had an acute event to establish goals and strategies to be able to return home to their family/whānau support. An Iwi based Home Support provider that is able to provide the care as a package of support delivered in a way that meets the persons and whānau needs.</td>
</tr>
<tr>
<td>Capital and Coast DHB</td>
<td>None noted.</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>Kainga Tautoko was put in place as part of an Ageing in Place programme. The service evaluation was positive. The service supports 125 enrolled kaumatua and a range of programmes per year. Option’s Hawke’s Bay monitors use of services by ethnicity.</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>These supports are effective – evidenced by the small number of people and whānau who use residential care as the option of support to meet their needs.</td>
</tr>
</tbody>
</table>

### Question 3: If services were available previously (last 5 years) which were specifically designed to maintain / support older Māori or Pacific Peoples to remain in the community, such as day programmes, kaumatua housing et, and they no longer exist, please note these below and if possible identify the reasons the services ceased.

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Response provided to the question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>None noted.</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>The DHB does not fund kaumatua housing. Tu Mai the previous Hawke’s Bay Māori Health Plan identified exploring options for service for older people as an action. At the time Central Health (previously Te Whatuiapiti Trust) discussed a cultural partnership with Mary Doyle a large residential and retirement complex. This did not progress. Several services have expressed interest in establishing kaumatua housing or a residential service. The numbers of Māori and Pacific over the age of 55 years would not yet make this development viable. Residential care services report a</td>
</tr>
<tr>
<td>DHB Region</td>
<td>Response provided to the question</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>minimum of 50 residential beds are required for a viable facility both in terms of staffing and capital.</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>MOA Trust provided a PI Day Care programme. Service ceased in May 2011 – provider decision to cease operation.</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>

**Question 4: Are there ARC’s in your area that cater specifically for Māori or Pacific Peoples? If yes, how many facilities are there?**

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>Response provided to the question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast DHB</td>
<td>No</td>
</tr>
<tr>
<td>Hawke’s Bay DHB</td>
<td>Gracelands in Hastings is a preferred provider. Glengarry in Wairoa has a high Māori population in a small rural remote community. These services are well known by families and recommended on to other families.</td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>No</td>
</tr>
<tr>
<td>MidCentral DHB</td>
<td>No</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>No</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>No</td>
</tr>
</tbody>
</table>
Appendix 8: Māori Focus Groups Themes & Quotes

This appendix outlines the themes which arose from the Māori focus groups. The four focus groups were in the Hutt Valley, Ohakune, Levin, and Wellington.

The importance of home and family

- Whānau were varied, ranging from three generations in a household across the spectrum to elderly living alone and estranged from their whānau.
- Care of the elder was dependent on the individual whānau, with elderly staying for periods of a few months to a year with each of their children, while others were looked after in their own homes or in rest homes.
- Family roster system. Some families will organise care so that the elder moves around the whānau homes.
- The wider whānau are important to support the caregiver. If principal carer needs to go away, will organise for other family to come and care.
- In a successful community the whānau and neighbours will all provide support.
- Whānau support – all need to take their turn. Some whānau don’t want to know, and don’t want to provide support. Whānau can be busy with their jobs and their own whānau and unavailable to provide any support.
- Care of the elder is dependent on the dynamic of the whānau.
- Love and guilt in the whānau can drive decisions on how to support older Māori.
- Māori can be private – we don’t want others coming into the house that is why whānau should be able to choose who provides care in the home within the family.
- Sense of pride amongst elders. Can sometimes mean a Kaumatua would rather be cared for by a stranger than their own family.
- In one instance elder fiercely independent, very stubborn and very proud – wouldn’t let anyone come and care for him, died alone.

“It is within our genes, our DNA to look after our elders – that they are comfortable, have dignity and never need for anything”

“I will often sleep on the floor at granddads with my two children, so that I can support grandfather”

“It is something we do for our kaumatua – can’t put a price on that. This mantle has been put on my shoulders. But I am comfortable with that. Whānau are watching to make sure that he is ok and I am ok. Me supporting him holds it all together”

Home versus ARC

- Older Māori have a preference to live at home.
- Try to keep family member at home for as long as possible.
• Elders want their own whānau to look after them. Young children taught to look after their elders.
• If whānau are fragmented and iwi are spread around the country, then aged residential care often becomes necessary.
• Sigma attached to ARC still. There is a perception that you are no longer cared for in your own family. Many have the image that you spend days sitting in rocking chairs.
• Often don’t understand the financial implications of ARC and having to contribute funding.
• There has been a cultural shift in the last 10 years. Before then Māori would never go to ARC facilities.
  “I won’t let grandfather go into an ARC. Putting him into residential care facility is like putting him into a coffin”.
  “One barrier for us putting dad into care was you just don’t do that, as Māori you just don’t do that”

Knowledge of services available
• Lack of formal information.
• Whānau don’t know where to go get information on support.
• There is a barrier for Māori in their knowledge of health systems and health professionals (health literacy). Some providers advocate to the whānau to use an ambulance to get immediate access to health services for their elder and then will coach the whānau to disagree with discharge until services are put in place.
• The following sources noted:
  o Friends and whānau
  o Other caregivers
  o Disability support
  o After admission to hospital (little known beforehand)
  o GP

Services accessed
• Services vary significantly depending on whether you live rurally or in urban centre. In rural areas there seem to be more geographical barriers to accessing services and there are fewer providers to choose from.
• Cultural barrier noted, e.g. family not wishing to elder to go into ARC.
• Respite care:
  o Hospice as respite for my mother was great. I could be me for a few hours.
  o I had no difficulty once I was assessed about finding out about respite care.
Families not offered any respite care. Respite is more shared between family. It comes down to the best care for that person.

**Stress on the carer**

**Elder not wanting services:**
- Carer stress can be due to the older person not wishing to let other family in or other services in.
- Elder didn’t want services, but I had to say yes as otherwise you drain yourself as a caregiver.
- Our people are proud, too proud to ask, they never ask for anything.

**Challenges with dementia:**
- Challenges can be tasks such as safety issues such as gas heater and cooker and repeating the same conversations (caring for someone with dementia).
- Couple where the husband has dementia. He is stubborn, sits back and expects to be waited on, is refusing showers, hiding pills etc. His wife still works and as he is physically capable of helping they aren’t entitled to any supports. But the issue is that he is refusing to do tasks, and this is causing stress on the wife.
- Dealing with dementia – wandering, restricting cooking.
- Personal care a big no. Father with dementia did not want his children to bathe him, nor did he want a stranger coming in to do it. A pride thing. Luckily there was a family member who was a trained nurse and offered to come in and do it and the father was ok with this.
- Whānau don’t understand the medical conditions of the elder, such as behavioural aspects of dementia which can lead to abuse. Need training for carers so they can understand the needs of the elder.

**Family not always supportive:**
- I cared for my koro for 3 years after my grandmother died, on my own. I was quite isolated, but then I got to a stage where I got a lot of support from work and friends, not family.
- I can’t detach and the rest of whānau don’t understand. With the hands on and seeing what they haven’t seen. When you are by yourself it’s pretty full on and consumes you.
- Riding this waka with the old man has been one of the most challenging things in all my life and I have had a few challenges in my life, both good and bad, but nothing as challenging as this. When you love someone so much you just can’t give up. No matter what, you keep striving. Little do you realise that it is pulling you so much, down, down, down. You don’t realise, you don’t sleep. The other thing that hurts a
lot is the ignorance of your family, because they don’t want to know, they don’t understand.

- Whānau opinions can be the biggest barrier “we don’t put our elders put into residential care”. Whānau can often have split decisions on what to do and those looking after the elder are stressed, but are stopped by the rest of the family.

Isolation and sacrifice:
- Without interventions put in place suicide was on my thoughts.
- I feel isolated even though I have 4 mokopuna living with me. I can’t drive, I don’t have a landline and whānau live away. I am in a prison, but not in prison. Home is a prison because I can’t get out like I would like.
- When you are the carer you sacrifice so much, you can’t lead your own life, employment, education, travel, and training. You are their whole world.

Other:
- People often need support at night, but formal supports are only available between 9am and 6pm.
- Struggle to deal with administration of people – like how to ensure cleaner is coming, or knowing when different people will be coming into the home and what to do if they don’t turn up.
- Families in urban areas have more pressure to go to work so caring for a family member puts more financial pressure on a family. In a rural setting caring for a family member will have less impact on lifestyle, the stress is different (not financial) but still need a break from caring – why a roster system is good.
- Family members feel put out when a paid support service comes in and is being paid to do the same work the family does. Think the family member should be paid too.

Stress on the elder
- Find it unfair that friends or live in caregivers who provide care can’t be paid to provide care. It would make me feel better (elder) if I could pay my caregiver to help me, but I can’t afford to and there is no government funding.
- Formal caregivers need to fit around the person and not set the schedule (like only having the shower at 9am). Sometimes when they want to shower me, I don’t want to. That is why they should pay the person who already lives in my house to give me a shower, cos’ they can do it when it suits me as a person.
- Older Māori won’t question health professionals. Will agree but not understand the implications of what they are agreeing to. Will often ask whānau ‘what was that?’

Cultural values

Elder’s wishes:
• Some older Māori don’t want their wider whānau involved whereas others do.

• Felt I couldn’t seek community assistance without elder’s permission to seek help. Felt like my hands were tied. Couldn’t step over my father and his wishes. It is not my place to go behind his back.

• Grandfather won’t let anyone help – if he does let people help (informal or formal) then I have to go over to grandfather’s house and clean up first and then let the person in. I have to wait while they are there. I might as well do it myself.

• Don’t want to bother my whānau because they are busy (Some elders will not call a member of the whānau often to their detriment).

**By Māori, for Māori:**

• Māori girl comes in to provide services. Is good to have a Māori girl. We fit together, so can be Māori, our way.

• It is easier for Māori to care for Māori.

• Need specific Māori support and need a holistic approach that is not perceived in the pakeha world.

• The elder can’t speak English, only fluent Māori.

**Cultural connections:**

• Cultural connections are important – when someone moves into the region the cultural connections need to be made. Services are not necessarily good at helping the elder or their whānau set those connections up (support of the emotional and spiritual health).

• The ARC hasn’t set up links with local Māori ministers or marae so isolated.

**Other:**

• Huge expectations on whānau, by whānau to care.

• The feelings of guilt are cultural.

• Traditional Māori medicine – Rongoā helps maintain spiritual wellness. Needs to be recognised within ARC.

• In ARC diversional therapy is often not culturally appropriate i.e. crossword puzzles, music.

**Issues with assessment**

**Not listening to carers/family:**

• One family had their mother assessed and told there was nothing wrong within five minutes. The assessor wouldn’t listen to the family.

• I keep in touch with my coordinator, she will get someone to come and do an assessment, but even that can be frustrating because they don’t always listen to you.
(the carer), they ask you what you think, you tell them and then they go off and do something different. They ring again and ask again what you think but they don’t listen. They do go by whatever the person (older person) they are questioning says, whatever they say they stick to that, whether they are right or wrong rather than also considering what the carer has to say. Sometimes they (the older person) can hold it together and come across good. You don’t go there and be with a person they don’t know and go by that person. By not listening to the carer, someone who has been there 4-5 years, they make you feel that they are just not taking any notice.

NASC assessment:
- There seemed to be a grey area when a person has dementia. The system can be adapted if the NASC assessor is experienced.
- NASC assessors said the assistance given depends on what the family members can do themselves. They don’t want home help to be too intrusive. Ideally you would sit down early on with the family and sort out who does what so everyone is clear.
- It took awhile to get a NASC assessment because they lived in a rural area. Because the dementia had progressed their father also required an assessment and sign off from a geriatrician. This prolonged the assessment process and they asked a lot of the same questions. There was a lot of crossover and repetition.
- Note: Having a geriatrician sign off a separate assessment is not an issue in an urban area as there is always a geriatrician available at the hospital.

InterRAI:
- InterRAI has made the assessment process more complex. The NASC assessors for those under 65 now sit with Enable NZ, while assessors for those over 65 sit with the DHB. There are no Māori assessors in the DHB. This has created a huge gap for Māori.
- The InterRAI tool doesn’t have a holistic view or take into account cultural aspects.

Other:
- For me, from first assessment the feeling was like it was a tangi, I had to separate myself from them. I couldn’t detach, like I was under assessment.
- It is hard work to do the paperwork if you don’t have help, or no computer or skills
- My husband (has dementia) did not understand the need for his assessment, believing there was nothing wrong with his health. From my perspective the health care assessor was very considerate. It was relatively easy to find out what was happening next after the assessment.
- The assessment process through the hospital was frustrating and confusing.
- One woman had to be re-assessed four weeks after her initial assessment as deemed to have moved onto the next stage of dementia. Very hard for the family.
- Assessors need to ask if they are connected to the marae, who their whānau are etc.
Deciding on an ARC facility

Proximity to family:
- The homes were disgusting close to where I live, I wouldn’t even put my cat in them. Found ARC that I liked and took the list to the GP. Eventually got him into ARC of my choice, but it was a long way away from where I live.
- You can’t always get into a residential care facility that is right beside where you live. My aunt wasn’t able to get into the home just across the road. Instead I had to take uncle every day in the car to visit (at least 15 min drive each way) instead of being able to cross the road. It added stress to Uncle and to me.

Māori staff/residents:
- One rest home in this area is often picked by Māori is because the Charge Nurse is Pacific Islander.
- Māori Health Providers will recommend a particular ARC if there are already Māori in the home.
- Even when we came to terms with doing it, it was finding a specific home that was compatible for him. There aren’t any, like specific to Māori and pacific islanders. Places are far and few when it comes to the cultural specifics.
- We tried to look where there was whānau. It is hard to find a place with other Māori.

Other:
- Family found GPs weren’t very helpful or informative. Told their family member needed a rest home then left to own devices for finding one at an already emotional time for families. This is to ensure assessment services staff do not influence the choice of rest home but an appropriate list for the whānau should have been provided.
- Older gentleman admitted to the DHB for malnutrition. He lived at home with his whānau. He expressed that he wished to be discharged to a rest home from hospital as he didn’t want to return to the whānau on discharge. The whānau were taking advantage of the gentleman and he was successfully transferred to an ARC.

ARC experience

General:
- Māori often go into hospital level care versus rest home level care, so transition is more difficult for elder and whānau.
- Māori are going into ARC at an earlier age. The age difference between Māori and Pakeha can be 20 or more years. Often have different diagnosis too.
• Community interaction with own culture is easier when living in the community. Harder for services to in reach to ARCs.

• When the elder goes into ARC it is important to encourage the whānau to visit the elder, take them out on the weekends, offer to feed and shower so that keep their cultural and whānau connections. ARC staff can care for the physical needs and whānau can care for the emotional and spiritual needs.

Good experiences:
• When made the decision to move their father into an ARC facility the staff were very supportive and made it an easy transition. Family members are still able to be very involved and this had helped.

• Respite care can work well when there are other Māori in the home and attendance at the facility is increased slowly. Have seen many older Māori flourish in the environment.

• No Māori in the ARC but the staff are terrific and he has excellent treatment there. They look after all of his cares, and used to take him out (but now he just doesn’t want to go out).

• Social worker in hospital was amazing. She worked alongside us the whole way to help us move Aunty into an ARC bed.

• Having father cared for in an ARC worked well. My father was physically and mentally cared for in his last days. He got his own room, so could spend time with wife before dying.

Room for improvement:
• Have to work harder with the rest home to make the transition for the older Māori person – food is not right and the care seems institutional.

• Having to develop a relationship with a whole different set of carers can be a hurdle. Someone who knows that process that can walk the journey with the whānau is necessary to make the transition easier.

• Moving to ARC facility upset elder’s equilibrium and she found the move stressful from an inpatient hospital bed to ARC.

• Cost of ARC is an issue, even with residential subsidy.

• Often don’t understand the financial implications of ARC and having to contribute funding.

• Have to fight for the ARC facility to work with Māori as Māori.

• Whānau wanted to sleep over at the ARC on the floor, so we could provide care to aunty. It is not forthcoming and had to battle with the residential facility. We won the battle, but it took a bit of effort. We were happy with the outcome and for the ARC
provider they got a new perspective and it freed them up to care for the other residents.

- Space in the ARC room was small making it more difficult when many whānau wish to visit.
- The elder can’t speak English, only fluent Māori. The ARC hasn’t set up links with local Māori ministers or marae so isolated.

**Suggestions from Māori focus groups**

The following are some suggestions:

Assessment:
- Assessment should consider the needs of the individual. A key question is how do you connect the physical and emotional needs so older Māori flourish.
- Assessors and health professionals need to understand more about the person – how can the system fit the person, not the other way round. One size doesn’t fit all.
- When doing assessments involve/listen to the whānau and or carer as they may have a better understanding about what is actually going on and add valuable insight.
- Assessment processes made easier and more readily available.
- Increase respite residential assessment services, so that elderly are not placed in an acute inpatient mental health facility inappropriate to the patients needs.

Co-ordination:
- Enhanced coordinated supports for whānau to care for their kaumatua/kuia in the community.
- Better coordination and communication with whānau across all services.
- For each kaumatua/kuia have a nominated key person who can liaise, coordinate care across all services and assist whānau through the relevant processes and paperwork.
- Improve service coordination or appropriately qualified or experienced support workers.
- Better support and coordination for professional carers in rural areas.

Education:
- Better education for elderly and their whānau about illnesses and services and options available to the elder (it would be great to have a rural education team to work with the whānau).
- Improved education to whānau and rural health providers about the InterRAI assessment process.
• Need to build it up the knowledge of community workers. When they talk with older Māori, what information should they be giving out to enable access to services in the community.

Culture:
• When an older Māori transfers into the region a NASC transfer is completed which includes a care plan (inter-NASC). However cultural aspects are not mentioned on the form. This should be adjusted.
• Every ARC should have a Māori health plan which should include up to date information on what is available locally for older Māori. Should be forming a relationship with their local Māori community or marae.
• Hospice is consistent with Māori culture now, where as once there was a stigma associated with hospice. A similar approach should be taken for ARC. A funded position to work with ARC providers, providing cultural support and helping to establish cultural connections.
• Need for culturally appropriate services for elderly and their whānau especially with regards to ARC, respite and day program.
• Need more Māori advocates in DHBs and in hospice to make it easier to transition to ARC.
• Residential care providers should be proactive – when you move your elder there they should say, you are Māori so here are some options for you. How do you want to care for your elder whānau?

Financial assistance/barriers:
• Funding informal supporters to be paid carers, e.g. via Whānau Ora.
• Remove barriers noted about funding for accessing residential care services.
• Improved assistance and support for grandparents parenting grandchildren, especially if they have disability and isolation issues.

Other:
• Not limit access to services to 65 years plus for Māori.
• Providers need to be talking to patients & whānau well in advance of any deterioration so they can sort out wills and enduring power of attorney (EPOA).
• Need for exercise/activity options available for elderly both in the community and within residential care.
Appendix 9: Pacific Focus Groups Themes & Quotes

This appendix outlines the themes which arose from the Pacific Peoples focus groups. Two focus groups at Palmerston North and Porirua.

The importance of home and family

- Carers for Pacific older people in the community are mainly spouses and children of Pacific older people. The care is provided mostly at home.
- Carers are often the main breadwinners or the spouses of income earners for the whole family.
- Older parents and grandparents live either in their children’s home or are looked after by children or grandchildren at own home.
- Numbers of family members under the same dwelling varied between two and ten. A lot of the times, family members visit regularly.
- The family shares the responsibility of caring for the older person between family members.
- Importance of older Pacific people in family – sounding board, decision makers, relationships with grandchildren.

  Daughter lives more at her mother's house looking after her, with the help of her children than living at her own house.
  
  At 3pm the grandchildren congregate to older person’s place to be with their grandmother until the principal carer finishes work.

Home versus ARC

- Preference to receive help from family first.
- Huge decision that the family has to make – any decision weighs heavily on the family. Concern over how decisions are seen by other Pacific people.
- Element of mistrust regarding the care received in ARC (e.g. falls, bruising during respite care for one older Pacific person).
- Balance of cultural responsibilities and obligations.
- Feeling of neglecting duties when family member placed in ARC. Feeling guilty about leaving family member with strangers.
- Concern around language barriers in ARC.

  “I will decline help if I know I can cope and that my family will provide the support I need” (Porirua).

  “I would prefer to access family members to look after my mother at home rather than in a home” (Palmerston North).
Knowledge of services available

- The following sources noted:
  - GP
  - Hospital staff
  - Pacific Unit (Porirua)
  - Social workers
  - Radio.
- In at least two cases, families had not looked into services available as don’t feel elderly family member needs then yet.
- Respite care:
  - While the majority of participants were aware of respite care, some had no knowledge or only found out incidentally about respite care. In one instance a carer only found about these services after her own health event, in another instance carer only aware of services after elderly family member placed in ARC. At least two participants not aware at all of services.
  - One family said that it was easy to access respite care and get information as it was all organised with visiting services that assist with care at home. The main issue for carer was the attitude of other Pacific people towards her and feeling guilty about leaving elderly family member with strangers.

Services accessed

- Care is provided through various agencies including:
  - Hospital Services
  - Needs Assessment Services
  - Accident Compensation Company
  - Age Residential Care
  - Home Care Support Services
  - Respite Care
  - District Nursing

Stress on the carer

- Juggling work, family and church commitments, for example getting elderly family member to doctors for bloods in the morning before leaving for work.
- Plan life around care and needs of elderly family member
Little time out for carers (lack knowledge of respite care)
Feelings of isolation and lack of support
Conflicts between family members who were not the principal caregiver but are occasional visitors
Dealing with changes in behaviour, deterioration in mental status of elderly family member
One carer noted her mother would at times “play up” when the carer was present during home visits from practice nurses.

Cultural values

The group had a long discussion about their cultural obligations and parental expectations. There is a view that New Zealand born Pacific island generations are more flexible and more accepting if there is a need to place an elderly parent in residential care. The opposing view of the island born Pacific generations tends to regard placing a parent in a home as not fulfilling their obligations and view this as being unkind to ones parent or grandparent (Porirua)
Cultural values (Le Va) respect between father and daughter with regard to personal hygiene.
Attitude of other Pacific people towards decisions, guilt, feeling of neglecting duties.

Issues with assessment

Most of the participants’ elderly family members’ were assessed at home. The needs of the family were included but, it does not reflect on the allocated resources or support for caregivers.
There was concern over some areas of the assessments.
  - Language – some unable to understand the process.
  - Phone assessments – inappropriate and does not provide an accurate profile of the older persons capabilities, limitations and required support. Some participants noticed a reduction in hours and time allocated for their older person following a phone assessment even though their condition had worsened (Porirua).

While most participants were happy with the timeframe for feedback following the assessment some identified a long wait for support or feedback following the assessment, in one case two years).
Pushed between the systems: One participant was frustrated at being pushed between the systems eg. ACC and NASC and no one seemed to own up to be responsible for her parent. In the meantime, her mother has deteriorated while waiting for support (Porirua).
Deciding on an ARC facility

- One family had no difficulty finding a rest home. They were offered tours of all the facilities. Once the family decided on a rest home they were supported to have a trial period.
- Another participant noted “It was easy to get the information we needed. We were also offered a tour of all the facilities so that we were able to choose the appropriate facility for our parent”
- No other responses.

Lack of cultural specific services available

The following are some suggestions:

- NASC services commit to employing Pacific assessors.
- Having a facility that is Pacific specific with Pacific caregivers, Pacific food and Pacific programmes.
- Having a facility where there are organised Pacific group activities for older Pacific people (cultural activities etc) like the Kaumatua groups, this is along the lines of prevention and diversional activities.
- Rest homes to have funded day programmes for the elderly so carers get time out.
- That DHBs and the MOH should consider allowing extended family members to provide Respite Care and be recognized as such financially (this is a much cheaper option than ARC) but need to have quality control measures in place.