

Ageing in Place

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Introduction

Changing demographics and increased recognition of health and social needs in later life have prompted many countries to seek ways to better support their older population. As a result, New Zealand and other governments have widely adopted ‘ageing in place’ as a policy objective in recent times. This approach promotes the ability of older people to remain living in the residences and communities of their choice whenever possible. The emphasis on ageing in place is already affecting support services for older people and is likely to continue guiding policy on population ageing in the future. This chapter explores ageing in place and factors that influence people’s ability to continue living well in the community as they age. Ageing in place has policy implications in terms of its likely impact on families and the state and on service provision. If members of our ageing population are to optimise living at home with a satisfying quality of life, a coordinated effort is required across all sectors of society that provide support for older people.

‘Ageing in place’ has been gaining currency in policy worldwide for more than 10 years and has undergone shifts in its interpretation during this time. The first major advance occurred in 1994 when OECD ministers reached a consensus that people should be able to continue living in their own residence in their later years. In the event that this is no longer possible, the alternative would be for older people to live in a “sheltered and supportive environment which is as close to their community as possible, in both the social and geographical sense” (OECD, 1994, p.37). The focus on remaining in the community has also been promoted in New Zealand (Associate Minister of Health and Minister for Disability Issues, 2002; Davey, 2006; Richmond et al., 1995). Emphasis has been placed on fostering values that underpin ageing in place (Dwyer et al., 2000; Minister for Senior Citizens, 2001).

Key elements of ageing in place

Definitions of ageing in place have varied across settings and over time.² For the purposes of this chapter, the authors are using the definition that is provided in the New Zealand Positive Ageing Strategy (Minister for Senior Citizens, 2001) and that has informed recent policy initiatives. Ageing in place is defined in the strategy as people's ability to "make choices in later life about where to live, and receive the support to do so" (Minister for Senior Citizens, 2001, p. 10). The main components of this definition are, therefore, choice, location and support. Thus ageing in place refers to a person's ability to remain dwelling in the community. Residential care in the form of rest homes or hospitals is specifically excluded. In this, the approach taken is consistent with that in the New Zealand report *Factors Affecting the Ability of Older People to Live Independently* (Dwyer et al., 2000).

Choice, autonomy and independence

The values most strongly associated with ageing in place are choice, autonomy and independence. Older people often voice these qualities as important in their lives, and they are frequently reported in research studies (Dwyer et al., 2000; Gabriel and Bowling, 2004; Godfrey et al., 2004; Netten et al., 2002). Older people want to be respected as individuals and to make their own decisions about what best suits their needs (Netten et al., 2002). Satisfaction in life comes from enhancement of these capacities.

Choice is a basic part of daily living and the decisions of older people need to be viewed within the everyday context in which they are made. Whether they are negotiating a way through the complexities of day-to-day life or undertaking major transitions such as a move into a retirement village, older people are continually choosing between competing priorities (Godfrey et al., 2004). The amount of choice older people can exercise differs depending on personal and environmental factors. For instance, income levels, housing and health will all influence perceptions of choice. Older people with severe ill health or disability are likely to have a more restricted range of choices available to them and more costly consequences from these choices than those people who are well. When health is deteriorating, people have to choose between activities into which they wish to put energy and maintain and those they will relinquish.

Autonomy and independence are similar in that they both relate to control over decision making. The concept of independence can be problematic because of its varying interpretations in the field of disability and care. In this chapter, independence is being used in the sense of being self-reliant in managing one's own life. Interestingly though, recent writing emphasises interdependence and

reciprocity within supportive relationships, which incorporates the notion that being able to give also allows one to accept help (Fine and Glendinning, 2005; Godfrey et al., 2004).

Location

Even in very late life, the majority of people live in their own homes and want to remain there for as long as possible (Keeling, 1999; Ministry of Social Development, 2005). In providing a context for their lives, the place in which people age has a special significance.

Home is a familiar place and a treasure chest of memories. It can be an expression of one's personality, hobbies and skills. Home provides a sense of identity and a face to the community. (Gee et al., 2000, p. 21)

The promotion of ageing in place with its implications of living independently does not simply mean living in a conventional family or couple-based or single-person household. A variety of new housing and household types are emerging. These include shared housing and retirement village options.

Support

Older people in the community live alone, or with family, friends or carers. The support they may require to age in place comes from diverse sources, both paid and unpaid, and can take a variety of forms. Services provided are likely to be more intensive for frail people with declining health and will more often come from paid formal sources.

Indeed, older people with high support needs may require a considerable amount of assistance to continue residing at home. Higher levels of care being provided outside institutions are tending to blur community and residential care living. Services such as day programmes and respite care are being delivered in the institutional sector for older people who live in the community; conversely, community settings such as retirement villages may provide residential care facilities.

Life-course approach to ageing

When considering ageing in place, a life-course approach ensures the everyday experiences of older people are explored within the context of life transitions and their individual life histories. The meaning of a person's actions and behaviour can be understood only in terms of the perceptions, aspirations and expectations that people form over a lifetime of unique experiences. Interests and activities are strongly influenced by lifestyles and attitudes set earlier in life.

One person may attend church regularly for 50 years and yet not hold religious beliefs, while another may never attend church and yet pray daily (Green and Sixsmith, 2005). These experiences and life chances all affect older people's ability to reside at home.

A life-course viewpoint presents a positive approach to ageing in that old age is seen as providing opportunities for personal growth and development as well as pressures in adjustment to life transitions and loss (Godfrey et al., 2004). Changes arising from life transitions will affect the meaning of home for an older person and influence their ability to manage, especially when there are significant changes to social networks or health status (Keeling, 1999) such as the death of a spouse (Gabriel and Bowling, 2004) or a loss of mobility. The extent to which changes are experienced as positive will depend on the complexity of factors that promote wellbeing and a good quality of life.

Quality of life and wellbeing: building a good life

Despite 'quality of life' being the focus of a growing body of literature and an expression social scientists and health professionals use frequently, there is no simple or agreed definition. Common characteristics emerging in the debate, however, are that quality of life relates to a subjective perception of wellbeing in its broadest sense. It is multifaceted and based on combinations of domains affecting daily life, such as social supports, health and role in society (Gabriel and Bowling, 2004; Netten et al., 2002). Older people's views are now informing the base of knowledge and the measures being developed to determine what constitutes a good quality of life for older people. Recognition is being given to differences in individual perceptions and to the need for a holistic approach.

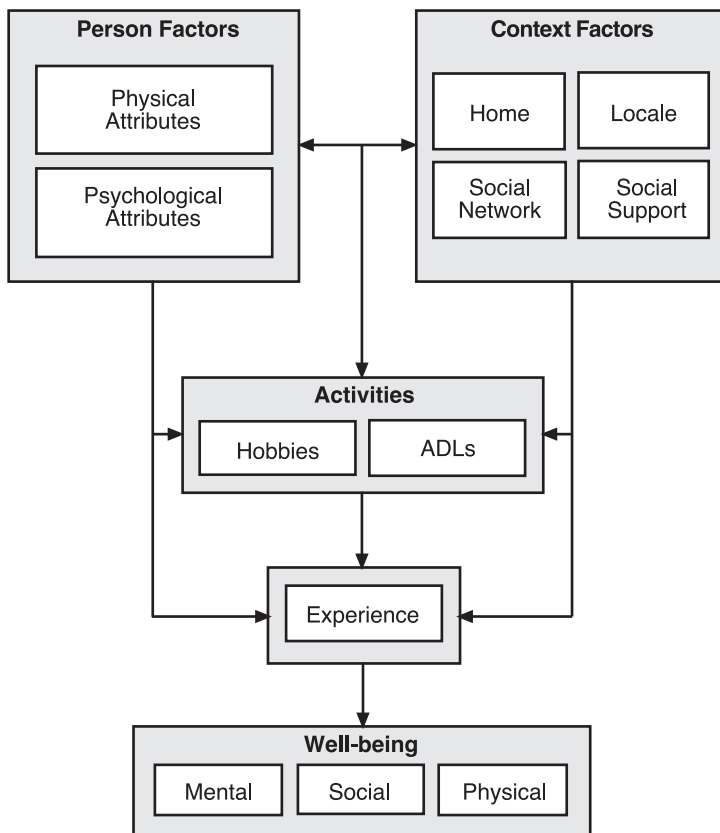
When older people have been participants in research studies, they have often used the words 'a good life' to describe their life situation. This expression, 'a good life', which is increasingly being used in reference to quality of life, relates well to the notion of 'goodness in life' implicit in the concept of wellbeing. A British report on older people is entitled *Building a Good Life* (Godfrey et al., 2004), reflecting the new trend towards a forward-looking and positive attitude on ageing. Building a good life is associated with personal agency and continuity in life patterns. Godfrey et al. (2004, p. 3) contend that, in old age, people are "seeking to make sense of and be actively engaged in a process of adaptation to physical, social, interpersonal and psychological changes embracing both learning and adjustment". This process of change or transformation is coupled with a continuation of the sense of self

and life that has been developed over the years. The phrase ‘building a good life’ is thus favoured for use in referring to ageing in place.

A good quality of life and a sense of wellbeing are interconnected. Figure 10.1 depicts a model being developed in Britain to aid the computer assessment of people receiving home support services (Brown et al., 2004; Hine et al., 2005).

This model captures basic elements of the mix of factors contributing to wellbeing in older people. Personal and environmental factors interact with everyday activities undertaken by an individual to influence the experience of daily living.

Figure 10.1: Conceptual framework of factors affecting wellbeing



Note: ADL = activities of daily living.

Source: Hine et al., 2005.

Factors that support and influence ageing in place

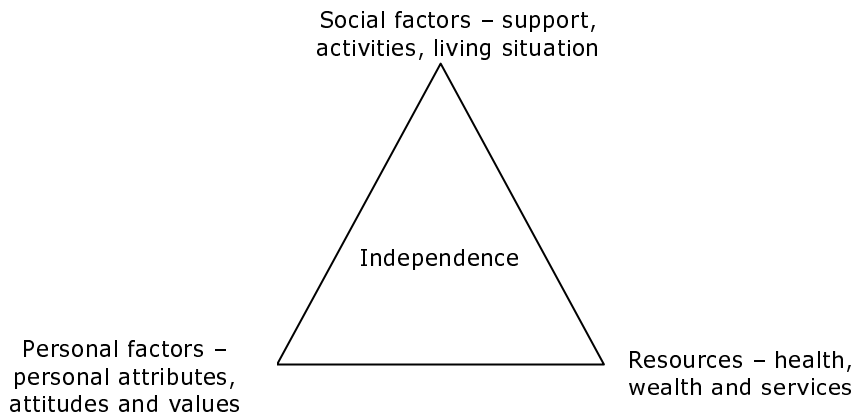
Government publications have already highlighted factors that affect older people’s quality of life in New Zealand. For example, ministerial briefing papers have identified a range of personal and environmental factors:

There are a number of factors that influence an older person’s capacity to maintain independence. These include personal health, income adequacy, safety and security, access to community-based support or social services, and mobility. For many older people the key to maintaining independence is remaining in their own home. (Ministry of Social Development, 2002, Chapter 4, p. 2)

Other factors are highlighted by Dwyer et al. (2000) in their summary of the literature on independent living. These include positive attitudes, housing, transport, interests and work. These factors merge together in their effects on older people and relate to the model of wellbeing of Hine et al. (2005).

Another way to explore the factors is by classifying them according to the Mosgiel model of independence illustrated in Figure 10.2. This model presents clusters of personal, social and resource factors emerging from interviews that explored older people’s perceptions of independence (Keeling, 1999).

Figure 10.2: Mosgiel model of independence



Source: Adapted from Keeling, 1999.

Each cluster of factors – social factors, personal factors and resources – is likely to be influential in determining whether older people are able to experience ‘a good life’ in the community. These are now examined in relation to older New Zealanders.

Personal factors

Age

Although chronological age is a convenient measure, the number of years lived is not necessarily related to biological ageing or to changes in social and economic roles, namely social ageing (Armstrong, 2002). The timing of life events and their effects differ markedly among older people. Difficulties arise from the rigid use of chronological markers when health status disparities exist across ethnic groups. Māori and Pacific peoples, with their lower life expectancy, can be disadvantaged by entitlement to income and health benefits commencing at 65 years. The consequences of arbitrarily imposed chronological markers need to be considered when analysing how policy influences the ability of people to age in place.

In discussions on ageing, it is important to differentiate between age groupings. Old age is a period in life that can last up to 40 years, covering several cohorts and more than one generation. As indicated in Chapter 2, people aged over 85 are the fastest growing group in the older population. They are distinctive as a group because of their special needs and their potential to make high demands on government expenditure (Davey and Gee, 2002). People of advanced years are likely to have less wealth and be in poorer health than younger old people.

Insufficient is known of survivorship, life experience and cohort effects in very old age (Tinker et al., 2001). Davey and Gee (2002) raise the issue of whether survival into advanced years is linked to low-risk lifestyles or if people change their lifestyles as they age. Survivorship is a mark of flexibility and resourcefulness. The more options people have to practise skills and abilities, the more ably they will survive. Studies in Scandinavia, of people over the age of 85, have found that living at home, even after a health event such as a stroke, was a significant factor in maintaining high morale (von Heideken Wagert et al., 2005). Other researchers found that nonagenarians had a positive outlook on life and tended to report optimistically on their health status (Hilleras et al., 2000). In New Zealand research, Wilkinson and Sainsbury (1998a) found people aged over 90 had lower death and illness rates for their age than younger old people, and suggest that extremely old people have a better health status than people aged 60–89.

Public policy frameworks and benefits accruing from policy initiatives influence how life is shaped for an individual over a life course. Thomson (1991) has argued that the generation of New Zealanders born from 1920 to 1945 have been advantaged by measures introduced under the umbrella of a

welfare state, such as universal family allowances, free education and access to affordable housing. These provisions have enabled people now aged 60–85 to enter old age with a higher standard of living than is likely to be available for succeeding generations (see Chapter 3).

Gender

Several gender-related differences affect the ability to age in place. Gender imbalances in age structures are marked as shown in Chapter 2. The majority of older people are female and this trend is expected to continue over the coming decades, although to a diminished extent. Thus, women typically spend a longer time in old age than men do. Women reaching the age of 65 can expect to have nearly 20 years of life ahead, with 16.5 years of these on average spent living in the community (Statistics New Zealand, 2004). Women's lower average personal lifetime earnings combined with their longer life expectancy put them at greater risk than men of being poor in old age (Ministry of Women's Affairs, 2002). In addition, they are likely to have more years living with a disability that requires assistance and to be high users of health and disability support services (Ministry of Health, 2002b).

Gender also impacts on living situations and supports in later life. More women than men live alone, with 50% of men in their late 80s still living in close relationships (see Chapter 2). These differences in living situations are reflected in gendered patterns of social integration. Older women are more likely to maintain social networks and establish new friendships than older men. Living alone affects the amount of social interaction experienced in daily life. Older women in single-person households have more frequent contact with family and close friends living outside their household than women living with others. The trend differs for older men living alone as their outside contacts are less than those of partnered men until very old age (Statistics New Zealand, 2004).

Ethnicity

The ethnic composition of older New Zealanders is less diverse than that of younger age groups, having been historically and demographically shaped by migration patterns and differing mortality rates. An increase in ethnic diversity over coming decades (Chapter 2) is expected to result in demands for a more culturally appropriate environment and improved language services (Minister for Senior Citizens, 2001; Statistics New Zealand, 2004).

Factors affecting the ability of Māori to age in place have special significance because of the lifetime of disparities between Māori and non-

Māori. Almost 75% of older Māori are aged under 75 (Office for Senior Citizens, 2005b). Thus Māori elders surviving into very old age experience cohort and peer effects of bereavements and diminishing social networks earlier than their non-Māori counterparts.

Māori also experience economic and health inequalities compared with the total population. The material disadvantage of older Māori is estimated to be three or four times higher than that of non-Māori (Cunningham et al., 2002). Poor living standards have been associated with low income, lack of savings, housing costs and past responsibilities in raising large families (Fergusson et al., 2001). The apparent onset of ill health for Māori is approximately 5 years earlier than for non-Māori and the severity of health problems is greater (Cunningham, 2000). Māori also experience higher rates of disability than the general population (Statistics New Zealand 2002).

Many older Māori have *kaumatua* (tribal elder) status and defined roles within their society that, while enhancing their cultural identity, also increase their social commitments. Their rates of participation in unpaid work for others outside the home are higher than for older people in other ethnic groups (Davey, 2003). Among older Māori, more than 50% are native language speakers. This is a considerably higher proportion than for younger adults (Office for Senior Citizens, 2005b). Weaker cultural affiliations of cohorts of Māori now moving into later life may place older Māori in a more marginal position in cultural terms (Durie, 1999).

People from other ethnic communities also face unique challenges in old age (Ministry of Social Development, 2001). Within Pacific and Asian groups particularly, there is a plurality of language and culture. This can lead to severe communication difficulties, particularly for older first generation migrants (New Zealand Guidelines Group, 2003). Added to this, a poorer standard of living and lower health status than the general population jeopardise their ability to manage well in old age. Pacific and Asian older people have lower median incomes than older people of European ethnicity have (Statistics New Zealand, 2004).

Family structure and household composition also differ across ethnic groups, with older Pacific and Asian people more likely to live in multiple-family households (Davey, 2003). Although nearly half of older Pacific people live with extended family, studies would suggest that many elders prefer living alone or with their peers (Davey et al., 2004; Dwyer et al., 2000). The capacity of older Pacific people and Māori to assume their expected leadership roles within their family and community depends on adequate support and their

physical, emotional and material wellbeing (Ministry of Social Development, 2001).

Research data on older people from minority ethnic groups in this country is scarce (Minister for Senior Citizens, 2001). Studies on the health and wellbeing of older Māori have been carried out (Cunningham et al., 2002; Durie et al., 1997; Waldon, 2004) and further research is being actively promoted (HRCNZ, 2004). Research into the experience of ageing for Pacific peoples is limited to small studies. Little empirical data exist on the experiences of older Asian people with the exception of findings from a large project on intergenerational relationships and communication within Chinese communities (Gee, 2002; Ng et al., 1998).

Attitudes, values and beliefs

The meaning and experience of ageing and values underpinning living at home vary across culture and time. The sharing of similar views and values is likely to enhance older people's sense of security. In Great Britain, issues of safety and security have been found to be less important when people feel integrated into community life (Godfrey et al., 2004). In the same study, common values expressed as basic to satisfaction in their daily lives included caring for others, reciprocal relationships and social engagement. Davey (2006) refers to the resourcefulness of older New Zealanders as a positive attribute enabling people to manage better at home.

Negative images of ageing that are prevalent in the wider society affect older people's beliefs and attitudes. Common stereotypic images in New Zealand have depicted older people as a non-productive burden on society or as selfish, affluent 'oldies' taking resources from younger generations (Glasgow, 2005). Older people's responses to ageism influence the quality of their everyday life. People who deny their own ageing have been found to modify their behaviour to meet the expectations of others or are self-conscious of being monitored by others for the signs of ageing (Minichiello et al., 2000).

A complex relationship can be seen between individual perceptions and the culture of older people. Cultural affiliations shape personal identity, attitudes to life and expectations. These will have an effect on the form of support acceptable to people living at home and their tolerance of risk. For instance, shame attached to disability and high expectations of kinship care that are culturally based act as deterrents against older Pacific people in poor health seeking help outside the family (Huakau and Bray, cited in New Zealand Guidelines Group, 2003).

Cultural beliefs may differ across cohorts and generations depending on life experiences and events. In recent years, varying attitudes to family support and piety have been noted across three generations of Pacific and Asian families in New Zealand with grandparents born overseas remaining traditionally oriented within their New Zealand setting (Ministry of Social Development, 2001; Ng et al., 1998).

A major survey of people in mid and later life that is being undertaken is expected to develop a greater understanding of variations in cultural beliefs and expectations. The project, *Enhancing Well-Being in an Ageing Society*, has a broad focus across ethnic groups and geographic areas (Waldegrave et al., 2005). Among dimensions of behaviour being studied are personal attitudes and experiences, social networks and intergenerational transfers.

Social factors

Social factors relevant to considering what constitutes a good life are social networks, participation in activities and living situation, including location. Together they provide a picture of how older people manage their daily lives and changing needs over the years.

Social and support networks

Social connectedness and inclusion within social networks are vitally important in everyday life. Networks may involve family and whānau members, friends, neighbours and people within the wider community. Patterns of family composition are changing. A notable trend of significance to ageing in place is the increasing numbers of older people who are separated, divorced or cohabiting (Office for Senior Citizens, 2005b). Changes in marital status may affect the nature and strength of social networks that develop before entry into old age and the supports that are available in later life (Wilton and Davey, 2006).

People can be socially isolated and lonely whether they are residing at home or in residential care. Vulnerability factors for loneliness include whether people have a partner, a past history of loneliness, deteriorating mental or physical health, and poorer health than anticipated in old age (Victor et al., 2005). Conversely, social participation mitigates loneliness and has a positive effect on quality of life (Netten et al., 2002; Victor et al., 2005). Friendships assist in giving meaning and continuity to life with shared experiences and reminiscence (Godfrey et al., 2004).

Informal care from family and friends in the form of emotional and practical support enables people to remain living in the community, even with disabilities (Dwyer et al., 2000). Social support is not necessarily caregiving. Support may take many forms, such as simply ‘being there’ when needed or providing ‘in kind’ assistance, such as home or car maintenance and funding holidays. Those living alone receive significantly more ‘in kind’ support from outside the home than those in two-person households (Statistics New Zealand, 2004).

Assumptions cannot be made that the presence of family members and friends ensures help will be available for an older person. Family members may not be available, willing or able to provide support. The ability to help is affected by a complexity of factors, including culture, expectations of support, location, level of workforce participation and the presence of other dependants. Furthermore, the size of a support network and the quantity of family members do not necessarily equate with quality support. Network density, or the strength of communication within networks, also needs taking into account (Victor et al., 2005; Wilton and Davey, 2006).

Reciprocity, or being able to give as well as to receive, is important for older people’s wellbeing. Unpaid work, that is, caring for people in the same household or voluntary work in the community, can meet needs for involvement and purpose (Dwyer et al., 2000). British research on intergenerational exchanges has found that the direction of giving support between younger old people aged 65–74 and their offspring is predominantly downward rather than upward (Grundy, 2005). The balance changes with increasing age as more support is required.

With changes in family structures and employment opportunities for women, the role of grandparents seems to have shifted in recent years with an increasing number of older people taking on the responsibility of caring for grandchildren. This has social and financial implications for older people, especially when they act as the primary caregivers (Wilton and Davey, 2006; Worrall, 2005).

Activities

Statistical data from the census and recent studies indicate that older people are active participants in community and social activities. They have greater time involvement in religious, cultural and civic activities than any other age group (Statistics New Zealand, 2004). They are also the age group most active in sport and active leisure pursuits (Ministry of Social Development, 2005). In all, most people appear to be content with their ability to participate in their interests and activities. In a recent urban study, 92% of older people expressed overall

satisfaction with their leisure time, the highest level of any age group (Ministry of Social Development, 2005).

Advances in technology have opened new possibilities for people who are housebound in obtaining information on services and communicating with kin from a distance. Although older people in New Zealand are more likely to have a telephone in their home than people aged under 65, the percentage having Internet access is only 12% (Ministry of Social Development, 2005). This has implications for how information on services is conveyed to older people.

Fears of potential harm may limit people's involvement in certain activities during later life. The National Survey of Crime Victims reported that, compared with other age groups, older people are more likely to feel unsafe walking around their neighbourhood alone after dark and are less likely to engage in unsafe activities (Morris et al., 2003).

Living situation

The location in which older people live has a profound effect on their lifestyle, including on the quality of their support networks, their opportunities for wealth accumulation through differences in the cost of living, and access to amenities (such as shops and transport) and health and social services. Older people in New Zealand are highly urbanised, especially those aged 85 and over (Chapter 2). When urban dwellers become very old, they are more likely to move into residential care than their rural counterparts. The very small proportion of older people residing in rural areas with low population density are, therefore, more likely to be living in their own homes or with family members and may be remote from urban centres and services (Chapter 2).

Internal migration and transience patterns change with ageing. Residential mobility in or across regions is more likely to occur as people become older. Factors that contribute to this include:

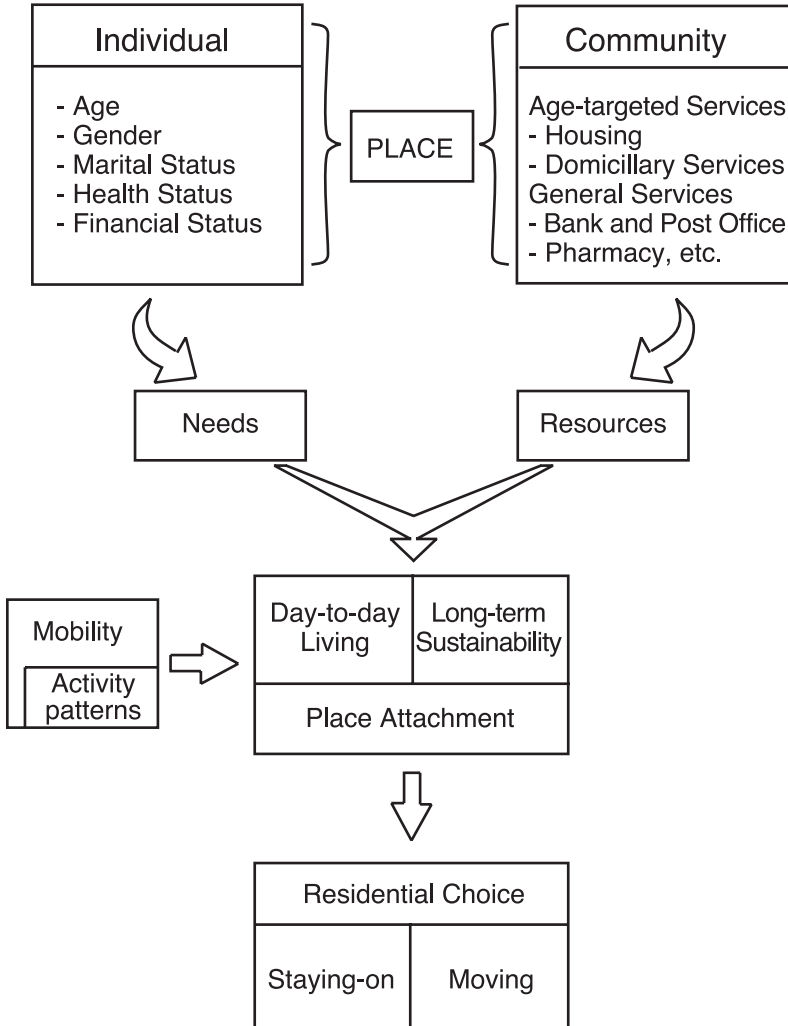
- climate, with older people moving to warmer temperatures;
- topography;
- distance from other centres; and
- availability of health services, such as major hospitals.

Choices in making a move may be constrained by comparative house prices, especially when considering a move to or within desirable urban areas. Elderly parents wanting to relocate near their adult children for support may experience tensions between their need to move for the security of assistance and their preference for remaining in a familiar location.

The place in which people live is intrinsically linked to a sense of community. Figure 10.3, from a study of older people's experiences in a rural

location in New Zealand, is a diagrammatic representation of factors impinging on decisions to stay or move location (Joseph and Chalmers, 1995).

Figure 10.3: The experience of growing old in-place



Source: Joseph and Chalmers, 1995.

In the rural township studied by Joseph and Chalmers (1995; Chalmers and Joseph, 1998), the strong attachment that older people had to their locality and the unavailability of alternative housing were influential motivators for people to remain in a community even in the face of insufficient support services. Similarly, research in the South Island has shown the resilience of rural communities in managing the depletion of support networks through urban migration (Keeling, 2001). These findings highlight the need to know more

about older people's decision making on relocation and to explore differences between locations.

Resources

Socioeconomic status

Older people tend to be asset rich and income poor because of past government policies that encouraged home ownership. Although a large proportion of older people live in houses that are mortgage free (Chapter 9), the gross income of people aged over 65 is significantly less than that of younger people (Statistics New Zealand, 2004).

Financial resources increase the options available to older people. Assets accumulated throughout life can be mobilised in old age to compensate for lower incomes, in the form of interest on savings, dividends, rents and so on. Adequate income is a key determinant of health status and is linked to security and the ability to meet needs and maintain social contacts (Dwyer et al., 2000). Succeeding generations are predicted to have a higher education level, which is likely to link through to greater earning capacity and resourcefulness (Chapter 3). This may enhance people's ability to live independently.

Home ownership allows people to mobilise their wealth in old age by trading down into less expensive accommodation or entering into formal and informal equity release schemes. Equity release schemes are not as highly developed in New Zealand as in some other countries. This may be because here home equity is traditionally preserved for intergenerational transference (Davey, 2005; Davey et al., 2004). People aged over 80 are more likely than other age groups to prioritise bequeathing property to others above meeting their own needs (Rowlingson and McKay, 2005). With changing attitudes towards inheritance, equity release schemes may become more acceptable and their intensity of use may increase (Davey, 2005).

Although levels of older people's participation in paid work are increasing, they remain generally low (Chapter 7). If diverse retirement pathways are available, people will have a greater ability to continue generating an income into old age. Research indicates that countries, like New Zealand, that abolish mandatory retirement see few immediate changes in retirement patterns (Taylor, 2002). The ages at which people have access to pensions or superannuation appear to be more influential.

Health status

In addition to the effects of genetic inheritance, health in later life is determined by a complex interplay of social and economic factors from birth, as well as by gender and ethnicity (Ministry of Women's Affairs, 2002). Rather than concentrating on health and disability deficits, it is more constructive to adopt a wider public health perspective of ageing well. Two areas of ongoing policy focus are as follows.

- *Health promotion and protection:* A community and environmental view is being promoted by local government in New Zealand through a programme generated by the World Health Organization, Healthy Cities. This programme mobilises sectors across the community and builds social capital to improve the outcomes of health determinants such as nutrition, social inclusion and housing.
- *Living with disability:* In New Zealand, more than 50% of people aged over 65 and 66% of people aged over 75 have a disability (Statistics New Zealand, 2004). The provision of a broad spectrum of initiatives with an emphasis on prevention and rehabilitation helps maximise health and wellbeing for older disabled people.

When discussing good health in older people, Statistics New Zealand (2004) differentiates between length and quality of life. Both these dimensions need consideration in planning support for people to maintain independent living. Older people with disabilities are likely to be more severely limited by their disability as they age and are likely to have their health affected by more than one disability (Statistics New Zealand, 2002). Furthermore, older people may be living with their disabilities for a lengthy period. In 2001, nearly 55% of older people with disabilities had been disabled for 10 years or longer (Statistics New Zealand, 2004).

Physical disability is the main form of disability experienced by people over the age of 65 (Statistics New Zealand, 2004). The most common causes of death of older people relate to disease conditions, such as ischaemic heart disease, cancers and stroke (Associate Minister of Health and Minister for Disability Issues, 2002). The severity of these conditions and the speed of their progression will affect older people's ability to live at home. Sensory deficits such as hearing or sight loss, which also significantly lower older people's quality of life, are less likely to threaten independent living (Dwyer et al., 2000).

Personal mobility is a key factor in sustaining the wellbeing of older people. Much physical decline in later years may be due to physical inactivity rather than to the process of ageing (National Health Committee, 1998). Research data has indicated that a sizeable minority of people living alone may have difficulty

walking any considerable distance or up stairs (Fergusson et al., 2001). Yet, physical activity can have multiple benefits, including maintaining muscle tone and bone density, helping to prevent chronic conditions, such as high blood pressure, and reducing the likelihood of falls.

Subjective wellbeing is often a strong indicator of physical health status. In old age, individual expectations of health gains may be set too low. For instance, the potential for rehabilitation will be reduced if an older person is demoralised by public perceptions that falling marks the beginning of inevitable functional decline. Expectations of improvement may be lowered imperceptibly by ageist attitudes in society. Older people vary in their insight into the impact of ageism on their life (Minichiello et al., 2000). Measures for raising expectations include community education programmes and groups that support people to live with disability.

Good emotional and mental health is important for independent living. Anxiety and depressive illness can arise from deterioration in physical health or lifestyle changes associated with ageing. The risk of depression is higher for older people living alone than people living with others (Ministry of Health, 1997). Depressive symptoms in older people tend to be under-recognised and adversely impact on both older people and their family members.

Cognitive disorders such as dementia also seriously affect the capacity of older people to age in place. The fear of developing dementia exceeds the fear of developing any other condition in later life (Godfrey et al., 2004). The prevalence and incidence of dementia rises with age, with about 20%–30% of people aged over 85 likely to be affected (Associate Minister of Health and Minister for Disability Issues, 2002; Henderson and Jorm, 2000). Supporting people with dementia in their own home can be particularly difficult and demanding on family and social service resources (Sainsbury et al., 1997).

Accessing and using health services

Older people are high users of health services compared with other age groups. With the exception of dental care, the use of health services increases directly with advancing years (Chapter 8). People in the oldest age groups have more visits to their general practitioner, receive more prescription items and have more admissions to hospital than people in younger age groups (Ministry of Health, 2002a). The prevalence of ill health and disability with age makes the need for support increasingly important (Dwyer et al., 2000). If the principles set out in the Health of Older People Strategy (Associate Minister of Health and Minister for Disability Issues, 2002) are to be met, a range of preventive and

home-based services is required. These services should be appropriate and accessible and based on holistic needs assessments.

Community care for older people with complex health needs raises issues around societal expectations of safety. Health professionals and policy makers face ethical dilemmas in determining how to manage risks. They need to balance threats to safety that may arise from older people's reduced competence and capacity against their requirement for autonomy. A sense of security is important for older adults, but often the perceived threat of harm outweighs the actual risk of harm (Kane and Levin, 1998). For older people worry about safety may be as much an issue as the actual level of risk (Netten et al., 2002).

Although some legal protection is offered through the Protection of Personal and Property Rights Act 1988, older frail people are also vulnerable to neglect and physical, psychological and financial abuse. In making provision for the support of older people, living in the community or residential care, a balance needs to be found between risk aversion and protection from harm. The prevalence of elder abuse and neglect among older New Zealanders is estimated at 3%–10% (Fanslow, 2005). The numbers of abuse cases known to support services fall far below these figures. Family loyalty and a fear of making a situation worse often prevent people from seeking assistance (Schofield, 2004).

Local authorities can play a key role in encouraging the use of health services by providing information and transport for older people. Public amenities (such as libraries), innovative support programmes (such as 'befriending' services) and driver schemes all contribute to the mix of resources that make services more accessible. For example, in some centres a shuttle bus is available for transporting older people to health appointments.

Housing

Remaining at home in a private dwelling is widely seen as a key component of independence to the extent that entry into residential care may be perceived as a 'failure' of healthy and successful ageing (Gee, 2002; Keeling, 1999). More than 70% of people aged 85 and over still live in private accommodation (Chapter 9). Insufficient sheltered accommodation alternatives can lead to a premature move into residential care, especially if an older person has failing health, has a low income or is feeling insecure in the family home.

Housing tenure has been linked to older people's physical and mental health status, although the relationship is not necessarily causal (Davey et al., 2004). Indications are that people living in rental accommodation experience higher mortality rates (Howden-Chapman et al., 1999). Housing tenure also affects the stability and security of accommodation in that ownership facilitates older

people remaining in their own home, provided this option is manageable and affordable (Dwyer et al., 2000). If people rent their accommodation in later life, issues of affordability arise. The cost of renting can represent a considerable proportion of household-related expenses (Chapter 9). Apart from research by Howden-Chapman and associates on health-related aspects of housing, little New Zealand research is available on the experiences of older renters and the comparable quality of their different types of rental housing. There is some evidence, though, that renters of privately owned accommodation may experience the worst housing conditions of all renters and have the least social and financial security (Davey et al., 2004).

The suitability of housing affects people's ability to continue living at home. Access to maintenance, renovation and adaptation that keeps homes in good condition and appropriate for age-related needs is thus an important determinant of being able to age well (Davey, 2006; Davey et al., 2004). Although government assistance is available for some people with disabilities to install adaptations, many people are not eligible.

Heating and ventilation are important considerations in terms of housing suitability. Despite its relatively temperate climate, New Zealand has greater seasonal mortality among older people than countries with more extreme climates (Davey et al., 2004). Older New Zealanders may not dress warmly or heat their houses sufficiently in cold weather. As people age their bodies are less able to adjust to temperature changes than younger adults. Very old people living alone in the community may be especially vulnerable to cold and dampness in their homes. Alternative types of housing are required to meet the diverse and changing needs of the older population. (See Chapter 9.)

Retirement villages are a housing alternative that has become a popular choice for older people with sufficient wealth to purchase this property. There is a wide variation in the size and scope of these villages, in the range of services offered and their capacity to support occupants with increasing care needs. Concerns about occupants' financial and legal vulnerability have been addressed with the implementation of the Retirement Villages Act 2003 (Retirement Commissioner, 2005).

Transport

Access to transport is crucial to independence and participation in family and community activities. A reduced ability to move freely away from home may lead to social isolation (Dwyer et al., 2000). There is a heavy dependence in New Zealand on private transport. Use of private transport accounted for 75%

of all trips taken by older people in 1997/98 (Davey and Nimmo, 2003). Older people were the drivers in more than half of these journeys.

Owning and driving a car is perceived by many as an important means of maintaining independence. Losing the ability to drive through failing health or licence retesting is a source of anxiety for older people because of the potential impact on their daily life.³ Increasingly though, heavy traffic flows, faster road speeds and complex urban design can be barriers to safe driving.

The most common substitute for personal private transport is to receive rides with others (Davey, 2004). However, the ability to procure rides depends on the size and strength of family and social networks. Very old people risk becoming socially isolated as death and disability reduce their friendship and community networks. Older people's concerns about reciprocity and 'not wanting to be a burden' may deter them from negotiating rides with others. Organisations' present inability to pay volunteers for the costs of transporting older people acts as a further deterrent against community engagement.

Options for transport other than private cars are available but are underused by older people. Travel by taxi is perceived as a luxury, even with the assistance of the Total Mobility scheme in which the cost of taxi fares is partially offset by regional government funding. Under this scheme, taxi vouchers are available to people whose poor health or disability prevents them from using public transport.

The ability to access public transport such as buses relates to its availability and the health of older people rather than their age (Davey, 2004). Factors to be taken into account in the provision of transport include not just the availability of suitable routes to an intended destination, but also older people's ability to reach bus or train departure points and ease of access on to and off vehicles. Another barrier may be the cost of travel, which varies across regions.

Pedestrian safety is particularly significant for ensuring older people are encouraged to maintain their mobility. Capacity to recover from injury reduces as people age and the mortality rate from pedestrian accidents is higher among older people than any other age group (Davey, 2003). The provision of footpaths, resting places and bus stops, and a safe means for crossing roads will help minimise the potential for accidents both from vehicle crashes and from falls.

Policy implications

In the years ahead, the emphasis on ageing in place is likely to determine the shape of service provision for older people and the direction of government

spending in this area. Many initiatives that are under way are in a developmental phase and further policy areas need to be addressed.

Impact of ageing in place on family and state resources

If people are to remain at home and maximise their ability to build a good life at a time of physical, social and economic losses, they need support from others. Even though substantial assistance for older people with health or disability needs is provided by social services, family members are the mainstay of support provision in the home. Apart from the findings of two disability surveys (Health Funding Authority, 1998; Statistics New Zealand, 2002), we have little recent research information in New Zealand on the number of older people receiving family support and the level and nature of that support. British research (Finch, 1989; Finch and Mason, 1993) clearly shows that family relationships and patterns of reciprocity are negotiated over a lifetime. Even though family members may live near to an older person, their support cannot be assumed (Wilton and Davey, 2006).

Growing levels of workforce participation among the generation of adult children who support older people to age in place highlight the need to accommodate working carers. These mid-life carers increasingly grapple with multiple commitments in their lives. In a survey of working carers (Davey and Keeling, 2004), participants indicated that they would manage their work–life balance better if access to relevant and accurate information about options for eldercare in their community were improved. Several mentioned the amount of time that was required in their already busy lives to track down services for their older relatives. They expressed a need for an integrated source of information that could be accessed through the Internet or by telephone.

Financial support for providing care is a recurrent concern for family members. If a family member leaves the workforce to provide full-time care, the Domestic Purposes Benefit is the main source of funding. This benefit is available only when the person being cared for would otherwise need hospital care and is not the carer's spouse. Flexible employment opportunities are required for those people who relinquish paid work for caregiving and wish to return to the workforce later.

The provision of care and support services from the voluntary, private and government sectors is crucial for the achievement of both ageing in place policy objectives and individual life satisfaction. The Health of Older People Strategy states that, "Particularly for frail older people, the way health and disability support services are provided is a key component of their quality of life" (Associate Minister of Health and Minister for Disability Issues, 2002, p. 13).

Only 15% of New Zealanders aged 85 and over live in the community independent of all service provision (Statistics New Zealand, 2002).

Supporting people in their later life has significant economic implications. For example, about 4% of New Zealand's gross domestic product is spent on New Zealand Superannuation (Treasury, cited in Retirement Commissioner, 2006). Older people are high users of health and disability services (Chapter 8). In 2001/02 about 39% of Vote: Health was spent on the care of people aged 65 and over (Associate Minister of Health and Minister for Disability Issues, 2002), with a considerable amount of the expense relating to the provision of end-of-life care. When comparing New Zealand with countries with a higher proportion of older people, the welfare and health costs associated with the predicted increase in our aged population are likely to remain manageable (Cornwall and Davey, 2004; Retirement Commissioner, 2006). However, given limited resources and competing demands, the role of government in supporting ageing in place may predominantly be one of harnessing capacity in society and underpinning assistance provided by families and the voluntary and private sectors.

Current initiatives that support ageing in place

Over the past 6 years, government policy in the area of ageing has been characterised by a strategic planning approach to health and welfare provision. There has also been a move towards encouraging intergenerational perspectives and key departments working together on major initiatives (Associate Minister of Health and Minister for Disability Issues, 2002; Office for Senior Citizens, 2005b). Although not always explicitly promoting ageing in place, several policies have been introduced to increase choice for older people living at home. These policies reinforce the benefits of longstanding programmes such as New Zealand Superannuation, pensioner housing schemes, the subsidisation of health care costs and accident compensation.

The major thrust for promoting ageing in place comes from the New Zealand Positive Ageing Strategy (Minister for Senior Citizens, 2001). Government agencies are obliged to report regularly on their plans and progress towards achieving objectives set out in the strategy. The fifth objective in the strategy is that "older people feel safe and secure and can age in place" (p. 21). In reports of annual progress, this objective is identified as the primary target for initiatives being undertaken by central and local government agencies (Office for Senior Citizens, 2005a).

Seventeen local authorities subscribe to the strategy and have developed policies that encourage independent living with choice. Local governments

provide assistance to older people through many programmes, including those related to infrastructure, public health, housing and recreational services. Gee et al. (2000, p. 6) argue that local authorities “can play a major role in ensuring maximum independence, safety and mobility in older people’s lives”.

The Health of Older People Strategy was developed in support of positive ageing (Associate Minister of Health and Minister for Disability Issues, 2002). It seeks to provide a seamless continuum of care that is responsive to older people’s individual needs. District Health Boards must meet progress goals and implement the strategy by 2010. The effects of this strategy have been most evident in the introduction of new community care projects. A national pilot scheme, ASPIRE, has trialled the effectiveness of a case-management model for support services in three different agencies.⁴ The focus has been on enabling older people to set and work towards their own rehabilitation goals. The management and delivery of care has been reshaped with new initiatives, such as the ‘one-stop shop’ coordination centre established by Capital & Coast District Health Board to provide a range of user-centred services (Capital & Coast District Health Board, 2004). A suite of comprehensive assessment tools, InterRAI, is being piloted nationally. This investment in innovative programmes has positioned care services along pathways recommended in ageing in place literature (OECD, 1994; Tinker, 1999), but services have yet to achieve the integrated and flexible responses to long-term community care envisaged in the Health of Older People Strategy (Glensor, 2006).

Other service endeavours that further enhance the opportunity to age in place relate to measures introduced for regulating standards of care and providing complaint mechanisms that are easy to access when service delivery is inferior in quality or harmful to the user. The Health and Disability Sector Standards (NZS 8134:2001) have formed the basis of audit workbooks for monitoring services, the latest providing guidance for dementia services in the community (Standards New Zealand, 2006). Despite the audit workbooks representing a major step forward towards improving quality of care, they will not make a significant difference until compliance becomes mandatory.

Since the establishment of the office of Health and Disability Commissioner in 1994 and the subsequent formulation of the Code of Health and Disability Services Consumers’ Rights, complaints procedures for services have been continually refined. If service delivery is unsatisfactory, a supporting advocacy service set up across the country provides an avenue through which older people can seek redress. These complaints services do not have a mandate to investigate people’s inability to access services, which is a major issue for older

people waiting for treatment such as elective surgery through the public health system.

Other services developed to protect the rights of older people are elder abuse and neglect prevention services, which are now located throughout the country. A pilot project commenced by Age Concern New Zealand in 1994 has since grown into a network of 24 agencies supported by government and providing mainly coordination and referral services. More government resources have been allocated to services since late 2004 when elder abuse was prioritised along with other forms of family violence as a key social issue for interagency action (Ministry of Social Development, 2004). Psychological abuse is the form of abuse most commonly referred to elder abuse and neglect prevention agencies, with cases of financial abuse also being frequently reported (Age Concern New Zealand, 2005). The misuse of the enduring power of attorney is an ongoing cause of concern.

Future directions in policy

Predicted increases in the older population and particularly of the very old age group give immediacy to addressing issues that will build older people's capacity to continue living independently. There are no easy solutions for ageing in place. A multifaceted approach is needed and future directions for policy include changing lifestyle patterns, adapting the environment for the growing diversity of older people, and strengthening social and care supports.

Lifelong patterns of living are often linked to disability and chronic illness in old age. A preventive, cost-effective approach to health that starts early in life is required. The government is already recognising this need in the New Zealand Health Strategy, which targets such areas as nutrition and exercise (Ministry of Health, 2000). Further emphasis in these areas would be beneficial in promoting a higher health status in succeeding generations. Advance planning for financial security in old age is also needed, particularly for additional expenses incurred through ill health. An option for supporting increasing numbers of older people that has been introduced in Japan and Germany is a long-term care insurance scheme to which contributions are made over many years (Quadagno et al., 2005).

The second course of action, adaptation of the environment to meet diversity, relates to such aspects as housing, transport, community facilities and assistive technology. Although these are dealt with separately, a point consistently emphasised in policy writing on ageing in place is that interagency collaboration is an essential component of effective development.

In housing, new mechanisms for tenure are required to encourage collective home ownership for people with limited wealth or increasing support needs. Innovative accommodation options also need exploring so older people can maintain their independence within shared family living. (See Chapter 9.) A range of initiatives addressing transport issues is discussed in publications by Davey (2004) and Davey and Nimmo (2003). Older people's use of public transport systems is likely to increase if services are more accessible and efficiently operated. Schemes involving the shared use of private cars are an alternative to public transport. Older people's diffidence about requesting assistance with private transport could be reduced by strategies such as having a third party arrange lifts in others' private cars or urban carpooling. In the wider community, increasing opportunities for older people to socialise with others may include such simple measures as providing more seating in public spaces and easy access to public toilets.

Although advances in assistive technology offer opportunities for improved support of older people in their homes, little such technology has been developed in New Zealand. Challenges lie ahead in seeking out innovative ways to maximise the benefits of such innovations. At the same time, ethical and social issues related to the use of technology such as surveillance equipment need exploring.

The third future direction, strengthening social and care support systems, is a vital element in assisting older people with high support needs to remain at home. As discussed earlier, action is already under way to improve the delivery and coordination of home-based services. The continued unbundling of health funding into separate accommodation and health-care components will help increase individual funding options for services. In developing a continuum of care, the introduction of funding alternatives such as a step-down period in asset testing could lessen financial barriers to older people moving in and out of residential care settings.

In the area of family caregiving, further research is required on family support for older people. The development of a variety of employment pathways for family carers and a review of financial and respite support would assist carers who are experiencing high care loads and are in paid employment. New Zealand Carers, an organisation formed to promote the rights of family carers, has yet to accomplish the legislative successes achieved by its counterparts in Britain.⁵

Finally, ageing in place raises questions about the capacity of communities to meet the increasing demands of ageing in place objectives (OECD, 1994). Older people will be better sustained in their communities if goodwill towards

them could be more effectively channelled into supportive initiatives. The promotion of ageing in place is a joint responsibility for the public, private and voluntary spheres. All need to be involved, with a shared vision for the future.

Conclusion

Ageing in place will have a major impact on the current and future development of age-related policies in this country. A complex interaction of situational factors (such as location and social context) and personal characteristics (such as gender and state of health) affect people's ability to age in place. More knowledge is needed about the many factors that contribute to building a good life in the community and the interrelationship of these factors.

Greater knowledge is also needed about the experiences of older New Zealanders in relation to ageing in place. Older people's views of the world will expand our understanding of what informs their choices for achieving quality of life and provide valuable consumer perspectives on service provision. Policy objectives in government strategies underline the importance of policy makers hearing older people's voices and involving older people in planning and implementing their own care. Understanding older people's attitudes and expectations is crucial to their wellbeing and ultimately contributes to sustaining autonomy and choice in their lives.

Population ageing will challenge policymakers to make the most of available resources and to seek new solutions in service planning. In this, initiatives introduced in countries that have already experienced a large proportional increase in their older population could provide valuable guidance. The successful adaptation of programmes from overseas and development of schemes unique to New Zealand will depend, however, on robust research data and a thorough understanding of local conditions. Insufficient research on ageing is being carried out in New Zealand. Research initiatives could usefully include the promotion of national data collection on age-related programmes and the establishment of a national clearing house for research on ageing that incorporates a good practice component.

As well as encouraging more research on ageing, gaps between research and policy development need bridging so the two are closely interrelated and research funding flows more easily into policy development. Government departments are ideally placed to promote projects that support ageing in place, which might include providing funding for, and evaluating, new services and then sharing the learning from such evaluations with communities nationwide.

The need for a holistic, inclusive and flexible approach in supporting older people has been a fundamental message put forward in government documents related to positive ageing (Associate Minister of Health and Minister for Disability Issues, 2002; Minister for Senior Citizens, 2001). The continuation of this approach, well backed with planning and resources, will give older people the opportunity to live in their community with dignity and choice.

Notes

- 1 The authors wish to acknowledge the Centre of Social Research and Evaluation, Ministry of Social Development, for permission to publish this chapter. Special thanks go to Diane Anderson and Pauline Fallon for their contribution and leadership of the project.
- 2 A recent trend in Australia and North America has been to restrict the use of the term to the provision of a continuum of care within sheltered- or assisted-living settings.
- 3 From December 2006 the mandatory requirement for an on-road driving test will be removed. A Medical Certificate for Driving Licence, indicating fitness to drive, is required for relicensing at age 75, and at 2-yearly intervals from age 80.
- 4 Results from the 2-year evaluations are due for release in mid 2006.
- 5 Carers New Zealand has now established a coalition of support organisations, New Zealand Carers Alliance, to strengthen advocacy for carers.

References

- Age Concern New Zealand (2005) *Age Concern Elder Abuse and Neglect Prevention Services: an analysis of referrals for the period 1 July 2002 to 30 June 2004* Wellington: Age Concern New Zealand.
- Armstrong, J. (2002) 'Grandmothers: ethnic approaches to social ageing', in S. Gee (ed.) *Ageing in a Diverse New Zealand/Aotearoa: 40+ Project* Wellington: Victoria University of Wellington, pp. 49–54.
- Associate Minister of Health and Minister for Disability Issues (2002) *Health of Older People Strategy: health sector action to 2010 to support positive ageing* Wellington: Ministry of Health.
- Brown, S., N. Hine, A. Sixsmith and P. Garner (2004) 'Care in the community' *BT Technology Journal* 22 (3), pp. 56–64.
- Capital & Coast District Health Board (2004) *Proposal for the Integration of Home, Community, Primary and Specialist Services in Capital and Coast District* consultation document, Wellington: Capital & Coast District Health Board.
- Chalmers, A. L., and A. E. Joseph (1998) 'Rural change and the elderly in rural places: commentaries from New Zealand' *Journal of Rural Studies* 14 (2), pp. 155–165.

Implications of Population Ageing: Opportunities and Risks

- Cornwall, J., and J. A. Davey (2004) *Impact of Population Ageing in New Zealand on the Demand for Health and Disability Support Services, and Workforce Implications* background paper, Wellington: Ministry of Health, available from <http://www.moh.govt.nz>.
- Cunningham, C. (2000) *Health and Disability Services for Older Māori* prepared for the National Health Committee, Palmerston North: Massey University.
- Cunningham, C., M. Durie, D. Fergusson, E. Fitzgerald, B. Hong et al. (2002) *Living Standards of Older Maori* Wellington: Ministry of Social Development.
- Davey, J. (2003) *Two Decades of Change in New Zealand: from birth to death V* Wellington: Institute of Policy Studies.
- Davey, J. (2004) *Coping Without a Car: summary report* Wellington: Office for Senior Citizens, available from <http://www.osc.govt.nz>.
- Davey, J. (2005) *Prospects and Potential for Home Equity Release in New Zealand: update to 1005* Wellington: Office of the Retirement Commissioner, <http://www.retirement.org.nz/files/ER%20Report%20Final%20March%202005.pdf>.
- Davey, J. (2006) “Ageing in place”: the views of older homeowners on maintenance, renovation and adaptation’ *Social Policy Journal of New Zealand* 27, pp. 128–141.
- Davey, J., V. de Joux, G. Nana and M. Arcus (2004) *Accommodation Options for Older People in Aotearoa/New Zealand* Wellington: Centre for Housing Research Aotearoa/New Zealand, <http://www.hnzc.co.nz/chr/pdfs/accomodation-options-for-older-people-23-aug04.pdf>.
- Davey, J., and S. Gee (2002) *Life at 85 Plus: a statistical review* Wellington: New Zealand Institute for Research on Ageing.
- Davey, J., and S. Keeling (2004) ‘Combining work and eldercare: a neglected work–life balance issue’, paper presented at the 2004 Labour, Work and Employment in New Zealand conference, Wellington <http://www.vms.vuw.ac.nz/vuw/fca/vms/files/Davey%20and%20Keeling.pdf> (accessed 20 April 2005).
- Davey, J., and K. Nimmo (2003) *Older People and Transport: scoping paper* Wellington: Land Transport Safety Authority, available from <http://www.ltsa.govt.nz/research/older-people/> (accessed 20 April 2005).
- Durie, M. (1999) ‘Kaumātua: reciprocity: Māori elderly and whānau’ *New Zealand Journal of Psychology* 28 (2), pp. 102–106.
- Durie, M., G. Allan, C. Cunningham, W. Edwards, M. F. Forster et al. (1997) *Oranga Kaumātua: the health and well-being of older Māori people* Wellington: Ministry of Māori Development.
- Dwyer, M., A. Gray and M. Renwick. (2000) *Factors Affecting the Ability of Older People to Live Independently* Wellington: Ministry of Social Policy.
- Fanslow, J. (2005) *Beyond Zero Tolerance: key issues and future directions for family violence work in New Zealand* Wellington: Families Commission.
- Fergusson, D., B. Hong, J. Horwood, J. Jenson and P. Travers (2001) *Living Standards of Older New Zealanders: a technical report* Wellington: Ministry of Social Policy.

- Finch, J. (1989) *Family Obligations and Social Change* Cambridge: Polity Press.
- Finch, J., and J. Mason (1993) *Negotiating Family Responsibilities* London: Routledge.
- Fine, M., and C. Glendinning (2005) 'Dependence, independence or interdependence? Revisiting the concepts of "care" and "dependency"' *Ageing and Society* 25, pp. 601–621.
- Gabriel, Z., and A. Bowling (2004) 'Quality of life from the perspectives of older people' *Ageing and Society* 24 (3), pp. 675–691.
- Gee, S. (2002) 'Intergenerational relations in Chinese families', in S. Gee (ed.) *Ageing in a Diverse New Zealand/Aotearoa* Wellington: Victoria University of Wellington, pp. 27–36.
- Gee, S., K. Glasgow, S. H. Ng, A. Weatherall, T. Higgins et al. (2000) *Creating Communities for All Ages: local government and older New Zealanders* Wellington: Victoria University of Wellington and Age Concern New Zealand.
- Glasgow, K. (2005) *Ageing is Living: an education and training resource to prepare for positive ageing* revised edition, Wellington: Age Concern New Zealand.
- Glensor, P. (2006) 'Insight from a DHB and PHO perspective', paper presented at Council of Christian Social Services conference, Dunedin, 20–21 April.
- Godfrey, M., M. J. Townsend and T. Denby (2004) *Building a Good Life for Older People in Local Communities: the experience of ageing in time and place* York: Joseph Rowntree Foundation, <http://www.jrf.org.uk/knowledge/findings/socialcare/014.asp>.
- Green, S., and A. Sixsmith (2005) 'Understanding the nature of occupation in old age', presentation at Actuarial Profession: Making Financial Sense of the Future conference, Division of Primary Care, University of Liverpool.
- Grundy, E. (2005) 'Reciprocity in relationships: socio-economic and health influences on intergenerational exchanges between Third Age parents and their adult children in Great Britain' *British Journal of Sociology* 56 (2), pp. 233–255.
- Health Funding Authority (1998) *Disability in New Zealand: overview of the 1996/97 surveys* Wellington: Ministry of Health.
- Henderson, A. S., and A. F. Jorm (2000) 'Definition and epidemiology of dementia', in M. Maj and N. Sartorius (eds) *Dementia* Chichester: John Wiley and Sons.
- Hilleras, P.K., P. Pollitt, J. Medway and K. Ericsson (2000) 'Nonagenarians: a qualitative exploration of individual differences in well-being' *Ageing and Society* 20, pp. 673–698.
- Hine, N., A. Jackson, S. Ashraf, J. Arnott, A. Sixsmith et al. (2005) 'Modelling the behaviour of elderly people as a means of monitoring well being' *Lecture Notes in Artificial Intelligence* 3538, pp. 241–56.
- Howden-Chapman, P., L. Signal and J. Crane (1999) 'Housing and health in older people: ageing in place' *Social Policy Journal of New Zealand* 13, pp. 14–30.
- HRCNZ (2004) *Ngā Pou Rangahau Hauora Kia Whakapiki Ake Te Hauora Māori 2004–2008: the health research strategy to improve Māori health and well-being 2004–2008* Auckland: Health Research Council of New Zealand, http://www.hrc.govt.nz/root/Publications/Maori_Health_Research_Publications.html.

Implications of Population Ageing: Opportunities and Risks

- Joseph, A. E., and A. I. Chalmers (1995) 'Growing old in place: a view from rural New Zealand' *Health and Place* 1 (2), pp. 79–90.
- Kane, R. A., and C. A. Levin (1998) 'Who's safe? Who's sorry? The duty to protect the safety of clients in home- and community-based care' *Generations* 22 (3), pp. 76–82.
- Keeling, S. (1999) 'Ageing in (a New Zealand) place: ethnography, policy and practice' *Social Policy Journal of New Zealand* 13, pp. 95–114.
- Keeling, S. (2001) 'Relative distance: ageing in rural New Zealand' *Ageing and Society* 21 (5), pp. 605–620.
- Minichiello, V., J. Browne and H. Kendig (2000) 'Perceptions and consequences of ageism: views of older people' *Ageing and Society* 20 (3), pp. 253–278.
- Minister for Senior Citizens (L. Dalziel) (2001) *The New Zealand Positive Ageing Strategy: towards a society of all ages* Wellington: Senior Citizens Unit, Ministry of Social Policy, <http://www.osc.govt.nz/documents/nzpositiveageingstrategy.pdf>.
- Minister of Health (A. King) (2000) *The New Zealand Health Strategy* Wellington: Ministry of Health, available from <http://www.moh.govt.nz>.
- Ministry of Health (1997) *Making a Pacific Difference: strategic initiatives for the health of Pacific people in New Zealand* Wellington: Ministry of Health, available from <http://www.moh.govt.nz>.
- Ministry of Health (2002a) *Advice to the Incoming Minister of Health: better health, better participation, reduced inequalities* Aim 3, Health of older people, Wellington: Ministry of Health.
- Ministry of Health (2002b) *Health of Older People in New Zealand: a statistical reference* Wellington: Ministry of Health, available from <http://www.moh.govt.nz>.
- Ministry of Social Development (2001) *Positive Ageing in New Zealand: diversity, participation and change: he organa kaumātua i Aotearoa* Wellington: Ministry of Social Development.
- Ministry of Social Development (2002) *Briefing Paper to the Incoming Minister for Senior Citizens: towards lifelong participation and independence* Wellington: Ministry of Social Development.
- Ministry of Social Development (2004) *Opportunity for All New Zealanders* Wellington: Ministry of Social Development.
- Ministry of Social Development (2005) *The Social Report 2005: indicators of social well-being in New Zealand* Wellington: Ministry of Social Development, available from <http://www.socialreport.msd.govt.nz/tools/previous-reports.html>.
- Ministry of Women's Affairs (2002) *Brief to Incoming Minister* Wellington: Ministry of Women's Affairs. <http://www.mwa.govt.nz/news-and-pubs/publications/bim>.
- Morris, A., J. Reilly, S. Berry and R. Ransom (2003) *New Zealand National Survey of Crime Victims* Wellington: Ministry of Justice, <http://www.justice.govt.nz/pubs/reports/2003/victims-survey>.
- National Health Committee (1998) *Active for Life: a call for action* Wellington: National Health Committee.

- Netten, A., M. Ryan, P. Smith, D. Skatun, A. Healey, et al. (2002) *The Development of a Measure of Social Care Outcome for Older People* discussion paper 1690/2, Kent: Personal Social Services Research Unit, Personal Social Services Research Unit, University of Kent at Canterbury.
- New Zealand Guidelines Group (2003) *Assessment Processes for Older People: best practice evidence-based guideline* Wellington: New Zealand Guidelines Group.
- Ng, S. H., J. H. Liu, A. Weatherall and C. S. F. Loong (1998) 'Intergenerational relationships in the Chinese community', In S. H. Ng, A. Weatherall, J. H. Liu and C. S. F. Loong (eds) *Ages Ahead: promoting inter-generational relationships* Wellington: Victoria University Press, pp. 85–104.
- OECD (1994) *New Orientations for Social Policy* Social Policy Studies 12, Paris: Organisation for Economic Co-operation and Development.
- Office for Senior Citizens (2005a) *New Zealand Positive Ageing Strategy Annual Report 2004/2005* Wellington: Ministry of Social Development.
- Office for Senior Citizens (2005b) *Taking a Positive Approach to Ageing: briefing to the incoming Minister for Senior Citizens 2005* Wellington: Ministry of Social Development.
- Quadagno, J., J. Reid Keene and D. Street (2005) 'Health policy and old age: an international review', in M. L. Johnston (ed.) *The Cambridge Handbook of Age and Ageing* Cambridge: Cambridge University Press, pp. 605–612.
- Retirement Commissioner (2005) *Retirement Villages Act 2003: recommendations to the Minister for Building Issues on the draft Code of Practice* Wellington: Retirement Commissioner, http://www.retirement.org.nz/Recommendations_report.html.
- Retirement Commissioner (2006) *NZ Super* Wellington: Retirement Commissioner, <http://www.retirement.org.nz/index.php?currentPage=7> (accessed 25 April 2006).
- Richmond, D., J. Baskett, R. Bonita and P. Melding (1995) *Care for Older People in New Zealand: a report to the National Advisory Committee on Core Health and Disability Support Services* Wellington: National Advisory Committee on Core Health and Disability Support Services.
- Rowlingson, K., and S. McKay. (2005) *Attitudes to Inheritance in Britain* York: Joseph Rowntree Foundation, <http://www.jrf.org.uk/knowledge/findings/socialpolicy/0385.asp>.
- Sainsbury, R., C. Collins, G. Duff, J. Harrison, R. Haydon et al. [1997] *Guidelines for the Support and Management of People with Dementia* Wellington: National Advisory Committee on Health and Disability.
- Schofield, V. (2004) 'Elder abuse and neglect: causes and consequences', in M. Connolly (ed.) *Violence in Society: New Zealand perspectives* Christchurch: Te Awatea Press, pp. 81–94.
- Standards New Zealand (2006) *Best Practice Guidance for Community Services for People with Dementia and Proposed Audit Workbook* SNZ HB8134.6: 2006, Wellington: Standards New Zealand.
- Statistics New Zealand (2002) *Disability Counts 2001* Wellington: Statistics New Zealand.

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- Statistics New Zealand (2004) *Older New Zealanders: 65 and beyond* Wellington: Statistics New Zealand, <http://www.stats.govt.nz/NR/rdonlyres/CF82C033-BE57-49E4-8F43-ECCDED9B30ED/0/OlderNZrs2004.pdf> (accessed 18 April 2005).
- Taylor, P. (2002) *Public Policy Initiatives for Older Workers* York: Joseph Rowntree Foundation, <http://www.jrf.org.uk/knowledge/findings/socialpolicy/d62.asp>.
- Thomson, D. (1991) *Selfish Generations? The ageing of New Zealand's welfare state* Wellington: Bridget Williams Books.
- Tinker, A. (1999) *Ageing in Place: what can we learn from each other?* The 6th F. Oswald Barnett Oration, Melbourne: Ecumenical Housing.
- Tinker, A., J. Askham, R. Hancock, G. Mueller and R. Stutchbury (2001) *Eighty-five Not Out: a study of people aged 85 and over at home* Oxfordshire: Anchor Trust.
- Victor C. R., S. J. Scambler, A. Bowling and J. Bond (2005) 'The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain' *Ageing and Society* 25 (3), pp. 357–375.
- Von Heideken Wagert, P., B. Ronnmark, E. Rosendahl and L. Lundin Olsson (2005) 'Morale in the oldest old: the Umea 85+ study' *Age and Ageing* 34 (3), pp. 249–255.
- Waldegrave, C., J. Poot, P. King et al. (2005) 'Enhancing well-being in an ageing society (EWAS)', <http://www.msd.govt.nz/documents/events/strategic-social-policy/forums/forum-on-ageing/forum-research-aging-current-research-3.doc>.
- Waldon, J. (2004) 'Oranga Kaumātua: perceptions of health in older Māori people' *Social Policy Journal of New Zealand* 23, pp. 167–180.
- Wilkinson, T. J., and R. Sainsbury (1998a) 'The association between mortality, morbidity and age in New Zealand's oldest old' *International Journal of Aging and Human Development* 46 (4), pp. 333–343.
- Wilkinson, T. J., and R. Sainsbury. (1998b) 'A census comparison of centenarians in New Zealand and those in the United States' *Journal of the American Geriatrics Society* 46, pp. 488–491.
- Wilton, V., and J. A. Davey (2006) *Grandfathers: their changing family roles and contributions* Wellington: Families Commission Blue Skies Research Fund.
- Worrall, J. (2005) *Grandparents and Other Relatives Raising Kin Children in Aotearoa/New Zealand* Auckland: Grandparents Raising Grandchildren Charitable Trust.