Promoting Mental Health for Older People:
Global Ageing and the Challenges and Opportunities for Nelson-Tasman and Aotearoa New Zealand

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Promoting Mental Health for Older People: Global Ageing and the Challenges and Opportunities for Nelson-Tasman and Aotearoa New Zealand

Overview

Health Action Trust (Nelson) supports an environmental approach to mental health and wellbeing which recognises that people’s decisions are affected by many factors, and that many determinants of health are out of the control of the individual. Building resilience both individually and collectively forms the basis of sound health promotion principles and practices and is in line with the World Health Organisation’s Ottawa Charter which is the basis upon which Health Action Trust (Nelson) was founded, and operates.

This document has been developed by the Health Action Trust (Nelson) Mental Health Promotion Team. Promoting Mental Health for Older People: Global Ageing and the Challenges and Opportunities for Nelson-Tasman and Aotearoa New Zealand has been developed to inform both Health Action Trust (Nelson) and other local and national organisations of the challenges facing our population. These challenges are especially significant for the Nelson Tasman region due to the proportion of our population that is older - and its rate of growth. From a clear understanding of the issues that face our region we aim to work collaboratively with organisations to assist with the development of policies and strategies addressing the needs of our older population, both now and in the future.

This document is focused primarily on mental health for older people, and the role of mental health promotion in creating and maintaining wellbeing and resilience for older people. The approach taken is to briefly review the literature on projected ageing patterns and on common mental health challenges facing older people in the context of mental health and wellbeing. Interspersed in this material is reference to evidence-based models and programmes which promote good mental and physical health. An assumption behind this approach is that while individuals must develop and carry into older age good practices for maintaining wellbeing it is essential that the social and economic context in which they live helps to establish and support these practices.
Executive Summary

The following section is a brief summary of the material covered in the body of this document, and is arranged under the same broad headings as the full document. More detail on the points made in the summary can be found within those sections, along with links to the supporting references.

Global and Local Ageing

By 2051 New Zealand’s over 65 year-old age group is expected to more than double in number to between 1.17 million and 1.48 million, at which point this group will represent at least a quarter of the population. Along with the effects of factors such as low birth rates in developed countries, this pattern in global demographic change is primarily the result of more people living, on average, much longer. The seismic shift in the make-up of the world’s population has been termed ‘global ageing’, presenting as it does some similar challenges for governments and their populations to global warming; global ageing is an unprecedented event in human history with huge implications for our societies, for our public services, and especially for how these are funded and structured.

Within the Nelson, Tasman and Marlborough region the population is older again than the national average; in the 2013 census the NZ median age was 38 years, Nelson’s was 42.5 years and Tasman’s 44.2 years old. The results of the 2013 census also show the rate of growth in the population of older people in Nelson and Tasman to be outstripping the NZ average, with the 80-84 age group being the single exception.

Ageing, disability and wellbeing

Current New Zealand data is consistent with World Health Organisation (WHO) surveys which show a trend for disability to increase with age. Beyond that basic correlation are other disability-related associations and implications; 1) prolonged life, or longevity, can be either a benefit or a burden to an individual and to society depending on the presence of disability and quality of that longer life, 2) there is a trend for physical and mental health issues to be connected, with losses in one area potentially producing losses in the other, and 3) wider determents of disease (e.g obesity) not only impact on the incidence of a specific disease like diabetes and on related health conditions (e.g depression, cardiovascular disease, musculoskeletal problems), but on the health resources available for other health sectors, like services to older people and for mental health services.

How the interaction between greater average longevity and disability within a population plays out over time can be summarised by three alternative patterns of morbidity; 1) ‘expansion of morbidity’, where a greater percentage of life-expectancy is affected by ill health; 2) ‘compression of morbidity’, where people have longer, healthier lives and any period of illness or disability comes at the end of life; and 3) ‘dynamic equilibrium’, where the number of years lived with disability increases, but there is a decrease in the number of years lived with severe disability.

If compression of morbidity is to be goal for New Zealand then reducing the prevalence of disability by achieving good mental and physical health becomes an essential complement to treating physical and mental illness as this occurs. This would mean making wellbeing a population-wide goal, where wellbeing is defined as a positive mental, social and physical (and in some models, spiritual) state of being. A particular
focus on mental wellbeing will be important since higher levels of psychological well-being (flourishing) having strong associations with greater productively, better social relationships, and better health and life expectancy. There are some indications that mental health issues impact more on people’s general wellbeing than physical health issues, that over the long-term people may adjust better to physical than mental ill-health. Physical health is, obviously, important, but good mental wellbeing is not simply a bonus in life, but a filter for how that life is experienced.

**Individuals and mental wellbeing: Losses, challenges, opportunities**

The current pattern for the NZ population has almost half experiencing some form of mental illness over their lifetime (Pakeha 46.6%, and 50.7% for Maori), and for 20.7% this will have occurred in the last 12 months. Over a 12 month period, for 4.7% of the population their illness will have been categorised as serious, for 9.4% it will be moderate and for 6.6% categorised as mild. Relatively common psychological conditions or illnesses amongst older people include dementia, anxiety, depression - often coexisting with anxiety - and suicide. Many of these are not well identified or diagnosed at a primary care level.

Comorbidity, where an individual has more than one mental illness, or a mental and physical illness, is also common feature for older people. Risk factors for the loss of mental wellbeing in older people include; loss, such as that involved in retirement; social isolation and loneliness; financial stress; physical inactivity; and (often under-identified) substance abuse. The mix of illnesses and risk factors, and the way these often interact with and compound each other, creates a complexity in older people’s ill health that is a challenge for health systems.

**Older people, mental health, and the unmet challenge of complexity**

Avoiding or delaying the onset and progression of illness and loss of function over this extended life-time for our population is not currently a preoccupation of the public health system, with its hospital-centred services primarily based on ‘evidence-driven’, treat-and-discharge interventions. As a form of investment in good mental and physical health, health promotion is, in contrast, inherently multi-dimensional and complex, with time lags between programmes and outcomes, and a concern with cause-and-effect relationships (e.g. low income/debt, and inequality as variables in health and wellbeing) that are not direct.

Perhaps as a partial consequence, funding of prevention and public health services makes up as little as 5.9% of total health and health-related expenditure in NZ. The challenge of addressing underlying complexity in health, with its reach across different aspects of society such as the wider determinants of good or poor health, may however be not be so much avoided by the current, more tightly-focused approach to delivering health but simply transferred elsewhere; in this case emerging as a burden to our treatment-based model of health in the form of the complex and interlinked presentations and challenges typically found in older people’s physical and mental health.

**Beyond individual wellbeing: Structural impacts on wellbeing**

‘Structural’ refers to how the results of a society’s values, attitudes and policies can shape the structure of health services and their operation. Not acknowledging and addressing these deeper structural pressures and difficulties results in systemic challenges in achieving public health. The stigma around ageing, for
instance, affects whether and how older people ask for help, and the wider social response to older people and their needs. Related to a pervasive devaluation of older people in society is a pattern of poor assessment, treatment and referral onwards for older people. In contrast, a similarly unhelpful but highly positive reframing of ageing celebrates what older age might be without ensuring that the mechanisms are in place to bring this potential to fruition.

These wider social and associated policy positions on ageing suggest a poorly grounded concept of ageing and the absence of a realistic model for how health might be actively maintained into older age, and what this might then require of individuals, communities and governments. The flow-on impacts of this become manifest in such areas as overstretched and under-supported institutional care for older people, and associated instances of elder abuse and the inappropriate use of medication. Another structural aspect involves the challenges associated with the ageing of the health workforce itself, although this also represents an opportunity to apply different approaches to the transition into retirement for health sector workers, and to apply principles of individual wellbeing within this workforce in order to address workforce sustainability.

**Revaluing health and wellbeing**

Estimates by the New Zealand Institute of Economic Research are that our Government’s ability to maintain its budget will be undermined by healthcare spending if the current approach to delivering healthcare is not realigned. Various responses are available to this looming crisis; one is the (ongoing) demand that the health system finds ways to make efficiency savings while being managing ballooning service costs and demands. Related responses will involve politically difficult choices between a marked reduction in the scope or the quality of service, or requirements for the greater application of user pays and/or compulsory medical insurance. These are, however, options that effectively reinforce the current hospital-based focus on illness treatment and fail to address the need to prevent where possible, and delay where not, the onset and progression of illness.

A readiness for a more fundamental shift in focus approach to addressing public health has been reflected in the views of some fifty attendees, included leading academics, economists, public and private healthcare providers and politicians at a health funding Tomorrow’s Healthcare ‘Think Tank’ in Auckland in May 2014. Pre-workshop interviews revealed that the dominant theme from participants was the need to modify and if possible reduce demand for healthcare, with a particular focus on maintaining good health at the outset by investing in and improving health literacy, public health education, and preventative behaviours.

Such a change to how good health - mental and physical - is created and maintained will require a strong evidence base that sets out the approach needed so that the promotion of health and the prevention of illness are valued equally to treatment. Extensive research into evidence for the effectiveness of mental health promotion, for instance, has refined theoretical underpinnings and models, programme methodology and evaluation and is creating clarity around both risk and protective factors for mental health while creating resources to guide best practice approaches in mental health promotion.

Importantly, this process of promoting health and wellbeing is less a collection of diverse programmes and more a set of evidence-grounded, guiding principles - including those of the The Ottawa Charter for Health Promotion and the Perth Charter for the Promotion of Mental Health and Wellbeing - from which a range
of programmes have been, and can be, developed. This creates a coherent and consistent approach, which is in itself a key success element.

Varied applications of the UK-developed Five Ways to Wellbeing model across individual and wider institutional settings is one prominent initiative that reflects such an approach. That model, with its focus on developing mental wellbeing, evolved from a major UK project which received input from over 400 leading international experts and stakeholders, and over 80 commissioned reviews. The model has a strong practical focus on creating and maintaining wellbeing and resilience through its focus areas; 1) Connect socially with others, 2) Give to others through activities like volunteering, 3) Take Notice of and appreciate the world around oneself, 4) Keep Learning, and 5) Be Active. There is strong evidence for the effectiveness of the separate components of the model, including with older people, although the combination of these elements is important - many of the impacts of ‘being active’ amongst older people, for instance, benefit from the social dimension of shared activity (Connect).

Nelson Tasman

While an over-arching policy approach that goes beyond specific programmes with limited aims will necessary, there is value in looking at start points for implementing change in the Nelson Tasman region. The large older population and its high rate of growth makes the task of addressing challenges associated with ageing, and of the loss of health and wellbeing, especially significant for this area. Three useful areas of development, which may serve as pilot projects for more wide application, could include:

- expanding sound health and mental health policies and practices across workplaces - and amongst health sector workers especially;
- supporting the role of general practices, and other primary health care providers, to more effectively assess the mental wellbeing and illness of older people and to engage both this group and the wider population in illness prevention and health promotion activities. Appropriate activities will need to be available at a sufficient level and be accessible;
- working with local councils so that their approach to such issues as urban design and other planning and provision functions all act to support the basic principles of, for instance, the Five Ways to Wellbeing model.

Health Action Trust’s Mental Health Promotion Team has developed this document to help inform the public, the health sector, and other organisations of the opportunities and the challenges facing our population. Establishing a clear understanding of these issues will allow Health Action Trust to work collaboratively with Local Government, health providers and other local organisations in the development of policies and strategies to meet the needs of our older population - both now and in the future.
Health Action Trust (Nelson)

Promoting Mental Health for Older People:
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and Aotearoa New Zealand

Chris Allison
Mental Health Promotion Team

“We cannot afford to deliver services, even to current efficient and best practice, unless radically new models of promotion, prevention and intervention are in place.” Dr Elizabeth Spellacy

“The purpose of looking to the future is to disturb the present.” Gaston Berger

1. Introduction

By mid-century New Zealand’s over 65 year-old age group is expected to more than double in number and will come to represent over a quarter of our population. This change is part of a global demographic pattern which is primarily the result of more people living longer, a change compounded by the effects of low birth rates in developed countries. That shift in the make-up of the world’s population has the potential to present significant challenges for societies like New Zealand’s, and for governments in particular, due to the implications for how public services are funded and structured.

As people age, for instance, their demands on health systems have tended to increase. At the same time, increasing costs of treatment goods and services, such as labour costs and medical technology and treatment, will be compounded by the impact of what has been described as an ‘epidemic’ of obesity and associated chronic health conditions.

What this means is that the current NZ health system, while being able to adapt up to this point, is unlikely to cope with the level of demand in the near-future. Estimates by the New Zealand Institute of Economic Research suggest that within eight years NZ will need to shift its approach to healthcare spending if this is not to undermine Government’s ability to maintain its budget.3

In the face of these social and health system challenges this document is concerned primarily with mental health for older people, and the role and value of mental health promotion in creating and maintaining wellbeing and resilience. Many physical health issues impact on mental health however, and in some cases the reverse is true. In addition, younger people will also take into their older age mental and physical health issues and vulnerabilities - or strengths - as they age. This means that aspects of physical health, and a wider focus on the general population are also touched on in this document. This approach is consistent with health and mental health promotion principles and practice, where whole-of-life and whole-population approaches are often applied.
2. Global and Local Ageing

2.1 Population trends: A general overview

The world’s population distribution is being reshaped dramatically by several factors, including the high-profile impact of the ‘baby boomer’ generation and lowered birth rates. The latter pattern, especially in developing countries, is combining with lower rates of mortality in childhood and maternal mortality.4

A critical factor in demographic change however, is that people are on average living longer - much longer. While the maximum lifespan has remained essentially unchanged over the last 100 years, average life expectancy in most developed and developing countries has increased dramatically. In 1900 average life expectancy in the US was age 47.3, by 1987 this had risen to 75 years, mostly due to dramatic reductions in rates of infant, child, and maternal mortality.5 Much of that shift was the result of public health measures such as improved sanitation, and water and food quality.6 Ongoing environmental, public health and medical changes mean that half of those born from the year 2000 onwards are expected to live to the age of 105 years7.

The evolving demographic pattern of ‘ageing populations’ began in Japan, was followed by Europe, and since then has progressively rippled out across other countries. The scale of this change is huge; by 2050 China will have over 100 million in its population aged over 80 - a larger proportion of older people in its population than in the United States.8

Population ageing on this scale is unprecedented - without parallel in human history. As a global phenomenon it is also pervasive, although countries are at varied stages in the process and are moving at a different pace relative to each other in this demographic shift. Population ageing is also enduring - the relatively ‘young’ populations that have characterised human history are highly unlikely to be a feature of our societies again.9

This phenomena has been called “Global Ageing”, and like Global Warming the implications are daunting; “the demographic shifts that are resulting in a substantially growing elderly population can be viewed alongside climate change as one of the new century's most pressing issues.”10 and with many more people living longer, the age of onset of any disability or ill health occurs becomes critical - for both the individual and for the health and public systems that support them.

New Zealand

Data from the 2013 census is currently being released but it confirms previously identified trends. The 2006 Census gave a count of 495,600 New Zealand residents aged 65 years and over, an increase of 45,200 from the 2001 Census. At the time this represented the largest between-censuses growth for this age group in NZ’s recorded demographic history.11

In the 2013 census the total number for this age group was 607,032, giving an increase of 111,432 - more than twice the previous count, although also over a slightly longer census-to-census period. Drawing on 2006 census figures, the age 65+ group made up 12.3% (one in eight) of all New Zealanders, compared with 8.5 % (one in twelve) in the early 1970s.
By 2051 the over 65 age group is expected to more than double in number to between 1.17 million and 1.48 million, at which point they will represent at least one-quarter of all New Zealand residents.\textsuperscript{12} Similarly, the number of people aged over 85 will nearly double from 56,667 in 2006 to 116,500 in 2026.\textsuperscript{13} Longer term, by around 2060, the older population is expected to level out at around 20-21% of the total NZ population.\textsuperscript{14} The bulk of this growth is expected to come from the age 75-84 and 85+ groups, and the gender balance is likely to reflect longer female life expectancy; on average women are living four years longer than men.

The largest increase in the older population is likely to occur between 2021 and 2031; an extra 276,000 people are expected to join this older age group.\textsuperscript{15} Smaller towns and rural areas in particular will experience a faster shift in their age makeup, including a local decrease in the number of young people. This aspect of the change in population is especially evident for Tasman in the 2013 census.\textsuperscript{16}

For the Māori population the trend is for a faster rate of ageing, but occurring at a later time than the non-Māori population. The older Pacific population is also increasing and by mid this century is projected to reach eleven times its current size. This population group is predominantly urban; two-thirds are based in Auckland with the second largest cluster being in Wellington.\textsuperscript{17}

\begin{figure}[h]
\centering
\includegraphics[width=0.8\textwidth]{figure1.png}
\caption{New Zealand population by age group for the years 2006, 2026 and 2051 (projected)}
\end{figure}

(Figure 1. from: Mental Health and Addiction Services for older people and Dementia Services, 2011\textsuperscript{18})

**Nelson and Tasman**

The population of the Nelson, Tasman and Marlborough region is significantly older than the national average. As at 2006 the median age for people in the region was 39.4 years old compared to 35.9 years for New Zealand as a whole. In the 2013 census the NZ median age had moved out to 38 years, with an increased gap to Nelson’s median at 42.5 years and a greater gap again for Tasman at 44.2 years old. This demographic pattern results in the Nelson Marlborough District Health Board receiving additional funding for this older, more expensive component of its population.\textsuperscript{19}

The results of the 2013 census also show that Nelson is the fastest growing region in the South Island - faster than any other region outside of Auckland. As can be seen by the comparative rates of the increase...
in various age groups in Figure 2 below, the rate of growth in the population of older people in Nelson and Tasman generally outstrips the NZ average, with the 80-84 age group being the single exception. Population increases for those aged 65+ in Tasman from 2006-2013 was 39.4% and for the same group in Nelson, 30.1%. Tasman has a particularly high rate of growth in its 65-79 age range (while also showing a particularly high loss of those aged 25-39).

Figure 2. Rate of change in population, with percentage of changer (increase or decrease) between 2006 - 2013 by age for Nelson, Tasman NZ average.

Figure 3 below shows the population levels for specific age groups and reveals the increases from 2006 to 2013. While the rate of change is relatively high for the age 85+ age group the real change is in the 65-69 age group, where both the numbers and rate of increase are substantial. Also evident here is the slightly higher growth in the 65-79 age group for Tasman relative to Nelson.

Figure 3. Numbers in age groups from age 65 plus, Nelson and Tasman 2006-2011

In 2009, prior to population changes driven by the Christchurch earthquake, it had already been noted that “in relation to population size, the lower populated regions in the top of the South Island (for example, Tasman and Nelson) had some of the highest in-migration flows of people aged 65+ from other regions.” A number of factors are driving the numbers and rate of growth in the region’s older population, but one indication is provided by Nelson’s census area of Ngawhatu, which is the "standout for population gain, rising to 2427 from 1334 in 2006 and 969 in 2001, far ahead of any other suburb across the wider region."
This census area is the site of several new retirement home subdivisions and more of these developments are underway in the neighbouring Saxton census area, although these are too new to be captured by the 2013 census data.

2.2 Ageing, disability, and wellbeing

Before looking at some of the potential mental health challenges for older people and the associated risk factors, it is useful to summarise the wider context; the relationship between ageing and longer average life expectancy, disability, and creating and maintaining wellbeing within New Zealand’s population - a central issue in this document.

Current New Zealand data is consistent with World Health Organisation (WHO) surveys23 which show a trend for disability increasing with age; NZ figures from 2013 show disability rates for 15-44 year olds of 16%, increasing to 28% for ages 45-64, and to 59% for those aged 65+.24 For the combined Nelson-Tasman population aged 65 years and over this would equate to just under 9800 people. In part, the increase from one-in-five with disability to one-in-four between 2001 and 2013 reflects the impact of an ageing population.

The main form of disability in NZ for adults was physical, essentially relating to disease and illness. Common long-term physical health conditions for adults aged 75 years and over include high blood pressure (53%), arthritis (51%), chronic pain (34%), high cholesterol (33%), ischaemic heart disease (22%), diabetes (15%) and stroke (10%).25 As will be covered in detail in following sections, older people can also effectively be disabled by a range of mental illnesses, typically including depression, anxiety and or dementia.

Looking at the rates of physical disability noted above for those over age 75 brings to bear the issue of adding greater life expectancy. For instance, compared to a 75 year-old living in 2012, a 75-year-old living in 2050 with the same level of disability but a longer predicted lifespan will live with that disability - and the related demands of care - for much longer. In some countries the increased level of disability and illness associated with the last stages of life means that a large proportion of health care costs associated with advancing age are incurred in the year or so before death. However, recent NZ research26 shows that health spending over the last year of life does not vary greatly across different age groups.

The central issue is therefore that health spending is cumulative with age. Longevity creates the potential for more health costs to accumulate over an extended lifetime, rather than being tied to the actual age at which an older person dies. As such, the estimated health costs accumulated over a lifetime almost doubles for a person dying at age 90 ($223,000) compared to dying at age 70 ($113,000).27 This additional 20 years results in a disproportionate increase in health costs so the question of whether this pattern can be modified becomes critical.

How the interaction between greater average longevity and disability plays out over time, both now and in the future, can be summarised by three alternative patterns of morbidity; the “expansion of morbidity” hypothesis, where a greater percentage of life-expectancy is affected by ill health; the “compression of morbidity” hypotheses, where people have longer, healthier lives and any period of illness or disability comes at the end of life; and the “dynamic equilibrium” hypothesis, where the number of years lived with disability increases, but there is a decrease in the number of years lived with severe disability.28 Past assumptions about NZ’s future pattern have predicted a “compression of morbidity”29 but more recent health trends suggest that is unlikely - while remaining possible with a timely and appropriate focus on the factors that shape the extent of disability within the population.
The impact of factors working against the compression of morbidity is illustrated by the issue of obesity. The 2012/13 New Zealand Health Survey found that among adults (aged 15 years and over) roughly one third were obese and a second third were classified as overweight. The rate of growth in obesity in our population is significant; between 1997 and 2012/13 obesity in males grew from 17% to 30%, and for females from 21% to 32%. Rates of obesity are worse for Māori (48%) and Pacific adults (68%). Obesity has some complex connections with mental ill-health, but there is good evidence for obesity increasing the risk of developing depression, and for a depressed individual being at increased risk of becoming obese, and there is some association between obesity and anxiety. Obesity is also a risk factor for several chronic diseases such as cardiovascular disease and type 2 diabetes which are themselves associated with depression.

Obesity will therefore impact on the mental health of a subgroup of older people, and on the mental health that other people take with them into older age. But the consequences of obesity also create significant demands on the public health system; recent data from the long-running Million Women Study in the United kingdom showed that one in eight hospital admissions for women aged between 50 and 84 years were caused by obesity and overweight. The estimated cost to the UK health system of this essentially preventable disease burden has been estimated to be over £500m annually.

In the context of limited health funding, this represents increased competition for funding of services to older people, and for mental health services, both of which have historically struggled for funding. This situation is exacerbated when people suffering obesity-related illnesses like diabetes, for instance, receive treatment that successfully prolongs their life (resulting in prolonged health care demands) while the incidence and the ‘drivers’ of what has been termed the ‘the diabetes epidemic’ remain unchanged. Under such circumstances, hopes for a compression of morbidity would seem highly optimistic, if not unrealistic.

A more subtle point about disability, including how physical health and mental health are interconnected, and how one disability or area of loss can create - or exacerbate - the impacts of others, is provided by hearing loss. Even in relatively high income countries such as NZ, hearing loss is one of the four major causes of disability for older people, the others being visual impairment, dementia and osteoarthritis. Hearing loss affects 34% of male adults in NZ aged over 65 years, and 23% of women.

The prevalence of this form of disability is particularly significant since age-related hearing loss is often overlooked as a cause of reduced functioning and increased vulnerability. Communication with others is an obvious casualty of untreated hearing loss, and the result is often social isolation and loss of an individual’s autonomy. People with normal hearing tend to under-appreciate the impact of this physical and social handicap, and there is a resulting tendency to see difficulties understanding spoken communication as some kind of ‘mental deficiency.’

This misunderstanding acts to further isolate the afflicted person since many of those with hearing loss withdraw from contact with others in order to avoid the stigma of being seen to be ‘mentally slow’, and the resulting loss of independence and increase in psychological distress sets the scene for a greater need of formal forms of support. Unsurprisingly then, hearing loss is also associated with depression and anxiety, and with cognitive decline.

These two examples underline three critical points 1) that physical health and mental health issues are often connected, with losses in one area potentially producing losses in the other, 2) that addressing wider determinants of a disease (e.g. obesity) can impact not only on the incidence of a disease like diabetes and on related health conditions (e.g. depression, cardiovascular disease, musculoskeletal problems), but on the
health resources available for other health sectors, like services to older people and for mental health services, and 3) prolonged life, or longevity, can be either a benefit or a burden to an individual and to society depending on the quality of that longer life.

This issue of longevity and quality of life returns the focus to the question of which pattern of health across the life course will be established and maintained for NZ’s population; the “expansion of morbidity”, the “compression of morbidity” or the “dynamic equilibrium” of morbidity. Whether current patterns of disability and time of onset of illness and loss will change over time, along with increasing longevity, will determine the future morbidity pattern for our population. Reducing age-related disability rather than only delaying this will also be important however; because the oldest age groups are at most at risk of disability, and are increasing in number, the increased demand for long-term care can still be seen as inevitable if the point of onset of disability alone is delayed.\(^{43}\) If compression of morbidity is to be goal for New Zealand, then achieving population-wide good mental and physical health through effective mental and physical health promotion becomes an essential complement to an approach of treating physical and mental illness as this occurs.

Two concepts that have gained widespread use in defining good health are ‘wellbeing’ and ‘flourishing’. A working definition of wellbeing is “a positive physical, social and mental state.”\(^{44}\) (Some models of wellbeing, including the Te Whare Tapa Wha model of health outlined in a footnote on page 42, would add ‘spiritual’ to that category list.\(^*\)). Wellbeing is seen as being influenced by physical, social, spiritual and environmental factors as well as psychological. This recognises the role of the world around the individual as a ‘shaper’ of their experience, and thus of the individual’s view of themselves.\(^{45}\) The focus of this document is particularly on mental wellbeing, and the state of having higher levels of mental wellbeing can be conceptualised as flourishing.

\(^*\) Professor Mason Durie, who was instrumental in finding a wider audience for the Te Whare Tapa Wha model, has noted that this failure is a limitation in addressing the spiritual dimension of an individual’s life which is shared by many contemporary health services,\(^{46}\) and by much of the mainstream approach to mental health promotion in NZ. That criticism can also be applied to the Five Ways to Wellbeing model where no element directly corresponding to spirituality. For some people, however, that focus might be covered by a wider conceptualising of the practices and underlying values associated with the ‘Take Notice’ component and its associated element of the practice of ‘mindfulness’ which involves awareness and an acceptance of the moment.\(^{47}\) What may be covered directly under the ‘Spiritual’, and perhaps indirectly as a result of ‘Taking Notice’, may be issues of life’s purpose and meaning; “spirituality is about searching for, understanding and experiencing ‘what matters most’ in our lives and in our communities. Thus, what is ultimately meaningful, our core beliefs, connectedness (for some to the unseen), who we are and why we exist, are all aspects of the spiritual terrain.”\(^{48}\) On a pragmatic level, attending to this dimension may have a direct physiological benefit, with some research showing impacts on “health related physiological processes - including cardiovascular, neuroendocrine, and immune function - although more solid evidence is needed.”\(^{49}\) On a psychological level, attending to and engaging with core beliefs, meaning and connectedness may be particularly important for older people, both for the intrinsic value of that focus but also for the assistance that this ‘meaning-making’ can provide for coping with challenges, losses and illness. As one author has noted about hospice settings, “spirituality needs to be considered for holistic care and is perhaps the key to a ‘good enough death’”,\(^{50}\) but this approach might usefully be extended back from death to the task of achieving a ‘good enough life’, or at the very least to achieving a ‘good enough’ latter stage of life.
Flourishing represents a measure of social–psychological prosperity; to flourish is essentially to “live within an optimal range of human functioning, one that connotes goodness, growth, and resilience.” Research shows that flourishing in individuals has strong associations with greater productively, better social relationships, and better health and life expectancy. This focus on flourishing underlines the positive side to ‘mental health’ – a term frequently and paradoxically used to refer to mental illness. To reframe the relationship between mental health and ill health it has been proposed that flourishing should be seen as one end of a continuum, with its opposite, languishing, at the other. On a second continuum would run the dimension of symptoms through to no symptoms, as shown in the figure below.

![Figure 5. Flourishing and languishing in relation to mental illness symptoms (From Norris, 2011)](image)

Combining these two dimensions provides a more realistic model of mental health, one which allows that languishing without a mental disorder is very possible, just as it is for someone with significant mental health symptoms to still live a flourishing life. This more nuanced and complete view of mental health supports those anti-stigma campaigns that target the negative assumptions about the wider lives, and the quality of life, of those who experience some form of mental illness.

The Te Whare Tapa Wha model of health has been referred to above, and from a Māori context the aim of Whānau Ora would be relevant to the concept of flourishing, and may be “a more useful, or complimentary measure of psychological and social wellbeing for Māori, with its greater focus on collective outcomes. The goals of Whānau Ora are met when whānau are:

- Self-managing
- Living healthy lifestyles
- Participating fully in society
- Confidently participating in te ao Māori
- Economically secure and successfully involved in wealth creation
- Cohesive, resilient and nurturing.

Whatever the model, these approaches would share the view expressed by the leading mental health promotion academic, Margaret Barry, that “Positive mental health is a key asset and resource for population wellbeing and the long-term social and economic prosperity of society.” In relation to achieving a compression of morbidity, the application of this goal of wellbeing and flourishing would therefore be to
have as much of the population as possible located in the upper range of overall functioning, which would mean their ‘tracking’ at or close to the blue line of Figure 4 below.

![Figure 4. Maintaining functional capacity over the life course](https://example.com/figure4.png)

**Figure 4. Maintaining functional capacity over the life course (from Active Ageing 2002)**

The definition of wellbeing given previously includes physical as well as mental wellbeing, and while the focus of this document is primarily mental wellbeing there is clearly an overlap between general and mental wellbeing; NZ’s Sovereign Wellbeing Index (primarily assessing mental functioning, see page 46) found, for instance, that high levels of wellbeing were also strongly associated with better overall general health, non-smoking, exercising and with healthier diet and weight.

Another aspect of this interplay between mental and physical wellbeing, and part of the rationale for focusing on mental wellbeing here, is reflected in a finding by the major UK Foresight project (discussed below under Mental health and Wellbeing: A model approach, page 41); “evidence indicates clearly that mental health problems affect general wellbeing at least as profoundly as physical health problems, particularly when looked at from the perspective of patients rather than the general public. There is [also] evidence that patients tend to adapt to adverse physical health conditions, so that their wellbeing is less affected in the longer term than in the short term, but this may be less true for mental health patients. Estimates of the value of better mental health also appear greater, relative to better physical health, when examined in the context of overall wellbeing, rather than in purely health-focused studies.”

So better mental wellbeing not only assists with general health but increases the quality of life when an individual is physically ill or disabled - a significant issue for all, but perhaps older people particularly. Physical health is, obviously, important, but good mental wellbeing is not simply a bonus in life but a filter for how that life is experienced. This focus on the mental aspects of wellbeing is supported by the findings from a 2011 meta-analysis of the importance of mental wellbeing; “our overall conclusion is that the evidence for the influence of SWB [Subjective Well-being] on health and all-cause mortality is clear and compelling ...the effect sizes for SWB and health are not trivial; they are large when considered in a society-wide perspective.”
3. Individuals and mental wellbeing: Losses, challenges and opportunities

3.1 The New Zealand context

Older people are a subset of the general NZ population so it is useful to look first at this wider context, not least since many younger people will take into older age their existing mental health issues or vulnerabilities. Almost half the NZ population will have experienced some form of mental illness over their lifetime (Pakeha 46.6%, and 50.7% for Maori), and for 20.7% this will have occurred in the last 12 months. Over such a 12 month period, this illness will be categorised as serious for 4.7% of the population, for 9.4% it will be moderate, and for 6.6% it will be categorised as mild. Applied to the Nelson-Tasman population the percentage breakdowns above would equate to 4,390 local residents with an experience of a serious illness, 8,790 with a moderate illness, and 6,170 with a mild mental illness.

The impacts of that ill health often results in visits for mental health care from the healthcare sector. The NZ-wide data indicates that this will involve 58.0% of those classified as having a serious illness over the last 12 months, 36.5% of those classified as moderate, and 18.5% of those with an illness rated as mild. Professional help appears to be sought for a particular cluster of issues including anxiety, depression/mood and bipolar disorders, substance abuse and eating problems. The 2013 Disability Survey indicates that 5% of the general population had a long term psychological/ psychiatric impairment severe enough to limit their everyday activities.

The higher risk factors for mental health problems within NZ are primarily those of being younger, of disadvantage (manifest in education and income) and of being Maori or Pacific Islander, although this ethnic weighting is largely due to a greater proportion of younger people and people with socio-economic disadvantage in those populations. (See page 24 for the location of high deprivation areas in Nelson-Tasman.) While Maori between the ages of 25-64 experience mental ill health around 1.4 times more than non-Maori (and non-Pacific Islanders), this drops to 1.1 from the age of 65.

In the 2006 census the Maori population in Nelson was 8.4% of the local population and Tasman was 6.9%. Of the region’s total older persons population (65 and over), different life-expectancy rates mean that Maori make up only 2.25%. This has led to a suggestion that in order for the ageing Maori population to receive equitable attention for age-related care, the older person demographic for Maori should be defined as 55 and older, but to maintain consistency with commonly used age groupings the age 65-and-over criteria will be used in this document.

Although mental health illness has tended to be more associated with younger age groups, some of this pattern may be the result of older people being less inclined to identify their mental health problems, or to seek help from specialty mental health services, or from their general practitioner. In general, the number of older people who experience mental health problems, addiction or dementia is expected to increase as the population ages. In addition, there are indications that the ‘baby boomer’ generation is already experiencing a higher rate of mental disorders than the existing population of older people. For Maori, the risk factors for age-related conditions such as dementia, cardiovascular conditions, head trauma, substance use disorders and depression are higher than the NZ population. That these ‘age-related conditions’ occur at younger ages for Maori is also one aspect of the lower life expectancy among Maori.

For those living in residential care facilities the rates of mental disorders are typically much higher than that found in the general population - one estimate is for the rate of mental illness within residential care to be three to six times higher than that within the wider community. This situation may reflect the fact that a
number of people enter these residential settings due to their higher need for care, but it is significant that some research places the rates of mental illness for rest home residents as high as 80%, and that almost half of those entering a rest home came with an undiagnosed mental health problem - which subsequently remained undiagnosed.\textsuperscript{74}

**Dementia**

The sheer number of older people with dementia, which is primarily an artifact of population-ageing, has led some NZ observers to suggest that the challenges associated with dementia will soon “dominate residential care need.”\textsuperscript{75} Because dementia is age-linked, the percentage of the population afflicted increases from less than 2% of those under the age of 60 years old to more than 30% of those aged over 85. With a 2013 census count of 4194 people aged 85+ years in Nelson Tasman this would equate to around 1260 individuals, an increase of 21.5% since 2006. As the older population in NZ grows in number so therefore does the number of dementia sufferers, such that by 2050 the number of those with the condition is estimated to have increased to 146,700.\textsuperscript{76} Amongst Maori, the proportion of those living with dementia is expected to increase from 3.6 percent in 2008 to 5.8 percent by 2026.\textsuperscript{77}

Dementia is clearly an age-related condition in that older age is the strongest risk factor, but there is growing evidence that the risk of dementia can be substantially reduced by lifestyle changes, some of which will be explored further in following sections. It is worth noting that when such protective issues are combined into an overall healthy lifestyle the size of this potential risk reduction for any particular individual would be in the region of 15-20%.

The impact of dementia also has a ‘ripple out’ effect in that those who have the condition often suffer from episodes of depression, paranoia, and anxiety,\textsuperscript{79} and this tends to set up stressful and challenging interactions between the afflicted and their partners, family, and other carers, both in the individual’s own home and in institutions. This secondary impact of the disease can have a major impact on the lives of those around the person with dementia, sometimes to the extent that a carer’s own physical and mental health suffers.\textsuperscript{80}

As such, general health problems and injuries, including strained backs resulting from lifting the unwell person, are frequent for informal, home-based carers, and this role is also marked by elevated levels of fatigue, stress, and depression. Around 25% of informal caregivers looking after an older person in their own home develop anxiety at a clinically significant level, and half of the home-based caregivers looking after people with dementia become depressed.\textsuperscript{81} For these informal carers, the impact of their situation can extend to a rest-of-life state of financial strain, a product of the limit that their caregiving role imposes on their ability to generate income, or as a result of the need to prematurely discontinue their working life.\textsuperscript{82}

**Delirium and dementia**

Delirium is a state that may affect up to 25% of older people and often results in a range of behavioural and psychiatric changes that can lead to misdiagnosis.\textsuperscript{83} This blurring of symptoms of delirium, dementia and other illnesses compounds the particular difficulty experienced by many primary care physicians in recognising early symptoms of Alzheimer’s Disease.\textsuperscript{84} For the Nelson-Tasman population aged over 65 years this is an issue that could involve just under 4200 individuals.

**Dementia and intellectual disability**

Dementia is a particular issue for the population with intellectual disability; for those with Down Syndrome the rate of Alzheimers is above 50% for those over 50 years of age, rising to 75% for those over 60 years. In
one study of a community-based population of older people with intellectual disability - which did not include Down’s - the rate of dementia was four times that of the age-matched population.85

The issue of dementia and intellectual disability is a particular challenge since such age-related illnesses are becoming more prominent as the life expectancy of people with intellectual disabilities increases. In addition, behavioural and communication issues make the detection of mental health disorders or dementia difficult in people with intellectual disability, and best practice models are not well developed for supporting those with intellectual disability who then develop mental disorders or dementia.86

**Anxiety**

Although anxiety disorders are the most common mental disorders seen by primary care providers (with depression second), anxiety in older adults is widely seen as an illness that declines in prevalence across older age groups.87 It has been suggested that this may be because older adults are better at adapting more quickly in order to cope with challenges, or that what might be viewed as anxiety are simply adjustments to ‘normal’ age-related changes and losses.88

There is some evidence that this perception is not accurate however, and the reasons for this may explain some of the variance in the rates of anxiety amongst older people, which range from just over 3% to over 14%.89 (For the Nelson-Tasman population aged over 65 years this would result in a range of affected individuals from around 500 at the lower rate to over 2300 individuals at the higher rate.) In part this variance in rates may reflect differences in research methodology, but somewhere between a third and a half of those with major depression also have anxiety and with older people it will often be the depression which becomes the focus of professional and family attention. The anxiety is consequently overlooked and left untreated.90*

Similarly, what older adults present to their General Practitioner may be viewed as somatic complaints when in fact these are symptoms of, or they at least coexist with, a significant level of anxiety. The task of detecting and diagnosing later-life anxiety may be further complicated by an individual’s cognitive decline and their co-existing medical problems. There is also good evidence that despite “a high prevalence of mental health problems amongst people presenting to primary care services... mental health problems are often missed in primary care consultations.”91 Perhaps relevant to this trend is the finding in the US that around three quarters of older people who complete suicide had seen their doctor within the month prior to their death.92

In summary, under-diagnosis of anxiety is much more likely and prevalent for older people than for younger age groups. Part of the challenge this creates for care services is that anxiety disorders are also associated with lower compliance with medical treatment, thus worsening chronic medical conditions and increasing the risk for nursing home admission.93

* This variability in dealing with anxiety is apparent when it is seen that anxiety is not listed as a mental health problem and is referred to only once in the Ministry of Health’s 2011 document, ‘Mental Health and Addiction Services for Older People and Dementia Services’. In contrast, the ‘Older Adults in New Zealand: Population Changes, Health, Service Use and Workforce’ document published the same year rates anxiety disorders as the most common for community-based older people.
Depression

Depression may be the most commonly identified mental health problem for older people, and it affects 15–20% of that age group. It also tends to increase with age, so that up to 40% of these aged over 80 are affected. Applying this rate to the Nelson-Tasman population aged over 85 years (the closest census age-grouping) gives an estimate of around 500 individuals in this age group alone likely to be experiencing some level of depression. Severe depression, the most common cause of suicide in older people, affects about 3% of that age group; again, applied to those aged over 65 years in Nelson-Tasman this would mean an at-risk population also numbering around 500 people. The risk of developing chronic disease increases in older people who are care. Unsurprisingly therefore, when depression is combined with another health issue in older people the frequency and cost of professional help tends to increase, as does the risk of moving prematurely into nursing homes.

Some researchers have suggested that the numbers of older people suffering depression “might be even higher if the whole spectrum of depressive syndromes, including sub-clinical depression and depressive symptoms, is considered ...yet this condition is often under-diagnosed and this is particularly true of residents in care homes.” Given the rate and impact of depression in older people it is useful to note that early recognition of the problem followed by brief interventions, and actively engaged family and friends, are shown to be effective for this group, and that these also help to maintain older peoples’ level of resiliency and of functioning. Both physical activity and social connection are potent factors in protecting older people from depression, and as will be discussed below these two protective elements can be combined to good effect - especially where intervention programmes are either long-term or ongoing.

Suicide

New Zealand men are three and a half times more likely to die as a result of suicide than NZ women. As can be seen in Figure 5 (below), when looked at by age group the rate (per 100,000 people) of suicide for men

![Suicide rates chart](image)

**Figure 5. Suicide age-specific death rates, by five-year age group and sex, 2011** (From “Suicide Facts: Deaths and intentional self-harm hospitalisations 2011” The rates shown here are for the frequency of suicides per 100,000 population relative to particular population age groups. For the older age groups the numbers of deaths are small, so the rates derived from these should be viewed in light of that limitation.)
peaks between the ages of 20-24, fluctuates through to age 64 when it dips, and then rises from age 75 to peak again at age 80-84 and remaining high after this. For women the pattern is similar; the initial peak is spread over ages 15-24, but the overall peak is in the 85+ age group.\textsuperscript{100} In Europe, where the death rates from suicide and intentional self-harm have been decreasing in recent years, older people have the highest suicide rates. The absolute numbers of suicides are expected to increase in the decades ahead due to the demographic shift towards an older population. For this age group the risk factors for suicide include psychiatric disorders (especially depression) chronic and painful illnesses, and social isolation.\textsuperscript{101} The latter factor is a compounding issue for males, who are also more likely to live alone as they get older, especially those between the ages of 75 and 90.\textsuperscript{102} What is unknown is the rate at which older people, who have previously enjoyed high levels of functioning and a high quality of life, may adopt suicide as a response to the diagnosis or onset of chronic or severe mental or physical ill health.

**Comorbidity**

Comorbidity is the occurrence of two or more conditions at the same time. For mental health problems, comorbidity is common in those with an illness over a 12-month period; 37.0% have two or more disorders, and US data showing rates of comorbidity when looked at over a life-time period is around 56%.\textsuperscript{103} One recent New Zealand survey of adults with complex health care needs revealed that 34% reported two or more conditions.\textsuperscript{104} Across physical and mental health issues, just over half of those with a disability (53%) have more than one type of long term impairment, but this rises to 63% for those aged over 65 years.\textsuperscript{105} In the Nelson-Tasman context this latter group would involve some 10,500 individuals.

For coexisting mental illnesses the most common combination is mood (e.g. depression) disorders and anxiety disorders, with roughly half (49.6%) of those with a mood disorder also having some form of anxiety.\textsuperscript{106} There is a strong association between comorbidity and the increased use of health services and suicidal behaviour.\textsuperscript{107}

In the relationship between physical conditions and mental health, around 25% of those who suffer a stroke go on to develop depression, for those who have coronary heart disease the rate is 20%, of people with a neurological disease 24%, and the rate increases to 42% of those with chronic lung disease, and to 50% for those with Parkinson’s disease.\textsuperscript{108} Cancer, a disease with some strong associations with age and lifestyle, is a illness which the World Health Organisation is warning will reach the scale of a ‘tidal wave’ over the next 20 years.\textsuperscript{109} Wealthier countries will experience less dramatic increases, around 20%, compared with poorer countries, but even this has implications when some 20-40% of cancer patients have significant levels of psychological distress, especially anxiety and depression.\textsuperscript{110}

Other conditions such as chronic pain and rheumatoid arthritis have also been found to be associated with mental health disorders such as depression;\textsuperscript{111} while depression later in life is often associated with chronic illness and disability, older people who are depressed are in turn more likely to develop chronic conditions such as ischemic heart disease.\textsuperscript{112} Overall rates for chronic disease amongst older people in the US are for around 85% of this population having at least one chronic illness, with the rate for arthritis being at 50%, heart disease and hearing loss both being at 30%, and 12% with diabetes.\textsuperscript{113} While these illnesses may not be directly associated with psychological problems, they frequently impact on mobility and may lead to isolation and loss of social connection and support, and thus indirectly impact on psychological health and resilience. Comorbidity involving mental and physical health problems also creates additional costs for health services. For example, Patients with chronic lung disease, for instance, spend twice as long in hospital when they also have a mental health problem.\textsuperscript{114}
As summed up by the Mental Health Commission; “there is growing evidence that people with co-occurring mental health and addiction, and medical conditions, experience substantially poorer clinical outcomes and a lower quality of life.... A growing volume of research suggests that more integrated approaches – with professionals responsible for a patient’s mental and physical health working more closely together – can improve outcomes and reduce costs.”

3.2 Mental Wellbeing: Risk factors for older people

The overview of risk factors below identifies several key areas but is not an exhaustive review. The intent of this section is to highlight some specific risk factors but also to underline the relationship between a number of these factors, including substance abuse, isolation, the state of older people’s homes, and levels of deprivation or financial strain. The relationships between factors such as these are dynamic; poor property maintenance or repair for instance, can be a factor in older people moving - sometimes prematurely - into higher dependency living,116 and one third of those in one NZ survey117 reported problems with damp, mould or condensation in their homes, with a quarter having had slips or falls in or immediately around their house.

An example of the interconnectedness of the factors is the relationship between financial strain (or at least socioeconomic status) and a higher risk home environment. While the precise connection may need clarification, such a link is suggested by the evidence for greater levels of deprivation being associated with higher levels of hospitalisation after a fall.118 Hazards in an older person’s environment, such as poor lighting and uneven or slippery surfaces, are believed to be a factor in between a third and a half of all at-home falls. For older people, alcohol consumption is also identified as one of the risk factors linked to falls.119 This interplay between factors highlights the need for caution over relying on a single-issue illness prevention approach when attempting to address these interconnected risk factors for individuals. This degree of interconnectedness similarly needs to inform efforts to increase mental health and wellbeing at a population level through mental and physical health promotion activities.

Loss, retirement and the stress of transition

A range of losses - and associated sources of grief - can occur for older people. This can include an individual’s loss of physical health (which may coincide with the onset of chronic or recurring pain), and with that loss of health may also come a loss of independence and a loss of the sense of being in control of one’s life. Over their old age people are likely to experience the loss of significant others, and also the experience of being confronted with the drawing to an end of their own life. For some, the context of dealing with these losses will be the prolonged and exhausting challenge of caring for a partner or family member with dementia, or who is otherwise becoming frail.120

A number of life transitions also occur for people later in life, including retirement, moving from a family home to a smaller apartment or retirement home, and even the process of moving from older age into what has been called ‘old old age’. The latter is an age status within which many of those who reach eighty will, unlike previous generations, live for at least another decade. The most researched of these age-related transitions is retirement.

Retirement can be a challenging transition because it involves significant change, but that change has the potential to either open up new aspects of life, or to represent a ‘net’ loss for an individual. Looking at the latter, when work is discontinued through retirement this can create a financial strain due to reduced income, but also the loss of the profession-based sense of identity which work confers (i.e. “so, what do
you do” as a standard conversation opener in social settings). Work for many also supplies some sense that a person’s life has some consequence; has purpose and meaning. The loss of these through the loss of work can powerfully undermine an individual’s resilience and wellbeing.121

Retirement trends are in a state of change; 70% of 60-64 year olds are continuing to work, as are 18% of people aged over 65 years, and by 2036 this proportion of older adults who continue to work is expected to double.122 Nevertheless, the United Kingdom’s Department for Work and Pensions identifies retirement as ‘a pivotal moment’ for most people, and for many it can be a fraught process, beginning with their level of preparation and the reasons for their retirement.

One UK survey found that for one third of older people the advice they received as they approached retirement was subsequently described as ‘poor’. Some commentators on retirement have noted that “even for those with plans for later life, and the financial means to execute them, [retirement] can be daunting; for those without either plans or financial stability, it can be both scary and depressing. Crucially, it can also be the first step towards becoming socially isolated, with all the associated negative impacts for physical and mental health outcomes.”123

For a number of people retirement is less of a choice and more of a step that is forced upon them by declining health or mental health; mental disorders in particular are a leading factor in early retirement and disability pensions. For example, in 2002 in Germany 40% of early retirement was as a result of mental disorders - a factor that has been the leading single cause of health-driven retirement in that country since 1996, exceeding that of musculoskeletal or circulation problems, or of cancer.124

When it comes to the process of retirement, higher morale for retirees is associated with a more flexible transition from work to retirement, while depressive symptoms are associated with an abrupt and complete retirement.125 It is unfortunate then that there is a current pattern where “employment in older age is often brutal; either it ends abruptly or it is difficult to negotiate a gradual tapering off or sufficient flexibility in part-time employment.”126

The United Kingdom’s Department for Work and Pensions has identified the characteristics of those who are most vulnerable at this point of transition from employment to workless life.127 The factors that marked out this vulnerable group were:

- lower socio-economic status
- an unhealthy lifestyle
- being divorced or widowed
- not owning their own home (e.g. rented)
- having a negative view of information technology and computers
- having a long-standing illness which limited their level of functioning

Social isolation and loneliness

A degree of social isolation and loneliness might be viewed as unpleasant but otherwise relatively innocuous aspects of ageing, with these being considered an inevitable part of the ageing process for many people as social networks contract and mobility reduces. In fact, social isolation is a surprisingly potent risk factor for reduced levels of functioning and increased illness amongst older people, as well as for increased cost of their care and increased mortality.
The subjective experience of loneliness has generally been regarded as the psychological manifestation of social isolation, and since the terms are often used interchangeably both terms will be used in the following section.128 Recent research, however, indicates that while both loneliness and isolation will impact on people’s quality of life and well-being, if the focus is on reducing the association of these factors with mortality it is likely that efforts to reduce isolation are the most relevant.129

Social isolation is an increasing challenge for middle-aged and older populations. In the US the number of people living alone increased from 17% of all households in 1970 to 28% in 2011 and in England and Wales the proportion of those aged 45–64 years living alone increased by 53% between 1996 and 2012,130 while in some European countries, more than 40% of women aged 65 or older live by themselves.131 A 2010 European social survey revealed that just over one quarter of those aged 50 years or more met up with relatives, friends, or colleagues either just once a month or at an even less frequent interval.132

NZ research is projecting an increasing number of older people will be living alone in their own homes. Already around one in three of older NZ adults with a disability currently live alone, and declining physical health and functional impairment may in turn lead to the isolation that creates loneliness and consequent psychological impacts. As people live longer, many individuals may be in turn be living for longer with a loss of social connection. Recent research indicates that around 8% of those in NZ aged over 65 (around 50,000 people) are rated as severely or chronically lonely.133 Applying this rate to the Nelson-Tasman population aged over 65 years gives an estimate of slightly over 1300 people living in this state of chronic loneliness.

One NZ study of older men (aged between 65-89) revealed that the most significant relationship to depression was that of loneliness; “age-related losses such as loss of professional identity, physical mobility, and the inevitable loss of family and friends can affect a person’s ability to maintain relationships and independence, which in turn may lead to a higher incidence of depressive symptoms.”134 In the UK, research on older people shows that those living with a partner were less likely to show signs of depression, those who were more at risk were divorced or separated, and those who were widowed were the most likely of this group to have signs of depression.135 In addition, older people with reduced incomes may be unable to move from, or may need to move into, more affordable neighbourhoods that they experience as less safe and socially inclusive.136

On an individual level, loneliness can also result from an individual’s loss of social skills over time, the constraints on being able to take part in activities due to low income, the loss of friends and family, rural isolation, and the impact of ageist attitudes within society. As a result of factors such as these “loneliness is an issue for many; loneliness has a detrimental impact on wellbeing and resilience, vital assets at any age but perhaps particularly precious for older people as they may become more physically fragile and have to adjust to a changing world.”137

Older people living at home, especially with reduced mobility, are vulnerable to the level of available resourcing and the resulting capacity of care-providers and social services to assist them to connect with others. The promise of social connection is one of the major elements in the advertising of, and a significant factor in the uptake of, retirement village developments.138 For some people, the alternative to living at home - moving into care facilities - will not necessarily be the solution, since care outcomes from homes for older people have been mixed, including high profile cases of abuse and neglect.139 It is also unclear whether the hopes and expectations of residents for continued membership of their village community will be realised once they require a greater level of care than many retirement villages can provide.140
The prevalence of loneliness among older people is expected to be heightened by shortfalls in government funding for those institutions that will be needed to house the future numbers of older people; people who, in the past, have been housed in dedicated old people’s homes. Other factors driven by economic constraints that potentially heighten loneliness and its results include the impacts of inadequate transport - public transport especially - fewer organisations providing leisure opportunities for this age group, and insufficient home-based services.

While older people’s loneliness can be the product of economic factors there is also an economic impact created by social isolation; “overlooking of the impact of isolation adds to the potential cost to the public purse as a result, for instance, of falls and undiagnosed illness. It also contributes to ‘bed blocking’.

Thousands of older patients are forced to stay in hospital after they are fit enough to leave because they have no support at home and they are waiting for an appropriate care package that is difficult to arrange, in part because of professional silos.

The importance of social connection is of concern given that recent research places NZ in the lowest cluster when ranked with twenty two European countries on two key aspects of wellbeing; Personal and Social Wellbeing. Personal Wellbeing is a construct that consists of a subset of measures; emotional wellbeing, satisfying life, vitality, resilience and self-esteem, and positive functioning. In the Personal Wellbeing measure NZ was ranked 17th of the twenty two comparison countries, while in the Social Wellbeing measure NZ ranked as the lowest. Social Wellbeing consists of a subset of supportive relations with others, felt lonely, meeting socially, sense of trust and belonging, people in local area help one another, treated with respect, feel close to people in local area, and ‘most people can be trusted’. Social closeness/connectedness was found to vary across different urban centres in NZ, with regional areas better than cities, and NZ’s largest city, Auckland, rating the worst.

**Financial stress**

The issue of low or reducing wealth as a challenge for older people applies on two levels; one is how this impacts on people before they move into older age and is then taken into later life, and the second area involves the impacts during old age itself. In relation to the first of these, studies in the UK show a “a systematic pattern of declining health linked to declining socio-economic status... people in lower socio-economic groups experience the highest level of anxiety and depression and are more likely to suffer from chronic illness such as diabetes.” This relationship between deprivation and poor health is found internationally and also in NZ where Maori households and those with children are particularly prone to longer periods of low income and deprivation.

Some UK research makes a distinction between debt and low income, noting that poor mental health is “largely mediated by debt, and that debt is a much stronger risk factor for mental disorder than is low income.” In the UK, those with a mental disorder “are 3-4 times more likely to have a debt problem than the general population, while people in debt are 2.5-4 times more likely to have a mental disorder than the general population.”

New Zealand data shows a strong relationship between an individual’s economic standard of living and feelings of loneliness, and between loneliness and poor mental health. An interplay of levels of deprivation, being vulnerable to ill health and the likelihood of receiving health care is, as noted above, evident with Maori; “access to primary care generally is likely to be an important barrier for primary care’s capacity to meet the needs of Māori with mental health problems. Almost 1 in 5 (18.9%) Māori reported not seeing a GP when they needed to in 2002/2003. In addition, Māori were 1.6 times more likely to report
not seeing a GP when there was need when compared with non-Māori (12.0%). Cost appeared as the single most [significant] barrier.*

With respect to the Nelson-Tasman area, although the numbers of older people across the different age groups are similar in Tasman and Nelson the proportion of older people (not in residential care) using specialist mental health services appears to be different - 25 in Tasman, and 46 in Nelson (with 42 in Marlborough, 2006/2007 figures). This uneven pattern is consistent with the pattern of deprivation; the proportion of older people not in residential care living in higher areas of deprivation (deprivation areas 7 to 9) is 4% in the Tasman area compared to 45% in the Nelson area (and 33.3% of those within the Marlborough district).*

Although it has been estimated that New Zealanders will need between $200,000 and $390,000 in savings to augment NZ Superannuation payments, some 40% of those aged 65 and older currently have no income source other than their superannuation. For another 20%, superannuation payments make up 80% of their income, and overall some 50% of older New Zealanders in one recent survey had less than $100 per week in income from sources other than government payments. This situation and the finding in another NZ survey that a third of respondents (from a range of ages) would not be able to survive on their savings for more than two weeks without assistance underlines the warnings of the Retirement Commission that some low income New Zealanders have little chance of reaching even the lower of the stated saving targets needed to create financial security in old age.

Despite this pattern of low incomes, older New Zealanders generally appear to be subject to a relatively low rate of financial hardship, and this is considered to be a reflection of the combined (positive) impact of NZ Superannuation and the private equity accumulated by older people over their lifetime - particularly in the form of mortgage-free homes. While home ownership is associated with higher wellbeing scores, having their primary form of ‘saving’ concentrated in this kind of asset makes the age group very vulnerable to fluctuations in property values.

There are also some indications that low or reduced incomes are undermining this primary form of equity; it is significant that a survey of over 65 year olds showed an increase in the value of unmet house repairs, with the result that while an average of $6,095 was needed to bring older people’s homes up to ‘new’ in 2004 this had increased to $9,000 by 2010/2011. This ‘slippage’ in house maintenance may have some impact on the equity available if older people wish to sell and move to more suitable accommodation, but the wider context of this situation is that New Zealand’s housing is relatively poor-quality, and homes that are cold and damp impact on health, and they increase both infectious and non-infectious disease and related hospitalisations.

The interplay of financial pressures with other aspects of older people’s physical and psychological health is illustrated by shifts in private medical insurance. New Zealand health insurance premiums have doubled in

* Deprivation levels range from 1 (lowest) to 10 (highest). The deprivation level from the previous census (2006) is listed in brackets. The contrast between Tasman and Nelson is marked in terms of the distribution of areas of higher deprivation; only one area in Tasman, Tapawera is currently rated index level 9 (unchanged at 9), with Motueka West 8 (was 7) and Motueka East 7 (also 7). In Nelson, Tahunanui is rated 9 (was 8) as is Broads (same in 2006). Rated at index 8 are Trafalgar (was 7), Isle park & Toi Toi (were 9), and the Airport Area, Washington, Kirks and Grampians areas (same in 2006). The Wood area is rated at index level 7 (was 8).
the past decade and increased by 8.2% in one year alone.\textsuperscript{163} This change is being driven by a high level of claims, especially by those in older age groups. As premiums have increased, the number of those with private health insurance has in turn declined to the lowest level for at least the past decade\textsuperscript{164} - Maori and Pacific Islanders are already under-represented in having health insurance.\textsuperscript{165}

The trend of declining insurance applies particularly to people over age 65 due to the impact of high premiums past retirement age, with those relying on superannuation and without significant savings most hard hit. This situation risks dramatic increases in public hospital waiting lists spiralling as baby boomers hit retirement age,\textsuperscript{166} with the result being an effective barrier to elective surgery for older people - without which many will suffer reduced mobility, increased social isolation, ongoing physical disability, and greater likelihood of psychological disorder, all of which will ultimately add to the cost and length of care.\textsuperscript{167}

**Physical inactivity**

As will be evident from the summary below, physical activity has the potential to markedly improve physical and psychological health, and to prolong life expectancy.\textsuperscript{168} In contrast to the factors outlined above, the risk factor in physical activity therefore involves its absence rather than its presence in the lives of older people. Lack of activity not only contributes to chronic health conditions but it also increases the risk of falls, the consequences of which have been briefly outlined previously.\textsuperscript{169} In addition, recent evidence indicates a strong connection between physical activity and lower rates of dementia.\textsuperscript{170}

The lack of this protective element for older people is a concern, given the often inadequate levels of physical activity amongst many older people and people moving towards older age. In the 1990’s US research showed that less than 40% of those over 65 years old were involved in any leisure time physical activity.\textsuperscript{171} This is a pervasive pattern, and the majority of those aged over 65, including those in NZ, are currently considered to lead relatively sedentary lifestyles\textsuperscript{172} - a factor the World Health Organisation identifies as a major health risk.\textsuperscript{173}

At least in part, this situation may reflect a widely held view that “the older sector of the population have lived through a time when exercising for the sake of it or for health reasons was deemed unnatural….” and where it was seen as “legitimate for older people to take a well-earned rest and opt for a passive lifestyle.”\textsuperscript{174} In addition, there may be poor awareness of the necessary levels of activity for older people - an Australian study looking at this issue found that very few people knew about the guidelines set by the Federal Government.\textsuperscript{175}

Inactivity (resulting in fewer calories ‘burnt’ off) and poor diet (more calories eaten) are closely linked to obesity, which in turn is associated with a range of chronic physical health conditions.\textsuperscript{176} There are also some indications that obesity is linked to a higher rate of falls among older people, with an overall pattern of greater obesity being correlated with a greater risk of falls.\textsuperscript{177} Falls and their prevention are significant because of their frequency and impact for older people; the Accident Compensation Commission estimates that in any one year a person over age 65 has a 1 in 3 chance of experiencing a fall. This risk increases to 1 in 2 for those over age 80, with most of these falls occurring in the home.\textsuperscript{178}

Falls are costly both to the individual and to the health and care sector; a number of falls lead to what is termed the ‘post-fall syndrome’; this downward spiral in health status typically includes increased dependence, the loss of autonomy, and the experience of confusion, loss of mobility and mental health impacts such as depression - all significant reductions to the individual’s wellbeing and often resulting in the need for costly long-term care.
Around half of those in the UK who fracture a hip are subsequently unable to live independently, and in NZ 20% of older people will die within the year following a hip fracture from a fall\textsuperscript{179} (less than the UK’s 33%).\textsuperscript{180} This ‘ripple-out’ impact of inactivity illustrates the way that risk factors can set up older people for a series of linked losses of health, wellbeing and functioning - losses that involve not only significant costs to the individual but also to the public health system.

### Substance abuse

Many of NZ’s ‘baby-boomers’ were raised during the 1950s and 60s “in a social climate of increased use of and addiction to heroin, cocaine, tobacco and alcohol. Histories of substance dependence and continued use among this cohort will have physical and mental health consequences as it ages”\textsuperscript{181} The same NZ study noted that “a significant proportion [already] reported patterns of alcohol consumption that put them at risk of future damage to their physical or mental health.”\textsuperscript{182} In particular, there is evidence that the risk of developing dementia is increased by binge-drinking through midlife.\textsuperscript{183}

As noted above, for older people alcohol consumption is identified as one of the risk factors linked to falls\textsuperscript{184} - a ‘gateway’ to reduced functioning, increased care needs and to increased, ongoing cost to the health system. Alcohol use is a risk factor for dementia\textsuperscript{185} and for depression, but it is also a good example of a risk factor that is associated with a range of physical illnesses such as cancer, stroke, and osteoporosis.\textsuperscript{186} Estimates in overseas research place alcohol abuse as the cause of 8%-18% of the total burden of disease in males, and in the range of 2%-4% for females.\textsuperscript{187}

The abuse by older people of alcohol, prescription drugs and other drugs is claimed to be a ‘hidden problem’ in New Zealand, and is also common in overseas populations.\textsuperscript{188} Research from the US indicates that around 40% of those older people who are at risk for substance use problems don’t raise the issue with clinicians or seek help, and their problem is seldom identified by their doctor.\textsuperscript{189} Substance abuse is particularly common amongst older males, particularly those who are socially isolated, single, and divorced or separated.\textsuperscript{190}

Co-morbidity is a common compounding issue for substance abuse and mental disorders; United States estimates are that 20% of older people receiving outpatient mental health services also have a substance use disorder, and for those receiving inpatient mental health services the estimate is 37%.\textsuperscript{191} While part of the ‘hidden’ nature of substance abuse may come from the poor diagnosis of unhealthy substance use in older people, that situation is often compounded by there being more limited options for referral on to appropriate services in comparison with other health or social problems.\textsuperscript{192}

### 3.3 Older people, mental health, and the (unmet) challenge of complexity

Despite the potential array of age-related problems surveyed above, many older people enjoy a good quality of life through much of their later years.\textsuperscript{193} However, when reviewing the more prominent areas of mental illness and distress amongst older people it is evident that some are relatively common, including depression, anxiety, dementia and suicide, and in the case of anxiety and substance abuse the actual rates are likely to be higher than assumed for this age group due to under-detection and errors in diagnosis.

As discussed above, a feature of mental illness or distress within the older population is the high level of comorbidty (the presence of more than one issue within the same individual) and the way that mental health and physical health issues often coexist, and of a dynamic interaction between various aspects of
illness so that one issue leads to and is compounded by another. This tendency for older person’s health issues to be complex and interlinked represents a major challenge in health care for older people.

An illustration of this interaction is provided by the ‘post-fall syndrome’ and its common sequence of an initial fall, a consequent loss of confidence and mobility, followed by the loss of autonomy and increased dependence, and a subsequently greater likelihood of long-term care, depression and early death. Looking at the wider context for falls, these events can often be caused by preventable or modifiable factors, including substance abuse, obesity, loss of mobility due to a lack of exercise, and the impacts of depression and poverty.

In this respect the preceding review of aspects of mental illness and distress and the major risk factors in the loss of older people’s mental health, including social isolation, substance abuse, financial stress/poverty and physical inactivity, makes it clear that resilience through life and into older age needs to be actively constructed in the face of a variety of threats to wellbeing. At the same time, these risk factors point to there being considerable scope for avoiding or reducing the loss of mental health and wellbeing by enhancing a range of well-established protective factors through a systematic use of sound mental and physical health promotion initiatives.

The extended longevity becoming apparent across our population means that avoiding or delaying the onset and progression of illness and loss of function over these extra years will be necessary if the level of medical care and support required can be contained and made sustainable. This is, however, not currently a preoccupation of the public health system, with its predominantly hospital-centred services being largely based on ‘evidence-driven’, treat-and-discharge interventions. While the delivery of mental health care is less centralized the approach is similarly focused on a ‘find and fix,’ illness and disease model. Moving the focus to building mental health and wellbeing is therefore a significant and valuable reframing of the issue.

* From around 2008, however, the Canterbury District Health Board has been developing an integrated approach to addressing health care and this represents a promising and potentially very significant shift in the otherwise prevailing public health delivery model. A critical part of this process was creation of a health service plan where two of the three goals involved an aim that “services should enable people to take more responsibility for their own health and well-being” and “as far as possible people should stay well in their own homes and communities.” As with a number of objectives of the board’s project, these goals appear to be being met. Working in conjunction with the region’s closely aligned general practices, the board has seen a previously “rising curve of demand for residential care [for older people being] flattened” and fewer patients entering aged residential care facilities as a result of more people being effectively supported within their community. This reorientation of services, and the expansion of the focus of care, provides a platform for preventing illness and lays the ground for a culture shift in health, one that extends beyond treatment and towards the active fostering (or promotion) of good mental and physical health. In light of the discussion in this document about the complexities inherent in health care for older people, and the need for service integration that this raises, it may be relevant that Dr Nigel Millar, the board’s Chief Medical Officer, is a geriatrician. That aside, the finding from a 2013 case study into the changes was that “Canterbury provides much food for thought for the many clinicians, funders and managers interested in better demand management in primary care, allied to significant improvements in hospital efficiency that in turn have an impact on the use of social care.”

* The progressive move away from hospital-based services for mental health and addiction interventions has resulted in the bulk of this area’s funding (76%) being allocated to community-based services as at 2009/10.
As it stands, the existing approach to health would suggest the impact of a poorly grounded concept of ageing, driven by the absence of a realistic model for how health might be actively maintained into older age, and of what this might then actively require from individuals, communities and governments if that goal is to be achieved. Longer-term thinking about how ‘health’ is perceived and resourced is also likely to address some unintended consequences of our current approach.

As a form of investment in good mental and physical health, health promotion, for instance, is inherently multi-dimensional and complex, with time lags between programmes and outcomes, and a concern with cause-and-effect relationships (e.g. low income/debt, and inequality as variables in health and wellbeing) that are not direct. This scope and complexity, however, creates difficulties in conducting studies that demonstrate programme effectiveness. These issues may result in health promotion being both less palatable (politically, and in the context of institutionalised approaches to health care) and less implemented in comparison with the treatment of illness, with its more narrow - and measurable - ambitions, especially when this has a single-illness focus.

The challenge of addressing underlying complexity, with its reach across different aspects of society such as the wider determinants of good or poor health, may be not be so much avoided by the current, more tightly-focused approach to delivering health, however, as simply transferred elsewhere. Elsewhere, in this case, means emerging as a burden to our treatment-based model of health in the form of the complex and interlinked presentations and challenges typically found in older people’s physical and mental health. In this way, one impact of this deeply embedded and institutionally established approach to health may emerge through older people as exactly the kind of challenge which the health system, within its currently structured delivery of health care, is ill-equipped to meet.

The effects of this institutional orientation, and its underpinning government policies, are pervasive. Published research on negative psychological states, for instance, outnumbers positive health-focused research by a ratio of seventeen to one, and there is similarly a (dis)proportionate level of funding and staffing of health and mental health promotion (and illness prevention) within public health bodies like District Health Boards. Funding of prevention and public health services makes up as little as 5.9% of total health and health-related expenditure in NZ. A result of this institutional orientation is “a paucity of mental health prevention initiatives,” so that while “some [District Health Boards] are managing to undertake and successfully implement prevention programmes in mental health.... generally prevention in New Zealand is in its infancy.”

This situation means that the barriers to addressing the determinants of health, and of shifting the pattern of morbidity in a way that moves more people, and older people, into later life with higher levels of wellbeing, are largely being reinforced or at least reproduced. At the same time, the need to focus on creating the context for good mental and physical health remains pressing; the Ministry of Health’s 2002/03 Health Survey revealed that only 13.1% of NZ adults met the classification of living a ‘healthy lifestyle’. The next survey, five years later, showed this figure to have barely changed (13.5%).

* Also relevant here is the comment that; “The interest groups that make health their highest priority and thus lobby hard for resources are those focused on research and treatment related to specific chronic diseases. In contrast, the millions of people who benefit from health promotion interventions each receive seemingly small benefits - usually sometime in the distant future. The result is a vacuum of political accountability for maintaining population health - in effect, a diffusion of responsibility for health.”
This ‘umbrella’ measure of healthy lifestyle (involving non-smoking, safe drinking, sufficient physical activity, eating adequate amounts of fruit and vegetables, maintaining a healthy weight) is no longer being used by the Ministry, but two of these basic healthy lifestyle indicators - eating five or more servings of fruit and vegetables per day and having sufficient physical activity - are not only the least practiced healthy behaviours but have remained essentially unchanged over the 2002/3, 2006/7 and 2011/12 Health Surveys.

Some prominent features of this wider, structural approach to ‘doing health’, and of planning and providing for ageing and older people, is discussed next, as are two specific aspects that directly impact both on the health and wellbeing of older people, and on those that care for them.
4. Beyond individual wellbeing: Structural impacts on wellbeing

Structural, in the sense used here, refers to how the results of a society’s values, attitudes and policies can shape the structure of health services and their operation. Not acknowledging and addressing these deeper structural pressures and difficulties results in systemic challenges in achieving robust public health.

An example is the issue of under-diagnosis of, and under-providing for, older people’s mental health. This is at least in part a reflection of perceptions about ageing that are common amongst professional providers and family members, including the view that many mental disorders in older people are simply ‘normal’ part of the ageing process. 210 One recent survey of UK doctors by the British Geriatrics Society, for instance, revealed that two thirds of respondents believed that older people were less likely to have their symptoms fully investigated, and 72% believed that older people were less likely to receive a referral for essential treatment. Over half of the doctors were concerned about the level of treatment they would receive when they became old, and similar findings have been reported in the United States. 211

These concerns appear well-founded. The evidence indicates that not only are these suspicions correct but there are other more subtle aspects to age-based discrimination; when psychological problems are detected by primary health care providers, for instance, their response to older patients is more likely to be the use of pharmacotherapy and less likely to be a referral on for psychotherapy. 212

This pattern of poor assessment, treatment and referral on for older people is part of a larger pattern that effectively devalues older people in society. The aged care sector, for instance, “will remain marginalised…. while society continues to devalue older people” according to a 2012 investigation by the Human Rights Commission. 213 But this structural aspect of the care for older people is itself the product of values that are reflected in NZ government policy and decision-making; OECD analysis has shown that spending on old age, including pensions, early retirement pensions, home-help and residential services for older people, had (as at 2010) “steadily reduced from 5.2% of the GDP in 1998 to 4.2% in 2005. This is below the OECD average of 7.0% for 2005, as well as Australia’s 4.4%, the UK’s 6.1% or the US’s 5.3%.” 214

Stigma, as a form of negative judgment towards some sector of society, can be subtle, remarkably pervasive, and a challenge to address. The NZ-wide Like Minds Like Mine initiative, updated with the recently released National Plan 2014–2019, is one example of an approach that targets “stigma and discrimination towards people with mental illness” by promoting “more inclusive attitudes, behaviour and structures in New Zealand’s social environment.” 215 As such, the primary focus of the new Like Minds, Like Mine National Plan is “placing focus on shifting attitudes and behaviours of those who exclude rather than on the excluded.” 216 While programmes like this are relevant to older people with mental illness, they also demonstrate what is possible in confronting widespread and embedded social stigma, and provide some guidance for what may be needed if the stigma around ageing and older people was to be systematically tackled in a similar manner.

The stigma around ageing, which also affects whether and how older people ask for help, and a wider social response to older people and their needs, contributes to the difficulty in addressing - and sometimes identifying - the challenges facing older people. This attitude to ageing and older people highlights something of a paradox in ageing policy and associated resourcing; the 2001 Positive Ageing Strategy 217 for instance, which followed on from the Prime Ministerial Taskforce on Positive Ageing, was developed with a strong focus both on ‘wellbeing’ and the more positive aspects of ageing, on lessening social and economic exclusion of older people, and similarly lessening the focus on ‘welfare’. 218
The Strategy represented an emphasis, which was widespread around this period (if not beyond), on “‘healthy’, ‘successful’, ‘positive’, ‘active’ and ‘productive ageing.’” that was accompanied with a confidence in “‘the potential to overcome the ‘problems’ of older age through medical advances’.”219 Such pervasive and positive reframing of ageing, aimed in part at countering pervasive associations of old age with ‘decline’ and ‘marginalisation’, is a theme in much of the media’s commentary on ageing and in some policy documents.

While well-intentioned, this heavy emphasis on the potential for ageing well may have had the unintended consequence of contributing to “insufficient attention being given to the needs of the frail old in policy and planning and increased denial of ageing amongst individuals.”220 Such celebrations of what older age might be - without ensuring that the mechanisms are in place to bring this potential to fruition - may have left an unfortunate legacy that is increasingly apparent in the current challenges facing both older people and those providing their care.221

NZ superannuation is similarly a structural issue determined by wider social and political attitudes. As a major pillar of financial security for many older people, government superannuation essentially depends upon the ‘political will’ of central government for its sustainability. This is evident in the current lack of response to repeated calls for an increase in the age of eligibility for NZ Superannuation from age 65 in order to maintain the affordability of the scheme. While such a move may benefit the sustainability of the scheme it will, however, disadvantage sections of the population like Maori with shorter life expectancy. In the meantime, the ratio of those employed to those retired is continually increasing, which both reduces the tax income for superannuation while increasing the demand.222

Just as current policy around government superannuation sets up future structural challenges, so does the kind and availability of community-based services present a path of least or greater resistance for individuals who wish to ‘age in place’ - to remain living in their own home for as long as is possible. Ageing in place is the preference of many people222 but for others this may be the result of economic necessity, or it may be where an individual can best care for and be with their partner.

*1 The same point about negative vs positive stereotypes of ageing is made in the World Economic Forum’s aptly named ‘Global Population Ageing: Peril or Promise’: “On the opposite end of the scale are the campaigns that suggest all older adults are ‘super seniors’. Portrayed in the media as healthy, wealthy and defying ageing, super seniors present an image of older adults that also distorts reality.”....“Yet to approach the topic of population ageing with rose-coloured glasses, overlooking the real vulnerabilities associated with advancing age, would be foolhardy. Societies today are enormously ill prepared for populations in which there are more people over 60 than under 15.”223

*2 This becomes clear when the ratio between those who may be earning or are potential earners and those who are retired is examined. The relationship is called the Potential Support Ratio and it sets the number of people aged 15–64 years against one person aged 65 years or older. Between 1950 and 2000, the global Potential Support Ratio fell from 12:1 (12 people in the working ages per each 65 year-old) to 9:1. By the middle of this century this ratio is projected to fall to 4:1.224 The NZ rates, expressed slightly differently, are for a change over the 25 years from 2009 from 1 person aged 65+ for every 5 people aged 15–64 years to a ratio of 2 people aged 65+ for every 5 aged 15–64 years.225 The ratio is a fairly crude indicator of the burden on society created by the relationship between these two sectors of society, but it indicates a trend with important economic implications.
Around 70% of people with dementia live in their own homes, and while this arrangement lessens the burden on residential care it is dependent on community or home-based support services in a context where many care delivery systems are now centralised. As it is, home-based support services face problems with workloads, wages, training and career progression that are similar to caregivers working in institutional care settings and discussed below. In addition, cuts in services (as at 2010) have resulted in already limited respite care for those looking after dementia sufferers becoming increasingly constrained. Where local community-based health and support services are not well supported and accessible, the pattern of more mature people swapping home ownership for a buy-in of retirement village-style accommodation is effectively encouraged. One risk in that pattern is where a large number of baby boomers simultaneously cash-up their equity for old age by downsizing their housing, thus devaluing their equity through housing oversupply. In addition, the trend of swapping home ownership for a buy-in of retirement village-style accommodation - with lower associated investment values and high service costs - is likely to mean much lower levels of available investment return or equity if or when these older people are later confronted by the costs associated with high levels of care. This situation also results in a lower ‘maximum contribution’ to the state as their share of residential care.

The issue of how attitudes to older people and ageing become structural - shapers of institutional functioning - is illustrated through a brief examination of two areas in the following section. The first of these concerns elder abuse and the relationship between instances of this and the inappropriate use of medication, the resources allocated to the care of older people and the support given to those delivering this care, and the treatment that older people receive from caregivers. The second context involves the challenges associated with the ageing of the health workforce itself. While this second area illustrates the way ageing impacts on the structure of the healthcare through its workforce, this challenge also represents an opportunity to apply different structural approaches to the transition into retirement, and to apply principles of individual wellbeing within this workforce, in order to address workforce sustainability.

4.1 Structural challenges

Elder abuse and over-use of medication in care facilities

Maltreatment of older people can lead to serious physical injuries and long-term psychological impacts. The extent of the maltreatment of older people by deliberate act or neglect is difficult to estimate, not least as it is often not recorded, but internationally the rate is put somewhere between 4-6% of older people who are living in their own home, and up to 30% within institutions if this includes inadequate levels of care. The most common abusers of older people within the community are their sons and daughters.

Abuse by informal caregivers like family can be contributed to by the strain of this task, such as that created by isolation and lack of support or difficulty accessing services, a caregiver’s pre-existing or consequent psychological problems, and their own poor physical health. Elder abuse in institutions is particularly concerning however, as such practices can become systemic - a routine aspect of the institution’s practices. Past assessments by organisations as diverse as the NZ Consumer Institute, an in-depth investigation by the NZ Herald, and by District Health Boards suggest a relatively widespread pattern of substandard care within institutions providing care for older people.

One such report found a number of “serious deficits in service delivery.” and suggested that “...incidents of institutional neglect” could not be ruled out. Similarly, a review conducted by the MidCentral District

Health Action Trust (Nelson) August 2014
Health Board identified specific instances of abuse and neglect, but again the more concerning finding was of “many other serious wide-ranging and systemic problems that were said to pose a serious risk to patient safety, including medication errors, untrained carers administering drugs and staff shortages.”

Managing the behaviour of older people who may be agitated, dementing or simply demanding beyond the resources of the institution and its staff may also contribute to the use of inappropriate use of control and restraint, whether this is through physical means (e.g. tying a resident to the bed with sheets) or medication. The same Ministry report referred to above has suggested that a “lack of training and leadership in residential care settings may be contributing to excessive use of antipsychotics as a ‘quick and easy’ response to challenging and disruptive behaviours.” A 2010 review found that prescription drug usage amongst older people in aged care within NZ was 42% higher than an international benchmark, and the major NZ care provider, Bupa, found in a survey of its own facilities that an estimated 30% of residents were on antipsychotic drugs, an issue that the organisation has since taken step to address.

The status and role of unregulated caregivers has become a critical issue in care for older people due to an acute shortage of nurses within aged care settings. Around 90% of rest home care in NZ is now provided by caregivers (Health Care Assistants, HCAs). A major concern over this workforce relates to its minimal level of regulation and the risk this presents to maintaining standards of care - there is no regulatory professional body, or minimum level of training, relevant past experience, or qualifications for those working in rest homes or home based support services.

Meanwhile, a survey of caregivers working in residential aged care recently conducted by the NZ Nurses Organisation found that unregulated caregivers were often required to undertake nursing tasks “more appropriately performed by registered nurses...” and that “medication was ‘very frequently’ given out without clinical supervision, and blood glucose monitoring and catheterisation are ‘frequently undertaken’. At the same time that the greater reliance on lower skilled staff is occurring, the increasing complexity involved in caring for this age group is requiring an evolving and increasing development of skills within the workforce.

As a group involved daily in highly demanding (physical, mental and emotional) work, these Health Care Assistants are both predominantly female and one of the lowest paid workforces in New Zealand; in 2010 the average pay rate was $14.40 an hour, although many received the minimum wage ($12.75 an hour). Given the demands of the role and the poor rewards it is perhaps unsurprising that “current estimates for staff turnover across the sector are around 40-50% per annum, while ....just 50% of caregivers stay with an employer for more than four years.” Other research puts staff turnover lower at 22%, but still warns that such “turnover rates compromise continuity of care for the older residents and continuity of carer is closely linked with quality of care.

As noted above, the 2012 investigation by the Human Rights Commission highlighted the connection between the level of support for the workforce caring for older people and social attitudes towards ageing; “the respect and value shown to older people in New Zealand is linked to the respect and value shown to their carers. While society continues to devalue older people, the aged care sector will remain marginalised in terms of both status and in adequacy of resourcing.

While the relevant workforce is under increasing pressure this is being compounded by the way that health services for older people have been structured. In specialist mental health and addiction services, for instance, the number of available acute beds and day hospital places has reduced over time. While this is consistent with a trend toward more community home-based care, the comparable increase in community-based mental health and addiction services has not occurred. As resulting pressure on this specialist
workforce grows, aspects of delivering professional care can also suffer. A 2011 Ministry of Health report identified a lack of education and opportunities for skills training, particularly relating to early onset dementia care, and a need for carers to develop and maintain skills in preventing depression amongst residents in aged residential care settings.\(^{249}\)

As will be discussed next, the move of very large numbers of the population into what is potentially (depending on whether wellbeing and resilience is systematically built and maintained) a higher need period of old and then ‘old old’ age may create a change in service use, and one that will impact on our health services over a relatively narrow time-frame. This raises questions about the supply of both funding and carers; specifically about who will provide the necessary care, and how pay and conditions for carers - already contentious - can be accommodated. If, as seems likely, future funding for this sector becomes constrained then further questions will arise over the sustainability and impact on ‘customers’ in settings where care for older people is delivered within the context of a profit-making business.\(^{250}\)

**Health workforce issues: Ageing and capacity**

The ageing of New Zealand’s population has led to predictions that problems currently experienced by the aged care sector are ‘set to explode’ in future decades,\(^{251}\) and that workforce issues may prove to become the greatest challenge for health systems in the future.\(^{252}\) This challenge also reflects the impact of ageing in the health workforce itself. The consequence of these combined trends is an expectation that the demand on the health workforce will outstrip supply; in specific terms, that by 2021 “there is predicted to be a 30 to 40 per cent greater health and disability workforce demand than [will be] available.”\(^{253}\)

In particular, training and supplying sufficient mental health specialists for the older age population may also be failing to meet the current demand. Surveys in the US showed that only 3% of psychologists were working primarily with older people, and the estimate of 700 psychologists currently specialising in the geriatric field was well short of the numbers needed - between 5,000 and 7,500. The implications of this can be seen in the example of treating (or failing to treat) incontinence. The use of behavioural training treatments by psychologists has been shown to be more effective in managing incontinence than drug therapy. Suffering incontinence not only undermines independence among older adults, and is associated with an increased risk of depression, but in the US it is the second most common reason behind families admitting their older relative into a nursing home.\(^{254}\)

This mismatch between workforce supply and demand is expected to be even greater for the unregulated workforce; 48,200 more caregivers, for example, “will likely be required by 2036 to meet the needs of older people requiring a high level of support.”\(^{255}\) That number would represent an additional 30,000 paid caregivers to those in place in 2006. These workforce challenges will be compounded if the pay rates amongst those caring for older people were to rise significantly, and in December 2013 the Service and Food Workers Union and the NZ Nurses Organisation filed applications with the Employment Relations Authority against the major caregiver employers BUPA, Metlifecare, Oceania, Presbyterian Support, Radius and Ryman Healthcare. The NZ Nurses Organisation expects that thousands of caregivers will be involved in legal action over the next year, which will focus on the demand for equal pay.\(^{256}\)

Beyond having sufficient numbers of staff to deliver services is the issue of supporting and training existing staff to meet the increasing demands of their roles. While a 2010 survey identified a range of specialist training needs amongst those working with older people, it also revealed that nurses received less professional supervision than others in the clinical workforce, and that they were also less satisfied with the supervision they received. This is of concern as supervision is a key element in maintaining quality of
service and keeping roles sustainable, and nurses are a critical group in Mental Health Services for Older People, comprising 48% of the workforce.\textsuperscript{257}

Other workforce pressures are evolving with equally wide-reaching implications for the delivery of care. Just as the general population is ageing, so too is the workforce which provides support to older adults; the average age of the District Health Board health workforce across NZ is already 45 years old, and within the DHB workforce providing mental health and addiction services for older people more than half of current staff will reach retirement age within the next 5-15 years. For nurses in residential care settings and for the aged care workforce there is a similar age profile.\textsuperscript{258} The impact of this process may be buffered slightly by the trend for later retirement; 1 in 16 people aged over 64 were active in the general NZ labour force in 1991, in 2012 this was 1 in 5, and by the mid-2020s it is projected to be 1 in 3.\textsuperscript{259} The issue of retirement, as is noted below, is therefore is both a challenge and an opportunity for the health workforce.\textsuperscript{*}

One of the consequences of the institutional provision of care for older people coming under increasing pressure is that in decades to come adult children will be expected to spend significantly more time caring for family members, and this will greatly increase if current approaches remain unchanged.\textsuperscript{260} Unfortunately this trend is occurring in many countries at the same time as a corresponding trend of families having fewer children, meaning a shrinking pool of available offspring to provide this care.\textsuperscript{261} The ‘attractiveness’ of taking on such a role is not aided by its often stressful nature, difficulty accessing support, and the associated increase in risk that the caregivers themselves will develop mental illness and poor health.\textsuperscript{262}

These systemic pressures may in turn link with other issues associated with workforce strain; elder abuse, as noted above, and professional burnout. Work overload, role conflict (e.g. conflict between the need to do work to a certain standard, but also the need to complete tasks within limited time) and role ambiguity (lack of clarity about who is responsible for what) are major factors in professional burnout.\textsuperscript{263} Given that NZ’s Occupational Health and Safety legislation is particularly concerned with occupational stress generated by structural aspects of workplaces - stress made inevitable by the resourcing and structuring of roles - it remains to be seen whether employment court claims against employers related to workplace stress will become an added feature of an already struggling sector.\textsuperscript{264}

Given the issues outlined above, it would seem difficult to imagine a more appropriate sector than health to begin to apply new and more flexible approaches to work for people in mid-life and those moving towards older age; in particular, facilitating the option of working on past the current retirement age, and taking steps to make ongoing work more sustainable through adopting key action steps contained in mental and physical health promotion. The need for a systematic focus on a healthy, sustainable work life in this sector may be pressing if US data is any indication; a 2012 study looking at health-risk and health care use across 740,000 hospital workers and their dependants compared that group’s health status and selected health behaviours with those in the general workforce. The hospital employees were not only more likely to be diagnosed with chronic conditions like depression, obesity and asthma, but were also more likely hospitalised. Their compliance with common preventive actions such as breast, cervical, and colorectal cancer screening was also consistently lower than non-hospital employees and dependants.\textsuperscript{265}

\textit{* In light of the discussion on the ageing health workforce, and the discussion above on the approach to delivering health care by the Canterbury District Health Board, it is interesting to note that there is no compulsory retirement age in that DHB’s workforce, and its oldest working nurse is aged 80.\textsuperscript{266}}
4.2 Structural challenges need structural solutions

In summary, the challenges outlined above - unresolved issues for NZ superannuation, stigma towards older people, insufficient support for ageing in place, elder abuse and over-use of medication, and health workforce strains - are all issues that need to be addressed at a policy level and through wider social debate and action. This does not detract from the responsibility of individuals to actively care for their own health - or to deliver adequate care to others - but it recognises that “peoples’… choices are strongly influenced by those around them and by local conditions.”267 The issues reviewed here not only powerfully shape the environment in which older people live and are cared for, but the context in which the rest of the population moves towards older age.268

Two different approaches to changing people’s behaviour are conceptualised by social psychologists; ‘downstream’ and ‘upstream’. Where the point of intervention is a reliance on motivating the individual to choose to make changes, the intervention is considered to be downstream.269 In contrast, upstream interventions look to changing the environment within which behaviour occurs. This may lead to identifying the default choices people make (e.g driving a car to work) and promoting alternatives (such as walking or cycling), or making change at a structural or policy level to either remove barriers or provide “services in such a way that they encourage more positive behaviours.”270 The Like Minds, Like Mine programme, discussed briefly above, is an example of an upstream initiative aimed at changing an environment or wider culture, within which the target behaviour (discrimination and resulting social exclusion of people with mental illness) occurs.

The emphasis on addressing structural issues is reflected in the guiding principles set out in the frameworks of The Ottawa Charter for Health Promotion,271 and in the Perth Charter for the Promotion of Mental Health and Wellbeing.272 Unsurprisingly, there is a good deal of overlap between these general health and mental health-specific frameworks, but both emphasise the need to address the wider social and structural level. Structurally focused principles in the Ottawa Charter are; building healthy public policy; creating supportive environments; strengthening community actions; and reorienting health services. (The remaining principle, developing personal (health promoter) skills, is essentially focused at the individual - although achieving this will likely require the kind of behaviour change that needs structural support.)

Similarly, the Perth Charter’s principles all emphasise structural issues; mental health is more than the absence of mental illness, it includes both preventing illness and increasing wellbeing; emotional wellbeing needs to be established in early childhood and sustained throughout the lifespan; mental health promotion must be integrated with public health as a cross-sectoral approach; mental health and illness are constructed, experienced, and viewed differently to physical health and illness; mental health and mental illness are a dynamic balance; essential components of mental health promotion are the destigmatisation of mental illness and addressing discrimination; mental health promotion must take place at the individual and societal levels.
5. Revaluing health and wellbeing

The structural shift in the focus of public health systems referred to by the Ottawa and Perth Charters may seem radical in the context of the approach currently dominating public health, but as will be discussed in following sections, the impetus for that change may have arrived. A glimpse of this can be seen in an invitation-only Tomorrow’s Healthcare ‘Think Tank’ held in Auckland in May 2014 to discuss a looming ‘healthcare funding blowout.’ This event, run by the Southern Cross Healthcare Group and Massey University, drew fifty attendees included leading academics, economists, public and private healthcare providers, and politicians. Prior to the meeting most of the attendees were individually interviewed and their key issues of concern and proposed solutions were distilled into clustered themes. The single dominant theme that emerged from this exercise was the need to modify, and if possible reduce, the demand for healthcare. Tellingly, there was considerable consensus on the means to that end; “keeping people well to begin with – investing in and improving public health education, health literacy and preventative behaviours.”

5.1 The pressure of economic necessity

Estimates by the New Zealand Institute of Economic Research suggest that within eight years New Zealand will need to shift its approach to healthcare spending if this is not to undermine Government’s ability to maintain its budget. The cost of providing health services is increasing due to a range of pressures, including growing costs in treatment goods and services like labour costs and medical technology and treatment, and the impact of what has been described as an ‘epidemic’ of obesity and associated chronic health conditions.

A further and potentially major driver of increased costs comes from the impact of a larger aged and ageing population; as people age, their demands on health systems have tended to increase. Internationally, more than 80% of all medical costs involve those aged over 65, and medical care of older people is becoming the core activity for general hospital-based medicine and surgery in New Zealand, and this focus seems likely to become “even more evident over the next 50 years.” The vast majority of older adults in NZ will visit a primary health care provider around four times per year. Over 90% of adults aged 65 years and over visit their General Practitioner at least once in a 12 month period, and over the same period about half of the older population will visit a medical specialist, and over a quarter of 65-74 year olds will visit a public hospital. That ratio increases to more than a third for those aged 75 and over.

Looking beyond hospital services, roughly one third of New Zealanders aged over 85 years live in residential care, and the greatest demand for this form of care is expected to continue to be from NZ’s growing age 80+ group. The cost of residential care in 2008 was estimated to total $1.05 billion, with government funding making up two-thirds of this amount. In that same year some 40,700 people were living with dementia, the estimated cost of which was $713 million. The number of New Zealanders living with that condition is expected to nearly double by 2026 to around 74,800.

The result of this pattern is a “100% increase in the needs of older people … projected in the next 15 years to 2026 with only a projected 30 per cent increase in the means (money and personnel) to support
this. Drawing on past growth and assumptions about the demands of future expenditure, the NZ Treasury has projected that publicly-financed health and long-term care spending costs will rise to rise 11.1% of GDP by the year 2060. This would represent 31% of all government spending when debt financing costs are excluded. As in NZ, one response in the UK to this funding pressure is the demand that the health system simultaneously finds ways to make efficiency savings while being confronted by ballooning service costs; just as age-related population changes are adding £1 billion a year to health service costs, the UK’s health system has been given the task of making efficiency savings of £15-£20 billion by 2015.

Cutting expenditure or transferring costs?

The tension between increasing service demand and limits to service funding has implications for the levels of daily functioning of those caught in the middle. This is illustrated by the marked increase in demand for hip and knee replacement surgery in New Zealand, largely driven by an ageing population of more active people. As increased funding for operations is outstripped by demand, it becomes more difficult for patients to be accepted onto a waiting list for surgery - even if they meet the clinical threshold - since district health boards now only list those that can be operated on within a four-month timeframe. As a leading figure in orthopaedic surgery and musculoskeletal medicine has warned, "the problem is going to get significantly worse in the future and if we don’t keep on top of it, then we’re going to have a disaster within the health system with the treatment of these patients."

One consequence is that some prospective patients either wait in pain or take the option of re-mortgaging their homes in order to fund private surgery. Some indications of what this means for people, and for health and social support systems, is apparent in the UK. Knee and hip operation numbers there have doubled in the last decade to almost 200,000 annually, but pressure to reduce costs has led to policy changes that have raised the eligibility threshold, lowered the priority, or placed on hold these operations, and so is now limiting - or rationing - access.

The consequences of this delaying or not providing knee and hip operations include risks of a poorer eventual outcome and longer and thus costlier hospital care, but delayed or withheld operations also reduce quality of life, and in particular reduce mobility and functioning. This, combined with increased pain and worry, can be expected to have mental health implications for older people, and is likely to

* Similar challenges to sustainability of care and of health services are occurring overseas; in Australia the increase will be from 0.8% to 1.8%. In 2009, health care costs in the US increased at the fastest rate in more than a half century - spending rising to an estimated $2.5 trillion, over 60% of which was attributable to chronic conditions. On the basis of OECD predictions of demand, if the UK’s “current system of care and support remains unchanged, by 2050 Britain will spend more than a fifth of its entire national GDP on services for the elderly,” and long-term care alone will amount to almost twice (2%) the current percentage level of total GDP by that date. There is a suggestion that this spending, which other sources identify as whole-of-population health and care services, would be “affordable – and would allow increased real spending on all other areas of the economy – if projections for a trebling in real GDP are achieved. Clearly, this would not be the case if growth is more sluggish. However, all other things being equal, such spending would consume around half of all government revenues and, despite allowing an increase in the real level of spending, would mean reducing the proportion of government spending in non-health and social care areas from around 80 per cent in 2016 to around 50 per cent by 2061.”
increase their isolation and loneliness: one UK study on patients waiting for total hip replacement revealed that most of the subjects were suffering serious pain and immobility and half of the subjects had either near or clinically significant levels of anxiety and/or depression.\textsuperscript{292}

This situation exemplifies the way that restricting services in one area in order to cut or contain expenditure can simply transfer costs to another sector; in this case efforts to contain costs in physical health services can lead to greater demands - and costs - in mental or primary health care, and in community-based care as a result of loss of mobility and independence.

**Choices**

In the face of the challenges outlined above, what this situation means is that while the current NZ health system “has been able to adapt until now, there are indications it will not be sufficient to cope with older adult population changes.”\textsuperscript{293} Maintaining the status quo - levels of health care funding and resources that are increasingly insufficient for population demands - will result in a politically difficult choice between a marked reduction in the scope or the quality of service. Individuals might be also be required to take greater contributions for health care through an increased application of user pays and/or compulsory medical insurance. The risk with these options is that they effectively reinforce the current hospital-based focus on illness treatment and fail to address the need to prevent where possible and delay where not the onset and progression of illness.

The choices confronting our society are summarised in a 2014 estimation of NZ health system costs; from their analysis, the authors point out that “the accumulated life time health costs for a person dying at age 90 years were almost double those of a person dying at 70 years ($223,000 versus $113,000). This difference raises distributional issues and is something that policy makers and citizens could ponder. That is, would some of this resource be better spent on preventing disease in younger people, e.g., by expenditure on protecting child health and investing more in education and housing quality... To start answering this question thoughtfully would require studies of how New Zealand citizens value years of healthy life over the life course and also the cost-effectiveness of different health sector interventions that achieve health gain at different points in the life course.”\textsuperscript{294}

In considering questions of investment and return it is useful to note the concepts of ‘Health Capital’ and ‘Health Investment’ as developed by health economist Michael Grossman.\textsuperscript{295} In Grossman’s model, Health Capital represents an individual’s ‘stock’ of good health, essentially their capacity for longevity and freedom from illness. Individuals invest in their own health stock through choices about factors such as medical care, exercise, diet, alcohol and smoking. (Applying this to mental health, and individual’s investment might take the form of connecting socially with others, giving to others through activities like volunteering, taking notice of and appreciating the world around oneself, keeping learning, and being active - elements of the Five Ways to Wellbeing model which are aimed specifically at maximising ‘mental capital’, as discussed in the next section.) While Grossman’s is a model of individual Health Capital and Health Investment, the same situation and decision-making applies to a society and its collective Health (and mental health) Capital, and the decisions it makes about what, and how, to invest in creating, maintaining and restoring health and mental health. (See Appendix 3).

That questions about how and where NZ invests in health are arising now reflects an observation by the Mental Health Commission regarding mental health; “fiscal issues often appear as clear drivers for change rather than the impact on people and communities.”\textsuperscript{296} But whatever the reason for change, clarifying the ‘cost-effectiveness of different health sector interventions that achieve health gain at different points in
the life course’ is assisted by an extensive body of research into the efficacy of health and mental health promotion, as has been touched on in preceding sections, and is summarized in the following.

5.2 From treating illness to creating and maintaining health

In a recent review of the prevention of common mental disorders in the Australian and NZ Journal of Psychiatry the authors concluded that “in an ideal world we would create a system from ground up that recognises the essentiality of physical and mental health promotion and protection at every level and in every setting: ensuring healthy public policies; creating healthy environments; ensuring adequate support for individuals and families; and ensuring social connectedness through strong community programmes. Pragmatically, we are left with the enormous and complex task of retrofitting programmes to existing systems. However, we now have potent tools at our disposal and the foundation of a strong evidence base on which to build a solid system that values prevention equally to treatment.” Two themes occurring here are addressed in this last section of this document; the evidence base for physical and mental health promotion and protection, and the task of retrofitting mental and physical health promotion and protection programmes into existing health and related systems.

Evidence for investing in wellbeing through physical and mental health promotion

The interconnectedness of physical and mental health means that many individual or wider social and structural interventions will have some impact on both. In either case, the evidence supporting the effectiveness of the promotion of mental and physical health and prevention of illness is substantial and mounting. An important point about which criteria for efficacy is applied needs to be made however; in regard to these health sector interventions it is sometimes argued that these need to save costs and not ‘just’ be cost-effective; “part of the problem leading to inadequate resourcing of public health is that public health interventions are sometimes required to meet a higher standard of economic effectiveness than health care services; public health is expected to save money (or at least break even) whereas health care services are not expected to meet this standard.” The same double standard applies when “it is .. claimed that spending money on public health strategies is not a good investment, since such strategies may allow people to live longer but then become ill later and die from other causes, which drain health sector resources. ...this criticism applies not only to public health [however]; health care interventions [treatment] also have the potential to extend life.”

In turning to the evidence for effectiveness, recent, large-scale reviews of physical health promotion in Australia and reviews in NZ affirm the impact of well-developed programmes and echo conclusions arrived at internationally; a key finding in a major US report on a prevention approach to sustainable health was that “keeping people healthier is one of the most effective ways to reduce health care costs,” and a Canadian inquiry concluded that “shifting attention to strategic investments in the socioeconomic determinants of health promises to deliver not only improvements in health outcomes, but also cost-
savings and economic benefits. Reviews on the effectiveness of mental health promotion in NZ and Australia are similarly supplemented by extensive international research, such as the comprehensive body of work for the World Health Organisation (WHO) by Jané-Llopis and colleagues, covering the efficacy and effectiveness of interventions aimed at prevention and promotion in mental health, the process of identifying and applying proven mental health promotion principles, and of conducting robust evaluation.

Beyond the impacts of restricted funding, effectiveness research in mental health promotion has its challenges; this is a field that involves “interventions which are dynamic, multifaceted and operating at many levels in complex systems;” there is considerable variety in the scope and implementation of programmes, and a focus on a range of social and other determinants of mental health - sometimes at different points in the life-course, and programmes often involve extended time lags until measurable effects emerge, and variations in how evidence is categorized and described.

Despite this, the ongoing refinement of theoretical underpinnings and models, of programme methodology and evaluation in this field, aided by an increasing development of resource material to guide best practice approaches in mental health promotion, all contribute to a situation where there is now good evidence that well designed interventions can enhance protective factors and reduce the risk factors, and so “lead to a “...range of positive health and social outcomes.”

At present, research on cost-effectiveness is less well developed across different approaches with older people, but this may reflect the poor resourcing of evaluation in this field and the variable quality of the initiatives. Nevertheless, a growing body of research can provide clear guidelines about the "common features of strategies used to enable healthy ageing." and while “...the determinants of healthy ageing are inter-related and do not always act as discrete domains. healthy ageing programs that targeted multiple domains (for example; social participation, physical activity, healthy eating and making a contribution)...have been found to be “...effective in enabling healthy ageing.” One approach with direct relevance to enabling healthy ageing, and which demonstrates a focus on inter-related determinants of health and wellbeing across multiple domains, is ‘Five Ways to Wellbeing’.

**Mental health and wellbeing: A model approach**

The Five Ways to Wellbeing model was developed out of the major UK Foresight Project which looked at the future challenges for the UK population, especially the impact of a larger population of older people. Two of the primary goals for the project were to maximise the ‘mental capital’ of the population, and minimise the threats to this capital. The project defined mental capital as “the totality of an individual’s cognitive and emotional resources, including their cognitive capability, flexibility and efficiency of learning, emotional intelligence (e.g. empathy and social cognition), and resilience in the face of stress. The extent of an individual’s resources reflects his/her basic endowment (genes and early biological programming), and their experiences and education, which take place throughout the lifecourse.”

*A recent example is the nationwide Like Minds, Like Mine programme which, while acknowledging that social change programmes of this type deals with complex problems and that “the international evidence on what works in programmes to increase social inclusion for people with mental illness is not well developed, is working at continually building its own evidence base through a mix of evaluation and monitoring. A cost-benefit analysis of the programme in 2010 “calculated that Like Minds had cost a total of £52m since its inception. The estimated economic benefits (increased access to employment, hours worked, and increased use of primary care) totaled £720m, or $13.80 for every dollar spent.”*
This view of mental capital has a great deal in common with the concept of Health Capital as touched on above and summarised in Appendix 3. In both models the focus is on the need to invest in creating and maintaining Mental or Health Capital as a whole-of-life activity, and in this respect the project’s position was that “it would be a mistake only to address the risk factors of cognitive decline when they occur in old age. Examples would include encouraging exercise in middle age in order to promote a healthy cardiovascular system, and encouraging education and learning through the life course to promote cognitive reserve.”

In the discussion below the focus is on applying the model at an individual level, but it also has wider social, community, workplace and policy applications, and some of these will be suggested in section 5.3.

The project drew on input from over 400 leading international experts and stakeholders, with diverse disciplines including neuroscience, genetics and mental development, psychology and psychiatry, sciences relating to education, work, wellbeing, and economics, modeling and systems analysis, and social sciences and ethics. In addition, over 80 commissioned reviews focused on five key areas of concern; Mental Capital through Life, Learning through Life, Mental Health, Wellbeing and Work, and Learning Difficulties. Out of this background work a wellbeing equivalent of the ‘five fruit and vegetables a day’ model was commissioned to communicate the project’s core messages on the essential components of wellbeing in the most easily accessible form.

The result was the ‘Five Ways to Wellbeing’ model. The model has a strong practical focus on creating and maintaining wellbeing and resilience through five critical areas for action; 1) Connect socially with others, 2) Give to others through activities like volunteering, 3) Take Notice of and appreciate the world around oneself, 4) Keep Learning, and 5) Be Active. (These components are covered in more detail in Appendix 1. Similarly useful are the NZ-based approach of the Te Whare Tapa Wha model with its focus on the physical, mental, social and spiritual elements of good physical and mental health, and the Fonofale model of health developed to be relevant to the culture of Pacific peoples.* The Five Ways to Wellbeing model is primarily used here because of the extensive supporting research.)

An important component of the Five Ways to Wellbeing model is to Be Active, and the following section uses this component both to highlight its potency in helping to maintain a healthy lifestyle, but also to indicate the interplay between the various components of the model. In effective applications of approaches to build, maintain or restore mental wellbeing, flourishing or resilience there will be strong

* The Te Whare Tapa Wha model initially appeared in 1982 at a Māori Women’s Welfare League meeting but received wider promotion through Mason Durie’s 1985 paper, ‘A Māori Perspective of Health’. In this he outlined the diverging perspectives of health in Māori and Western society and presented a “‘traditional perspective’ of Māori health as being a ‘four sided concept representing four basic tenets of life’ (Durie, 1985, p. 483). The balance and symmetry with each of these tenets were essential for wellbeing. The four components of wellbeing are; te taha wairua (spiritual wellbeing), te taha hinengaro (mental wellbeing), te taha tinana (physical wellbeing) and te taha whānau (family wellbeing). The essential feature of Te Whare Tapa Wha is that it takes a holistic perspective to wellbeing, and that to achieve wellbeing, or health, each component needs to be in balance.” The model has enjoyed increasing application since this time. The Fonofale model of health presents the key features for maintaining good health from a Pacific perspective. “In the Fonofale model, these components include cultural values and beliefs, seen as a shelter for life, with family forming the foundation. Connecting culture and family are four inter-related dimensions – spiritual, physical, mental and ‘other’ – which together contribute to an individual’s wellbeing. ‘Other’ refers to factors that can directly or indirectly affect health, such as gender, age, social class, employment, education and sexual orientation.”

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connections between such components, and there is a high degree of applicability of the core aspects of this approach to wellbeing (and flourishing and resilience outcomes) to a number of physical and mental health challenges.

The wide-ranging benefits of physical activity have been recognised for some time, with inactivity being an identified risk factor for a number of chronic diseases, including diabetes, colon and breast cancer, cardiovascular disease, obesity, hypertension, and joint and bone diseases like osteoporosis and osteoarthritis. As noted above, physical activity is also an identified protective factor for dementia. Apart from the good evidence for physical activity’s impact on depression, activity also impacts on physical illness through the psychological benefits of being active; an example being the prevention and management of cardiovascular disease which is aided by psychological well-being, which in turn is aided by physical activity.

There is now clear evidence that physical activity leads to and is not simply ‘associated with’ improvements in individuals’ psychological well-being. Perhaps the most well recognised connection between activity and psychological well-being involves depression, which as noted above is a major mental health issue for older people and has been found to be relatively common amongst older adults in care facilities. Various forms of physical activity have been found to be protective against depression for older adults living both in the community or in care facilities, but also for promoting a more positive attitude towards the ageing process generally - in turn a protective factor.

It appears that some of the psychological benefits of physical activity relate to aspects of an individual’s psychological functioning that are directly connected to depressive states, such as an improved sense of mastery or control over one’s life, improved life satisfaction and mood, and the reduction of negative feelings like anger and fatigue, and also reduced levels of loneliness. The findings that physical activity might provide an experience of mastery for older adults is significant (e.g. ‘hey, I can do this’ - an example of Keep Learning in action), as many in this age group will be encountering a diminishing sense of confidence in their physical abilities, so countering or balancing this perception has implications for maintaining older people’s independence.

The interplay between older people’s physical health, mental health and social and general functioning is well demonstrated by physical activity. Research has often attributed the physical health benefits of physical activity directly to engaging in the activity itself, but there is an increasing awareness that the psycho-social elements of being active are a potent part of this benefit. Physical activities (especially programmes run for older people) generally have a social aspect, and this relating-to-others component (Connect) in itself can reduce stress and loneliness, and it has direct impacts on physiological processes such as the functioning of the immune system.

This social engagement aspect of physical activity also helps older people gain or maintain their ‘social role’ (‘by doing this I have a place in this group, and I belong’), plus a sense of self efficacy or mastery, and it helps provide a sense of meaning and purpose in life, all of which are linked to important health outcomes and to longer survival. This interplay between the physical, social and psychological is evident in an issue like depression; for many of those in care facilities particularly, the experience of depression can be related to unmet psychosocial needs, and these can be addressed through the social engagement and contacts that accompany exercise or activity sessions.

The power of this social element of activity has led some researchers to suggest that group activities which entail little physical exertion may still bring many of the same benefits, and this has important implications for ‘older older’ people with restricted movement and mobility. Group physical activities not only allow the opportunity for keeping Learning, and helping others in the group by helping to organise or lead a
group, if ‘only’ by providing encouragement and motivation (Give). Activity groups, especially those outside like gardening, walking or cycling, also provide the opportunity for Taking Notice of and appreciating the world around oneself, a useful redirection of attention away from a preoccupation on one’s own worries or physical concerns.

The relationship between age, level of activity and benefit from activity is not straightforward, but some themes are apparent. One is that the greatest gains are found in those who are inactive and then become active, and that once the level of physical activity reaches what researchers describe as ‘moderate levels’ the gains for psychological health (at least) usually appear to plateau. In regard to ‘older older’ people and activity, current research has variable findings; some shows no differences across older age groups (or gender) and some indicate that the psychological gains lessen with older age, especially with those aged over 76 years.

What does seem clear is that the activity needs to be ongoing, not one-off or sporadic. This may be linked not only to keeping the physical activity going for the physical movement it involves, but the need to maintain the ongoing social element so that the social engagement and connection is retained and the associated benefits can develop from this. One of the implications for older people may be that as they are less able to engage in physical activity, the need to continue with social activity (and productive activities e.g. crafts) becomes even more important.

The multiple functions played by activity groups goes some way to explain why for those who are ‘home alone’ and not easily able to travel due to disability, mental health issues, or financial constraints, loneliness does not generally seem to be effectively alleviated by services offering one-to-one in-home visiting, although visits by peers appear more effective. Most effective are group interventions for loneliness (thus involving the Connect with others component) that involve some form of training or education (Keeping Learning), and also social activities which target a specific group of people.

**Wellbeing: greater than the sum of its parts**

While the case for physical activity has been established for some time, evidence is also rapidly accumulating for the effectiveness of another Five Ways to Wellbeing component, the practice of Taking Notice of and appreciating the world around oneself. Take Notice has much in common with, and provides a platform for, a set of habits of mind also known as ‘mindfulness.’ As part of its presentation on Five Ways to Wellbeing, the New Zealand Mental Health Foundation outlines Take Notice in these terms; “Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.” As noted above, other models of wellbeing will frame some of these aspects of Take Notice in

* The American Psychological Association, in a useful article which is linked below, provides a definition of mindfulness as being a “moment-to-moment awareness of one’s experience without judgment.” The connection between this and the ‘Take Notice’ component of Five Ways to Wellbeing is made explicit in resources provided to the community such as the detailed description and application available from the New Zealand Mental Health Foundation’s website: [http://www.mentalhealth.org.nz/page/1183-five-ways-to-wellbeing+take-notice](http://www.mentalhealth.org.nz/page/1183-five-ways-to-wellbeing+take-notice), which also links to further mindfulness information and resources. The American Psychological Association provides a good overview of the psychological applications of mindfulness on its website: [http://www.apa.org/monitor/2012/07-08/ce-corner.aspx](http://www.apa.org/monitor/2012/07-08/ce-corner.aspx) and since 2010 a list of research relating to mindfulness has been available through: [http://www.mindfulexperience.org/newsletter.php](http://www.mindfulexperience.org/newsletter.php)
spiritual terms, and for some individuals and groups this will represent a particularly significant dimension to personal wellbeing.

The application of mindfulness has shown effects in the treatment of atherosclerosis, high blood pressure, psoriasis, elevated cholesterol, tension headaches, chronic pain, and several areas of mental ill health including anxiety and depression. Impacts have also been demonstrated for patients with chronic disorders or associated risk factors including coronary artery disease, fibromyalgia, a range of cancer diagnoses, obesity, eating disorders, alcohol abuse, and smoking cessation.

There is good evidence to the effectiveness of mindfulness when applied to older people, and for their carers (primarily in reduced stress amongst professional carers). Benefits to older people include reduced anxiety and depression, decreased pain* improved visual attention and executive control (attention shifting, planning, and concentration), and increased positive emotion. While neurological changes consistent with reduced depression - and possibly reduced suicidality - and of improved immune function, have been noted in younger age subjects clarifying these impacts for older age-groups awaits further research.

Given the point made above about the interconnection of the components of Five Ways to Wellbeing it is useful to note that research shows mindfulness also supports interpersonal relationships (Connect) directly through an improved sense of interpersonal closeness and relatedness, and indirectly by enhancing components of emotional intelligence that lead to better social skills and perspective taking.

The protective role of developing good wellbeing through approaches such as Five Ways to Wellbeing is evident across illness and risk factors for older people that are as divergent as dementia and the psychological upheaval of retirement. For dementia for instance, a key factor with strong evidence for risk reduction is engaging in exercise (Be Active), and there is also evidence for the protective role of having and maintaining social Connections. Similarly, in creating welling and building resilience against the stress of retirement, identified protective factors such as a healthy lifestyle requires exercise (Be Active) and other protective factors involve social Connectedness and Keeping Learning.

While the Be Active and, briefly, Take Notice elements have been focused on here, all of the components of Five Ways to Wellbeing are important in developing or preserving wellbeing. As noted above, several aspects of the model will be contained in any effective application at an individual or community level. A good example is that of community gardening initiatives as established in many cities to grow and share food in community settings. That these initiatives have shown good mental health benefits in follow-up evaluation is unsurprising given the social connection these initiatives facilitate (Connect); the greater involvement in giving to others through sharing tasks, knowledge and food (Give); increased physical activity (Be Active); greater awareness of and engagement in participant’s surroundings (Take Notice); and learning through new knowledge and new skills (Keep Learning) - a complete application of the Five Ways to Wellbeing model.

Community gardening is one example of finding a ‘path of least resistance’ - offering a health-promoting activity that has a degree of intrinsic public interest, rather than presenting a specific health-related

* Studies in the US indicate that pain is a common problem for residents in resthomes; one review covering fourteen resthomes gave prevalence rates for pain that ranged from 27% to 83%, and another study found that over a third of residents had constant pain.
behaviour as a ‘should’, or as a duty (gardening, for instance, is rated as second only to walking in popularity as a recreational activity in the Top of The South region\textsuperscript{353}). Adopting this approach may mean taking the opportunity to capitalise on areas of local or growing interest.

One example of both is cycling, where increased levels of recreational and commuter involvement in the region and nationally involves several components of the five-ways model; in addition to the physical activity itself (\textit{Be Active}), cycling is often an activity that fosters social connection (\textit{Connect}), and for many riders an element of \textit{Taking Notice} as the riding environment is an important aspect of the activity.\textsuperscript{354} See Appendix 2 for an example of the advantages in health economy terms of adopting a cross-sector approach to opportunities such as cycling.

As noted above, the Five Ways to Wellbeing model is based on a comprehensive platform of UK and international background research, but the 2013 Sovereign Wellbeing Index, which represents New Zealand’s first national measure of wellbeing, has confirmed a strong association between the Five Ways to Wellbeing elements and higher levels of measured wellbeing in a local setting.\textsuperscript{355} Given the interconnection between physical and mental health it is unsurprising that in this research high levels of wellbeing were also strongly associated with other health indicators such as better overall general health, healthier diet, non-smoking, exercising and healthier weight.

The authors of the Sovereign Wellbeing Index make the point that research such as this, which looks at the section of the population with the highest wellbeing scores and examines their defining factors, “underpins the idea that psychological wealth and resources can be identified and public policy and action, and personal resources utilised to improve these determinants.”\textsuperscript{356}

\textbf{From evidence to action - the task of retrofitting mental and physical health promotion}

Reorienting health services and other related sectors to integrate what has been learnt about effective mental and physical health promotion at a structural level - a shared focus of the Ottawa and Perth Charters - is unlikely to be either easy, or quick. This challenge is the equivalent to requiring, as a result of changing demands and markets, a cruise liner to be partially reconfigured to also carry freight - while still at sea, and with a full complement of passengers. The risk, under such circumstances (and to continue the analogy), may be the temptation to drop overboard and tow one of the lifeboats, designate this as ‘freight capacity,’ and declare ‘mission accomplished’.

A serious commitment to developing an effective, cross-sector programme aimed at the compression of morbidity in the NZ population, and the associated task of retrofitting mental and physical health promotion and protection programmes into existing health and related systems, might usefully apply the framework (below) developed by Professor Margaret Barry, international authority on health promotion, and her colleague Rachel Jenkins.

\textbf{Developing the infrastructure for promoting mental health (from Barry & Jenkins, 2007\textsuperscript{357})}

- Establish a policy framework that provides a mandate for action
- Develop a strategic action plan which identifies priorities, key goals and objectives for action
- Co-ordinate an inter-sectoral and partnership approach to policy implementation at governmental, regional and local levels
- Invest in research to guide evidence-based mental health promotion policy and practice
• Invest in human, technical, financial and organisational resources to achieve priority actions and outcomes
• Support capacity building and training of the mental health promotion workforce to ensure effective practice and programme delivery
• Identify models of best practice and support the adoption and adaptation of high quality, effective and sustainable programmes, particularly those meeting the needs of disadvantaged groups
• Engage the participation of the wider community
• Put in place a system of monitoring policy implementation and impact
• Systematically evaluate programme process, impact, outcome and cost

Using the framework’s steps as an ‘audit’ of existing policies and initiatives would make it more likely that their aims will be met. In this way, the aims of the Mental Health Commission’s Blueprint II, including catering for the needs of older people through “effective health promotion and self care [by measures including] “physical exercise programmes, social support and activities, home visits, volunteering and attention to spiritual needs,” will receive the necessary strategic planning and allocation of resources.

The same auditing approach could apply to the current Ministry of Health plan for mental health and addiction services, a plan which is broadly supportive of physical and mental health promotion and which offers some important goals for greater integration across health care services. The plan also has a strong emphasis on earlier and better intervention, including better access to assistance, for those of all ages who have what are termed high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms). One of the four population groups specifically targeted in the plan is that of older people with such high-prevalence conditions. This is clearly a useful step, but in this, as in other aspects of the plan, much of the focus remains on treatment rather than on preventing those who are not unwell from becoming unwell, and on a wider promotion of mental health and wellbeing.

An exception to this more limited focus is a key Priority Action in ‘Rising to the Challenge’ (section 6.3) which commits the Ministry to ‘Fund Mental Health Literacy Programmes’....

“... that are evidence-informed, culturally appropriate and aimed at increasing awareness among all New Zealanders of how to recognise and respond to mental health and addiction issues within local communities. Where possible, these programmes will be linked to wider health literacy programmes.”

The steps in Barry and Jenkins’ framework would be usefully applied to this Priority Action. For instance, applying the framework’s step of ‘Invest in human, technical, financial and organisational resources to achieve priority actions and outcomes’ against this Priority Action allows useful questions to be generated about the Action’s implementation. These questions might include ‘has this investment in those human, technical, financial and organisational resources occurred, and if so to what extent?’ A follow-up question to this and to the other steps in the framework might be; ‘If not, why is that, and what will be done to make this Priority Action achievable?’ Using this approach to the Priority Action and similar directives would ensure that these can be effectively implemented - and that meaningful results will be produced.

*Rising to the Challenge. The Mental Health and Addiction Service Development Plan 2012–2017. See point B under section 5.3 below for the role of General Practitioners in helping to assess whether and how such plans and policies impact on the daily lives and functioning of their patients.
A number of other specific areas of attention are identified in the Rising to the Challenge plan, although measurable targets for these are not, so there is a risk that the excellent intentions of the plan will remain largely ‘aspirational’ rather than implemented at a level which will make a significant difference across the NZ population. In terms of funding it should be noted that many useful initiatives are essentially to be funded from ‘within existing resources’. Similarly, the promising approach of developing ‘self-management education and programmes provided by peer support specialists’ which are to “equip people with the knowledge and skills to manage their condition and minimise its adverse impact on their life, and to work in partnership with services to enhance their wellbeing”\textsuperscript{360} are to be DHB funded, presumably again from within (limited) existing resources.

In any discussion on moving the focus in the public health system ‘upstream’, towards creating wellbeing and resilience to avoid illness, two points need to be made. One is that illness prevention initiatives (e.g. alcohol tax) are an important step away from a treatment-focused system and can create sizeable savings to the health system by reducing future admissions. But by resulting in an extension of patient’s lifetimes, the scene is set for additional and ongoing health costs; in other words “an intervention that prevents premature death means that these people continue to live longer and incur health system costs for other unrelated diseases, making the intervention less cost-effective.”\textsuperscript{361}

This makes an approach to avoid or reduce the impact of a range of key diseases which burden the public health system - especially the chronic diseases with their lifestyle risk factors - a critical step if individual illness prevention initiatives are not to simply shift health spending from one treatment area to another. As such, targeting wider determinants of health through the systematic promotion of good health and wellbeing becomes essential.

The second point is captured in a UK review of health and older people; “prevention for older people.. means providing services that avoid or delay the need for costly intensive interventions and strategies and approaches that promote quality of life and social engagement,”\textsuperscript{362} but this “isn’t just providing the same service in similar portions at an earlier stage. It should be about equipping people with the skills, coping techniques and circumstances to remain independent. It’s as much about learning how to use a computer, purchasing an active lifestyle or ensuring a safe neighbourhood as it is about providing one hour of home care per week. It is a responsibility that extends well beyond social services.”\textsuperscript{363}

The first three items in the framework above - which could be equally and usefully applied to physical health promotion - underline the point that a strength of the process of promoting health and wellbeing is less a collection of diverse programmes and more a cohesive set of evidence-grounded, guiding principles from which a range of programmes have been, and can be, developed. As the Mental Health Commission has highlighted, there is now a good body of evidence behind the view that “more integrated approaches – with professionals responsible for a patient’s mental and physical health working more closely together – can improve outcomes and reduce costs.”\textsuperscript{364}

As such, the coherent and consistent approach of health and wellbeing promotion is a key success element; within the US the identified reasons behind a lower use of mental health services by older people include factors like the shortage of geriatric mental health providers and the problem minimisation and denial referred to previously, but also factors of service disconnection and fragmentation, including poor or insufficient coordination between providers of mental health, primary care, and ageing services, and barriers to accessing services like lack of transportation and mobility problems.\textsuperscript{365}
5.3 Opportunities for Nelson-Tasman, and beyond.

Notwithstanding the need for an over-arching approach such as that laid out in the framework suggested by Professor Barry, there is value in looking at areas suitable for greater attention in a specific setting like Nelson-Tasman. The large proportion of the local population that is older, and the higher than NZ average rate at which this proportion is growing, makes the task of addressing challenges associated with ageing and loss of health and wellbeing especially significant for this region. Drawing from the material covered in this document, some ideas for development, which may serve as pilot projects for wider application, could include:

A) Expanding sound mental and physical health wellbeing policies and practices across all workplaces (and amongst all health workers especially)

There is strong evidence for the effectiveness of workplace mental health promotion programmes. One recent NZ example is the evaluation research, as summarised in the Like s, Like Mine 2014-2019 National Plan, with its particular focus on addressing mental health stigma in workplaces. Mental and physical health programmes based in the workplace, with their focus on reducing employees’ risk factors and increasing fitness, both improve workers’ health and have proven to be cost-saving; one recent review showed that the return on investment in such programmes was between $2.50 and $10.10 saved for each dollar spent.

A greater mental wellbeing focus in health workplaces would also ensure that health workers will, by maintaining their own wellbeing capacity, be modeling to both their patients and the wider community a different approach to ‘doing health’. An interesting exercise in applying the Five Ways to Wellbeing model in a health setting is described in a 2011 UK review of its applications. In this, a psychiatrist recognised the potential of the model to “bridge the gap between secondary and primary care through a shared emphasis on mental health promotion” Using an interactive educational package delivered as part of lunchtime meetings, the evidence for the model was reviewed and then the principles were applied to the participant’s own lives before supporting material was distributed.

Workplace programmes also represent something of a ‘micro application’ of wider population-based approaches to health and mental health promotion, and systematically shifting health behaviours amongst workers creates a good platform for engaging the wider community in more general health and mental health promotion programmes. In addition, wellbeing applies not only on an individual or population level - workplace policies and practices create a workplace culture which can effectively foster or undermine an individual’s wellbeing. This dimension is well captured in the observation that “mental health at work is generally thought of as a problem to be fixed, or at least managed. But mental health can also be the greatest resource in [a] workplace or business. Good mental health needs to be deliberately cultivated, protected and increased. In the workplace this can be done through leadership strategies, behaviour changes and organisational policies.”

As noted earlier, the health sector is an important place to begin to apply new and more flexible approaches to work for people in mid-life and moving towards older age. This will involve supporting the option of working past the current retirement age - and taking steps to make this more sustainable. Useful steps would include greater flexibility around work hours and part time work, encouraging slowed
transitions into retirement, greater access to training and retraining for older people,* and the systematic fostering of the five ways to wellbeing model across the health workforce, perhaps through personalised action plans. In this way, skilled older workers in healthcare can continue to contribute - sustainably - to meeting health system demands. Such an initiative would mesh well with the strong emphasis on workplace wellbeing, and the focus of working with regional communities, that is a feature of the recently released Like Minds, Like Mine National Plan 2014-2019.

The aim of workplace programmes has been not only to improve the quality of life of the health workers, but by having these individuals experience the value of the Five Ways to Wellbeing to create greater understanding, valuing and likelihood of passing on the key messages - as the instigating psychiatrist observed; “if you don’t have it, how can you give it?” A useful first step in this process might be to conduct a ‘stocktake’ of the practice of health behaviours (e.g. the Five Ways to Wellbeing components), and to attitudes to retirement and to a longer working life within the local health sector.

B) Increasing the roles and responsibilities of general practices, and other primary health care providers to incorporate sound mental health practices into their service delivery

The large proportion of older people in Nelson-Tasman, with their associated higher frequency of visits to General Practitioners, means that managing demand on existing services will be critical in the face of limits to hospital and tertiary services. In this context it is of some concern that despite “a high prevalence of mental health problems amongst people presenting to primary care services... mental health problems are often missed in primary care consultations.” A slightly different view is suggested in other research which proposes that identification of mental health problems by General Practitioners may occur at a higher rate than some studies indicate, but that such problems may not become a focus of the GP’s consultation, possibly due to the complexity involved, and the additional time associated with the assessment and follow-up of these issues.

The Rising to the Challenge plan for mental health acknowledges both elements of this situation; “mental health and addiction issues in older people are often complicated by other issues, including social isolation and physical and cognitive conditions associated with ageing. This complex mix of inter-related issues means that often mental health and addiction issues go unrecognised in this group.” In response, the plan requires Non-Government Organisations and DHBs to “provide support and advice to primary care and general health services for older people so that together they can better address the complex interrelationship between mental health and addiction needs and general health needs.”

* The need to address such issues on a cross-sector level is illustrated by the subtle and less subtle ways structures work against extending careers and working life; retraining or up-skilling for older people is poorly supported by allowance provisions, for instance. In a recent commentary on this issue, “Unitec Student Union president Ben Kevey said the student allowance system was designed for young, single university students - not for older married students at polytechnics and training institutes. Tertiary Education Union president Lesley Francey, an English tutor at Manukau Institute of Technology, said the system would get even harder for older students next year when the student allowance will be stopped after three years for students aged 40 and over. Younger ones are allowed up to five years.”
A previous policy document from the Ministry*¹ usefully extends this approach by recommending that “primary health care providers should undertake regular holistic reviews of the physical and psychological wellbeing of older people, and of older people who are caring for a family member.” Holistic reviews of the physical and psychological wellbeing of older people*² may have additional value when these are combined with specific approaches to identify those at particular risk of comorbidity and of complex health and mental health problems, so that targeted building of health and mental health can be provided earlier rather than relying on treatment later. This step may require a strengthened focus on screening for and targeting those showing vulnerability across a cluster of key risk factors, like social isolation/loneliness, depression, hearing loss, anxiety and inactivity.  

The same Ministry document suggests that “primary health care providers should be aware of the illness prevention and health promotion activities that occur in their localities, and promote participation among their patients,”*³ an approach that should support older people to remain well, and also support the preference of many older people to continue to live ‘safely and comfortably’ in their own home as they age. As the Rising to the Challenge Plan states, this requires “newer models of health care delivery [that] are increasingly focused on supporting ageing in place” which will form “a connected and coordinated health service that recognises and responds early and effectively to mental health and addiction issues in older people, while optimising their ability to live in the home and community of their choice and to contribute positively to that community.”*⁴

For this admirable approach to be viable two points need to be made. One is that for primary health care providers to be ‘aware of [local] illness prevention and mental and physical health promotion activities’ these must be appropriate for the level of need, available at a sufficient level, and be accessible. The material covered in previous sections of this document indicates that priority focus areas for older people will usefully include physical activity (or for the less mobile an appropriate form of productive activity) and social interaction, since the evidence shows these to be particularly potent contributors to wellbeing and relatively easy to combine. Such programmes might support and involve the collective resources and potential energies of those within service clubs, community organisations and retirement villages.

It would also be important for General Practitioners and other primary health care providers to be supported in taking a particular responsibility for actively encouraging and empowering older people to maintain as much independence as possible for as long as is feasible. This will require the provision of sufficient supportive community-based care services and health and mental health promotion programmes and associated workforce infrastructure. Enabling older people to age in place requires more than good intentions and their GP’s encouragement, and encouraging people to age in place without sufficient supportive services would be a ‘setup to fail’ for both older people and their GP’s. GPs are likely to be

*¹ Mental Health and Addiction Services for older people and Dementia Services. Guideline for District Health Boards on an Integrated Approach to Mental Health and Addiction Services for Older People and Dementia Services for People of Any Age. 2011.

*² Holistic reviews of the psychological wellbeing of older people might usefully include the level of an older person’s core beliefs, meaning and connectedness since these may be particularly given the instrumental value this dimension has in providing ‘meaning-making’ for coping with challenges, losses and illness, and since attending to this dimension may have a direct physiological benefit, as discussed in regard to spirituality on page 12.
amongst those best placed to answer some of the questions posed above (derived from Barry and Jenkins framework, page 46-47) regarding whether the aims of the Rising to the Challenge Plan are being achieved in meaningful terms at a population level.

The second point is that it has to be acknowledged that primary health care providers work in a provider context and funding model that reflects the same ‘find and fix,’ illness-focused approach as the wider health system, and that many of their patients currently bring the same health model and expectations. It would therefore be important for General Practitioners and other primary health care providers to be well supported in promote a shift in focus onto actively maintaining wellbeing. For this to be realistic, such an approach would need to be legitimated by the systematic, population wide adoption of the concept and practice of ‘health investment’, and an emphasis on and the support for the critical role of individuals to put in place the basic steps of that investment (e.g. healthy lifestyle components such as non-smoking, low alcohol, plus Five Ways to Wellbeing elements). If such an approach is not reflected across national and local government policy and actions, why would individuals shoulder the task of applying this approach in their own lives?

C) Enhancing the role of local councils in their approach to design and planning which maintains social connection and good public health.

Writing in an opinion editorial for participants of the ‘Tomorrows Healthcare’ Think Tank referred to previously, Professor Paul McDonald, Massey University Pro Vice-Chancellor, College of Health, comments that “DHBs and service providers have improved their efficiency, and will continue to do so, but they can’t rein in healthcare costs on their own. What if we established the health equivalent of an auditor general to report the effect that government actions have on health and the need for healthcare? What if local councils were rewarded for transportation or housing decisions which reduced asthma? What if we re-examined the potential and scope of public-private partnerships to reward businesses who reduce the need for healthcare by improving health, wellbeing and prosperity?” These are important questions, and it would be naive of local councils to assume that the requirement for change will limited to central government and to public health policies and delivery.

The World Health Organisation has made the point that “living in a neighbourhood that is safe, and where older people can be seen on the streets, might encourage older people to engage more frequently in community activities. But active ageing is a lifelong process, and these same neighbourhoods can also increase the likelihood of younger people being physically active. This is positive for their health and helps to ensure that when they, too, transition to older age, they do so from a stronger base.” While issues such as neighbourhood accessibility - footpaths, seats, road crossings, access to green space - are (or should be) part of the routine concerns of planners and urban designers, achieving real gains in local population health and wellbeing will come when “Local Authorities … incorporate outcomes based on the Five Ways to Wellbeing into the commissioning specifications for all kinds of services, not just the obvious areas of mental health and adult social care.” And when decisions made across all relevant aspects of council functioning are audited against the advancing of these outcomes through practical, measurable steps.

A useful step in achieving that would involve Nelson and Tasman to jointly apply, preferably in conjunction with the NMDHB and other health providers, for membership of the World Health Organisation’s Age-friendly Cities Programme. This international programme is aimed at assisting cities prepare for two global demographic trends being seen in this region: the rapid ageing of populations and the process of increasing urbanization. In an approach closely aligned to good health and mental health promotion, the Programme
has as its target those environmental, social and economic factors that influence older people’s health and well-being. This WHO initiative was launched with participation from 33 cities in 22 countries in 2006, and from this beginning developed The Global Age-friendly Cities Guide to map out the key elements of the urban environment which will support healthy, active ageing. The guide provides a framework for assessing the “age-friendliness” of any city and the role of older people as active participants in this process is a core aspect of its approach.

Eight domains of city life are identified in the guide as potential shapers of older people’s health and quality of life:

- Outdoor spaces and buildings
- Transportation
- Housing
- Social participation
- Respect and social inclusion
- Civic participation and employment
- Communication and information
- Community support and health services

Member cities work through a programme cycle of four stages involving 1. Planning (Year 1-2): 2. Implementation (Year 3-5) 3. Progress evaluation (end of year 5) and 4. Continual improvement.

Another aspect of how councils can play an important part in creating a supportive environment for people as they age is illuminated by the Living Well project in Golden Bay. The project commissioned research in 2011 which identified two key challenges; one was the absence of a range of suitable housing options that would allow people to live in the environment and manner of their choice as they retire and grow older, and as their housing needs evolve. The other issue involved the difficulty for this smaller and more isolated community in keeping its population of younger people – a challenge for many communities in NZ as the population ages and urbanization draws younger people to large cities. This issue touches on one of the potential drawbacks of retirement villages, their clustering of older people (those with the means to afford this option) together in more socially exclusive, age-specific communities, away from the wider multigenerational community with its diversity of community linkages and activities.

Both of these issues relate to local authority approaches to land use regulations, and the need for councils to take a more flexible and responsive approach to housing and higher density land-use has been raised by the Golden Bay NZ Listener journalist Linda Sanders. Her argument that council’s should allow informal urban or rural communities to make use of cooperative or unit property titles has a wider NZ application, and this would mean that groups within the community could, for instance, form their own retirement housing clusters, embedded in their existing communities. As Sanders suggests, “instead of forcing people with such aspirations into expensive, complex and time-consuming resource consent processes, local government could be taking a more flexible approach to land use. It should be about figuring out how things can be done, rather than why they can’t.”

Whether based in retirement villages, their own retirement housing clusters, or remaining in their own homes, transport for older people will be critical to preserve participation in the wider community, maintain social connection, and carry out the normal tasks of daily living. Many people will drive their own vehicle (if they have one) as long as possible, others will share rides with friends, family, and contacts. But adequate public transport will also be critical; as the WHO Age-friendly Cities Guide states; “Transportation,
including accessible and affordable public transport, is a key factor influencing active ageing.”389 The guide gives detailed criteria to assess age-friendly transportation and this could be usefully applied to the Nelson-Tasman urban area.

* Subsequently published as Ageing in Place in Golden Bay: An investigation of the ageing population in Golden Bay and what they need to be able to ‘Age in Place’.
Conclusion

An approach to mental health and wellbeing which gives attention to individuals, populations and their environments recognises that people’s decisions are affected by many factors, and that many determinants of health are out of the control of the individual. This is the approach taken by Health Action Trust (Nelson). The basis on which the Trust was founded and operates is that the building of resilience, both individually and collectively. This is also the basis of sound health promotion principles and practices, as is reflected in the Ottawa Charter for Health Promotion and the Perth Charter for the Promotion of Mental Health and Wellbeing. This approach is the lens through which this document has reviewed ageing and mental health and wellbeing for older people.

‘Global ageing’ is a seismic shift in the make-up of the world’s population and it presents some pressing challenges for governments and for our communities. This trend for prolonged life, or longevity, can be either a benefit or a burden to an individual and to their society depending on the quality of that longer life. If the goal of compression of morbidity over this longer lifespan is to be achievable for New Zealand then reducing the prevalence of mental and physical disability, by achieving population-wide good mental and physical health, will be an essential complement to treating existing illness.

Older age is currently a period which some enter in a good state of wellbeing and are able to largely retain that throughout the period of later life. Others lose wellbeing in older age, or take ill health with them. Some groups, particularly those with greater financial hardship, and Maori and Pacific Island populations, are more likely to fall into the latter category. For those facing challenges in their older age, several psychological illnesses or issues can be relatively common, including anxiety, depression (often coexisting with anxiety) suicide and dementia, with comorbidity and complexity in their state of health being a particular feature. The risk factors for loss of mental wellbeing in older people are diverse, and include; loss, such as that involved in retirement or death of a spouse or partner; social isolation and loneliness; financial stress; physical inactivity; and (often under-identified) substance abuse. This mix of illnesses and risk factors, and the way these often interact and compound each other, adds to the complexity in older people’s ill health in a way that presents a challenge for centralised, illness-focused health systems.

Investment in good mental and physical health through the systematic promotion of mental and physical wellbeing involves a very small proportion of total health and health-related expenditure in NZ. This allocation of resources would indicate that creating and maintaining general or mental wellbeing, and thus avoiding or delaying the onset and progression of illness and loss of function - especially over the increasingly extended life-times characterizing our population, is not a current preoccupation of the public health system. Global ageing is one factor within a cluster of issues, however, which raise questions about the sustainability of such an approach to public health; a system that is almost entirely focused on servicing the ‘health debt’ of disease and illness at the cost of preemptive investment in building health capital.

Neglecting the systematic fostering and promotion of good mental health is particularly short-sighted; as has been discussed, people appear to adapt better to negative physical health than mental health conditions, with consequent long-term impacts on wellbeing. Better mental health and wellbeing not only assists with general health but increases the quality of life when an individual is physically ill or disabled - a significant issue for all, but perhaps older people particularly. Physical health is, obviously, important, but mental wellbeing is not simply a bonus in life, it is a filter for how that life is experienced.

In an opinion editorial for participants of the ‘Tomorrows Healthcare’ Think Tank, Professor Paul McDonald, Massey University Pro Vice-Chancellor, College of Health, touches on many of the themes raised in this
Health Action Trust document, including the need to address the determinants of health in a new and structural way. In that editorial he makes the point that “now is the time to challenge our assumptions, consider new operating paradigms, and take responsibility to generate whole of society responses.” As Professor McDonald urges, there is no better or more necessary time than the present to revalue mental and physical health and wellbeing and to begin the process of applying new approaches to living - and growing old - well.

While the questions raised by Professor McDonald are being asked at a national level, a good deal of their applicability will be local. Health Action Trust (Nelson) has therefore developed this document to inform the Trust, the health sector, and other organisations of the opportunities and the challenges facing our population. Establishing a clear understanding of these issues will allow Health Action Trust to work collaboratively with Local Government, health providers and other local organisations in the development of policies and strategies to meet the needs of our older population - both now and in the future.

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Appendix 1

Five Ways to Wellbeing

Health is more than just the absence of disease. Evidence suggests that building the following five actions into our day to day lives is important for our own wellbeing and that of our workplace and community.

Connect...

Social relationships are critical to our wellbeing. Survey research has shown that choosing life goals involving family, friends, social and political life supports and enhances our lives:

Develop your relationships with family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

Be active...

If you do 20 minutes of moderately intensive exercise, research shows that your mood can be elevated for up to 12 hours afterward:

Physical activity helps you to feel good so find something that you enjoy and suits your ability. Move your body. Step outside, Walk, Cycle, Play a game, Garden, Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

Take notice...

Research shows that raising the awareness of sensations, thoughts and feelings can improve our knowledge of ourselves and our wellbeing for several years.

Be curious. Be thankful. Catch sight of the beautiful. Remark on the unusual, notice the changing seasons. Savor the moment whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

Keep Learning...

In achieving personal goals to learn something new, research has shown that higher levels of life satisfaction are achieved:

Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a Bike. Learn to play an instrument or how to cook your favourite food. Be creative. Set a challenge you will enjoy achieving. Learning new things will make you more confident as well as being fun.

Give...

We are hard wired to help each other! Research shows that cooperative behaviour activates the brain, and that giving and receiving is the simplest way of developing trust between people and communities:

Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.
This model describes how these five actions help to enhance wellbeing

The concept of wellbeing comprises two main elements: feeling good and functioning well.

Compiled by Health Action Trust, Nelson, from the following sources:


Appendix 2

Cycling: A Cross-sector Opportunity for Improving Mental and Physical Health

In its Global Brief for World Health Day, the World Health Organisation warns that “numerous determinants of healthy and active ageing lie beyond the health system. They also start to exert their influence at earlier stages in life. Our response, therefore, needs to tackle issues across the life course and in many social spheres.” Physical activity is an area where there are opportunities for cross-sector investment in physical and mental health by promoting a health-related behaviour that has wide relevance to challenging issues such as depression, obesity, and dementia.

In broad terms, New Zealanders’ levels of physical activity have, as noted previously, remained relatively unchanged from the 2006/7 Annual Health Survey where 52.1% of the population were classified as active, this rose slightly to 54.4% in 2011/12 and dropped to 51.7% in 2012/13. By comparison, over the same period other health status factors like smoking and ‘hazardous drinking’ have improved. Significantly, both of these areas have been the target of extensive and prolonged nationwide health promotion and behaviour change programmes. Since achieving widespread behaviour change is neither simple nor easy, any opportunity to markedly increase physical activity in a wide section of the population would therefore have considerable significance for both a population’s health status and NZ’s health spending.

It is significant then that a 2013 survey of 500 Dunedin residents found that 75% reported using a car as their main mode of transport for daily activities, with 5% cycling. Of the residents surveyed, 63% owned or had access to a bike, and 25% wanted to cycle but didn’t, with safety concerns being cited by 46% and over a third identifying the lack of good facilities. This high level of untapped demand for cycling as an active transport option is consistent with findings outside of NZ urban areas; also conducted in 2013 was a survey involving 1000 residents of London from thirty two local borough councils; this revealed that 47% of respondents would cycle more if road safety improved.

Such results are therefore not isolated anomalies but rather reflections of a widespread trend; in the same year a reader’s survey conducted by the New Zealand Automobile Association’s ‘Directions’ magazine asked, ‘if we could improve the safety of cycling on our urban roads, would you give cycling a go?’ The answer from 92% of the respondents was ‘yes’, with 8% answering ‘no’, and despite relatively limited improvements in transport cycling infrastructure, cycling-to-work rates in NZ have increased by 16% between the 2006 and 2013 Census, while in Nelson this growth figure was 26%.

The impact of providing appropriate infrastructure is underlined by the creation of a local Nelson-Tasman ‘rail trail’ for easy off-road recreational riding; the Great Taste trail. Recent user counts show this facility to have up to 370 daily users on popular sections of the trail, mostly locals, and significantly for the focus of this document, mostly in the 50-79 age group, riding with their partner and or with friends in a social group. A slightly younger age group (40-50s) is the dominant user of the similarly popular Otago Central Rail Trail, but a key issue here is that these users are likely to carry this form of activity into their older age.

These examples demonstrate how changing people’s environments can bring about otherwise difficult to achieve changes to health-promoting behaviour. Both of these facility projects, however, relied on sectors beyond health; the Ministry of Tourism (now under the Ministry of Economic Development), the Department of Conservation, and local authorities.
If facilities were to be provided in NZ to address the ‘safety barrier’ to urban cycling the subsequent impact on health spending is measurable for a given level of behaviour change. A 2010 study,\textsuperscript{402} for instance, found that a 5% shift in NZ short-trip vehicle use to cycling would result in 116 deaths avoided each year as a result of increased physical activity, and another six deaths avoided due to lessened air pollution from vehicle emissions (a reduction of 50,000 tonnes of CO\textsubscript{2}).

The economic gains of such a 5% shift, focusing only on fatalities and using the NZ Ministry of Transport ‘Value of a Statistical Life’, would represent net savings of about $200 million per year due to the health benefits from increased cycling, even after factoring in an additional five cyclist fatalities annually from road crashes due to the greater numbers of people cycling.\textsuperscript{403}

Taking the opportunity to shift transport behaviour, which has considerable impacts on health spending, is clearly an activity that lies, as the World health Organisation suggests, beyond the health system. Such a cross-state-sector application would require a coherent and strategic central government approach that is not contained by sector-specific areas of focus. Again, this is consistent the with the observation in Blueprint II’ by the Mental Health Commission that to maintain functioning and independence - and to slow decline - for adults and older people there are opportunities to integrate mental health interventions with health and wider social sector responses.
Appendix 3:

Language and Rethinking Health

The language used to discuss and conceptualise established systems can act to perpetuate the ways in which they operate, or assist with rethinking that operation. A useful ‘thought experiment’ in examining how mental and physical health promotion relates to the prevailing model of health is provided by applying the concepts of ‘Health Capital’ and ‘Health Investment’. In the approach developed by the eminent health economist Michael Grossman, Health Capital represents an individual’s ‘stock’ of good health, roughly defined as longevity and freedom from illness. This stock is dynamic or changeable over time, and individuals invest in their own health stock through their choices about factors such as medical care, exercise, diet, alcohol and smoking. Positive choices in those activities represent aspects of Health Investment. Some mental health equivalents might be dealing with stress and taking steps that are psychologically ‘feeding’.

Medical treatment is one of a range of Health Investment activities in Grossman’s model, but the treatment of illness, which might here be termed Reactive Health Investment, is usefully differentiated from other forms of Health Investment like health and mental promotion and illness prevention, which can be considered Pre-emptive Health Investment. Reactive and Pre-emptive Health Investment clearly address the issue of illness very differently, with different consequences for both individuals and for public health systems.

For the purposes of this exercise its useful to extend the concepts of Health Capital and Health Investment to wider social constructs. An individual’s Health Capital will be influenced, for instance, by family and community attitudes and behaviours related to maintaining good mental and physical health, which in turn would be influenced by health promotion activities when these are a form of community-level Health Investment. Similarly, community-wide illness prevention components of Health Investment (e.g. national immunisation programmes) will impact on the level of Health Capital at a community as well as an individual level. Both mental and physical health promotion and illness prevention can operate as short-term (immediate impact) and long-term forms of Health Investment.

It may also be useful to conceptualise the loss of Health Capital - whether in the form of mental and physical illness, as a result of insufficient Health Investment, or from the impact of accident - as a kind of Health Debt. Health Debt similarly has a wider community and government dimension; in a public health system like NZ’s, Health Debt (experienced as illness or disability on the individual level) is transferred to the government as Health Debt in a literal, economic form; the economic cost of restoring the individual’s Health Capital through treatment goods and services falls largely on the state.

Borrowing the language of health economics is particularly apt as it is likely that any change to the existing health model to make health care sustainable is likely to be largely driven by economic necessity. Thinking of the dynamic relationship between individual and community Health Investment (how we maintain and strengthen our individual and community levels of mental and physical health and wellbeing) and Health Debt (the loss of wellbeing, vulnerability to illness) drives home a central point; neglecting the former sets up increases in the latter. In health, as in economics, a system focused on servicing debt at the cost of investment cannot be expected to be sustainable.
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