

Determinants of Wellbeing for Older Aucklanders

December 2016

Technical Report 2016/047





Determinants of Wellbeing for Older Aucklanders

December 2016

Technical Report 2016/047

Auckland Council
Technical Report 2016/047
ISSN 2230-4525 (Print)
ISSN 2230-4533 (Online)

ISBN 978-0-9941429-4-8 (Print)
ISBN 978-0-9941429-5-5 (PDF)

This report has been peer reviewed by the Peer Review Panel.
Review submitted on 31 October 2016 Review completed on 15 December 2016 Reviewed by three reviewers
Approved for Auckland Council publication by: Name: Dr Lucy Baragwanath Position: Manager, Research and Evaluation (RIMU) Name: Eva McLaren Position: Manager, Economic and Social Research and Evaluation (RIMU)
Date: 15 December 2016

Recommended citation

Rootham, Esther (2016). Determinants of wellbeing for older Aucklanders. Auckland Council technical report, TR2016/047

© 2016 Auckland Council

This publication is provided strictly subject to Auckland Council's copyright and other intellectual property rights (if any) in the publication. Users of the publication may only access, reproduce and use the publication, in a secure digital medium or hard copy, for responsible genuine non-commercial purposes relating to personal, public service or educational purposes, provided that the publication is only ever accurately reproduced and proper attribution of its source, publication date and authorship is attached to any use or reproduction. This publication must not be used in any way for any commercial purpose without the prior written consent of Auckland Council.

Auckland Council does not give any warranty whatsoever, including without limitation, as to the availability, accuracy, completeness, currency or reliability of the information or data (including third party data) made available via the publication and expressly disclaim (to the maximum extent permitted in law) all liability for any damage or loss resulting from your use of, or reliance on the publication or the information and data provided via the publication. The publication, information, and data contained within it are provided on an "as is" basis.

Determinants of Wellbeing for Older Aucklanders

Esther Rootham

Research and Evaluation Unit

Auckland Council

Executive summary

With 11.5 per cent of its population aged 65 and older at the 2013 Census, Auckland has one of the youngest age structures among New Zealand's regions. Nonetheless, both the number of Aucklanders aged 65 and over, and the portion of the overall population in this age group, is on the rise due to declining birth rates and increased longevity. While older Aucklanders are not particularly ethnically diverse in 2013 compared to other age groups, this is set to change. Ageing populations in ethnic groups other than Pākehā/European will likely lead to an increase in demand for culturally relevant policies and services above the current levels. This report can inform Auckland Council's policy responses to address the changing demographic profile of Auckland.

The Auckland Plan sets out a broad strategic direction to create a strong, inclusive and equitable society that ensures opportunity for all Aucklanders. Embedded within this broad aspiration, the Plan identifies a need to recognise the evolving nature of being 'older' and to find ways to value the contributions of older residents. In order to meet this, Auckland Council is seeking to create a baseline set of measures of the wellbeing and contributions of older adults in Auckland that can be updated at regular intervals in order to monitor change.

The purpose of this report is to review a selection of available literature on ageing and on the determinants of wellbeing in older adults, which will inform the selection of appropriate indicators to be used in monitoring progress in this area for Auckland.

The concept of 'wellbeing' is widely used in research and policy on ageing. How it is defined and measured is subject to variation and debate. The report outlines academic and policy debates relating to defining, identifying and measuring the constituent parts of wellbeing in older adults. It distinguishes between objective and subjective measures of wellbeing as well as individual and collective level indicators of wellbeing. The report also discusses three ways of conceptualising wellbeing in older adulthood: a biomedical view, a material view and a socio-psychological perspective. The report discusses the importance of including the views of older people themselves in developing a model for wellbeing in older age due to the socially constructed nature of the concept and the fact that it changes over time and as broader social norms change.

There are several examples of multidimensional frameworks that have been developed both internationally, such as the WHO Active Ageing model, or the Age-Friendly Cities approach as well as in New Zealand, through the Positive Ageing Strategy which can serve as starting points to develop a monitoring approach appropriate for the Auckland context. 'Active Ageing' was promoted by the World Health Organisation in the late 1990s to emphasise the need to optimise the opportunities for ongoing participation of older adults in social, economic, cultural, spiritual and civic affairs. The 'Positive Ageing Strategy' was released in 2001 by the Office for Senior Citizens in New Zealand. This framework emphasised older adult's wellbeing as ageing in good health and being

independent, connected, respected and able to enjoy life. Finally, the 'capabilities approach' was applied in the Enhancing Wellbeing in an Ageing Society study conducted in New Zealand between 2004-2009 with funding from the Foundation for Research, Science and Technology. The model of wellbeing operationalised in this study combined subjective aspects, that is, people's sense of satisfaction with life, as well as a capabilities dimension, that is, the extent to which individuals were acquiring the capabilities to achieve a good quality of life.

The report acknowledges that the experience of wellbeing is achieved and given meaning through a socio-cultural frame. The research reviewed shows that there are culturally inflected ways of understanding wellbeing in older age that vary by ethnicity. Available research on Māori, Pacific and Asian models of wellbeing are reviewed. The report also considers research identifying barriers to achieving wellbeing faced by these groups.

To conclude, there are a wide range of approaches to conceptualising quality of life and wellbeing in the later stages of life and to a certain extent, these vary across cultural groups. It is recommended that a mix of objective and subjective indicators be used. It is also recommended that a multi-dimensional approach be developed which includes a range of dimensions associated with wellbeing in older age. The report provides a list of possible determinants of wellbeing for older adults to consider for future monitoring. Finally, the research reviewed found that including older people themselves in helping to identify the aspects of wellbeing helps make multidimensional models especially robust as it ensures they are fit for the social context in which they will be used. This is particularly relevant for the multicultural context of Auckland.

Table of contents

1.0	Introduction.....	1
2.0	Who is old in Auckland?	2
2.1	Defining ‘older’ age	2
2.2	Demographic profile of older Aucklanders	2
3.0	Concepts of Wellbeing for Older Adults.....	5
3.1	Objective versus subjective measures of wellbeing	5
3.2	Individual versus collective wellbeing.....	6
3.3	Healthy or successful ageing: a biomedical view	7
3.4	Material wellbeing	8
3.5	Socio-psychological wellbeing	9
3.6	Older people’s own definitions of wellbeing	9
4.0	Multidimensional Frameworks of Wellbeing in Older Age	11
4.1	Active ageing	11
4.2	Positive ageing (New Zealand)	12
4.3	The capabilities approach (Enhancing Wellbeing in an Ageing Society).....	14
5.0	Wellbeing in Diverse Cultural Contexts	16
5.1	Māori perspectives.....	16
5.2	Pacific perspectives	21
5.3	Asian perspectives.....	24
6.0	Key Determinants and Indicators of Wellbeing in Older Age.....	29
6.1	Health	29
6.2	Income and living standards	29
6.3	Gender.....	31
6.4	Social connectedness	31
6.5	Leisure and recreational activities.....	33
6.6	Housing.....	33
6.7	Mobility and transport.....	34
6.8	Neighbourhood, area/locality	34
6.9	Safety/security	34
6.10	Absence of elder abuse	34
6.11	Absence of discrimination and racism.....	35
6.12	Autonomy.....	35
6.13	Control	36

6.14	Productive activities and work.....	36
6.15	Education and learning	37
6.16	Cultural security	37
6.17	Religion.....	37
6.18	Sexuality	38
6.19	Age-friendly cities.....	39
6.20	Dying well.....	39
7.0	Conclusion and Discussion	41
8.0	References	44
	Appendix: Checklist of Essential Features of Age-friendly Cities.....	48

1.0 Introduction

With 11.5 per cent of its population aged 65 and older at the 2013 Census, Auckland has one of the youngest age structures among New Zealand's regions. Nonetheless, both the number of Aucklanders aged 65 and over, and the portion of the overall population in this age group, is on the rise due to declining birth rates and increased longevity.

The Auckland Plan (Auckland Council, 2012) sets out a broad strategic direction to create a strong, inclusive and equitable society that ensures opportunity for all Aucklanders. Embedded within this broad aspiration, the plan identifies a need to recognise the evolving nature of being 'older' and to find ways to value the contributions of older residents. In order to meet this, Auckland Council is seeking to create a baseline set of measures of the wellbeing and contributions of older adults in Auckland that can be updated at regular intervals in order to monitor change.

The purpose of this report is to review a selection of available literature on ageing and on the determinants of wellbeing in older adults, which will inform the selection of appropriate indicators to be used in monitoring progress in this area for Auckland. The review included peer reviewed academic publications from a range of disciplines, as well as grey literature published by governments and organisations in the subject area. When possible, research carried out in New Zealand was prioritised.

The rest of this report is structured as follows. Section 2 outlines how 'older' age is variously defined and who can be considered as 'older' in Auckland. It is acknowledged that what it means to be 'older' varies on an individual level, and across the various ethnic groups that make up the current and future population of Auckland.

Section 3 explores issues related to measuring wellbeing in older adults, while Section 4 considers multi-dimensional approaches to wellbeing, including the concepts of 'active ageing' and 'positive ageing'. Section 5 provides a review of available research that has focussed on models of wellbeing relevant to major cultural groupings in New Zealand, notably Māori, as well as Pacific and Chinese. Section 6 discusses a range of determinants of wellbeing in older adults that are identified in various models of wellbeing in later life and provides examples of indicators used to measure them.

Attention to the divergence in the conceptualisation and experience of ageing by gender, ethnicity and other variables is woven throughout the report, when appropriate data is available.

The report concludes with recommendations on research-informed approaches to monitoring the wellbeing of older Aucklanders.

2.0 Who is old in Auckland?

2.1 Defining 'older' age

There is no precise definition of 'older' age. The age at which a person is considered, and considers themselves, old depends on the interaction between their individual biological experience and the meanings attributed to age in their wider social context. In other words, what is considered 'older' differs from person to person, and group to group.

The United Nations (UN) and the World Health Organisation (WHO) identify older people as those 60 years old and above (Stegeman, Otte-Trojel, Costongs, & Considine, 2012; United Nations Population Fund and HelpAge International, 2012).

In Auckland, as in New Zealand more generally, 65 tends to be the age at which older age is officially recognised and at which entitlement to old age social security benefits begins. However, in New Zealand there is also recognition on the part of government agencies such as the Ministry of Health (MoH) that there is some degree of variation amongst cultural groups as to how older age is defined and experienced.

In the *Health of Older People Strategy* and other documents, the MoH recognises that many Māori face age-related disabilities and illnesses at a relatively younger age and have a shorter life expectancy than non-Māori, particularly European/Pākehā (MoH 1997). For this reason, a report focusing on the health of older people and kaumātua explicitly uses 55 as the age at which Māori are considered to have reached 'older' age (MoH, 1997: 4). A similar situation exists for Pacific peoples for whom the status of 'older person' is not necessarily only based on age but can also be conferred with increased social status, and who also face shorter life expectancies than the wider population (MoH, 1997). Section 5 focuses specifically on culturally-informed models of wellbeing in later life for minority groups in Auckland. It also addresses the available research findings on the contributions of, and challenges, faced by these groups.

2.2 Demographic profile of older Aucklanders

Auckland Council understands 'older Aucklanders' as people aged 65 years and over and living in Auckland. At the 2013 Census there were 163,161 older Aucklanders, making up 11.5 per cent of Auckland's total population.

There are higher numbers of older females than older males. Overall, the Auckland population aged 65 years and over had a ratio of 120 females to 100 males in 2013 (Auckland Council, 2015).

This overall category of 'older Aucklanders' can be broken down into three different age-defined groups, namely 65-74 years, 75-84 years, and 85 years and over - commonly referred to as the "young old," the "old," and the "old-old". In 2013, over half (58.3%) of older Aucklanders were aged 65 to 74 years. A smaller proportion (29.7%) were 75 to 84

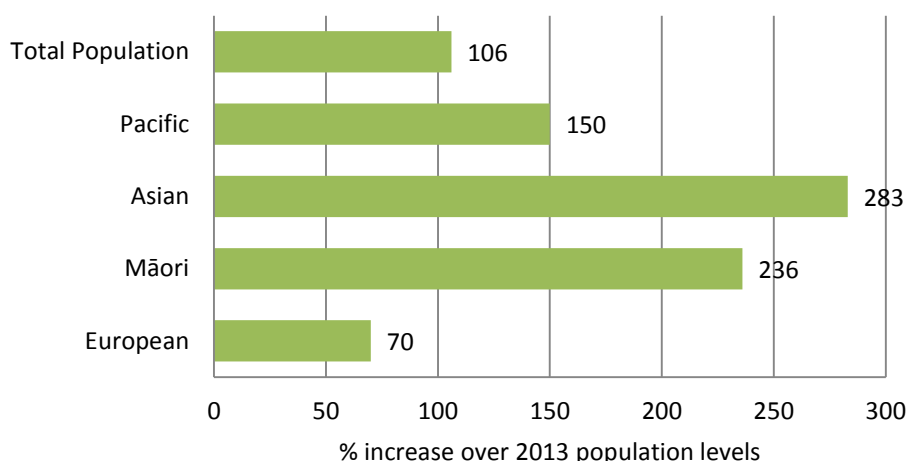
years, and 12.0 per cent were 85 years and over. There were 1401 people aged 95 and over. The largest numbers of older Aucklanders lived in the Hibiscus and Bays (16,017 people), Howick (15,993), Orākei (11,901) and Henderson-Massey (11,388) local board areas (Auckland Council, 2015).

In the coming decades, Auckland will experience numerical and structural ageing. This means that both the number and proportion of older people living in Auckland is expected to increase. As the 'baby boom' cohort move into older ages, the number of people in Auckland aged 65 years and over is projected to double in the 20 year period from 2013 to reach 349,800 by 2033 (Statistics New Zealand, 2014 in Auckland Council, 2015). This is shown in Figure 1 where the total population of older adults in 2033 is projected to represent an increase of 106 per cent over the population levels registered in 2013.

While older Aucklanders are not particularly ethnically diverse in 2013 compared to other age groups, ethnic diversity in younger age groups means that older Aucklanders will be more diverse in the future. In 2013, the majority of Auckland's older peoples identified as being of a European ethnicity (77.7% in 2013), 12.2 per cent identify with an Asian ethnicity, 6.2 per cent with a Pacific ethnicity and 4.0 per cent as Māori. People could identify with more than one ethnicity and in the 2013 Census, older Aucklanders identified with over 100 ethnic groups.

Figure 1 illustrates that the projected increase in population size varies by ethnicity. Asian older Aucklanders are the group that are expected to experience the most growth, as they are projected to increase by 283 per cent above their population levels in 2013. Māori are projected to increase by 236 per cent, Pacific by 150 per cent and Europeans by 70 per cent.

Figure 1: The medium projected population percentage increase in 2033 over 2013 levels by ethnicity for older adults 65+ in Auckland

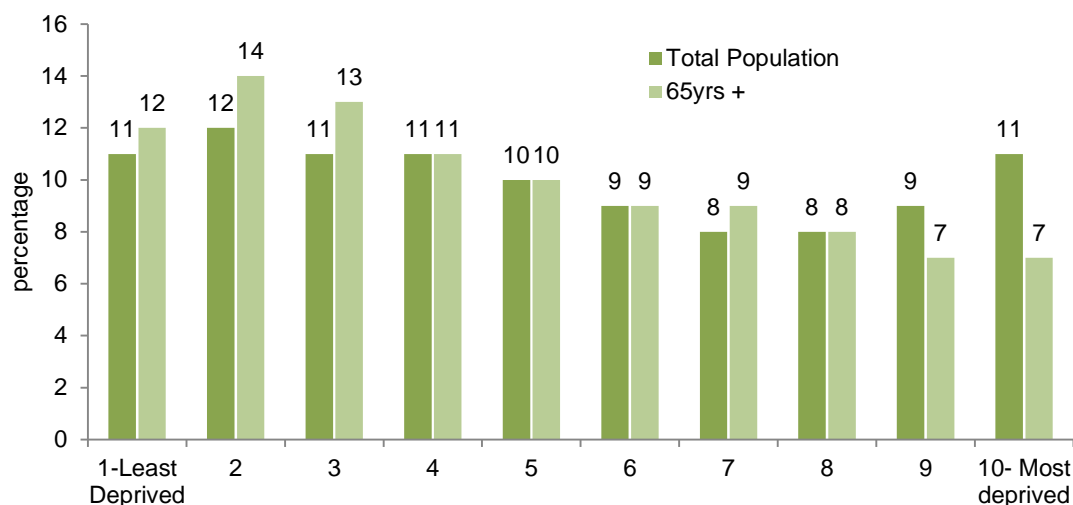


Source: Statistics New Zealand, subnational ethnic population projections, medium series, by age and sex, 2013(base)-2038, data extracted on 18 Jan 2016.

*Ethnicity categories are not mutually exclusive because people can and do identify with more than one ethnicity. People who identify with more than one ethnicity have been included in each ethnic population.

The New Zealand Deprivation Index 2013 (NZDep2013) combines nine variables from the 2013 Census which reflect eight dimensions of socio-economic deprivation: communication (internet access), income, employment, qualifications, home ownership, support, living space and transport. The deprivation ordinal scale ranges from 1 to 10, where 1 represents the areas with the least deprived scores and 10 the areas with the most deprived scores. Figure 2 shows that older Aucklanders over 65 years of age are less likely than the total Auckland population to be living in the most deprived areas, and more likely to be living in the least deprived areas.

Figure 2: Distribution of people 65+ compared to the total Auckland population by NZ Dep Index decile (2013)



Source: Department of Public Health, University of Otago.

3.0 Concepts of Wellbeing for Older Adults

The concept of 'wellbeing' is widely used in research and policy on ageing. How it is defined and measured is subject to variation and debate (George, 2010; Smith, Fleeson, Geiselmann, Settersten, & Kunzmann, 1999). Certain aspects of wellbeing, such as good health, are used as components of wellbeing and positive ageing more generally in some models, while in other models these dimensions are used as a determinants or precursors of wellbeing.

This section outlines selected academic and policy debates relating to defining, identifying and measuring the constituent parts of wellbeing in older adulthood.

3.1 Objective versus subjective measures of wellbeing

Measures of wellbeing can be divided into two types: objective and subjective.

Objective measures of wellbeing refers to an assessment based on factors that make up wellbeing which are observable in a manner that is independent of individual subjective reporting. Relying on objective indicators of wellbeing is based on the assumption that everyone shares a basic set of needs.

An important advantage of objective measures of wellbeing in comparison to subjective ones is that they can provide a means to consider those who might not otherwise be able to articulate their level of wellbeing, due to disability for example (King, 2007). Another advantage of objective indicators is that they avoid the difficulty of attempting to make sense of the variability in how people self-report their levels of satisfaction in relation to a particular set of shared objective conditions (King, 2007).

One limitation of objective measures of wellbeing is that variations in what is valued across individuals and groups can be rendered invisible. Differences in the conception of the good life due to 'experience; ethnicity; sociocultural background; belief systems; age; gender; employment; education; and so on' which can be useful to inform policy approaches are best uncovered through subjective measures of wellbeing (King, 2007: 11).

Subjective measures of wellbeing refer to the dimensions that can be reported by an individual such as how they feel about themselves and those around them and how they perceive their personal circumstances and wider societal institutions (Kukutai, 2006). For example, individuals can be asked to report on whether their income meets their everyday needs for such things as accommodation, food, clothing and other necessities, as was asked in the Enhancing Wellbeing in an Ageing Society study (EWAS) in New Zealand, carried out in 2007.¹

¹ The EWAS study included a sample of 1,680 older people aged 65-84. It found that close to 58 per cent of older respondents reported having enough to meet their needs (Waldegrave & Cameron, 2009). More recently, this question has been included in the Quality of Life survey commissioned by Auckland Council. In 2014, 15 per cent of older

Subjective wellbeing can also be studied by asking individuals to report to what extent they perceive life to be good as a whole (George, 2010).²

Research suggests that older adults are often likely to compare themselves to those that are less fortunate than themselves. The result of this is that they tend to report relatively higher levels of subjective wellbeing compared to other age groups. Income is found to decrease in significance as a factor contributing to the overall rate of subjective wellbeing in older adults in comparison to other age groups, likely because older adults have reduced expectations of earnings at that point in their life cycle (George, 2010). In some psychological models of wellbeing in older age, successful ageing is defined by having the competencies to adapt expectations and cope positively with the decline in capacities that takes place with ageing.

Therefore from a policy perspective, it is worth bearing in mind that self-reported overall satisfaction with life, especially for older adults, is not necessarily a direct reflection of their everyday needs being met.

3.2 Individual versus collective wellbeing

There is some debate regarding the appropriate way to measure *collective wellbeing* in contrast to measuring wellbeing for *individuals*, particularly in concepts of Māori wellbeing.

As Kukutai (2006) notes, measuring wellbeing for a population, or a sub-population, is typically carried out by aggregating individual level data, however it can be argued, that wellbeing at the collective level is more than the aggregate of the wellbeing of the individuals who are part of the group and measuring it requires different approaches (see also Durie, 2006). For Kukutai, collective wellbeing includes ‘the quality of the relations between individuals and institutions’ (Kukutai, 2006: 8). Durie (2006) identifies the collective capacity and scope of influence of a group as examples of dimensions of collective wellbeing.

The advantage of measuring individual and collective wellbeing separately and with different measures is that it enables the interaction between the two to be analysed (Kukutai, 2006). In Section 5.1, examples of ways to measure collective wellbeing for Māori are discussed.

respondents in Auckland indicated that they did not have enough money to cover their everyday needs compared to 23 per cent of respondents under 25 years of age (Nielsen Research Ltd., 2014).

² The EWAS study found that 88 per cent of individuals aged 65-84 reported feeling satisfied with their lives (Waldegrave and Koopman-Boyden, 2009). Note that the proportion of respondents reporting feeling satisfied with their lives overall was much higher than those who report having enough income to meet their everyday needs.

3.3 Healthy or successful ageing: a biomedical view

Biomedical models of ageing focus on optimising life expectancy as well as mental and physical functioning in older age (Bowling, 2009; Bowling & Dieppe, 2005). This approach tends to interpret successful ageing as ‘the absence of chronic disease and of risk factors for disease; good health; and high levels of independent physical functioning, performance, mobility, and cognitive functioning’ (Bowling & Dieppe, 2005).

Most of the research available examining determinants of positive ageing of older people examine negative health outcomes such as disability and morbidity which can be measured objectively (Peel, McClure, & Bartlett, 2005; Read, Grundy, & Foverskov, 2015). Peel et al. (2005) carried out a systemic review of studies published between 1985 and 2003 that reported statistical associations between baseline determinants and healthy ageing (as opposed to negative health outcomes) and could only include eight studies. Their review found evidence of an association with healthy ageing and not smoking, being physically active, maintaining weight within normal ranges, and moderate alcohol consumption (Peel et al., 2005).

Biomedical research into ageing identifies individual-level lifestyle interventions that improve health in old age. The determinants identified when positive ageing is defined in this way are relevant to policy interventions across the lifespan and not only at the later stages of life. This is because healthy ageing is found to be ‘a lifelong process optimising opportunities for improving and preserving health and physical, social, and mental wellness; independence; quality of life; and enhancing successful life-course transitions’ (Peel et al., 2005: 298). Moreover, a re-occurring theme in the biomedical literature on successful and healthy ageing is the importance of initiating preventative measures in early childhood and continuing to implement measures across the life course (Stegeman et al., 2012). It is also emphasised in this literature that it is never too late to take measures that promote healthy ageing, as even actions taken later in life show positive impacts on wellbeing in older age.

An important limitation of biomedical definitions of successful ageing that distinguish between those who have aged successfully from those who have not relates to the stigmatisation of the latter. In other words, categorising people as either the ‘successful’, versus the ‘diseased’ marks out those who fall into the latter category as having ‘failed’ at ageing (Bowling & Dieppe, 2005). One adaptation of the approach which partially addresses this issue is to change the terminology applied. Rowe and Kahn’s influential work on ageing distinguish between ‘usual’ and ‘successful’ ageing instead:

“usual ageing” (normal decline in physical, social, and cognitive functioning with age, heightened by extrinsic factors) and “successful ageing” in which functional loss is minimised (little or no age related decrement in physiological and cognitive functioning, with extrinsic factors playing a neutral or positive role). (Bowling & Dieppe, 2005)

In Rowe and Kahn's model, successful ageing includes three components: minimising the risk of disease and disability, maintaining physical and mental function, and continuing engagement with life. From this research, they identified four factors contributing to healthy ageing: genetics, education level, physical fitness, and self-efficacy, defined as a person's perception that they can cope with specific environmental demands.

Another major limitation of defining 'success' strictly in terms of health and longevity is that it excludes the majority of older adults. This is precisely what is recognised by Rowe and Kahn's model which acknowledges that most fall into the 'usual' category, rather than the 'successful' one. Bowling and Dieppe (2005) point out that it is unrealistic for most people to age without facing disease and disability, even though effective health interventions have managed to increase longevity of life and lead to less time lived with disabilities (Bowling & Dieppe, 2005). In fact, a review of 28 published studies operationalising a concept of successful ageing finds that only one-third of older adults were classified as having aged successfully (Depp & Jeste, 2006).

A final disadvantage of measuring wellbeing on physical and mental functioning in older years is that it does not match up well with how older people themselves interpret successful ageing (Bowling, 2007). As a result, Bowling and Dieppe (2005) argue that it is important to take into consideration whether older adults themselves consider themselves to be ageing well. When this is taken into account, half of older adults consider themselves to be ageing successfully, rather than under one-fifth that are identified through medical definitions.

3.4 Material wellbeing

Material wellbeing is typically used in the field of economics and relies on measures of the resources that individuals have to indicate wellbeing. These measures can be divided into those that focus on resources available, and those that focus on consumption (King, 2007). When applied to older people, by international standards, New Zealand's older population does well in terms of material wellbeing overall as it has a relatively low rate of income poverty. This is related to the universal distribution of superannuation (Breheny & Stephens, 2010).

One shortcoming of income/consumption-based interpretations of wellbeing is that it can be argued that they are better understood as a means to wellbeing and do not indicate 'the actual living that people manage to achieve' (Sen in King, 2007: 14). The EWAS model of wellbeing recognises this and draws from Amartya Sen's (1987) capability approach. This framework helps to shift attention away from the actual material conditions of life and focuses instead on 'opportunities for choice and autonomy enabled by commodities and resources' (Breheny et al., 2013: 1036-7).

3.5 Socio-psychological wellbeing

Socio-psychological models of successful ageing serve to broaden the perspective on what constitutes 'success' in older age beyond health and economic status, to include subjective factors, including 'life satisfaction, social participation and functioning, and psychological resources, including personal growth' (Bowling & Dieppe, 2005).

Psychological models conceive of successful ageing as possessing the following: 'a sense of control over life or self-efficacy; effective strategies for coping, adaptation and self-worth; and goals' (Bowling & Iliffe, 2006: 608). Another domain of psycho-social wellbeing is 'continued social function'. This is understood as 'high levels of ability in social role functioning, positive interactions or relationships with others, social integration, and reciprocal participation in society' (Bowling & Dieppe, 2005). Psychological competencies are useful measures of wellbeing in advanced age as they enable a person to cope well with the decline in health and functioning that accompanies ageing.

As already mentioned in the discussion of subjective measures of wellbeing, it should be noted that older adults tend to approach these types of questions with a positive perspective. Their responses often reflect an acceptance of declines in health and capacity and furthermore, they tend to compare themselves to disadvantaged groups, and therefore show high rates of satisfaction. This is referred to as a 'self-regulation processes', that is, the process by which older people adapt their aspirations and points of reference to their changing life conditions (Rowe & Waldegrave, 2008). Nonetheless, longitudinal research such as the Berlin Study of Ageing has found that the accumulation of changes and losses that take place with ageing can tap the limits of the capacities of older people to adapt and that it remains important to have adequate supports in place for older adults (Rowe & Waldegrave, 2008: 24).

3.6 Older people's own definitions of wellbeing

There are convincing arguments for including the views of older people themselves in developing a model for wellbeing in older age. Doing so recognises the socially constructed nature of the concept, and the fact that it changes over time as broader social norms change (King, 2007).

The interpretation of wellbeing also shifts over a person's life course, as discussed above, and therefore including the views of someone in the later stages of life can offer useful insights (King, 2007).

Drawing from socially relevant concepts of wellbeing in older age helps to ensure that the concepts, policies and interventions that are developed are also applicable. Including lay-people also helps to mitigate against possibility that academics and policy makers impose interpretations of what it means to be ageing successfully that are not meaningful to older people themselves, or that stigmatise them (Bowling, 2009). Surprisingly little research has

actually focussed on how wellbeing and quality of life is perceived and experienced by elderly people themselves (Hambleton, Keeling, & McKenzie, 2008). Research suggests that when older adults define wellbeing for themselves, they have a multi-dimensional understanding of what it means to age successfully (Bowling & Dieppe, 2005; Hambleton et al., 2008).

A qualitative study undertaken in 2008 on how older New Zealanders who were receiving low-levels of home support perceived their quality of life found that 'quality of life' is a dynamic concept and the following interlinked dimensions were important aspects of it according to the participants: 'having good people in your life, being able to take care of the day-to-day things, keeping healthy, living with a sense of loss, and contemplating the future' (Hambleton et al, 2008:156). The presence of the components identified as part of a good quality of life help to mitigate the negative impact on quality of life caused by ill health and loss.

Another example comes a study of people aged 50 and over in Britain in 2005. When asked in an open-ended question what people viewed as 'successful ageing', the most common responses, in order of frequency, were: health, psychological factors, social roles and activities, finances, social relationships and neighbourhood (Bowling & Dieppe, 2005). The neighbourhood dimension of wellbeing related to place-based amenities available to them, such as access to transport, closeness to shops and services and whether where they lived had a nice place to go for a walk. Also important was the sense of security an older person felt when walking alone in the day, as well as at night, and problems in their local area (e.g. crime, vandalism, graffiti, speed and volume of traffic, air quality).

In the following section, models of wellbeing that integrate components from a range of health, material, psychological and social dimensions of wellbeing are discussed. Some have involved consulting older people themselves in the process of identifying the key components of wellbeing.

4.0 Multidimensional Frameworks of Wellbeing in Older Age

This section focuses on multidimensional frameworks of wellbeing in older age. A landmark early example of this approach is the *Berlin Ageing Study*, a longitudinal investigation of people aged 70 and over who lived in the former West Berlin. The interdisciplinary nature of the research led to the development of a model for wellbeing which drew from medical, sociological, and psychological approaches to integrate a range of both objective and subjective measures of wellbeing (Smith et al., 1999).

The section starts by reviewing an important international policy framework which operationalises a multidimensional model of wellbeing (Active Ageing) and then turns to two examples in New Zealand (The Positive Ageing Framework and the Enhancing Wellbeing in an Ageing Society research).

4.1 Active ageing

The WHO adapted and promoted the term 'active ageing' in the late 1990s. The emphasis of this model of ageing is on the competencies of older adults and therefore represents a move away from a deficit view of older age (Boudiny, 2013). It is defined by the WHO as

The process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups. Active ageing allows people to realize their potential for physical, social, and mental wellbeing throughout the life course and to participate in society, while providing them with adequate protection, security and care when they need. (WHO, 2002)

The concept of active ageing is sometimes used in single-dimensional ways, such as in research or policy that takes an interest in older adults maintaining activity in either an employment context, or in relation to physical activities. However, the WHO uses the concept specifically to define active in ways that extend beyond economic and physical to include the ongoing participation of older adults in social, economic, cultural, spiritual and civic affairs (Boudiny, 2013). Figure 3 illustrates the multi-dimensional determinants of active ageing identified in this approach: social, economic, health and social services, behaviour, personal, physical environment determinants.

Figure 3: Determinants of active ageing



Source: WHO (2007): 5

An important strength of this multidimensional model of active ageing is that it does not depend on health and independence in older age as indicators of successful ageing. Instead, it shifts attention to the following questions: 'How can the active-ageing ideal be realised under circumstances of declining health? How can active ageing be fostered under circumstances of dependence?' (Boudiny, 2013: 1086). In asking these questions the model leaves room to recognise the multiple pathways for older adults to reach the objective of active ageing, such that even frail and dependent older people can potentially age actively. However, in ensuring that active ageing framework is truly inclusive of frailer older adults, interventions must not only focus on the 'young-old', but also consider the needs of 'older-old' and the frail by finding ways of 'fostering adaptability, supporting the maintenance of emotionally close relationships and removing structural barriers related to age or dependency' (Boudiny, 2013: 1095).

4.2 Positive ageing (New Zealand)

The *Positive Ageing Strategy* was released in 2001 by the Office for Senior Citizens, administered at the time by the Ministry for Social Development. 'Positive ageing' in this framework was understood as 'ageing in good health and being independent, connected, respected and able to enjoy life' (Office for Senior Citizens, 2014: 4).

The strategy articulates the Government's commitment to positive ageing, and provides 10 key goals and numerous suggested indicators which were intended to serve as guidance for policies and interventions for both central and local governments. These are summarised in Table 1.

Table 1: Positive Ageing Strategy goals and indicators

Domain	Goal	Indicators
Income	Secure and adequate income for older people	disposable, private, living standards, low incomes
Health	Equitable, timely, affordable and accessible health services for older people	life expectancy at 65, general health (self-report), cigarette smoking, unmet needs in primary health care, flu vaccination
Housing	Affordable and appropriate housing options for older people	quality (self-report), ownership, affordability
Transport	Affordable and accessible transport options for older people	licensed drivers, public transport use
Ageing in the community	Older people feel safe and secure and can age in the community	living at home 85+, disability allowance, criminal victimisation 60+, fear of crime 60+, trust in others
Cultural diversity	A range of culturally appropriate services allows choices for older people	Māori cultural identity: Te ao Māori 65 to 69, te reo speakers
Rural services	Older people living in rural communities are not disadvantaged when accessing services	non-big city access to services, internet access
Positive attitudes	People of all ages have positive attitudes to ageing and older people.	life satisfaction, physical activity, perceived age discrimination 18+
Employment opportunities	Elimination of ageism and the promotion of flexible work options	paid employment, average hourly earnings
Opportunities for personal growth and participation	Increasing opportunities for personal growth and community participation	voluntary work, loneliness, participation in education, community inclusion (self-report), participation in cultural and arts activities

Source: Rowe & Waldegrave, 2008:8 and Office for Senior Citizens, 2014

In 2007, the New Zealand Government produced a report entitled *Positive Ageing Indicators 2007* which examined the overall wellbeing of the older population of New Zealand (Ministry of Social Development, 2007). The report's key findings can be summarised as follows. Older New Zealanders are faring well in terms of income and standard of living, although older single women are more likely to face challenges than men. In addition, older New Zealanders are living increasingly longer and healthier lives

although there remain inequalities by ethnicity, and in particular, the gap between Māori and non-Māori life expectancy remains. The levels of cultural engagement of older Māori in particular were found to be high. In terms of housing, older New Zealanders had relatively high levels of home ownership and satisfaction with their dwellings. Furthermore, older adults are increasingly ageing at home with a degree of support delivered in place. Older New Zealanders are taking up paid employment as well as finding other ways of fostering their own personal growth and development. Older people are reporting good access to facilities and services. Interestingly, however, even when good public transit is available, a relatively low portion of older New Zealanders are using this service.

4.3 The capabilities approach (Enhancing Wellbeing in an Ageing Society)

The Enhancing Wellbeing in an Ageing Society (EWAS) study shares much in common with the multidimensional approach to defining wellbeing in older age developed by the Positive Ageing Strategy described above. EWAS was conducted between 2004 and 2009 and was the first major study of ageing in New Zealand. It was funded by the Foundation for Research, Science and Technology and was conducted by staff in the Population Studies Centre at the University of Waikato, Hamilton and the Family Centre Social Policy Research Unit in Wellington. It is worth examining because of the conceptual work involved developing a concept of wellbeing that can be operationalised for older adults in New Zealand. It is also particularly relevant for the purposes of this report because of its investigation of wellbeing of older people as well as any direct and indirect determinants of wellbeing. The aim of EWAS was to provide the understanding that is essential for policy formulation and the delivery of services for enhancing wellbeing in an ageing New Zealand society (Koopman-Boyden & Waldegrave, 2009).

Wellbeing in this research included both a subjective component, that is, a measure of whether people experience a sense of satisfaction with life, and a capabilities dimension, that is a measure of the extent to which individuals were 'acquiring appropriate capabilities to achieve a good quality of life' (Waldegrave & Koopman-Boyden, 2009: 207). This approach draws from Amartya Sen's capability framework. In order to explain what is meant by 'capabilities', they are distinguished from 'functionings', as follows:

Functionings are the various things [a person] manages to do or be in leading a life (Sen, 1993, p.31). These range from the most elementary functions, such as providing for basic physical needs, to such complex functions as those associated with achieving social integration and self-respect, for example.

A person's capabilities, on the other hand, represent their capacity to combine the functions available to them in ways that enable them to achieve chosen goals and objectives in their lives (King, 2007; King & Waldegrave, 2009).'

(cited in King, 2014: 5)

The concept of agency is central to this study. King (2007), drawing from Sen, defines agency as ‘the ability of the individual to act and interact with their environment, to experience independence and interdependence, and to possess capability in all the dimensions of their lives’ (in Rowe & Waldegrave, 2008: 2). As a result, this research operated with the following working definition of wellbeing: ‘the satisfaction of an individual’s goals and needs through the actualisation of their abilities and lifestyle’ (Koopman-Boydan, 2007 in Rowe & Waldegrave, 2008: 6). This way of framing wellbeing is grounded in the international literature and also supported by stakeholder groups who were involved in its definition in the early stages of the research (Waldegrave & Koopman-Boydan, 2009). The stakeholder consultation process helped identify five dimensions or conceptual attributes as critical factors influencing the quality of life of older people – attachment, security, role, enjoyment and control (King, 2014: 5).

In addition to health, the determinants of wellbeing considered in their model include the following: ‘connectedness (intra- and extra-familial), income and wealth, participation in paid and unpaid work, access to market and government goods and services, satisfaction with one’s life and circumstances’ (Rowe & Waldegrave, 2008: 2).

The research built on the 10 domains developed in the NZ General Social Survey (NZGSS), New Zealand’s official survey of wellbeing (Rowe & Waldegrave, 2007). This survey defines wellbeing as ‘those aspects of life that society collectively agrees are important for a person’s happiness, quality of life and welfare’ (Ministry for Social Development, 2006: 8). It in turn drew from research conducted by the Royal Commission on Social Policy in 1988 on what New Zealanders consider important to their wellbeing:

[New Zealanders] have said that they need a sound base of material support including housing, health, education and worthwhile work. A good society is one which allows people to be heard, to have a say in their future, and choices in life ... [they] value an atmosphere of community responsibility and an environment of security. For them, social wellbeing includes that sense of belonging that affirms their dignity and identity and allows them to function in their everyday roles. (Ministry of Social Development, 2006)

The NZGSS monitors the following areas of wellbeing: health, knowledge and skills, paid work, economic standard of living, civil and political rights, cultural identity, leisure and recreation, physical environment, safety and social connectedness. While some components of wellbeing may be shared across the general population, there may be variation in the components for different population subgroups within New Zealand.

5.0 Wellbeing in Diverse Cultural Contexts

The experience of wellbeing is achieved and given meaning through a socio-cultural frame (King, 2007). General measures of wellbeing, such as health, fail to capture aspects of wellbeing that are salient for specific groups (Kukutai, 2006). The research reviewed in this section shows that there are culturally influenced ways of understanding older age.

For many cultures in New Zealand there is an ideal view of the position of older adults in society. The ideal bestows a high degree of social status to those in older age and also often assigns the main responsibility for caregiving for elders to family. It is important to note however, there is always the potential for a gap to exist between the ideal of the position of older adults and the actual practice. For example, the ideal of the position of older adults often in minority communities as 'elder' sometimes conflicts with the actual practice of depending on family members and extended family for support and care. This is because ideals are subject to change, as cultural understandings of the various roles in a family change over time and in different circumstances. It can also be an ideal more than a reality because it is not achieved by families who may be struggling to make ends meet and to juggle a range of responsibilities, including the care of older family members (Li, 2013).

In New Zealand, as elsewhere, individuals have complex identities and often identify with more than one ethnic or cultural group as a result of mixed-family heritage, migration and personal biographical experience. In recognising the significance of culturally informed concepts of ageing, it is also important not to have essentialist or static understanding of ethnic groups or assume that there are fixed boundaries between groups.

5.1 Māori perspectives

When developing measures and policy interventions to promote wellbeing of an ageing population in Auckland it is important to consider the contributions and needs of older Māori.³

Māori older adults have lower life expectancy, and relatively poor outcomes regarding general health, housing, tenure, paid employment and educational qualifications in comparison to the rest of New Zealanders (Ministry of Social Development, 2007; Waldegrave, 2009; Waldegrave, King, & Rowe, 2012). Many older Māori face compounded disadvantage from multiple sources. However, the existing data also reveals strength found within older Māori and their communities. For example, an increasing number of Māori are living longer lives (Dyall et al., 2014). Older Māori are recognised as

³ Auckland Council has made a commitment in its strategic planning documents to lift the overall wellbeing of Māori. The Independent Māori Statutory Board (IMSB) has been formed to ensure that the views of Māori are taken into account in decision making. The IMSB has created the Māori Plan for Tāmaki Makaurau which addresses the cultural, social, economic and environmental wellbeing of Mana Whenua (Māori with tribal affiliations within the Auckland region) and mataawaka (Māori with tribal affiliations outside the Auckland region).

being experienced, knowledgeable and wise (Dyall et al., 2014). Many have lived through systemic discrimination over the course of their lives. Those who are 80 and above have lived through policies that have marginalised their communities, such as those which sanctioned the use of te reo Māori in school and interventions with imposed assimilation in the dominant Pākehā culture (Dyall et al., 2014). In spite of the multiple sources of oppression and disadvantage faced by many older Māori, their subjective self-assessments of how satisfied they were with their lives *as a whole* was found in the EWAS study to be similar to that of non-Māori groups (Waldegrave, 2009; Waldegrave et al., 2012). Māori older people were found to be as involved as non-Māori in the full range of leisure and service organisations that was explored in the EWAS study (Waldegrave, 2009). There was an even greater percentage of Māori than non-Māori involved in events associated with sport, Māori cultural activities, political parties and social events with barbecues or hangi.

It should be noted, however, that while overall satisfaction with life and involvement in leisure activities was similar between Māori and non-Māori, a significant difference was found in terms of the subjective reporting of income meeting everyday needs for such things as accommodation, food, clothing and other necessities. This will be discussed further below in relation to barriers to achieving wellbeing.

5.1.1 Understanding ageing in Māori society

Addressing the wellbeing of older Māori requires a recognition of the specific cultural meanings attributed to elder age and wellbeing of this group. The term *kaumātua* is defined as ‘one who holds knowledge of tikanga and reo Māori and is recognised by hapū, iwi or organisation’⁴. The term is often used to refer to the wise and experienced older members of the *whānau*, although it should be acknowledge that not all Māori older people identify as *kaumātua* (Ministry of Health, 2002). *Kuia* is the term used more generally for elder women and *koroua* is the term for elder men. In the ideal view of Māori society, ageing is part of a positive life course transition that increases a person’s standing in a community (Kukutai, 2006). ‘To be older is to be an elder or *kaumātua* with the necessary experience, wisdom or cultural knowledge to fulfil well defined roles and responsibilities’ (Kukutai, 2006: 2).

In this model, *whānau* (family/kin group members) are receivers and providers of support, exhibiting values of interdependence, reciprocity and the importance of family. *Kaumātua* have important functional and symbolic roles in relation to the transmission of *tikanga* (customary lore, practice and protocols), *kaupapa Māori* (a philosophical doctrine incorporating the knowledge, skills and values of Māori), and *whakapapa* (genealogy that links Māori to their Māori ancestors) (Dyall et al., 2014; Kukutai, 2006; Love, Moeahu, & Love-Shariff, 2007). With age, then, comes an increased role and set of responsibilities vis-à-vis the wider community. In fact, some elder Māori are the *pou*, ‘that is, the main

⁴ This definition as well as others in this section are drawn from Auckland Council’s Māori glossary.

support of their whānau and hapū' (Dyall et al., 2014: 64). Kukutai (2006) notes that the role of Kaumātua can be demanding in terms of time and personal resources to actively participate in community events such as tangihanga (funeral) and hui (gatherings). As such, Māori organisations could enhance wellbeing of older members by offering remuneration in the form of a stipend or non-cash benefits such as rent subsidies or petrol vouchers.

The Māori view of ageing is in sharp contrast to a 'deficit' view of ageing as deterioration, dependency and vulnerability (Kukutai, 2006). As Kukutai (2006) makes clear, this is an idealised version, or cultural archetype, but may not reflect the typical experience of older Māori and their families. Many older Māori may lack cultural expertise and ties to Māori communities. Furthermore, older Māori tend to occupy residential homes at the same levels of Pākehā (Richmond et al, 1995 in Kukutai, 2006). As a result, Kukutai suggests: 'The potential disjuncture between the model and modal older Māori therefore needs to be borne in mind when designing policy approaches that seek to enhance the wellbeing of Māori individuals and groups' (Kukutai, 2006: 3).

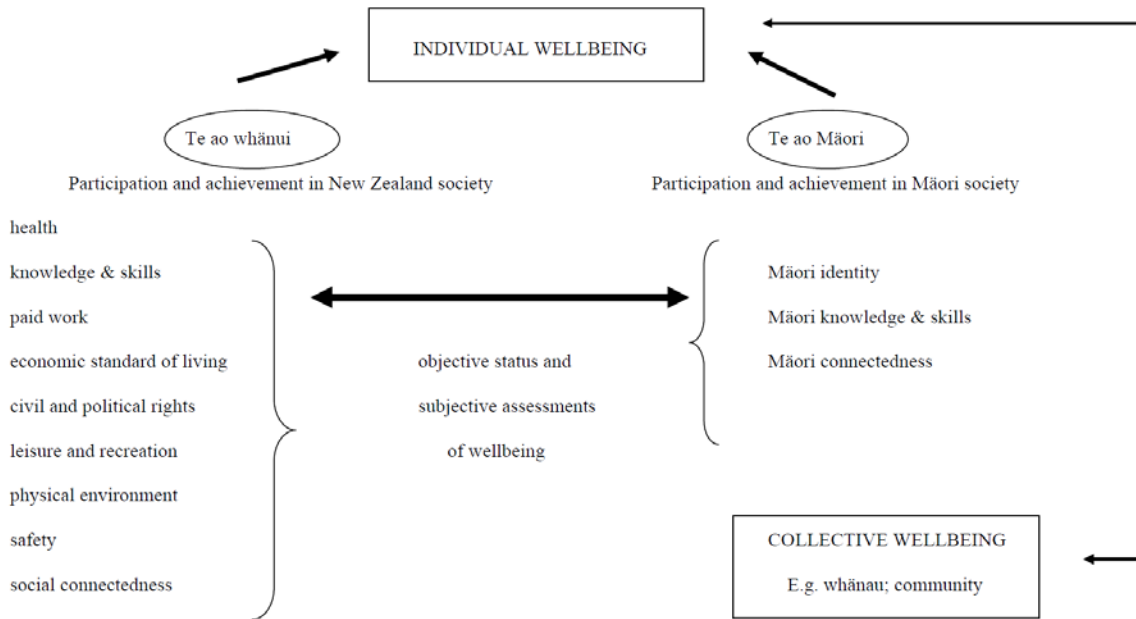
5.1.2 Māori concepts of wellbeing in older age

Māori concepts of wellbeing share with other multidimensional models of wellbeing a recognition of the importance of a range of components such as physical, mental and social health, access to healthcare and adequate housing and other resources. Māori perspectives differ in the emphasis they place on the following dimensions (Love et al., 2007: 14):

- wairua (spirituality);
- whānaungatanga (family, sub-tribal, tribal and social, sense of family connection);
- mana (authority, status and prestige); and
- whakapapa (genealogy, extended family and community relationships, past, present and future, genealogy that links Māori to their Māori ancestors (Dyall et al., 2014).

Kukutai (2006) developed a multidimensional conceptual framework for the wellbeing of older Māori (see Figure 4 below). Individual wellbeing is the focal point in the model, but it is shown as connected to collective wellbeing. The model also illustrates the interdependent nature of wellbeing for Māori in both New Zealand and Māori society with a two-way arrow. She explains that none of the outcomes are positioned as more important than others, but instead the model allows for exploring the relationship between any of the variables. In this model, Māori cultural identity is broken into identity (self-naming, tribal affiliation), knowledge and skills (knowledge of and ability to speak te reo, familiarity with marae protocols) and connectedness (participation in whānau networks).

Figure 4: Conceptual framework for the wellbeing of older Māori



Source: Kukutai, 2006: 9

5.1.3 Māori indicators of wellbeing in older age

Building on Pere's 'Te Wheke' model (1991), Love et al (2007: 14-15) suggest the following indicators of wellbeing for Māori throughout the lifespan:

Wairua	Acknowledgement and affirmation of the ongoing place and primacy of wairua in all endeavours. Participation in activities and events that affirm and uplift wairua.
Mana	Affirmation of mana whenua (territorial rights), mana tangata (power and status accrued through one's leadership talents, human rights, mana of people) and mana atua (sacred spiritual power from the atua, ancestors). Activities that enhance the mana of whānau, hapū, iwi and community. For example, the provision of manaakitanga (hospitality), leadership roles in the rohe (boundaries), protection and growing of resources, active participation in facets of life that affirm wellbeing including health, education, cultural preservation and vitality
Whānaungatanga	Acknowledgement of the vital role of kaumātua in whānau, hapū and iwi affairs, and involvement of kaumātua in intergenerational endeavours. Activities that promote and affirm whānau, hapū and iwi connections, shared history, continuity and future visions.
Mauri	Affirmation of the vital life force and essence of kaumātua, and their role in nurturing this essence in the environment and for future generations. Leadership roles and/or participation in settling the mauri for people, places and things (e.g. hui, blessings, whakatuwheratanga (opening ceremony), tangihanga (funeral, rites for the dead).
Whatumanawa	Acknowledgement and affirmation of the emotional aspects of life and death, creation and continuity. Activities that engage and involve a range of emotions (e.g. happiness, suspense, excitement, joy, sorrow, anger).
Hinengaro	Acknowledgement and affirmation of the intellectual contributions, understandings and wisdom of kaumātua, both past and present. The involvement and leadership in decision-making, directing and direction setting.
Ha a Koro ma a Kui ma/Taonga tuku iho	Acknowledgement and affirmation of the value of ngā taonga tuku iho (e.g. cultural heritage and traditions, land, tikanga, kawa (house opening ceremony). Activities that protect, build and pass on for future generations the heritage provided by tupuna.
Tinana	Acknowledgement, acceptance of and allowance for the physical frailties that can come with increasing age. Having needs met and where possible playing an active role in providing for physical wellbeing, including health, housing, and endeavours that sustain the body and ongoing nourishment and survival of whānau.

Māori perspectives on wellbeing have a strong collective component, and possible collective wellbeing for Māori is outlined below:

The vibrancy of Māori communities might be approximated by the number of organisations they comprise (e.g. active marae, sports clubs, Māori committees), their level of functionality, and the quality of relations between them. Using parent-child dyads, whānau wellbeing may be captured through indicators of the quality of relationships (e.g. how older Māori are cared for), concrete expressions of solidarity (e.g. the presence of a whānau trust); and subjective assessments of whānau wellbeing and support (Durie et al (2003) in Kukutai, 2006:8).

In the case of Māori older adults, strong cultural identity and cultural competence (knowledge and skills, cultural connectedness, language skills etc) are identified as resources that benefit individual and collective wellbeing (Kukutai, 2006). Gee et al 2003 found that satisfaction with te reo was positively associated with life satisfaction (in Kukutai, 2006). However, being culturally secure is also associated with being materially disadvantaged.

5.1.4 Barriers faced in achieving wellbeing

Many older Māori face economic and health disparities in comparison with the rest of New Zealanders. Māori generally have less equity than older non-Māori, and Pākehā in particular as a result of their disproportionate struggles with disrupted work histories and lower paying jobs, as well as whānau obligations (Kukutai, 2006; Waldegrave, 2009). The current and future cohorts of elder Māori will have been affected by the restructuring of the late 80s and early 90s, in which Māori communities were disproportionately negatively affected (Kukutai, 2006). Many of those who became 'discouraged workers' at this point in time will have limited financial resources in comparison with other groups in their older age (Kukutai, 2006). Most older Māori were found by Durie et al. (1996 in Waldegrave 2009) to rely heavily on New Zealand Superannuation for survival. Financial hardship is especially high for older Māori women.

There is evidence that Māori older people with high levels of health care need are the least likely in New Zealand to receive it (Hirini et al, 1999 in Kukutai, 2006). Possible reasons for this include low levels of trust with mainstream health providers, particularly among older Māori whose experience with the health system may have predated attempts to improve its ability to be culturally responsive. In addition, there may be issues of unfamiliarity with the rules and bureaucracy of the system.

5.2 Pacific perspectives

Very little research exists on the perspectives and experience of ageing Pacific communities in the New Zealand context. This section relies heavily on one of the few studies available, namely 'Pacific perspectives on ageing in New Zealand' (Tamasese et al, 2014). This was qualitative research prepared for the New Zealand Longitudinal Study of Ageing (NZLSA). Ten focus groups were held to gather the views of Pacific elders over 60 in Wellington who identified as either Tokelauan, Niuean, Tongan, Cook Island and Samoan. The study documents the issues that affect the lives of an important generation of Pacific elders in the community. Those that participated in the study make up the first generation of Pacific migration to the country and have faced the hardships of establishing themselves and their families. It is this cohort which also played a key role in establishing key Pacific community and service institutions such as churches, language training, and radio stations in New Zealand.

5.2.1 Ageing in Pacific communities

Tamasese et al. (2014) find that being an elder in Pacific communities is understood as being at the prime of one's life. Terminology for elder age varied across the ethnic groups involved in the study, although Tamasese et al (2014) use 'elder' and 'eldership' to recognise the respect and recognition afforded to this age group across all Pacific communities. While dominant mainstream views in New Zealand tend to emphasise the present and see time as unfolding in a linear, chronological manner, Pacific views on time are 'relational and cyclical' (60). From the Pacific perspective, the present cannot be disconnected from the past, with the important result that 'the aged are not part of the past that has become unproductive, rather, they are part of the continuity into the future and because they are an earlier generation they are accorded a special place of prior knowledge' (60).

Pacific peoples recognise different stages of eldership, all of which are accorded equal levels of respect, from the stage in which the elder is physically active, to the *Matua tausi* stage at which they are less physically active and more vulnerable. The concept of 'retirement' did not resonate with those who participated in the study and who wished to be recognised as still living full lives and contributing to their communities. Samoan women, in particular, expressed concerns that categorising them as 'aged' or 'elderly' did not take into account their ongoing and meaningful contributions to their families, churches and communities.

In addition, the research finds that spirituality plays a unique and vital constituting role in the concept of self with all its relationships, and because of its fundamental role, spirituality cannot be distinguished from age and ageing in Pacific communities. As the authors explain, 'spirituality is the base from which values such as sacredness, reverence, and respect emanate. These are the values that safeguard and protect elders, eldership and the ageing process' (Tamasese et al., 2014:59).

5.2.2 Pacific concepts of wellbeing in older age

Wellness for Pacific elders is described as 'a state of relational harmony where the personal elements of spiritual, mental and physical are in balance' (67). As discussed above, spirituality is seen as 'the overall constituent underpinning of the self in relationship, age, wellbeing, the aged, ageing and even in death' (58-9) in Pacific communities.

Pacific concepts of wellbeing placed a high degree of emphasis on the collective rather than the individual. The concept of self in Pacific perspective 'derives its meaning, wholeness and sacredness from its place of belonging, its family, genealogy, language, culture and the environment' (Tamasese, Parsons, & Waldegrave, 2014: 59). In the ideal model of ageing for Pacific people, the family and community is able to care for their older members. This expectation shifts the focus of wellbeing in eldership away from individual's independence and autonomy towards the interdependence of elders and their wider families and communities. This model of wellbeing encapsulates both the capabilities of

the collective to support and care for the elder as well as the elder's capacity to contribute their maturity and wisdom to the benefit of their families and wider communities. Pacific elders are expected to take on a leadership role in resolving tensions and conflicts and promote harmonious relations in family networks as well as in church, village and community groups. Leadership and guidance extends to matters relating to land, genealogies and the sea. In addition, they 'are called upon to guide and give comfort at times of crisis, for example to those who mourn' (Tamasese et al., 2014: 62). They are also associated with the transmission of heritage and the survival of their cultures into the future - a role which is increasingly challenging in light of the effects of colonisation, migration, urbanisation and globalisation. The ability to fulfil their role and responsibilities as an elder can contribute to their sense of self-worth. When unable to function as an elder, self-worth can be severely undermined: 'As such, their relational harmony is at risk and they live with continual worry and stress. The dual forces of economic constraint and consequential lowering of social status destabilises elders' physical and mental health and wellbeing' (Tamasese et al., 2014: 65).

5.2.3 Barriers faced in achieving wellbeing

Tamasese et al (2014) express an urgent need to address broader social and economic constraints faced by Pacific communities when addressing the specific needs and interests of elders (see also Waldegrave et al., 2012). Their study found that the following issues pose challenges and constraints to Pacific elders being able to fulfil their role, and thus compromising their physical and psychological wellbeing:

- marginalisation of Pacific norms around ageing and wellbeing
- access to adequate income and appropriate employment
- lack of appropriate and affordable housing places
- elders ideally need to live in close proximity to their families
- access to appropriate spaces for elders to gather regularly
- barriers to access to good quality and familiar food such as taro, banana and fish
- access to adequate and appropriate health care due to income constraints which meant they faced long surgical waiting lists and were impeded by the costs of medication. In addition, language and cultural barriers and dominant cultural assumptions and practices limited the way that Pacific elders were able to access health support.
- access to services in appropriate languages and by service-providers who recognise the social status of elders and act with due respect
- access to affordable energy for heating in the winter months
- accessing culturally appropriate clothing deemed appropriate for their age group was sometimes noted as a challenge, as was the constraint of the cool months on wearing lava-lava worn by Pacific men

- access to training to be better able to take advantage of communication technologies to maintain their connectivity across New Zealand and with their homeland. This is particularly important in order to fulfil their role as elders.

Focus groups carried out in Glen Innes, Auckland and Tokoroa, Waikato as part of the Resilient Ageing in Place Research of the University of Auckland established a number of recommendations, primarily relating to the need for culturally appropriate services and support (Wiles, 2011: 7-8). In that study, older Samoans recommended the following:

- A rest home for Samoan and Pacific elderly people be established
- Samoan and Pacific people are employed to provide care and treatment, and cultural advice in rest homes
- Training is provided for mature children in providing care for their elderly parents
- Family members designated by the family with the care of their elderly are paid
- Approach the local council to urgently provide safe crossing on the main road
- Subsidise scooters and wheelchairs for elders
- Make scooters and wheelchairs available in supermarkets
- Provision within immigration policy to allow children living in Samoa to come to New Zealand to care for elderly parents
- School activities for senior students include programmed visits to rest homes (need for young people to connect with elders in their area)

Older Cook Island people living in Glen Innes/Ukutoia provided the following suggestions:

- Older people need more information about Housing New Zealand (HNZ) processes for dealing with repairs and maintenance, as well as more information about entitlements to support from Work and Income New Zealand (WINZ) and home care services
- The timeliness of the Housing New Zealand (HNZ) maintenance service needs to be addressed
- There is a need for more HNZ accommodation that suits the needs of older people
- Older Cook Islanders need an advocate at WINZ who can speak their language.

5.3 Asian perspectives

At the 2013 Census, 12.2 per cent of older Aucklanders aged 65 and over identified with an ethnicity within the broader 'Asian' category. Within this group, just over half (54.3%) identified as Chinese (10,281 people), and 30.4 per cent identified as Indian (5,763 people) (Auckland Council, 2015). These are the two major groupings within Asian classification and multiple other ethnic groupings will be represented among older Asians.

Very little research is available on the perspectives and experiences of ageing within the heterogeneous communities that fall under the broad category of 'Asian'. This section focuses on a research study that concentrates on the largest ethnic group within New Zealand's older Asian population: those that identify as 'Chinese' (Li & Chong, 2012).

5.3.1 Chinese perspectives on ageing in New Zealand

Chinese communities have been present in New Zealand for over a century, although the numbers of migrants from China accelerated in the 1990s with changes to immigration policy. This means that most older Chinese Aucklanders have likely migrated in relatively recent waves of migrations. In 2006, half of the older Chinese people in New Zealand had been in the country for less than 10 years, compared to 12 per cent of all other older people in New Zealand (Li & Chong, 2012). However, a portion of older Aucklanders identifying as Chinese were likely either born in New Zealand, or have lived in the country for longer periods of time. These groups may have endured the discrimination of restricted migration and citizenship rules as well as the waxing and waning of anti-Asian prejudice faced historically by Chinese migrants to New Zealand (Li, 2013).

Research on the experience of Chinese ageing in New Zealand has highlighted the need to recognise that the place of older people in Chinese society is changing, both in China and amongst migrant communities, in response to broader social and economic changes. The changes that transform cultural perspectives on ageing and the place of older people in families include the decrease in family size, the prevalence of women working in paid work, and the effects of the experience of migration and living in different contexts with varying forms of social welfare regimes. Li (2013) carried out qualitative research with 32 older people (aged 65 and over) who immigrated to New Zealand from China under the family reunion programme and who were staying in New Zealand with permanent residency or New Zealand citizenship. Her findings reveal the way in which filial piety, considered an important distinguishing feature of Chinese families in relation to other cultural groups, has evolved and transformed in Chinese migrant communities in New Zealand.

Filial piety refers to the centrality of the relationship between the parent and the child in social structures (Li, 2013). Stemming from this, Chinese culture tends to regard older age as a positive life stage, rather than a negative one, associated with wisdom, contributions to society and a point in life in which respect and care is deserved (Li, 2013). Adult children, in this model, are expected to live with, and care for, their parents. While this is an ideal, Li (2013) finds that these expectations are constantly evolving over time and in different contexts. She makes the following argument for the New Zealand context: 'The notions of reciprocal support and community piety indicate that filial piety is no longer a concept that is merely focused on the aged care children provide to their parents. Instead filial piety also includes ageing parents and their children offering support and assistance to one another as well as what the community provides in terms of aged care for elders (Li, 2013:45).' Li summarises the key findings from this research as follows:

Briefly, participants' living arrangements can be said to have evolved as families adapt to social and cultural changes when living in New Zealand. Filial piety at a distance is regarded as a new form for children to demonstrate filial piety. Regarding support from children to parents, greater emphasis was placed on love and affection than financial and practical support. Respecting parents was viewed as essential by the parents who emphasised mutual parent-child respect. Children's achievements were considered by the participants as an important component of filial piety. Ancestral worship was symbolic of participants' cultural heritage, connecting one generation to the next generation. The cultural belief of "falling leaves returning to their roots" served as a symbol connecting the participants not only to China but also to New Zealand. Parental support to the children was shown to be more about the collective responsibility of the family than gender oriented practices. (Li, 2013: 193)

Li's research, as well as that of others, has found shifting preferences amongst older Chinese adults in relation to whether they seek to live independently of their adult children or not. Reasons that some expressed for preferring to live apart included a desire for freedom, autonomy and independence (Ho, Lewin, & Muntz, 2009; Li, 2013). Li's research also shows how the tensions of reforming multigenerational households as older Chinese migrants move to join their children in New Zealand can be overcome successfully and are a source of personal growth and development for older adults. Li also finds a high tendency amongst the Chinese older adults in her study to rely on spouses (as opposed to children) for personal support, with children identified as secondary sources of assistance. Emotional support and care were viewed as very important, above financial support amongst the families she researched. This was in part a response to the New Zealand financial support systems in place for older adults which meant that financial support from children was less crucial.

As part of the Enhancing Wellbeing in an Ageing Society research program, a survey was conducted to investigate the experiences of ageing in New Zealand among older Chinese adults who have migrated to New Zealand since 1986 (Ho et al., 2009). This finding supports those of Li (2013) in relation to the changing nature of filial piety in Chinese families. A growing preference for independent living amongst older Chinese was found in the survey results, as was a deep desire not to burden their families. Issues relating to housing quality, including heating issues and problems with dampness emerged as challenges, as did transport and financial barriers which made it difficult for older people to take part in community activities.

Research has also been carried out with Chinese older adults to explore their experiences of their neighbourhoods and their overall sense of community in New Zealand. This research finds that the sense of community for this group involves both a local and transnational component (Li & Chong, 2012). In other words, Chinese older adults valued the sense of community they felt with the residents in their local neighbourhoods as well as the local and transnational communities with which they identify which extend from New Zealand back to China (Li, 2013: 197). Visits to China, as well as the use of the internet

through programs such as Skype as well as watching satellite television programs help older Chinese residents maintain their transnational social ties and sense of belonging (Li et al., 2014). It was also found that language barriers, while not irrelevant, do not necessarily prevent older Chinese migrants from developing a sense of belonging and community in their New Zealand neighbourhoods. This is because, 'many established good relationships and emotional bonds with their neighbours through their engaging in helping practices' (Li, Hodgetts, & Sonn, 2014).

In addition, Li and Chong (2012) discuss the phenomenon in which some Chinese migrants return to China for health care provision. The health care they sought in China includes health checks, dental services, cancer treatments, acupuncture and traditional Chinese medicine. The reasons that the participants sought health checks and treatments from China include push factors, such as language barriers, and their unfamiliarity with the New Zealand health system; as well as pull factors, including their continuing eligibility to access health insurance schemes in China (Li and Chong, 2012).

5.3.2 Barriers faced in achieving wellbeing

Research identifying what Chinese migrants see as important issues to address in achieving wellbeing in older age in New Zealand finds the following:

- **Health and service provision:**
 - service providers should devote more efforts to understanding the evolution of cultural values and practices among ethnic communities, so that aged care services can be rendered more acceptable and accessible to older Chinese (and other ethnic) migrants (Li and Chong, 2012, Li, 2013).
 - Providing information about aged care services to family members will also help increase the flow of information to older Chinese migrants. In addition, family members will become informed about the services that are available to their parents and grandparents and this will help ease the pressure that arises when older family members require care (Ho et al., 2007).
 - The need to 'support and empower ethnic communities to develop programmes for assisting older ethnic migrants to positively age in place, strengthening participation in aged care and achieving better aged care outcomes' (Li, 2013: 242).
 - Housing and aged care provision in the Chinese language will enhance older Chinese migrants' understanding of the social services available to them (Li, 2013, Wiles et al., 2011).
 - Delivering face-to-face seminars with interpreters will increase older Chinese migrants' knowledge and awareness of aged care related services (Li, 2013, Wiles et al., 2011).
 - Access to a Chinese-speaking doctor in their local area (Wiles, 2011).
 - While some older Chinese residents were found to return to China for health care, this is not possible for others, and furthermore, even those that

currently do seek health care outside of New Zealand may not be able to do so as they get older.

- **Social connectedness:**
 - The recognition that older migrant Chinese may value a sense of community and social ties that include but also extend beyond their local setting (Li, 2013, Li & Chong, 2012, Li et al., 2014).

- **Affordable and stable housing:**
 - Housing ownership rates are lower amongst this group than other groups in New Zealand (Ho et al., 2009).
 - Many older Chinese migrants experience difficulty in gaining access to public housing (Li, 2013).
 - Older Chinese focus group participants in the Resilient Ageing in Place Study suggested that Housing New Zealand (HNZ) create areas of housing specifically for older people, so that they can socialise and help each other out more easily. They also requested that HNZ housing for older people has smaller easy-care sections.
 - They also recommended older Chinese people work together to set up a scheme to share domestic support staff so that they can stay in their homes longer (Wiles, 2011).

- **Safe neighbourhoods**
 - Incidents of discrimination and targeted crime experienced by older Chinese residents in their neighbourhoods emerged in the research as a stress factor. However, when these challenges were overcome through collective action, the resulting improvements in sense of community resulted in benefits to older Chinese residents. (Li and Chong, 2012).

6.0 Key Determinants and Indicators of Wellbeing in Older Age

The following is a list of determinants of wellbeing in older adults that emerges from this review of the available policy and academic literature. It includes relevant determinants from studies using various conceptions of wellbeing and some examples of potential indicators. It should be noted that there is often interrelation between the determinants of wellbeing included in this list. For example, socioeconomic status has an impact on a range of the other determinants, notably health and access to social support, and good quality housing.

6.1 Health

Good physical and mental health and the absence of disability is used in some cases as a determinant and, in other cases, as a component, or an outcome, of wellbeing in older age. Health is an important predictor of subjective wellbeing for all ages, but the effects of health are heightened in older age (George, 2010). However, the research does not clarify whether it is objective or subjective good health that predicts subjective wellbeing in older adults, partly because most studies rely on self-reported accounts of health (George, 2010).

The EWAS study in New Zealand confirms the positive association between good health and subjective wellbeing found elsewhere (Waldegrave & Koopman-Boyden, 2009). In addition, the study finds that health indicators fully explain the negative effects of age on psychosocial resources and on mental health. However, the research finds that the significance of objective health for subjective wellbeing decreases significantly with age. This is considered to support the hypothesis that in older age there are 'multiple intra-individual mechanisms working to maintain positive self-appraisal despite objective decline' (Rowe & Waldegrave, 2008: 28). Furthermore, *expectations* of access to adequate health and residential care is also associated with positive wellbeing in New Zealand (Waldegrave & Koopman-Boyden, 2009).

6.2 Income and living standards

Lower living standards are related to poorer mental and physical health outcomes across the lifespan, and is thus a relevant determinant of wellbeing for older adults (Breheny et al., 2013; Noone, Stephens, & Alpass, 2014). It is not only the case that those with less means are negatively affected, but research suggests that better health and lower mortality rates continue to increase with socioeconomic position, such that those who are comfortable have less positive outcomes than those who are wealthier (Breheny et al., 2013). Lower socioeconomic status among older people is also associated with less access to social supports (Breheny et al., 2013; Noone & Stephens, 2014).

A systematic narrative review of studies published between 1995 and 2013 on socio-economic inequalities on the outcome measures of self-rated health, quality of life and life satisfaction of older Europeans finds a strong evidence base for the association between socioeconomic position and subjective health and wellbeing of older people (Read et al., 2015). In other words, lower socioeconomic position was associated with poorer subjective health and wellbeing among older Europeans. The socioeconomic inequalities were more evident as determinants of self-rated health than in quality of life and life satisfaction measures. Importantly, Read et al (2015) find a consistent association between area deprivation and subjective health and wellbeing. They also find evidence that some of the inequalities in subjective wellbeing outcomes can be mediated by health-related behaviour and social support. The associations they found weakened amongst the oldest age groups.

6.2.1 Measuring living standards/ socioeconomic status

There are a range of possible indicators of socioeconomic status and living standards in the literature on older people. For Read et al.'s (2015) review discussed above, studies included used current indicators of material position of older people such as income, wealth, housing tenure as well as the degree of area deprivation of where they lived. They also included studies which used indicators of socioeconomic position from an earlier point in older adult's life course such as education and past occupation. In fact, trying to assess living standards for people after retirement is contentious. The challenges in pinning down an indication of a person's standard of living in older age are multi-fold (Breheny et al., 2013). Occupation is not always a good indicator of socioeconomic status for older people as many have retired and furthermore, many older women never had paid employment (Lotoala, Breheny, Alpass, & Henricksen, 2014). There is also a 'survival effect' in which those with less means are less able to survive into very old age (Breheny et al., 2013). As with any group, but perhaps heightened for older adults, there can be reluctance to report deprivation (Breheny et al., 2013).

There are also different ways of measuring living standards depending on the theoretical framework employed by a study. Through a capabilities approach lens, living standards can be interpreted on a range from causing hardship to enabling freedom (Breheny et al., 2013). Breheny et al advocate a measure of living standards which captures 'lack of autonomy around consumption and social participation' (1037). Another way to interpret socioeconomic status attempts to capture the resource as well as prestige and social location based aspect of social class position (Noone et al., 2014).

6.2.2 Socioeconomic status and ageing in the New Zealand context

Consistent with international findings, socioeconomic status is found to be a determining factor in health outcomes in New Zealand and helps to explain in large part the different mortality rates of ethnic groups in the country (Lotoala et al., 2014). In addition, indicators of living standards are found to be associated with higher reported subjective wellbeing in

older adults. The EWAS study in New Zealand finds a higher personal income to be linked with higher levels of subjective wellbeing (Waldegrave & Koopman-Boyden, 2009). Relatedly, having access to essential items and services is also positively associated with subjective wellbeing (Waldegrave & Koopman-Boyden, 2009).

6.3 Gender

Gender has a significant effect on levels of wellbeing, both objective and subjective. Women tend to live longer than men, but also are more likely to be widowed and to live relatively more years of life with illness or disabilities in comparison (Pinquart & Sørensen, 2001). Women are more likely than men to face material deprivation due to their subordinate status in society and the associated inequalities in their labour market earnings which in turn reduce their pension incomes (Pinquart & Sørensen, 2001; Rowe & Waldegrave, 2008; Waldegrave et al., 2012).

Inglehart (2002) finds that gender has an effect on the reported levels of subjective wellbeing in a manner that changes over the life course. Up to the age of 45, women report higher levels of subjective wellbeing than men, after which it is men that report the higher levels and the gap widens at older age.

6.4 Social connectedness

International research has consistently shown that the type, quality and character of personal and social relationships are important determinants of wellbeing for older people (King, 2007). As explained by Stegeman et al (2012):

Socially embedded older people who are in frequent contact with family, close friends, and neighbours tend to have better physical health than those who are less involved. Involvement in neighbourhood and community activities is in addition associated with better social support, greater physical activity and lower levels of stress. A danger in getting older and retiring however, is the loss of such social networks. (Stegeman et al., 2012: 28)

The Berlin study found that the size of an older person's social network was not related to mental health and subjective wellbeing, confirming that it is the type and quality of the relationships ultimately that make the difference (Rowe & Waldegrave, 2008). The 'strategic investments' perspective can help to explain this. It refers to the way in which as an older person ages and has less resources and abilities to maintain social networks, they reduce their social circles to those people who best help them sustain their subjective wellbeing (George, 2010).

Qualitative research carried out in New Zealand on the way older adults receiving low-levels of support care in their homes perceived their quality of life found that 'good people' was identified most frequently by participants as a key component. Participants indicated

that family, friends, neighbours and also home helpers were contributing to their quality of life (Hambleton et al., 2008). Participants identified the support they received from home helpers was valuable both in terms of practical household help, but also as people to whom they could turn for emotional and social support.

6.4.1 Marriage and living alone

In a meta-analysis of 300 studies, Pinquart and Sorenson (2001) find that older married adults have higher rates of subjective wellbeing than their unmarried counterparts (George, 2010). Leaving marriage in later years leads to an initial decrease in subjective wellbeing but it rebounds after 1-2 years (George, 2010). Marriage and kinship are also found to offer protection from mortality (Dyall et al., 2014). The EWAS study found that living with a partner or with others is positively associated with higher levels of subjective wellbeing than living alone (Waldegrave & Koopman-Boyden, 2009). Māori older women were found to be much more likely to be living alone than men in Dyall et al.'s (2014) study of the oldest Māori population. However, this research also found that for the oldest Māori, living arrangements did not relate independently to quality of life. They suggest that close social ties and collective support available in Māori communities may make living alone less difficult for this group in comparison to others, and follow up research will investigate this hypothesis (Dyall et al., 2014).

6.4.2 Intergenerational relationships

Intergenerational relationships were found to be positively related to physical health and psychological wellbeing in older people (Lowenstein & Ogg, 2003). This result somewhat contradicts the finding included in George's (2010) survey of the literature that interacting with adult children has a weak or non-existent relationship with subjective wellbeing reported by older adults (George, 2010). Family size tended towards being important to mental wellbeing for the oldest Māori (Dyall et al., 2014). The relationship was not linear, however, and modest numbers of surviving children were associated with higher levels of mental wellbeing (Dyall et al., 2014).

6.4.3 Interdependence

Higher levels of subjective wellbeing are associated with an individual's sense they have access to social support in terms of both emotional and practical assistance (George, 2010). Providing support to others is also associated with subjective wellbeing, although this is not the case in relation to providing caregiving which is associated with a decline in subjective wellbeing in older age (George, 2010). EWAS in New Zealand found that expecting family support was part of the rights and entitlements that were linked to higher reported subjective wellbeing.

For Māori and Pacific peoples there is more of a likelihood of three generations living together in one household (Kukutai, 2006; Waldegrave, 2009). For older Māori with a high level of cultural knowledge and language expertise, there may be a high degree of

potential for reciprocal exchanges with other generations (Kukutai, 2006; Waldegrave, 2009). The Oranga Kaumātua (Waldon, 2004) study has shown that in addition to cultural capital, older Māori are often providing other forms of support to younger members of their families. This study, which is biased towards older Māori who are also elders in their communities, finds that three quarters of kaumātua are providing help such as accommodation, help during illness, and language learning support, and between one third and half of kaumātua received help from their extended whānau when they required it.

For Pacific older adults, the ideal situation that emerged through Tamasese et al.'s research was a space in which elders could live with some independence 'within an interdependent familial context' (Tamasese et al., 2014: 66). Such an arrangement would contribute both to the security and safety of elders as well as ensuring they were still able to take part in their family life. It would also allow families to care for their elders without undue stress of distance, costs and time.

6.5 Leisure and recreational activities

The EWAS study confirms that in New Zealand (as elsewhere), participation in leisure and recreational activities is positively associated with subjective wellbeing, as is participation in community organisations (Waldegrave & Koopman-Boyden, 2009). More recently, it has become recognised that it is not simply a matter of the overall number of activities an older person takes part in that shapes their quality of life and wellbeing. Instead, recent thinking places the emphasis on the capacity to adapt to the challenges involved in the ageing process such that activities are substituted and redistributed appropriately to ensure continued wellbeing over the later periods of a person's life (Bowling, 2009).

6.6 Housing

There is a consensus amongst government and international organisation policies that it is ideal to create the conditions for older adults to age 'in place', that is, for them to continue living in their communities for as long as possible (Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009). Factors that can determine whether an individual can remain in their home as they age were explored in the EWAS including sources of income, assets and expenditure, access to shops and transport (Rowe & Waldegrave, 2008).

Home ownership is found to have a positive association with subjective wellbeing in the EWAS study in New Zealand (Waldegrave & Koopman-Boyden, 2009). Research has shown that older Māori are significantly less likely to own their homes and much more likely to be renting their accommodation than non-Māori (Waldegrave, 2009). Chinese older adults were also found to have lower rates of home ownership in an exploratory study of Chinese older adults wellbeing in New Zealand (Ho et al., 2009).

Residential homes were viewed as problematic by Pacific elders because they rendered elders invisible to wider society and removed them from their extended families. In focus groups conducted for this research, special Pacific Elders' villages were considered as a

way to provide security, safety, a sense of belonging and culturally and linguistically tailored activities (Tamasese et al., 2014).

6.7 Mobility and transport

Access to amenities like shops and public transport is linked with positive subjective wellbeing in research in New Zealand (Waldegrave & Koopman-Boyden, 2009).

6.8 Neighbourhood, area/locality

Living in a good neighbourhood improved the quality of life reported in the English Longitudinal Study of Ageing (Rowe and Waldegrave 2008).

Social integration discussed earlier has an environmental dimension to the extent that residential contexts can be described as places where social bonds exist amongst residents, and where residents act communally to improve their locality and where community interactions are sustained and ongoing (George, 2010).

6.9 Safety/security

The extent to which an older person is, and feels, safe is an important factor in their overall wellbeing. Safety can be an issue within a person's home, their neighbourhood, and the wider environment. A lack of security can be a barrier to full functioning and participation. Feeling unsafe due to uneven footpaths, unsafe street crossings, aggressive dogs, threatening people, etc. can prevent an older person from getting out and fully engaging in their life activities (King, 2007).

6.10 Absence of elder abuse

Age Concern defines elder abuse and neglect as a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person. (Definition adopted from WHO Toronto Declaration on the Global Prevention of Elder Abuse, 2002), and reports that elder abuse is a serious issue in New Zealand. They receive more than 2,000 referrals of elder abuse every year, with the most common types being financial, physical and psychological (Age Concern, 2015). Action on Elder Abuse identifies five types of abuse faced by older people: physical, psychological, financial and sexual abuse and/or neglect (King, 2007).

A systematic review of international research which measures the prevalence of elder abuse and neglect concluded that over 6 per cent of the older general population, a quarter of vulnerable adults and a third of family carers report being involved in significant abuse, but only a small proportion of this is officially reported to protective services (Cooper, Selwood, & Livingston, 2008). While only one in six professional carers reported committing abusive acts, over four-fifths reported observing it (Cooper et al., 2008). The research did not include forms of financial abuse.

One important lesson from their review is that it is possible to learn about it by asking vulnerable older adults and their families directly. This was also found to be the case, although to a lesser extent, on the part of professional carers (Cooper et al., 2008).

6.11 Absence of discrimination and racism

The experience of discrimination and racism is detrimental to overall wellbeing (Butt, Moriarty, Brockmann, Hoong Sin, & Fisher, 2002). Reports of discrimination were found to be independently related to lower mental health-related quality of life for the oldest Māori (Dyall et al., 2014). According to Dyall et al (2014), the degree of contact with other Māori was not found to offer any protection against discrimination and the negative effects of it on mental health. Kukutai warns that the experience of ethnic discrimination in personal interactions and in interactions with institutions might lead older Māori to have lower levels of trust (Kukutai, 2006). This can lead to an underutilisation of available supports and services and this can contribute to discrepancies in the health outcomes of Māori in comparison with Pākehā older adults. This concern is echoed in research with Pacific and Chinese communities (Li, 2013; Tamasese 2014).

The English Longitudinal Study of Ageing, a large-scale representative survey of older adults, revealed that one third of English adults over the age of 52 and 36.8% of those over 65 reported experiencing age discrimination (Rippon, Kneale, Oliveira, Demakakos, & Steptoe, 2014). The New Zealand Longitudinal Study of Ageing found that increasing levels of discrimination were associated with non-European ethnicities (Noone & Stephens, 2014).

6.12 Autonomy

The OASIS: Old Age and Autonomy: The Role of service Systems and Intergenerational Solidarity Study funded by the European Union provides empirical evidence exploring the factors which contribute to older people's autonomy, a key factor in wellbeing (Lowenstein & Ogg, 2003).

6.12.1 Formal care services

There is evidence to demonstrate that older people have a higher sense of satisfaction and autonomy when there are more choices of care available to them (Lowenstein & Ogg, 2003). The same cross-national research found that family care is *complementary*, rather than competitive, with state-provided care services (Lowenstein & Ogg, 2003):

A division of labour emerged between families and services, with less demand on the family to provide physical or constant instrumental support. It appears that families are specialising in care provision: when some needs were met (and substituted by care providers), families directed their efforts to other needs and concerns. An example of this is emotional support, where services are traditionally poor at replacing the family's role. (Rowe & Waldegrave, 2008: 18-19)

This research suggests that formal care is very important to helping older adults maintain their autonomy and enhances, rather than replaces, informal care provided by family networks. Research on older New Zealanders receiving low-levels of domestic assistance to age in place also found that the support they had with household chores enable them an independence in their daily life that was highly valued (Hambleton et al., 2008).

6.12.2 Wellbeing of caregiver

Families remain important sources of care that enhance the wellbeing for people towards the end of their lives. In relation to this, an indirect determinant of wellbeing of older adults is the wellbeing of their care providers (Rowe & Waldegrave, 2008). Women continue to be the main providers of care for older people, even when in paid employment (Lowenstein & Ogg, 2003). As a result, the OASIS researchers suggest that policies that support women in the work place and in the family are part of any interventions intended to enhance the wellbeing of older people. In addition, older people themselves are often caregivers for their partners and policies should take this into consideration.

6.13 Control

The sense of control or mastery is an important psychosocial variable which affects subjective wellbeing levels (George, 2010). George explains two working hypothesis related to this issue, both of which are substantiated in the literature:

The direct effects hypothesis posits that believing that one is in control of the outcomes in one's life (i.e., a sense of internal control) will predict higher subjective wellbeing. The mediating hypothesis is that better objective life conditions will enhance a sense of being in control, which, in turn, will increase subjective wellbeing (George, 2010: 335).

6.14 Productive activities and work

Research suggests that socially productive activities of different kinds are associated with higher wellbeing and health outcomes for older populations (Wahrendorf, Knesebeck, & Siegrist, 2006). Based on the Survey on Health, Ageing, and Retirement in Europe (SHARE), any form of occupational activities, not only professional ones, help to improve cognitive functioning as people age (Rowe & Waldgrave, 2008:51).

6.14.1 Work and retirement

Research suggests that both early retired and late employed people report high levels of wellbeing and that they key factor is that the employment status closely reflects respondents' personal choice. In other words, 'Older people's wellbeing is thus not a simple function of their employment status. It is associated with personal preference (was a person's status more chosen or enforced?) and the nature of environmental characteristics experienced in that status.' (Rowe and Waldegrave, 2008: 109). This

finding is echoed in the research in New Zealand. The EWAS study found that not having long periods of time outside of the work force during working lives is associated with subjective wellbeing in older age, as is not being forced into early retirement (Waldegrave & Koopman-Boyden, 2009).

According to the Office for Senior Citizens (2014) report, there is an increasing proportion of older New Zealanders who are continuing to work past the age of 65, yet most workplaces have not adapted accordingly. Most workplaces have not made plans for an ageing workforce and high levels of discrimination are reported.

6.14.2 Volunteering

There is evidence that volunteering promotes subjective wellbeing in the literature. For example, Greenfield and Marks (2004 in George, 2010) find that volunteering mediated the negative effects of age-related role losses on subjective wellbeing.

6.15 Education and learning

Research demonstrates that personal resources such as education contribute to wellbeing in later life (Lowenstein & Ogg, 2003). Research also reveals that the ability to learn persists across the lifespan, although is severely curtailed in cases of dementia (Rowe and Waldegrave, 2008).

6.16 Cultural security

A number of studies of ageing have documented a positive association between wellbeing and identification with, and participation in the values, practices and activities linked to an individual's cultural heritage (Waldegrave, 2009). In addition, and as discussed in Section 5 of this report, the meaning of older age and wellbeing takes on different inflections depending on ethnicity and context. It is beneficially for categories of wellbeing to be reconceptualised in order for the diversity of experience of communities to be reflected in the overall framework.

6.17 Religion

Religious practice and attitudes are found to be positively associated with quality of life indicators (Waldegrave, 2009). Furthermore, religious affiliation is found to be higher in older populations in New Zealand census data (Waldegrave, 2009). The link between religion, spirituality and wellbeing and ageing in New Zealand has not received much academic attention (Waldegrave, 2009). For example, the New Zealand Positive Ageing Strategy and the selected indicators do not include any references to spirituality and religion. Measuring religious participation is difficult due to the lack of available and reliable data and also due to the complexity of the task of defining spirituality (Waldegrave, 2009).

As a result, while recognised to be a potential factor in wellbeing in older age most international research on positive ageing do not focus a great deal, if at all, on religion.

In the Enhancing Wellbeing in an Ageing Society study, two questions were asked with regards to faith: 'the first enquired as to how much they practiced religion, attended services or otherwise participated in religious activities. The second involved a question asking how important faith was to them' (Waldegrave, 2009: 196). Māori older people were found to attach more importance to faith than non-Māori, and women did so at higher rates than men. This study did not have enough numbers of other ethnic groups to be able to make statistically robust assessments of their attachment to faith in a comparative frame, although research on Pacific perspectives on ageing discussed earlier suggest that it is likely also very important for this group. In addition, the study found a modest but significant relationship between the importance of faith to participants and their overall wellbeing, as measured by the World Values Survey indicator (Waldegrave, 2009).

6.18 Sexuality

Maintaining sexual health and sexuality in its many forms is an often neglected component in the health and wellbeing of older adults (Kessel, 2001; Lee, 2015). This is particularly the case in relation to the needs of lesbian, gay, bisexual and transgendered (LGBT) older adults who have lived through a period of time in which homosexuality was criminalised and punishable by imprisonment in New Zealand. It was not until 1973 that homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (Neville et al., 2015). LGBT older adults are a group that requires 'a person-centred approach to care that promotes wellbeing' (Neville et al., 2015: 29).

Studies in the United States find that older LGBT-identifying adults are more likely than others to live alone and deal with health and economic disparities in comparison with their heterosexual counterparts (Alpert, 2015). Discrimination, and the sense that some in this group have of the ongoing need to conceal their sexuality from health providers and others, can contribute to negative effects on their overall wellbeing. Research on the experience of older gay men in New Zealand finds that the impact of opening up to others about sexual orientation can be very stressful, and therefore take a toll on their physical, social and psychological wellbeing. However, if the experience of making sexual orientation public is responded to with openness, the experience can be empowering and lead to an increased in quality of life (Neville, Kushner, & Adams, 2015). Participatory action research carried out over three years in the UK with LGBT older adults identified the need for knowledge development and skills training for healthcare and human service providers. It also recommended strong anti-discriminatory policies and that diversity and equality be enshrined in codes of conduct in order to provide adequate supports and services for this group of older adults (Health and Care Development Ltd, 2006).

6.19 Age-friendly cities

The degree of 'age-friendliness' of an urban environment can be a determinant of active ageing for older adults. The WHO defines an age friendly city as one that: 'encourages active ageing by optimising opportunities for health, participation and security in order to enhance quality of life as people age' (2007:1). They have developed a guide designed to help councils plan for an ageing population, and covers eight key areas:

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

The WHO provides a checklist of essential age-friendly city features (See Appendix A) which is based on the results of the WHO Global Age-Friendly Cities project consultation in 33 cities in 22 countries. The checklist is a tool for a city's self-assessment and a map for charting progress.

6.20 Dying well

An often overlooked aspect of wellbeing is the ability to die well (Billington, 2015). This is particularly relevant in light of longer life expectancies which means that some people can expect to live more of their lives with a disability and psychological mortality (e.g. loss of identity, psychological autonomy and a sense of control) (Baltes & Smith, 2003; Billington, 2015). According to Baltes and Smith (2003), 'future study and discussion should focus on the critical question of whether the continuing major investments into extending the life span into the fourth age actually reduce the opportunities of an increasing number of people to live and die in dignity.'

To act comprehensively to improve the end-of-life experience some advocate a community-wide perspective. Byock et al. (2001) argue that a community achieves a high quality of life at both the individual and collective level when dying, caregiving and grieving are recognised as important aspects of life and woven in to the social fabric of a given society. These authors outline the following as key indicators of a good quality of life end-of-experience at the community level:

- an adult population composed of individuals who have prepared for dying through discussions with family, friends, neighbours, and healthcare and other professionals;

- a population in which people support, and feel supported by, one another during times of caregiving and grief; and
- schools, faith communities, businesses, associations, and social clubs that commonly include issues and activities pertinent to dying, caregiving, and bereavement in their agendas. When acting otherwise would seem unnatural, these community attributes will comprise the social and cultural norm and will be self-sustaining.

7.0 Conclusion and Discussion

The purpose of this report was to review selected academic and policy literature across a range of disciplines on positive ageing and determinants of wellbeing in older adults in order to inform the selection of appropriate indicators to be used in monitoring change in this area for Auckland. The report can also contribute to informing the council's policy levers to respond to the changing demographic profile of the city.

Auckland has one of the youngest age structures of New Zealand, however, both the number and proportion of older Aucklanders is projected to increase in the future due to population growth and structural ageing. While the majority of older Aucklanders currently identify as European or Pākehā in terms of ethnicity, the number and proportion of older adults aged 65+ who identify as Asian, Māori and Pacific is projected to increase.

It is recommended that a mix of objective and subjective indicators be used to monitor wellbeing amongst older Aucklanders. When using and interpreting subjective indicators of wellbeing for older adults it is important to remember that elderly people are more likely to compare themselves to those who are less fortunate than themselves than other age groups. This can result in a comparatively higher rate of subjective wellbeing being reported by a population overall, but does not necessarily reflect the extent to which older adults may be facing hardship. Therefore, it is important to ensure that a monitoring framework be developed that is sensitive to any potential challenges faced by older Aucklanders in relation to maintaining decent living standards, particularly if relying on subjective indicators for this area.

A number of disciplinary approaches to conceptualising determinants of wellbeing in older age were discussed in this report, notably medical, economic, psychological and 'lay-person' concepts (or concepts defined by older adults themselves). Each has their strengths and weaknesses and captures a particular dimension of wellbeing in older age. As a result, it is recommended that a holistic and multi-dimensional approach be developed which includes a range of types of determinants of wellbeing in older age. Including older people themselves in helping to identify the aspects of wellbeing helps make multidimensional models especially robust as it ensures they are fit for the social context in which they will be used. This is particularly relevant for the multicultural context of Auckland.

The report has provided several examples of multi-dimensional frameworks that have been developed both internationally, such as the WHO Active Ageing model, or the Age-Friendly Cities approach as well as in New Zealand, through the Positive Ageing Strategy which can serve as starting points to develop a monitoring approach appropriate for the Auckland context.

The report also addresses the way in which quality of life and wellbeing in the later stages of life can vary, to a certain extent, across cultural groups. A monitoring framework should

ideally resonate and be meaningful to the full range of subgroups that make Auckland their home. A monitoring framework that is culturally sensitive must take into consideration the special social status and role attributed to 'elders' in a range of communities living in New Zealand, particularly Māori, Pacific and Chinese. However, at the same time, it is important not to maintain an overly rigid view of cultural approaches to ageing and bear in mind that over time and in different contexts, such social norms change. As such any monitoring framework or policy intervention must recognise that the idealised status of an older adult in Māori, Pacific and Chinese and other cultures is not a given, but may vary across individuals, families and communities.

The report included a list of possible determinants of wellbeing for older adults to consider for future monitoring which are supported by research. These determinants are often interrelated, that is, income and living standards are identified as a determinant of wellbeing but they are also determinants of a range of other factors that influence quality of life in older age such as health and access to good quality housing, transport and appropriate health care and support. Furthermore, gender is a form of determinant of wellbeing in older age as a result of inequality between the genders. This combined with the longer life spans experienced by women results in women being more likely to face material deprivation than men in older age.

It is recommended that in developing a monitoring framework for the wellbeing of older adults in Auckland, that not only the changing ethnic and socioeconomic makeup of the population is taken into consideration, but the existing power relations and inequalities between groups also be considered. The research reviewed in this report suggests that a monitoring framework needs to be sensitive to the existing inequities in access to decent standard of living and culturally appropriate services as well as exposure to discrimination and abuse. Ideally, a monitoring framework would make visible the issues faced in relation to the unequal position of groups in society such that disparities registered across groups can be identified and addressed. Such a framework should also help to interpret differential outcomes in their social context rather than promoting an individualised account of differential outcomes that fails to take into consideration the wider social factors that have led to these.

Finally, amongst the determinants of wellbeing that are discussed in this report are three that are often overlooked: the wellbeing of an older person's caregiver, the sexual wellbeing of an older person and the opportunity to die well.

The wellbeing of caregivers, often, but not always women in the family of the older person or women working in the care industry, contributes to the wellbeing of older adults. The literature cited in this report highlights the significance of policies that support women in the work place and in the family as part of any interventions that are intended to lead to enhanced outcomes for the older people they support.

The sexuality and sexual health of older adults is another often forgotten dimension of wellbeing in older age. In particular, lesbian, gay, bisexual and transgendered (LGBT)

older adults in New Zealand have lived through a period of time in which their sexuality or gender identity has been criminalised and may have experienced, and still continue to experience, discrimination in relation to their sexuality. It is particularly important to ensure that services and supports in relation to sexual health are provided for older adults and also that they take into consideration the gender and sexual diversity and corresponding diversity of needs of this population.

Finally, the third often forgotten aspect of wellbeing in older age relates to the opportunity to 'die well'. In light of longer life expectancies, older adults can increasingly expect to live longer lives, although many can also expect to live more of their lives with a disability. Part of what determines the quality of life at the end of life relates to the broader societies ability to incorporate dying, caregiving and grieving into social life. When monitoring wellbeing in older age, broader social attitudes towards death and the ease at which individuals can find support to help prepare for, and cope with, death and dying are potentially relevant dimension to bear in mind.

8.0 References

- Age Concern. (2015). *Elder Abuse Awareness Week*, https://www.ageconcern.org.nz/ACNZPublic/Services/EANP/ACNZ_Public/Elder_Abuse_and_Neglect.aspx. (Retrieved 10 October 2016)
- Alpert, J. (2015). Out, Proud And Old: LGBT Seniors More Likely To Age Alone. *CommonHealth*, <http://www.wbur.org/commonhealth/2015/01/02/lgbt-seniors-age-alone>. (Retrieved 31 October 2016)
- Auckland Council. (2012). *The Auckland Plan*. http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/plansstrategies/theaucklandplan/Pages/theaucklandplan.aspx?utm_source=shorturl&utm_medium=print&utm_campaign=Auckland%2BPlan. (Retrieved 4 February 2016)
- Auckland Council. (2015). *Older Aucklanders. Results from the 2013 Census*. <http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/reports/Documents/olderaucklandersresultsfromthe2013censusjune2015.pdf> (Retrieved 31 October 2016)
- Baltes, P. B., & Smith, J. (2003). New Frontiers in the future of aging: From Successful Aging of the Young Old to the Dilemmas of the Fourth Age. *Gerontology*, 49, 123-135.
- Billington, C. (2015). A Changing Face: The Implications of Democratic Change. *Public Sector. Journal of Public Administration New Zealand*, 38(4), 6-10.
- Boudiny, K. (2013). 'Active ageing': from empty rhetoric to effective policy tool. *Ageing and Society*, 33(6), 1077-1098.
- Bowling, A. (2007). Aspirations for Older Age in the 21st Century: What is Successful Aging? *Ageing and Human Development*, 64(3), 263-297.
- Bowling, A. (2009). Perceptions of active ageing in Britain: divergences between minority ethnic and whole population samples. *Age and Ageing*, 38(6), 703-710.
- Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *BMJ*, 331(7531), 1548–1551.
- Bowling, A., & Iliffe, S. (2006). Which model of successful ageing should be used? Baseline findings from a British longitudinal survey of ageing. *Age and Ageing*, 35(6).
- Breheny, M., & Stephens, C. (2010). Ageing in a Material World. *New Zealand Journal of Psychology*, 39(2), 41-48.
- Breheny, M., Stephens, C., Alpass, F., Stevenson, B., Carter, K., & Yeung, P. (2013). Development and Validation of a Measure of Living Standards for Older People. *Social Indicators Research*(114), 1035-1048.
- Byock, I., Norris, K., Curtis, J. R., & Patrick, D. L. (2001). Improving End-of-Life Experience and Care in the Community: A Conceptual Framework. *Journal of Pain and Symptom Management*, 22(3), 759-772.
- Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: a systematic review. *Age and Ageing*, 37, 151-160.
- Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful ageing: A comprehensive review of larger quantitative studies. *American Journal of Geriatric Psychiatry*, 14, 6-20.
- Durie, M. (2006). *Measuring Māori Wellbeing*. The Treasury. <http://www.treasury.govt.nz/publications/media-speeches/guestlectures/pdfs/tgls-durie.pdf> (Retrieved 31 October 2016)
- Dyall, L., Kēpa, M., Teh, R., Mules, R., Moyes, S. A., Wham, C., . . . Kerse, N. (2014). Cultural and social factors and quality of life of Maori in advanced age. Te puawaitanga o nga tapuwae kia ora tonu –Life and living in advanced age: a cohort study in New Zealand (LiLACS NZ). *The New Zealand Medical Journal*, 127(1393), 62-79.
- George, L. K. (2010). Still happy after all these years: research frontiers on subjective well-being in later life. . *J Gerontol B Psychol Sci Soc Sci*, 65B(3), 331-339.
- Hambleton, P., Keeling, S., & McKenzie, M. (2008). Quality of life is...: The views of older recipients of low-level home support. *Social Policy Journal of New Zealand*, 33(March), 146-162.

- Health and Care Development Ltd. (2006). *Gay and Grey in Dorset. Lifting the Lid On sexuality and ageing.*, Dorset, UK: http://www.equality-ne.co.uk/downloads/85_Gaygreereport.pdf. (Retrieved 31 October 2016)
- Ho, E., Lewin, J., & Muntz, M. (2009). *Ageing Well in a New Country: Preliminary Findings of a Survey of Older Chinese in New Zealand*. Waikato, NZ: <http://www.ewas.net.nz/Publications/filesEWAS/EWAS%20CS%204%20PSC.pdf> (Retrieved 31 October 2016)
- Inglehart, R. (2002). Gender, Aging, and Subjective Well-Being. *International Journal of Comparative Sociology*, 43(3-5), 391-408.
- Kessel, B. (2001). Sexuality and the Older Person. *Age and Ageing*, 30, 121-124.
- King, P. (2007). *The Concept of Wellbeing and its Application in a Study of Ageing in Aotearoa New Zealand*. Wellington and Hamilton, NZ: <http://www.ewas.net.nz/Publications/filesEWAS/Conceptualising%20wellbeing.pdf> (Retrieved 31 October 2016)
- Koopman-Boyden, P., & Waldegrave, C. (Eds.). (2009). *Enhancing Wellbeing in an Ageing Society 65 – 84 year old New Zealanders in 2007*. Hamilton and Wellington: The Population Studies Centre, University of Waikato and the Family Centre Social Policy Research Unit.,
- Kukutai, T. (2006). *Elder or merely older? Enhancing the wellbeing of older Maori in an ageing Maori population*. The Family Centre Social Policy Research Center, Lower Hutt, Wellington and the Population Study Centre, University of Waikato, Hamilton.
- Lee, D. (2015). *Sexual health, quality of life and well-being among older people in England*. University of Manchester: http://hummedia.manchester.ac.uk/institutes/micra/events%202015/11%20February%20event%20/ELSA_MICRA_presentation_060215.pdf (Retrieved 31 October 2016).
- Li, W. W. (2013). *Shifting Selves in Migration. Home, Ageing in Place and Well-being*. Beijing, China.
- Li, W. W., & Chong, M. D. (2012). Transnationalism, Social Wellbeing and Older Chinese Migrants. *Graduate Journal of Asia-Pacific Studies*, 8(1), 29-44.
- Li, W. W., Hodgetts, D., & Sonn, C. (2014). Multiple Senses of Community Among Older Chinese Migrants to New Zealand. *Journal of Community & Applied Social Psychology*, 24(1), 26-36. doi:10.1002/casp.2174
- Lotoala, F., Breheny, M., Alpass, F., & Henriksen, A. (2014). Health and wellbeing of older Pacific Peoples in New Zealand. *New Zealand Medical Journal*, 127(1407).
- Love, C., Moeahu, N., & Love-Shariff, S. (2007). *New Zealand Māori Case Study: Wellington Tenth's Trust and Palmerston North Māori Reserved Lands Trust*. Wellington and Hamilton: <http://www.ewas.net.nz/Publications/filesEWAS/EWAS%20CS%201%20Tenth'sTrust.pdf> (Retrieved 31 October 2016)
- Lowenstein, A., & Ogg, J. (Eds.). (2003). *Old Age and Autonomy: The role of service systems and intergenerational solidarity*. Haifa: Center of Research and Study of Ageing, University of Haifa.
- Lui, C.-W., Everingham, J.-A., Warburton, J., Cuthill, M., & Bartlett, H. (2009). What makes a community age-friendly: A review of international literature. *Australasian Journal on Ageing*, 28(3), 116–121.
- Ministry for Social Development. (2006). *The 2006 Social Report. Indicators of social wellbeing in New Zealand*. <http://socialreport.msd.govt.nz/2006/> (Retrieved 31 October 2016)
- Ministry of Social Development. (2007). <http://socialreport.msd.govt.nz/2006/>. Wellington.
- Ministry of Health (MoH). (1997). *The Health and Wellbeing of Older People and Kaumātua. The Public Health Issues*. Neville, S., Kushner, B., & Adams, J. (2015). Coming out narratives of older gay men living in New Zealand. *Australasian Journal on Ageing*, 34, 29-33.
- Nielsen Research Ltd. (2014). *Quality of Life Survey 2014: Results for Auckland. A report prepared for Auckland Council*. Wellington, New Zealand.
- Noone, J., & Stephens, C. (2014). *New Zealand Longitudinal Study of Ageing - Summary Report: Social Integration, Health and Quality of Life*. Palmerston North, Massey University: http://www.massey.ac.nz/massey/fms/Colleges/College%20of%20Humanities%20and%20Social%20Sciences/Psychology/HART/publications/reports/Social_integration_NZLSA_2014.pdf?BBF47602F46659D4500727BFBC30F1E1 (Retrieved 31 October 2016)

- Noone, J., Stephens, C., & Alpass, F. (2014). *New Zealand Longitudinal Study of Ageing - Summary Report: Socioeconomic Status*. Palmerston North, Massey University: http://www.massey.ac.nz/massey/fms/Colleges/College%20of%20Humanities%20and%20Social%20Sciences/Psychology/HART/publications/reports/Socioeconomic_Status_NZLSA_2014.pdf?2257496FE39DAA291AB01911A7EEF7A0 (Retrieved 31 October 2016)
- Office for Senior Citizens. (2014). *2014 Report on the Positive Ageing Strategy*. Ministry of Social Development (MoSD). Wellington.
- Peel, N. M., McClure, R. J., & Bartlett, H. P. (2005). Behavioral determinants of healthy aging. *American Journal of Preventative Medicine*, 28(3), 298–304.
- Pinquart, M., & Sörensen, S. (2001). Gender Differences in Self-Concept and Psychological Well-Being in Old Age: A Meta-Analysis. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 56(4), P195-P213. doi:10.1093/geronb/56.4.P195
- Read, S., Grundy, E., & Foverskov, E. (2015). Socio-economic position and subjective health and well-being among older people in Europe: a systematic narrative review. *Ageing & Mental Health, On-line first*, 1-15.
- Rippon, I., Kneale, D., Oliveira, C. D., Demakakos, P., & Steptoe, A. (2014). Perceived age discrimination in older adults. *Age and Ageing*, 43, 379–386.
- Rowe, E., & Waldegrave, C. (2008). *Studies of Ageing and Wellbeing: Summary Descriptions of Key International Studies and Their Implications for the Development of the EWAS Research*. Wellington and Hamilton: http://www.ewas.net.nz/Publications/filesEWAS/EWAS%20WP%2010%20ER_CW.pdf (Retrieved 31 October 2016)
- Smith, J., Fleeson, W., Geiselman, B., Settersten, R. A., & Kunzmann, U. (1999). Sources of well-being in very old age. In P. B. Baltes & K. U. Mayer (Eds.), *The Berlin Aging Study: Aging from 70 to 100* (pp. 150-471). Cambridge: Cambridge University Press.
- Stegeman, I., Otte-Trojel, T., Costongs, C., & Considine, J. (2012). *Healthy and Active Ageing*. Brussels: <http://www.healthyageing.eu/sites/www.healthyageing.eu/files/featured/Healthy%20and%20Active%20Ageing.pdf> (Retrieved 31 October 2016)
- Tamasese, T. K., Parsons, T. L., & Waldegrave, C. (2014). *Pacific Perspectives on Ageing in New Zealand*. The Family Centre, Massey University: https://www.massey.ac.nz/massey/fms/Colleges/College%20of%20Humanities%20and%20Social%20Sciences/Psychology/HART/publications/reports/Pacific_Elders_NZLSA_2014.pdf?6A68389EA6EAB37148E4AE22BA963822 (Retrieved 31 October 2016)
- United Nations Population Fund and HelpAge International. (2012). *Ageing in the 21st Century: A Celebration and A Challenge*. New York.
- Wahrendorf, M., Knesebeck, O. v. d., & Siegrist, J. (2006). Social Productivity and Well-being of Older People –Baseline Results from the SHARE Study. *European Journal of Ageing*, 3(2), 67-73.
- Waldegrave, C. (2009). Culture and Religion. In P. Koopman-Boyden & C. Waldegrave (Eds.), *Enhancing Wellbeing in an Ageing Society - 65-84 year old New Zealanders in 2007* (pp. 191-205). Waikato and Wellington: The Population Studies Centre, University of Waikato, Hamilton and the Family Centre Social Policy Research Unit, Lower Hutt, Wellington.
- Waldegrave, C., & Cameron, M. P. (2009). Income, Assets, Living Standards and Housing. In P. Koopman-Boyden & C. Waldegrave (Eds.), *Enhancing Wellbeing in an Ageing Society - 65-84 year old New Zealanders in 2007*. Waikato and Wellington: The Population Studies Centre, University of Waikato, Hamilton and the Family Centre Social Policy Research Unit, Lower Hutt, Wellington: p 83-108.
- Waldegrave, C., King, P., & Rowe, E. (2012). Aucklanders 50 and over: a health, social and demographic summary analysis of the life experiences of older Aucklanders. Auckland Council: <http://www.aucklandcouncil.govt.nz/EN/planspoliciesprojects/reports/technicalpublications/Documents/aucklanders50andoverfullreport.pdf>. (Retrieved 28 October 2016)
- Waldegrave, C., & Koopman-Boyden, P. (2009). Ageing and Wellbeing in New Zealand- An Overview. In P. Koopman-Boyden & C. Waldegrave (Eds.), *Enhancing Wellbeing in an Ageing Society - 65-84 year old New Zealanders in 2007* (pp. 207-216). Waikato and

- Wellington: The Population Studies Centre, University of Waikato, Hamilton and the Family Centre Social Policy Research Unit, Lower Hutt, Wellington.
- Waldon, J. (2004). Oranga Kaumatua: Perceptions of Health in Older Māori People. *Social Policy Journal*(23), <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj23/23-oranga-kaumatua-perceptions-of-health-in-older-mori-peoplep167-180.html>. (Retrieved 31 October 2016)
- Wiles, J. (2011). *Resilient ageing in place: Project recommendations and report*. Auckland, University of Auckland:
<https://www.fmhs.auckland.ac.nz/assets/fmhs/soph/sch/ageing/docs/Resilient-Ageing-in-Place-Recommendations-and-Report.pdf> (Retrieved 31 October 2016)
- World Health Organisation. (2007). *Global Age-Friendly Cities: A Guide*. Geneva:
http://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf?ua=1 (Retrieved 31 October, 2016)
- World Health Organisation (2002). *Active ageing: a policy framework*.
http://apps.who.int/iris/bitstream/10665/67215/1/WHO_NMH_NPH_02.8.pdf (Retrieved 31 October 2016)

Appendix: Checklist of Essential Features of Age-friendly Cities

This checklist of essential age-friendly city features is based on the results of the WHO Global Age-Friendly Cities project consultation in 33 cities in 22 countries. The checklist is a tool for a city's self-assessment and a map for charting progress. More detailed checklists of age-friendly city features are to be found in the WHO Global Age-Friendly Cities Guide (World Health Organisation, 2007b).

This checklist is intended to be used by individuals and groups interested in making their city more age-friendly. For the checklist to be effective, older people must be involved as full partners. In assessing a city's strengths and deficiencies, older people will describe how the checklist of features matches their own experience of the city's positive characteristics and barriers. They should play a role in suggesting changes and in implementing and monitoring improvements.

Outdoor spaces and buildings

- Public areas are clean and pleasant.
- Green spaces and outdoor seating are sufficient in number, well-maintained and safe.
- Pavements are well-maintained, free of obstructions and reserved for pedestrians.
- Pavements are non-slip, are wide enough for wheelchairs and have dropped curbs to road level.
- Pedestrian crossings are sufficient in number and safe for people with different levels and types of disability, with nonslip markings, visual and audio cues and adequate crossing times.
- Drivers give way to pedestrians at intersections and pedestrian crossings.
- Cycle paths are separate from pavements and other pedestrian walkways.
- Outdoor safety is promoted by good street lighting, police patrols and community education.
- Services are situated together and are accessible.
- Special customer service arrangements are provided, such as separate queues or service counters for older people.
- Buildings are well-signed outside and inside, with sufficient seating and toilets, accessible elevators, ramps, railings and stairs, and non-slip floors.
- Public toilets outdoors and indoors are sufficient in number, clean, well-maintained and accessible.

Transportation

- Public transportation costs are consistent, clearly displayed and affordable.
- Public transportation is reliable and frequent, including at night and on weekends and holidays.
- All city areas and services are accessible by public transport, with good connections and well-marked routes and vehicles.
- Vehicles are clean, well-maintained, accessible, not overcrowded and have priority seating that is respected.
- Specialized transportation is available for disabled people.
- Drivers stop at designated stops and beside the curb to facilitate boarding and wait for passengers to be seated before driving off .
- Transport stops and stations are conveniently located, accessible, safe, clean, well lit and well-marked, with adequate seating and shelter.
- Complete and accessible information is provided to users about routes, schedules and special needs facilities.
- A voluntary transport service is available where public transportation is too limited.
- Taxis are accessible and affordable, and drivers are courteous and helpful.
- Roads are well-maintained, with covered drains and good lighting.
- Traffic flow is well-regulated.
- Roadways are free of obstructions that block drivers' vision.
- Traffic signs and intersections are visible and well-placed.
- Driver education and refresher courses are promoted for all drivers.
- Parking and drop-off areas are safe, sufficient in number and conveniently located.
- Priority parking and drop-off spots for people with special needs are available and respected.

Housing

- Sufficient, affordable housing is available in areas that are safe and close to services and the rest of the community.
- Sufficient and affordable home maintenance and support services are available.
- Housing is well-constructed and provides safe and comfortable shelter from the weather.
- Interior spaces and level surfaces allow freedom of movement in all rooms and passageways.
- Home modification options and supplies are available and affordable, and providers understand the needs of older people.

- Public and commercial rental housing is clean, well-maintained and safe.
- Sufficient and affordable housing for frail and disabled older people, with appropriate services, is provided locally.

Social participation

- Venues for events and activities are conveniently located, accessible, well-lit and easily reached by public transport.
- Events are held at times convenient for older people.
- Activities and events can be attended alone or with a companion.
- Activities and attractions are affordable, with no hidden or additional participation costs.
- Good information about activities and events is provided, including details about accessibility of facilities and transportation options for older people.
- A wide variety of activities is offered to appeal to a diverse population of older people.
- Gatherings including older people are held in various local community spots, such as recreation centres, schools, libraries, community centres and parks.
- There is consistent outreach to include people at risk of social isolation.

Respect and social inclusion

- Older people are regularly consulted by public, voluntary and commercial services on how to serve them better.
- Services and products to suit varying needs and preferences are provided by public and commercial services.
- Service staff are courteous and helpful.
- Older people are visible in the media, and are depicted positively and without stereotyping.
- Community-wide settings, activities and events attract all generations by accommodating age-specific needs and preferences.
- Older people are specifically included in community activities for “families”.
- Schools provide opportunities to learn about ageing and older people, and involve older people in school activities.
- Older people are recognised by the community for their past as well as their present contributions.
- Older people who are less well-off have good access to public, voluntary and private services.

Civic participation and employment

- A range of flexible options for older volunteers is available, with training, recognition, guidance and compensation for personal costs.
- The qualities of older employees are well promoted.
- A range of flexible and appropriately paid opportunities for older people to work is promoted.
- Discrimination on the basis of age alone is forbidden in the hiring, retention, promotion and training of employees.
- Workplaces are adapted to meet the needs of disabled people.
- Self-employment options for older people are promoted and supported.
- Training in post-retirement options is provided for older workers.
- Decision-making bodies in public, private and voluntary sectors encourage and facilitate membership of older people.

Communication and information

- A basic, effective communication system reaches community residents of all ages.
- Regular and widespread distribution of information is assured and a coordinated, regular information and broadcasts of interest to older people are offered.
- Oral communication accessible to older people is promoted.
- People at risk of social isolation get one-to one information from trusted individuals.
- Public and commercial services provide friendly, person-to-person service on request.
- Printed information – including official forms, television captions and text on visual displays – has large lettering and the main ideas are shown by clear headings and bold-face type.
- Print and spoken communication uses simple, familiar words in short, straightforward sentences.
- Telephone answering services give instructions slowly and clearly and tell callers how to repeat the message at any time.
- Electronic equipment, such as mobile telephones, radios, televisions, and bank and ticket machines, has large buttons and big lettering.
- There is wide public access to computers and the Internet, at no or minimal charge, in public places such as government offices, community centres and libraries.

Community and health services

- An adequate range of health and community support services is offered for promoting, maintaining and restoring health.
- Home care services include health and personal care and housekeeping.
- Health and social services are conveniently located and accessible by all means of transport.
- Residential care facilities and designated older people's housing are located close to services and the rest of the community.
- Health and community service facilities are safely constructed and fully accessible.
- Clear and accessible information is provided about health and social services for older people.
- Delivery of services is coordinated and administratively simple.
- All staff are respectful, helpful and trained to serve older people.
- Economic barriers impeding access to health and community support services are minimized.
- Voluntary services by people of all ages are encouraged and supported.
- There are sufficient and accessible burial sites.
- Community emergency planning takes into account the vulnerabilities and capacities of older people.

Find out more: phone 09 301 0101, email rimu@aucklandcouncil.govt.nz or visit aucklandcouncil.govt.nz and knowledgeauckland.org.nz