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**WHO CARES?: MAKING ELDER CARERS VISIBLE: ELEVEN  
WOMEN TALK ABOUT THE IMPLICATIONS OF THE  
CAREGIVING ROLE.**

A thesis submitted in

partial fulfilment of the requirements

of the degree of

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P 27

## ABSTRACT

This research was prompted by my personal experience of dealing with elder carers as a social worker and seeing formal resources available to this group diminishing. Eleven women caring for elderly relatives were interviewed. The aim of the research was to discover how they came to be in the elder care role, and to explore the impact of this role on their lifestyles. Any change in the relationships between the person cared for and themselves, and the wider relationships of friends and family, since care began, was also investigated. A constant theme throughout the study was the issue of elder care being unrecognised and unpaid.

Feminist theory was used to inform the thesis; qualitative feminist method was used in the research. The main method used in the study was the formal interview and initial direction in the interviews was based on a semi-structured questionnaire. The interviewees, however, soon took control of what information was provided and what they thought was important. Time use diaries covering a twenty four hour period were used to record the activities of the respondents. This allowed analysis of the unpaid work by the carers.

One of the goals of the thesis was to provide an opportunity for the carers to be heard by social workers and policy makers. The implications for social work were discussed as a result of the professional issues highlighted during this study. Time was spent with carers identifying formal and informal services. They were given an opportunity to verbalise their areas of need which can be presented to policy makers.

Issues presented by the carers included feelings of isolation from friends and family, lack of formal recognition of the work they do and the expectation of women to fulfill an elder care role by family and society.

The challenge to me personally and professionally was to gain an understanding of the women's stories and to present them in a meaningful way which highlights the

experiences and needs of elder carers. Although having worked in the area for several years, some of the information given by the carers I was hearing for the first time. The common themes in their stories surrounded lack of choice in becoming carers and the subsequent isolation of the role. These were not explored through current social work methods which revolve around the organisational needs of discharging the individual back to the community as soon as possible not always working with the carers to identify the supports they need. The final section of this thesis explored some of these issues and provides social workers with an opportunity to share what I had previously not had the opportunity to hear.

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## CHAPTER 1

### Introduction:

Having come from a background of being a probation officer, a punitive role, working with the elderly was refreshing. Most people who receive the social work service appreciated any work done and were thankful. They also shared their feelings and thoughts freely; quite a change from non-communicative clients who have no choice about the working relationship.

Five years ago I began working in an Assessment and Rehabilitation Unit, which at that time, was for people over the age of 65 years. The majority of the people I was working with had both long and short term disabilities. All clients were discharged either back home or into a residential facility. I soon began to see that this group of people had problems that were not recognised by the majority of New Zealanders.

One of the first issues to challenge social workers who work with elderly clients is acknowledging the issue of ageing itself. The people who are the focus of the work represent what will inevitably happen to you, your parents and grandparents as the natural life cycle takes its course. On the positive side it also became apparent that the people who are disabled either by disease or accident represent the minority of the elder population, the majority of whom live independently in the community.

Ageism is another issue that confronts the social worker. A period of enlightenment occurs when, as a worker, there is an awareness of how older people are viewed by society generally and by agencies. This is highlighted when acting as an advocate, and when dealing with families and statutory organisations. At an organisational level most social workers experience the strong marginalisation of minority groups and the elderly are included within this. Most agencies are relieved that they are dealing with a social worker, someone who understands systems and this may facilitate the fulfilment of the advocacy role. There is also an understanding that social workers will persist when seeking support for a client, and it is more difficult for the agency to "brush off" the social worker than the elderly person.

Another example of organisational ageism was noted by social workers with the inclusion of under 65 year old patients in the rehabilitation ward. Observations by the social workers tended to support the view that the under 65 year old patients stay in hospital longer and receive more attention from the staff. This was further highlighted

by social workers when a family meeting was called. Usually when meeting with over 65 year old rehabilitation patients and their families, only staff that are free to attend do so, whilst the family meetings with under 65 year old patients tended to draw all staff. The implication is that patients under the age of 65 years have a higher priority.

It is surprising that ageist views were held by the families of the elderly. It is a familiar experience to have families making decisions for their relatives when the relative is capable of making these decisions themselves. The role then becomes one of protecting the rights of the client. This leads to conflict with families and it is here that social workers can clearly see the older person being manipulated.

Manipulation can be subconscious; born out of a genuine concern for the older person's safety. Conscious manipulation can take many forms, the most prevalent, in my experience, was financial. It is defined as abuse when the older person is capable of making decisions about the management of their finances but the other people control the money. Other forms of elder abuse are physical, where an elder person is either assaulted or whose physical needs are ignored or subverted; psychological, where, for example, a mentally capable person is treated as if they suffer from dementia; and self abuse; a common form of which is for the older person to suffer from a medical condition which, with treatment, could be quickly resolved.

On a personal level one vivid recollection was watching a game of charades and the portrayal of an 'old' person, the old person was portrayed as bent over and using a walking stick. This was a graphic demonstration that society views the majority of older people as "sick" or "disabled".

When these issues were discussed with my health social work colleagues, I found the majority of the people we were working with across the health sector were older people, mostly in their 70's and 80's. The exception were those working with children. This was a common experience. Although a social worker may be in a medical or surgical ward much of their day to day business involved working with the elderly.

Having been educated within New Zealand and having completed a social work qualification, I was surprised at how little published information was available on social work and the elderly, and that I had not previously been able to learn much about this area. The information I received advising of conferences on working with families indicated the family consists of young parents with children - there was seldom any mention of older people within the family. Several of my colleagues were very

experienced and had worked in this area for many years but were so involved in casework they were not interested in putting 'pen to paper'.

Health social workers nationally continue to see the impact of an ageing population and find difficulties responding to the needs of these people and their carers, due to the constraints of current government philosophy on social policy. The centralisation of funding has reduced the options available when seeking resources for older people and their carers. Further on within this chapter information will be presented highlighting the marked increase in the number of older people within the New Zealand population. The implications have yet to be recognised fully in the current health policies. Within the health promotion contracts sought by the funders, there are no programmes directed specifically at those over 65 years of age. Health funders recognise the secondary medical and surgical services but are yet to develop preventive strategies to encourage the elder population to take responsibility for "good" and "ill" health.

Social work with older people is a specialist field in its own right. The dynamic of working cross-generationally requires a specialist knowledge base. It requires the understanding of values and beliefs that may be sixty years different from your own. It is important to develop an appreciation that relationships and marital roles have grown through times of war and financial strain as well as good times as life's milestones have been reached.

Working with the elderly is a varied experience which requires a broad-based approach from the social worker. The cross-cultural work, in terms of working with a diverse group which includes a number of immigrants, and in Northland, different religious groups. Family work includes working with the older person and supporting their rights to be independent while balancing the safety of the individual and the needs of those who are providing the support, which may include working with any of the carers and their families.

Although an aspect in most social work, grief and loss is a constant theme when working with the elderly. Grief and loss involves the individual making adjustments to their own personal situation and the subsequent changes that this brings in their interpersonal relationships. An individual's dignity is threatened when they can no longer perform basic personal tasks independently. The prospect of having a partner or child doing these tasks for them can be difficult to accept. Being a social worker within the health system, indicates the people needing the service are disabled either by disease or accident. These may be reversible conditions, or if not, plans are needed for people

to deal and cope with the future in relation to their altered health status, the disability, and/or change in lifestyle.

However, for the carers these tasks can be unpleasant and the carer's perspective is often not explored. This research focuses on those who care for older people in the community, specifically carers who live with the ones they care for. The goal is to provide social workers and policy makers with information so that carers needs may be heard and met on a daily basis.

For the first time, the elder cohort is becoming a significant proportion of the overall population structure. Never before in human history have so many people lived for so long. The needs and desires of this group and their carers, which have been largely ignored, will need to be addressed in New Zealand social policy in particular, and by society in general. Once again issues surrounding the elderly were discussed in the recent 1996 election and, as a result several means tested social policies now existing may be reviewed. However, there was little mention of the carers of older people. Society is grappling with the ageing phenomenon. There are still many myths surround ageing including the belief that once retirement is reached there is a decline in both the physical and mental abilities of people.

The thrust of social policy in a number of areas has been to decentralise resources and aged care has followed this trend. There have been a number of changes in policy to limit the use of residential facilities, which have been rationalised under the term 'capping' of funding. Changes have been made to ensure that the needs of those requesting institutional care are appropriate for the level of care available. Alterations to funding have reduced the numbers of residential facilities, known as "stage one" facilities, that cater for individuals who are mostly independent. The impact on the community has been for the elderly in this category to remain in their own homes or live with family. The main load of caring has fallen on women carers.

### **The Organisation Of The Thesis:**

#### **Literature Review:**

Little literature has been written in New Zealand on the topic of elder care either in relation to those cared for or their carers. Anne Opie and Peggy Koopman-Boyden are the leading New Zealand authors who have addressed these areas. As a consequence, the literature review has been largely developed from international sources.

To seek clarification on why women become carers or assume this role, several themes were explored in the literature pertaining to those providing care for older people. The role of women as carers was explored from a number of different angles, including the assumptions made within social policy and by society that establish women as the nurturers. The literature also evaluated the difference in how men and women performed this care giving role.

As stated earlier elder abuse is an issue that confronts most social workers dealing with carers. Having found very little written within New Zealand, I was interested to review some of the international literature which defines abuse and debates how to address these issues at a policy level.

Socialist feminism has been the theoretical perspective used to underpin this thesis. Issues surrounding unpaid work and related research were reviewed to uncover the invisibility of women and the role they are providing.

The final section of this chapter presents the Royal Commission on Social Policy report (1988). This report was collated by Peggy Koopman-Boyden. The information presented within the report illustrates the issues, current at the time, raised by New Zealanders representing different sectors of society who present varying theoretical positions. The RCSP has presented eight philosophies in relation to the elderly. Of these the dominant perspectives currently affecting social policy are medicalisation of the elderly, institutionalisation of the elderly and community care. Although it must be acknowledged that all perspectives are valid, the one this thesis will focus on is the community perspective as the policy in relation to community care affects carers the most. These carers are providing informal care in the community. The medicalisation of the elderly focuses on the disease process of the one being cared for and the institutionalisation of the elderly refers to formal care.

### **Resources:**

An important part of the social work role and one familiar to me, is to be a broker of formal services. Three organisations fund all formal services for the elderly and their carers, and these are presented. This gave me a personal opportunity to become more familiar with those services and reflect on the systems that provide them. From this reflection came an opportunity to evaluate the implications for those who receive or benefit from the services offered.

Central to the research has been to find out from carers what they view as necessary resources to enable them to fulfill their caregiving roles. The reciprocity essential in feminist research was active in these discussions with carers and as indicated within this chapter an opportunity was given to talk about the reality for them in relation to the formal resources offered.

To develop this further a social worker, new to the area of working with the elderly and their carers, was interviewed. The systems and the responses of the carers become familiar to those experienced in this work. The opportunity to interview Nikki enabled me to present, at a grass roots level, her experiences of learning the systems while at the same time having an expectation from her employer to provide a brokerage role. Implicit in this expectation is that a social worker has this knowledge.

Finally, Gillian, a carer, told me about her experience with placing her husband in a residential facility. Her story echoed other experiences I have heard describing the difficult decision for her to look at residential care and the consequences of the decision.

### **Methodology:**

The backbone of the thesis has been the stories provided by the eleven research respondents. The research was based on feminist methods and as a consequence was driven by these women. Initially a questionnaire was developed to direct the questions I had of carers. This revolved firstly around what the caregiving role actually consisted of, secondly how being in this role affected their relationships between the person cared for and the wider relationships of friends and family, and finally what personal benefits and costs were associated with caregiving.

New to feminist methodology, I learnt quickly that the women themselves develop the conversation and relay the information important to them. The challenge for me was to forget my usual interviewing style and be non-directive. Responding openly to the womens' questions was also unusual as the 'professional' social worker clearly separates the 'personal' to limit transference within the client/worker relationship. Transference refers to the development of the relationship outside of the 'normal' working relationship to transfer to another type of relationship, for example parent/child.

The relationship between researcher and recipient developed and, due to the previously stated reciprocity, time was spent on reviewing formal services to revisit whether the

carers could receive more entitlements. Several referrals were made and the majority of carers did enquire about different services they had previously not canvassed.

The feminist method provided a way of allowing the women to break their silence and become visible. For the first time these carers were able to talk about the difficult and unpleasant aspects of the caregiving role without guilt. Often the women felt guilty if they discussed what it was like for them because they were the lucky ones who could live independently and did not have a disability. Since society encourages this elder carer I believe there is an assumption by society that the carer should feel privileged at being able to provide care for the 'less fortunate'; it is almost viewed as a 'saintly' thing to do - "a calling".

The ethics guiding this thesis have been drawn from Massey University's "Code of Ethical Conduct for Research and Teaching involving Human Subjects" 1990.

The carers were provided with time use diaries in which they were able to record the amount of time spent on different tasks during the day. The time use diary was a tool designed to enlighten the consciousness of carers to the work and commitment their role required. This was also to provide quantitative data to analyse what care was provided and the time that carers spent on different activities. Four of the eleven carers did not fill in the time use diaries, in itself an indication of the lack of energy some carers had.

The information provided by the women respondents averaged approximately twenty pages of text and these have been formatted, and in some cases edited for clarity, to provide as much information untouched as possible while maintaining contextual integrity. Some of the subjugated knowledge, that is, understandings which were not part of mainstream learning, were lost through the necessary editing. The results presented were developed by collating the themes that ran through the transcripts.

### **Introduction of Interviewees:**

In this chapter my initial objective was to introduce the women respondents. It was important that they were named<sup>1</sup> and made visible so that their stories would be heard and understood as dictated by the methodology. A key element in understanding the consequences of becoming carers was to recognise what these women did prior to

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<sup>1</sup> The women respondents all have pseudonyms to provide confidentiality, named implies the information is personalized.

taking on this role. This provided an identity which enabled me to get to know each one and in doing so share what the elder person meant to them.

These women also shared how and why they had taken on this role. Several acknowledged for the first time that they had not made a conscious decision to be in the role and if they had, they expressed that they had no idea of what they were getting themselves into. This provided me with an insight into the context surrounding the decision of becoming a carer and the process of socialisation that had taken place. This socialisation was expressed in the decisions made by their families and the expectations the carers placed on themselves to provide care.

The carers were asked to talk about the care that was provided. Some talked about the lack of recognition given to the work they do. Defining what the work was reinforced and validated the role. This provided a platform to unpackage and demystify the hidden nature of the caring role. Most of the carers had not considered their care giving as work because it occurred in the private world of the home. A clear indication of this was when they were asked about their working lives and none of them discussed voluntary work, or work in the home as part of their descriptions; in a number of cases they described taking time 'off work' to raise children or care for their parents.

The carers also discussed some of their informal supports and networks. Several of them have strong networks with other women that are often almost invisible. Of particular of interest to me was the Closed (also known as Exclusive) Brethren: three of the women respondents described themselves as belonging to this group. Although these carers were receiving formal services, the bond between them and their informal support network was very strong and these women in particular described a feeling of belonging rather than isolation. This informal support of each other was described in the literature as the third shift (Gerstel and Gallagher 1994) behind paid work and caring for the immediate family.

### **How has becoming a carer affected your life?**

One aspect of social work that interested me was how situations changed an individual's life and their wider relationships. For several of the carers their new role had changed their lifestyle and it is the social realm that is of interest within this chapter.

In some cases the women were caring for their partners and the response from them revolved around grief and loss for the person they once knew and were originally

married to. This was reflected in a described change in dynamics, marital roles changed as wives had to learn new tasks, such as managing finances and maintaining their homes. My interest was to discover how they felt about this and in this regard the generational context must be remembered. These women have had a relationship that has, in most cases, had clear roles, the women being the housewife and the man the provider. The move from interdependence to dependence changes the balance in relationships. Not only do the women have to perform all the financial transactions but the majority of husbands in this study no longer have the mental capacity to even discuss problems and advise their wives.

When the carer brings the older person into the marital home, marital relationships are affected. How does the introduction of an older person needing care into the home affect the relationship between the carer and her partner? In particular, how does the husband deal with having to share his wife's time and energy with the person being cared for? The majority of respondents did not have a problem with this and one reason may be that all the husbands were working outside the home and the elder people receiving care were mostly undemanding.

The relationship which seems most affected is the mother/daughter as roles are reversed and the mother becomes dependent on the child. It is common for the parent to state they believe the child 'owes' the parent as they have given them several years of their life raising the child. If the child takes this on board the ironic factor is that the daughter may continue caring for a parent for several decades.

With a carer used to being totally independent, the lifestyle change can be drastic. Some of the women recipients have lived a single life for some considerable time and the upheaval of having to share a home, quite apart from the commitment of hands on care, can make the living arrangements almost unbearable.

Finally I wish to undertake a cost/benefit analysis of the role of caregiver. I was interested in both positive and negative aspects of the physical, social and emotional demands of the job. Again this explored the invisibility of these women and allowed for a deeper understanding of the caregiver role. One factor in the silencing of women is the taboo of not being able to express any negative feelings about their role and the personal costs of caring. This also included how the carer felt about the support, or lack of support, from the extended family. The exciting thing about this was that previously these questions had not been asked, or if they had, the 'professional' relationship had limited the depth of sharing from the carers.

To summarise this chapter and all the information provided by the women, they were asked how they would advise others in their own personal situation. This provided an 'open licence' for the carers to discuss their situation. The expectation was that the carers would now be able to identify stresses in their roles and potential solutions. These solutions could be defined as the formal and informal services needed, or support that enabled them to continue with their own lives and transcend the perimeters that keep them hidden in the private world of the home.

### **Theory:**

It is unusual to have the theoretical discussion come so late in a body of research but, as stated before, I am new to feminist methods. As this study was developed on the interviews and information provided by the women, the inductive methodology indicated that the theory could not be applied until the themes had been clearly identified from the transcripts. This approach was consistent with the structural feminist theory underpinning the thesis.

Using structural feminism to inform the study led to a natural examination of the position of women in production and reproduction, specifically in relation to elder care. The role of women in production links to their place in the private and public spheres; (Cox and James 1987) most of these women recipients have been active in the public sphere but their contribution in the private sphere is unrecognised, even by the carers themselves. The familiar reproductive role in the private sphere as experienced by them when they were raising their children is comfortable to most of the women and they embraced the opportunity to once again become nurturers. This of course is not the experience of all carers - those who have functioned only in the public sphere find the nurturing (private) role uncomfortable.

Elder care as unpaid work has been a continual theme throughout this study. This directly relates to the value or worth of this work placed on it by social policy and society. The evaluation of the time use diaries is discussed within the context of this chapter as the theory about unpaid work is developed. The theory surrounding unpaid work can be applied to the elder care situation.

Poststructural feminism in relation to the position of carers is briefly discussed as postmodern theory provides a new critique. The philosophical position as expressed through social policy in New Zealand as at 1996 explored the health system because it is through this system that the majority of carers receive formal support. As stated

earlier, one of the goals of this research has been to challenge the policy makers to listen to the voices of the carers identified needs.

### **Implications for Social Work Practice:**

Demographically the New Zealand population is showing an increase in the number of people over 65 years. By the year 2031, 892,000 New Zealanders will be over 65 - nearly 20% of the population. More than a quarter of those will be 80-plus (Clifton 1995). The main reason given for this is the improvement in medical services this century which has increased life expectancy. At the turn of the century the life expectancy of a man in America was 43 years, now it is 77 years (Moody 1988: 1). This trend has also been established in New Zealand. While life expectancy at birth in 1931 for a female was approximately 69 years, in 2031 it is expected to be between 82 and 85 years. For men over the same period, life expectancy has risen from approximately 65 years to between 74 and 78 years (Department of Statistics 1990: 19).

There are direct implications for New Zealand society faced with a growing older population, and a need to address these through both economic and social policy. Superannuation is always a hot election topic as its projected cost is increasing along with the older population. There is stress on health services and the current graduated care system has a phenomenal cost. For people who choose residential care there are four stages provided. The government means tested daily subsidy is, as at June 1996, approximately stage 1 - \$60.00, stage 2 - \$70.00 and stage 3 and 4 - \$125.00 respectively. This subsidy is negotiated with the purchaser and may vary from one residential facility to another and provides the total cost of residential care.

Family systems are being challenged more and more to care for older people. Some families can have up to five generations within the family structure, while others have only three generations and the middle one is having to cope with caring for the young as well as the old.

Within families the ratio of dependent elderly to working aged relatives will increase thus limiting inputs from private sources of care. If the dependent elderly use their own resources to purchase such care, then assets will decline thus reducing the magnitude of inter-generational wealth flows through inheritance. Because of their size, the cohorts that reach retirement during the decade commencing 2020 will place increasing demands on public and private pension and superannuation schemes. It might also be the case that these particular cohorts are less equipped to provide their own personal

savings to this end. Due to intergenerational differences in the timing and space of major life cycle events in the years before retirement, these cohorts could expect to have dependent children and/or dependent elderly parents, and expenditure on their own health and other needs. These demands will place constraints on their capacity to save for retirement (Department of Statistics 1990: 39).

It is important when looking at older people and carers' needs to put these in a political context. The major changes in services have been the result of the restructuring of the health system by the National government through Regional Health Authorities<sup>2</sup>. Prior to this system the majority of home-based support in their own homes was provided by Area Health Boards<sup>3</sup>. The main services were meals on wheels, home help and attendant care (although this service was only for those under 65 years old). Rest homes and hospitals have always been available but the means testing for hospital care has been recently altered to bring it in line with rest home care. ACC has always provided home help and attendant care for all ages if they need the service after an injury, but there have also been changes in the service provision from ACC. The political developments leading to these changes will be discussed later.

Locally in Whangarei the services that were available to carers at home were mostly means tested and the main service used was the 28 day relief. This provided a carer with a break, half a day a week. Those caring 24 hours a day appreciated the service but acknowledged that this did not give them the opportunity to continue with their other interests that they had prior to becoming carers. These include joining friends weekly to socialise, continuing with support groups or interest groups and, in fact, just to have the freedom to please themselves. One might say that a parent of small children is in the same situation, however, with an older person the care situation can go on for years leading to increased, not decreased dependence and there are more facilities available for child-care.

Some of the information provided by the carers, I have heard for the first time. I thought in my role as a social worker that I would have asked questions in such a way that carers would have told me how they felt and what caring was like for them. The major difference has been that the interviewing within the context of this study was non-directive and the questions were unprescribed.

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<sup>2</sup> RHA: purchasing agencies for the distribution of funding dollars.

<sup>3</sup> Area Health Boards: locally elected boards that ran health services, money for which went directly to the boards.

This chapter is a summary of my reactions, from a professional perspective, to the information I have been receiving from the carers. It is important that the information provided by the carers had pragmatic implications for social work and that this exercise was not only of academic use. The purpose of the final chapter is to challenge social workers working with the elderly to assess their practice and to raise awareness of the carers and the implications of the assumptions made about carers' choices and carers' needs. To enable the social work practice issues to be explored first a review of the literature must be conducted.

## CHAPTER 2

### Literature Review:

#### Introduction:

Increased life expectancy in New Zealand has created a new phenomenon - ageing. Ageing can be seen in two ways: the natural process where individuals grow older and the gradual variance in proportion of older age classes in the population. Reduction in fertility and increased life expectancy all contribute to a higher proportion of older people in the population. Medical treatment of the elderly, and fertility control both have had a significant impact on New Zealand society as people are living longer and having less children. As the population ages, the community is faced with a new group of issues and problems which are finally coming to the attention of New Zealand's media. Jane Clifton (1996) explored the need for centralised planning to cope with the 'age bubble' created by the baby boom after World War Two.

A discourse results in a particular representation of the social 'facts', which are not the truth but are a construct of practices arising from beliefs, knowledge and power. The dominant discourses of ageing in Western society have represented old age as a time of futility, despair and dependency. ( Biggs 1989, 47)

The literature review provides an overview of some of the current information available on ageing. The concept of ageing itself is presented and as reflected in the New Zealand writings of Anne Opie, encapsulate the myths surrounding ageing. More detailed data on the projected population statistics highlight the trends in New Zealand's demographics. The literature on caring itself is explored and this includes the role of women as carers. A number of authors discuss this and evaluate different stresses that are experienced by carers of older people. This includes the stress of being wife, mother, and carer daughter. The difference between how the role of carer is performed by men and women is questioned to evaluate if there is any variance.

A large proportion of literature on older people focuses on elder abuse and the majority has been written in America. This issue is defined and the social policy responses to elder abuse from different countries are discussed. A comparison of social policy responses to child abuse and elder abuse is made.

When studying women carers the issue of informal or unpaid work is developed by the literature. This is explored through articles on unpaid work, definitions of womens' caring role and defining caring work.

Peggy Koopman-Boyden, Dean of Social Services University of Waikato, collated the 1985 Royal Commission on Social Policy submissions on ageing. This report reflects the differing perspectives on ageing within New Zealand. The perspectives will be discussed pragmatically.

### **New Zealand Perspective:**

The concept of old people, presented by Jane Clifton, as having no future, with no reason to live and being a burden on society is a view that doesn't reflect New Zealand's multi-cultural nature. In New Zealand the western concept of retirement as an end to a useful life is in contrast to the Maori experience where old age is seen as a new chapter of life. The Western idea is one of slowing down while the expectations for Maori are the opposite. The leadership and direction of the *whanau*, *hapu* and *iwi* are now the primary focus and the practice of children being raised by grandparents is common. Older people have a sense of worth and are essential within Maori culture by providing leadership. I had this explained to me when in 1991 Dame Whena Cooper was in hospital, she felt very tired because of her role and the subsequent demands.

Literature on care-giving and care-givers is gaining exposure within New Zealand society. Anne Opie, a sociologist, has addressed the issue of what place older people have in our society. The principal focus in her work on carers has been the care of people with dementia. Anne Opie (1995) describes quietism, social withdrawal and isolation as further social discourses. Quietism relates to a slowing down in the pace of life, as older people become reflective. The majority of the population tend to socialise with others who are working outside the home and the 'social scene' tends to revolve around the forty hour working week. Isolation of older people is often defined by those who do not socialise with older people during the day. This concept of social isolation as discussed by Opie is however a misnomer. The majority of voluntary organisations are only running due to retired people providing their unpaid work. For example, in Meals On Wheels, run locally, the majority of volunteers are in the retired age bracket. This is also reflected in other groups such as Age Concern and ADARDS<sup>1</sup>. The notion of waiting to die has been the subject of the popular television series

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<sup>1</sup> Alzheimers Disease And Related Disorders Society Incorporated.

'Waiting for God'. This series challenges many of the generalisations about older people from issues about sexuality to concerns over residential care situations. The concept of older people being socially withdrawn, isolated and dependent on others is belied by the fact that eighty per cent of older people in the community are living independently.

Alternatively, ageing has been theorised as constituted by activity, the purpose of which appears to be to hold decline at bay (Fry, 1992; Wilson, 1991). In different ways both position older people as deviant because both characterise ageing as a withdrawal from productivity (in the capitalist sense of the word) and as predominantly concerned with loss (or trying to avoid loss) of capacities and relationships. Loss, expendability and decline are, according to both theories, defined as integral to ageing; both work to exclude other dimensions of the ageing process. Such discourses are productive of a certain fatalism, which has certainly been active within medical thinking and practice. Older people have been deemed not in need of services because ill health, loss and discomfort were seen as an inevitable part of ageing. These were conditions to be accepted. Both theories, then, justify a reductionist approach to the needs of older people and a dismissive approach to their significant contribution to society (Kendig, 1987; Walker, 1990), in part because the goals of older people may be very different from, and not understood by workers from very different age cohorts with different imperatives (Biggs, 1989)...

...Over the last 10 years, competing discourses of ageing have begun to emerge as researchers, practitioners and policy-makers have begun to identify the structural, practical and psychological outcomes of ageist theories.

(Anne Opie 1995: Introduction 4-5)

As well as raising the awareness of ageing issues, Anne Opie has promoted the role of care-giving and provided practical information about providing care.

Giving and receiving is an integral part of all human relationships, some give more and some take more depending on the relationship. Care-giving can be seen as an extreme case where the needs of an individual are provided, sometimes at the expense of any other relationship. This is common, and expected, when looking after babies, but this

care-giving role is becoming increasingly important at the other end of the age continuum, as population age cohorts change.

**Table 1: Projected New Zealand Population by Ethnicity and Age 1991-2031**

Age Group (Years)	0-15	16-64	65+	Total
Total Population (000)				
1991 Base	843	2190	385	3418
2001	965	2399	455	3819
2011	947	2631	543	4121
2021	886	2767	711	4364
2031	928	2765	892	4585
Maori Population (000)				
1991 Base	173	251	11	435
2001	204	292	18	514
2011	203	343	26	572
2021	200	385	39	624
2031	212	402	59	673

(Statistics New Zealand 1994: 21)

Changes in the age structure of the New Zealand population in future will be more pronounced than those in population size:

The population will age steadily, reflecting the impact of both low birth rates and the passage of baby boomers into retirement ages. By 2031, there will be nearly as many elderly as children and half the population will be older than 39 years.

(Statistics New Zealand 1994: 22)

This indicates that there will be increased growth in the working population 16-64 years. The working population is expected to remain stable but there will be an older age profile. Linking this to implications for carers and older people in general, those that are currently in the age range as carers will be increasing their participation in the work force and therefore may not be available to provide informal care. The work force will change by having more workers that are heading towards retirement age. The impact of this may be that retirement, or societies perceptions of retirement, may change and the work patterns of older people may transfer from voluntary to paid work. As most voluntary agencies rely on the contribution of older people, the informal care through voluntary agencies may also be reduced. Some areas that will need to be

addressed are the ability of the work force to support those that become dependent on others help and the social policies needed to meet the needs of both groups.

More importantly, who will care for this large number of older people? Women are again providing the care.

A new phenomenon is the number of elderly women who are providing the care for those in the same age bracket (Braus, 1994). This care is usually provided by their spouse, or in some cases an in-law. This generation was socialised through the media, church and education systems of the thirties, forties and fifties. The values perpetuated during this time are however, different from today. Present day women have more choices due to advances in contraception and changes promoted by the feminist movement, such as changes in womens' paid work. It was more common in the past for women to be at home caring for their husband and children. Demographics now show that women do not marry as often, work in a wider range of jobs and have less children at an older age. Traditional family values and roles play a very important part for those who are carers today. While the ties of family and marriage provide a commitment to care that could not be generated by the state (Levin, Sinclair and Gorbach 1989), one wonders if this will be so in future decades.

The role of carers and the role of women is central to the following literature. One of the concerns raised that a number of carers are also in the role of being a wife and in the role of being a mother. In their article 'Caregiver Burden and Generic Well-Being: Opposite Sides of the Same Coin?' Stull, Kosloski and Kercher (1994) question whether being a care-giver is stressful. The participants come from Ohio and were self-referred, the study was advertised through local media and mass mailing by the local congressional representative. Stull et al (1994), query whether the care giver burden, and well-being are actually mutually exclusive. It is assumed that because someone is providing care for a dependent that they have a great deal of stress, however, the question raised is whether there is a reward for providing that care and whether that reward actually outweighs any stressors. This study is inconclusive but does challenge the concept that being a carer compromises your personal well-being.

Stephens and Franks, of the Psychology Department at Kent State University analysed the 'spillover' between caring for a parent and the carers' husband's perception of the change in the wife role (Stephens and Franks 1995). This study concentrated on the links between the two roles rather than looking at the number of roles occupied. The respondents were 125 married women who cared for a parent, and responses were also

collected from the husbands. The conclusions of this study indicated that the positive and negative effects of being a care-giver spill over into the wife's role. This was also reflected in the husbands responses. Time limitations were identified as the major source of interference in a marriage relationship.

The concept that women are caught between two roles, caring for an older person and caring for children, is explored by Donald Stull, Karen Bowman and Virginia Smerglia in 'Women in the Middle' (1994), a study sponsored by the National Institute on Ageing (USA). The people selected for the study lived in north-east Ohio and had volunteered for the research. The focus of this research was to explore whether employment and parenting increases the stress for carers. Responses to a questionnaire provided a measure of perceived stress. The results, however, found that in relation to employment and care-giver strain, the care-givers who were employed experienced high levels of physical strain. There were no indications that working reduced the level of strain. The impact of children was interesting. The children either had a positive effect reducing the stress of care-giving, or no effect whatsoever. The increase in care-giver stress was related to the increasing dependence of the older person, this effected the carers life in other ways i.e. "...greater care-giver physical strain, greater social constraints and greater caregiver-elder interpersonal strain." (Stull et al 1994, 322 )

Gerritsen and van der Ende (1994) attempted to develop a care-giving burden scale endeavouring to quantify the relationship of the carer and the care-receiver, and the limitations on the personal life of the carer. This study was presented as objective, "*An improvement seems to be that this assessment is not contaminated by objective evaluations of health, income and social support.*" (Gerritsen and van der Ende 1994, 484 ) It seems difficult to evaluate information in relation to carer stress without taking these factors into account.

Susan Allen, of Brown University's Centre for Gerontology and Health Care Research (1994), presents another perspective on gender differences in spousal care-giving. Although this research was focused on the caring being in response to cancer, two interesting aspects of gender care-giving were presented. Firstly, wives provided twice as many hours of care as did the husbands. Secondly, a perception that

..care-giving for most women (especially wives) is generally an extension of their normal social roles of family nurse and household manager, whereas care-giving involves the assumption of an entirely new role for many men.

(Allen 1994: s187)

As women are the majority of care givers (Opie 1995, Levin, Sinclair & Gorbach 1989, Doress-Worters 1994, Gerstel & Gallagher 1994) the present study has focused on women in this role. There has been a major focus on research about how men and women cope differently as carers.

The literature on elder care as noted, points to the unique stressfulness of the elder care role, but fails to place it in the broader perspective of the array of the roles in women's lives. The multiple roles literature, on the other hand, suggests that accumulation of roles is generally enhancing to women as it is to men, but that a simple additive model is not adequate to describe women's role configurations. However, the multiple roles literature has failed to include the elder care role, and has only begun to address multiple care-giving roles.

(Doress-Worters 1994:612)

When caring for a child, the usual process results in the child becoming more mature, independent and leaving home. In the case of an older person the degree of dependence usually increases and the amount of energy required also increases. Some people are happy to provide that care however, the concern is that when people are providing this ongoing care without the resources to manage, then abuse may occur. The first publications in relation to abuse were seen in the 1970's (i.e. Block and Sinnott 1979, Lau and Kosberg 1979). No books have been written or published about elder abuse in New Zealand, however Age Concern (1992) have developed a manual for training in relation to Elder Abuse.

It is estimated that 4% of the elderly population are victims of elder abuse (Eastmann 1984). Pillemer and Finkelhor (1988) provide what is considered to be the first solid evidence of the existence of elder abuse. Research based in the Boston metropolitan where 2020 elderly persons were interviewed regarding their experience of physical violence, verbal aggression and neglect. This group was randomly selected. The rate of elder abuse was presented as 32 per 1000. Spouses were the most likely abusers with equal numbers of males and females as victims.

The current study clearly establishes that incidences of elder abuse can be obtained that are free from some of the biases of clinical samples and reported cases. It is hoped that this effort will open the door to other investigations and that many of the remaining, troubling questions about this disturbing problem will soon yield to greater insight.

(Pillemer and Finkelhor 1988: 57)

Four factors were identified to explain violent feelings and violent behaviours by care-givers toward relatives with dementia. These were; shared living situation, care-giving demands, interactional stresses, care-giver characteristics. Care-giver characteristics were predictive of violent feelings on the part of care-givers, including physical aggression by the care recipient, disruptive behaviours. Violence by the older person with dementia was related to violence by the care-giver (Pillemer and Suito 1992).

Concern has been expressed at the fact that abuse cannot be identified until after the event. Prevention is therefore paramount. Education is seen as the most effective method of prevention with the family education model (Gold and Gwyther 1989). Their programme identified four areas of potential conflict. These included financial, functional (problems of long-term disability), age-linked physiological limitations and social implications such as changes on roles from receiving care to providing care. The idea is to teach older people and their families appropriate strategies for coping with the problems of ageing. The model promotes the philosophy that if solutions to possible problems are taught early then people have the resources to solve them. Kosberg (1988) believes potential abuse can be predicted through systematic assessment of the older person and the potential care-giver, as well as the family. Risk factors have been identified which are not seen as the cause of elder abuse but also contribute to the problem these are; poverty, unemployment, lack of community resources, intra-family cycles of abuse and personal hedonism. Pre-assessments of a potential carer for these factors is presented as an effective method of elder abuse prevention rather than the process of detection and intervention once abuse has occurred.

American literature is well advanced on the issue of elder abuse with debates on whether mandatory reporting, and the legislation, is successful. Definitions are discussed by Salend et al (1984) and it is believed that raising the awareness of physicians and other professionals, and clarifying definitions of abuse will result in appropriate interventions, and professionals also need to have wider knowledge of the services available (Salend et al 1984). Legislation is scrutinised by Skelos (1988), who presents a personal view of the legislation process. A number of hearings provided a

platform for victims to tell their story, and resulted in a push towards establishing respite services. The information collected by Skelos (1988) has provided data on abused and abusers, which could be used to increase public awareness and develop a co-ordinated response to the problem of elder abuse.

Older people are seen as capable of being self determining, a position that children cannot share. It is recorded that child abuse was recognised in the 1800's but it took until the 1970's for elder abuse to be identified. The emphasis in child abuse has moved from saving the child to saving the family. This same process is now occurring for the elderly. It has been valuable to draw on some of the lessons learned from the Child Protection service. The consequences of raising issues of abuse is that people become defensive and the problems are hidden if people who are not coping, as carers, feel they will be labeled as an abuser. The issue of child abuse was initially politicised by arousing anger and outrage in concerned people in a variety of communities. In the 1960's public awareness was raised by the medical community. Reporting laws established information systems and evidence of incidents of abuse that kept the issue in the public eye. Emphasis was originally on defining, identifying and reporting child abuse and the establishment of central registries rather than intervention, treatment and the provision of services. Expectations for universal protection of children are unable to be fulfilled by the public social service. The growth of single parent families, between 1960 and 1988, poverty and divorce exacerbated the problem. The demand for tax resources outgrew the political support for the intervention system. However, involvement of a broad range of public and private agencies in the past and present is building support in responding to the problem (Schene and Ward 1988) and the focus has now shifted from a rescue of children in at risk situations to one where the families were given the opportunity to parent through leadership and public education.

This background knowledge about child abuse provides a useful basis from which the development of programmes to prevent elder abuse can start, with people telling their stories to raise awareness of the problem, to the obtaining of support from key professionals, and the politicization of the issue. Reporting laws need to create systems that will collate reported elder abuse, and regular press releases need to be made. Emphasis needs to be on intervention, treatment and services for both the abused and the abuser, to support families to relieve carer stress and protect the abused. Adequate resources need to be provided to public service organisations to successfully detect abuse and intervene in an abusive situation. A multi-agency approach will be needed in responding to the problem. One advantage of working with adults is the involvement of the people themselves in the helping process. Based on current knowledge it is an

opportune time to introduce both preventative and remedial programmes. Some ideas can be taken from the programmes for child abuse prevention, as long as the differences between children and adults are identified and noted.

There is concern that health professionals become desensitised to elder abuse and can even accept neglect as the norm and only respond to 'special cases' labeled as abuse. Giving service providers access to avenues of intervention, practice and training issues are presented in cases of family abuse of the elderly. One training programme uses responses to vignettes describing four levels of elder abuse; verbal, pushing, hitting and severe beating is used to determine how service providers categorise the severity of the abuse (Pratt et al 1983).

The complexity of confronting abuse is more involved than definitions portray (Phillips and Rempusheski 1986). It is suggested that social and health professionals need training on how to respond to the special needs of the elderly and this includes the development of the skills for sensitive interaction with both the abused and the abuser. Procedures for assessing the needs of the victim and the abuser should be developed to ensure timely interventions, and the involvement of police and other legal professionals. A review process is also required.

Currently carers in New Zealand are beginning to be identified as a group by government policies such as the Disabilities Services Act 1993. There has clearly been a trend since 1984 when Labour became government, to move towards a community care philosophy and this has affected people providing care.

New Right ideologies and the policies derived from them for community care are internationally regarded as problematic by many researchers and practitioners. There has been extensive debate about the sustainability of such policies, in part because of their gender and equity issues as well as the weight placed on informal family care-givers who play a key role within the health system because of the quality of care they provide (Anderson, 1994; Hanson, 1994) and because of the economic significance of that care. In many countries, delivery of services to care-givers continues to be fragmented and poorly co-ordinated. New Zealand is no exception in this regard although it also needs emphasis that in different parts of the country the degree of support offered care-givers may very well vary.

(Anne Opie 1995: 220)

The socialisation of women to care for their own families has saved western governments millions of dollars as institutional care is far more expensive than community care (Braithwaite 1990). It would be difficult for a number of older people to remain in the community if they did not have support. It is acknowledged that if informal care was not available in the community many people would not be able to remain in private households and institutional care, for many, would be avoidable. However, it is generally recognised by those working with older people that individuals are happier if they are living in their own home with family and friends. In my experience a number of carers believe that they are providing something for the dependent that is very precious. They are promoting the older person's independence as much as possible and enabling them to live outside an institution. The quality of life a carer can provide for a dependent person should not be underestimated, however one of the questions for this research is at what cost to the carer?

Unpaid work is the subject of Braus' work (1994). She identifies that two-thirds of all home-care assistance is provided free of charge by friends and family. The implication of this is that it is not a valued service provided in our society and as outlined in Gerstel and Gallagher's (1994) article, women provide an enormous amount of care on a number of different levels. The work is usually appreciated by those receiving it but it appears to be taken for granted by policy makers.

While it is valuable to show that women benefit as men do from participation in socially integrative and valued work, it is equally crucial to call attention to women's continuing and unequal contribution to nurturing and care-giving ..... It also obscures the fact that women are recognised and compensated only for part of their work, their market work, while their family care-giving contributions continue to be as under recognised in the social science literature as in the GDP.

(Doress-Worters 1994: 611)

A woman over the age of 18 can expect to spend 17 years of her life caring for children and 18 years helping an ageing parent. Thus women who care for an elder parent may actually provide such care for more time than they spend rearing children ..... Eighty-three percent of women over 18 will care for both children and elders at some point in their lives (OWL, 1989).

(Doress-Worters 1994: 601)

Naomi Gerstel and Sally Gallagher (1994) believe that a more structured approach to gender differences in care-giving is needed. The underlying hypothesis is that 'wives' will provide care to a much larger group of people than will their husbands. Gerstel and Gallagher observe that men provide less hands-on care. The focus of the research looked at working women to try and evaluate if employment was a factor that may create similar patterns of caring for both women and men. The sample was randomly selected from the phone book and the participants were interviewed face-to-face. The findings of the research confirmed that care-giving remains predominantly women's work. Care was provided on a number of levels, to friends, neighbours and strangers through volunteer work.

To put it quite starkly, wives add more than an extra work week to their monthly load by caring for those outside their nuclear households.

(Gerstel and Gallagher 1994: 533)

This extra care was called the third shift as it came after paid work, while the second shift was that done in the home, attending to the house and the family. From a structural approach at a time when community care is being encouraged women are already stretched by providing care on these three levels. The study identified that women who are employed try to provide paid help rather than provide hands on care.

Changes in work patterns of women caring for an older person were examined by Susan Franklin, Barbara Ames and Sharon King (1994). The study was in response to an American corporate concern about their obligations to women employees. This research involved 630 Michigan family care-givers of elderly relatives in three month intervals over a period of eighteen months who were interviewed by telephone and completed self report questionnaires. The three types of employment issues were short-term work adjustments, leave of absence and leaving work all together. The major discovery in this research was "*the immediacy of the influence of acquiring the eldercare role on the employment adaptation of women.*" (Franklin et al 1994, 355) The impact of moving into the role of caring for a dependent elder directly affected the woman's' employment situation. The companies then need to be able to provide flexibility in employment conditions at an early time to support their employees.

The focus of the literature presented is largely on women as carers. Care-giving itself is a role that is provided mainly by women and benefits all levels of society from the policy makers to the husbands at home. The multiple roles of women have been discussed and also the debates on the benefits for women. More recently in America, the issue of care-giving is beginning to affect employers and research is focusing on

developing social policies that will help retain good workers and encourage them to be able to remain in the work force while caring for an older person at home.

**The Royal Commission on Social Policy:**

Peggy Koopman-Boyden is acknowledged as one of New Zealand's leading authorities on ageing in New Zealand and this has been recognised by inviting her to contribute to the Royal Commission on Social Policy (RCSP).

The exploitation of women by the family and state has been identified and the emancipation of women from their private worlds will decrease the number of women who choose to take on a role that is not valued by society. Already carers are speaking out about the financial hardship experienced by them due to their financial situation when choosing to care for an older person. The comments made by the carers when asked to give advice to others thinking about becoming carers was to take time to make a choice rather than take on a role because of societal expectations. Self sacrifice was also discussed and the personal costs were also displayed as reasons to be clear about the choice the carer is making. The concept of institutionalisation was not one which was favoured by the carers, in fact it was seen as a last resort. This role, however, may be given value within the Community Care model. As more women choose to continue to work, the role they once would have provided is given productive value by these women paying for caring services. Pay carers in institutional facilities receive very poor remuneration and they are mostly women employees. The report provided by the RCSP provided some progressive theoretical perspectives that have not been developed in current social policies.

Several concerns were identified in the RCSP report;

For the past decade community groups have encountered various problems in maintaining their activities. For example, agency funding takes an ever increasing portion of the volunteers' efforts, members' household incomes are failing to keep pace with expenses incurred doing community work, and volunteers are hard to recruit.

This pool of carers is rapidly declining through the increasing participation of women in the paid work force and the smaller cohort of 40-55 year olds.

What demographic and employment trends do not reveal is the onerous nature of the burden placed on many families members who support and care for elderly relatives. Many of the carers are themselves older people, so that when intensive care is required, this can have severe effects on the

carer's health and emotions, particularly when the effects of her/his own ageing are being felt.

The long-standing assumption that a community care system can be sustained with a minimum investment from the state is also now being questioned in relation to these social and demographic changes. When the full cost (including hidden costs such as the opportunity costs of the family members, additional home heating and lighting in the family home and transport costs of family members) are compared with the publicly available costs of institutional care, the costs of the two forms of care are now being shown to be very similar (Green 1987). The extent to which the community, and particularly the family, will continue to bear these costs without further state support is the central question facing the community care perspective.

(RCSP 1988: 640)

The RCSP was commissioned to provide a nationwide investigation into social issues and to provide information that can be used in the formation of appropriate social policy. The information presented in relation to the elderly has been used as a basis for theory on elderly as it provides a comprehensive theoretical base that, although compiled in 1988 has relevance in influencing the policies of today.

The RCSP released a report presenting summaries of the submissions received on a number of social policies. The information outlines as previously stated, several theoretical perspectives on the elderly. In brief these are; (1) medicalisation of the elderly, (2) 'welderly' approach-a health promotion approach, (3) institutional perspective, (4) community care, (5) dependency perspective, (6) empowerment-life enhancement, (7) social construction of old age and retirement and finally the (8) continuity and integration perspective.

### **(1) Medicalisation of the elderly:**

This process views the elderly through the paradigm of the medical model. The prime focus of the medical model is diagnosis and treatment. 'Growing old' is diagnosed as the problem and treatment through the form of medication is prescribed. Explanation of a problem, for example lack of energy, may be attributed to ageing. The spin off from this theoretical approach is that decline to ill-health is just a matter of time and that all older people can expect less satisfaction with life as a result and they are not prioritised for treatment, or treated at all. A common problem for older people, as an example of

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This process views the elderly through the paradigm of the medical model. The prime focus of the medical model is diagnosis and treatment. 'Growing old' is diagnosed as the problem and treatment through the form of medication is prescribed. Explanation of a problem, for example lack of energy, may be attributed to ageing. The spin off from this theoretical approach is that decline to ill-health is just a matter of time and that all older people can expect less satisfaction with life as a result and they are not prioritised for treatment, or treated at all. A common problem for older people, as an example of

The report discusses the Geriatric Hospital Special Assistance Scheme (GHSAS). This scheme was functioning for those who were needing hospital category care (highest 'dependency' care). The main element of this scheme was that the person's contribution to their care was income but not asset tested. Therefore a person with no income, but who owned a million dollar farm, would not be contributing towards the cost of their care. This has changed with the development of the Regional Health Authorities (RHAs). The system now has 'capped' the number of residential beds (at all levels of care) and brought in the same means testing criteria for all residential care. People on the scheme were 'grandparented' until June 1996.

The means testing introduced by the RHA's was still seen to be unjust (and subsequently changed) as the carers of the older people were not recognised or identified as having supported the older person. The carer did not come into the equation when reviewing the older person's assets. In practical terms this meant that if you were living with your mother (who owned the house) and caring for her for a number of years, the house you were living in could be sold from underneath you and any money given to you (within the past five years) by your mother would have to be repaid.

Another aspect of the changes in means testing was that \$2000.00 cash assets in the bank would exclude you from community support. However for residential care it has been set at \$6500.00 (single individual) in cash or \$20,000.00 excluding house and car for a married couple with one partner going into residential care. Obviously, there are people who have partners and fall within the residential care means testing but outside the community means testing. Therefore older people are faced with a decision whether to utilise residential care because they are financially disadvantaged not to do so. The development of the Community Services Card as the means testing criteria for community services has increased the number of people now eligible for these services. However there is still hardship for a number of those elderly relying on superannuation as their principal source of income.

Attempts to review the needs of the elderly before becoming admitted to a residential care facility has been reviewed with the introduction of the RHAs. One assessment has been developed to identify needs of a person whether they are living in a facility or at home. This 'needs assessment' is then used to assess resources either in the community or services provided at home. The development of Assessment and Rehabilitation (A&R) services has improved the quality of these assessments and community assessment teams were developed in 1993. The focus on inpatient assessment and

rehabilitation however focuses on a short intensive period of rehabilitation to address the possibility of reversibility and those people with long term rehabilitation needs at this time (locally) are not being met.

The changes in residential care have resulted in a decline in the facilities that formally provided supervision for people, to a service which copes with higher needs and provides more 'hands-on' care. Rest homes are categorised as stages one, two and three. Stage one provides supervision for most independent people rather than hands-on care. Stage two provides for people who may be mentally astute but require hands-on help to shower and provide most day to day support. A new category of care, stage 3, was developed in 1993. This is in response to those who need a secure environment, due to wandering and behavioural differences of dementia. The majority of people receiving this service are physically fit but are unable to make decisions about personal safety.

The standards of care in rest homes are now monitored in two ways. The first of these is through the Ministry of Health who are responsible for the licensing of the homes under the Old People's Homes Regulations 1987. This tends to be more of a functional approach checking sizes of rooms and staffing numbers and rosters to ensure minimum standards are being met. The RHA is the other watch dog. The RHA sets the level of funding that each facility will receive. As stated earlier the RHA also sets the number of beds available in each category and a contract with the RHA is essential to ensure subsidies from the government will be paid. Responsibility for the payment of subsidies has been transferred from New Zealand Income Support Service (NZISS) to the RHA. Within these contracts the standard of care is defined and includes minimum expectations. The effect of this on the market is that rest homes are providing more services to the residents and the majority of homes are charging private and public residents the same fees thus reducing the division between the two. A recent audit of rest homes has identified the rights and responsibilities of the residences. It is the Rest Home Association's view that the outcome of the audit will reflect on the price paid by the RHA therefore encouraging rest homes to provide a "five star" service.

#### **(4) Community Care:**

This section reviews information on community support services and evaluates the availability of them to the consumer. Support of the carers is an issue illustrated by the RCSP's report. The focus on this area was mostly financial and presented the benefits available. One concern raised in the report (which assumed the majority of carers were

women) was that the current 40-50 year cohort was being expected to provide a caring role for both their parents and grandchildren. The other factor was the increasing number of women participating in the work-force and excluding this group from providing the care now expected to be provided in the community because of deinstitutionalisation of residential facilities (including mental health, physically disabled and elderly).

The majority of volunteers in community agencies were recorded as women in the 40-50 years cohort group and the report expressed concern at the availability of these volunteers in the future.

Housing for older people is also presented as an issue in the report. This is even more so now that Housing New Zealand has decided to rent houses at market rates. Some older people move into retirement villages and isolate themselves from the rest of the community because they feel safer and closer to services. Retirement villages of this nature are being marketed at an increasing rate and targeting those now in their 50's. A local example of this is the planned development at Coopers Beach; 100+ single and double units, a community centre and a rest home/hospital to ensure that you can remain in the area for the rest of your life. Although this is a beautiful spot, it is isolated from any city (the closest being Kaitaia three quarters of an hour away).

#### **(5) Dependency:**

Society has generally placed the elderly within a dependent stereotype. This is one factor in the 'invisibility of the elderly'. The institutionalisation of older people creates a dependency. The assessment and rehabilitation service workers often find sending people home to break cycles of dependency. It can take a short period, often a few weeks for people to adjust to having things done for them, rather than doing things themselves. Psychological and political dependency are illustrated in the stories of elder abuse. Abuse can happen either in the home or in a residential setting and has yet to be addressed within social policy and by statutory organisations. Several submissions to the RCSP suggested a separate statutory agency to protect the elderly. The 1985 Protection of Personal and Property Rights Act provides some answers in relation to protecting the personal rights of an older person. However, the Act is used more commonly to establish powers of attorney. Provision in the remainder of the Act, which allow for the allocation of property and welfare guardians who are audited to ensure the safety of the individual, are often hampered by the slow rate of the process in the family courts. Furthermore, the commitment of welfare and property guardians is

based on the good nature of the individuals, which is not a role supported by the state, thus it is difficult to find people eager to take on these roles.

**(6) Empowerment Life-Enhancement:**

This perspective challenges the traditional life development stages of early childhood, adolescence and adult. It explores the continuation of development at the adult stage and present retirement and beyond as the further stage of life. Harry Moody (1988) in his book "The Abundance of Life" also promotes this concept of the third stage of human development.

Will this problem-focused approach to old age persist? There is evidence to think it may not. There are reasons to believe we are now at a historical turning point in our view of late-life development, a change in our concept of the kind of growth or development that is possible in the last stage of life. A theoretical foundation for a new view of late-life development is now emerging from studies of lifespan development psychology. These studies demonstrate that the human capacity for learning and growth continues well into later life, provided opportunities and incentives are available.

(Moody 1988: 5)

This empowerment model considers that the elderly should have equal opportunities to continue to work if they choose, and have the opportunity to be involved in the decisions that are made in relation to policies that affect them. The current systems have tended to exclude the elderly from being able to maintain their position in the market place, that is being able to continue to buy goods and services once they are removed from the work-force. The submissions to the RCSP indicate that financial maintenance systems should remain to enable an adequate standard of living for the elderly to be possible.

The concept of the elderly being able to participate in studies and contribute to community service are promoted. These philosophies are certainly promoted through Age Concern and Grey Power who are constantly promoting an empowerment model in the community. Age Concern work mostly at a community level responding to a variety of needs, although submissions are made to government. Grey Power on the other hand is a political movement that challenges structural inequalities. This group are particularly vocal in election year.

### **(7) Social Construction of Old Age and Retirement:**

Once again the notion of socially constructed old age is promoted by this perspective. Here the concept of retirement itself is to blame. If the productive time in life is considered to be related to income potential then retirement dictates that you no longer have a value in society and your contribution is defined by Ian Shirley (1995), as a thirty year period within the life span continuum. Those years that occur between birth and employment are described as a 'youth ghetto' with the following thirty years considered a persons 'life' where the person is in paid employment. The time following retirement is considered to be old age redundancy.

If we define the period from birth to death on a continuum, then 'life' is designated as those years in which we engage in 'productive' work. The concept of production used here is one which dominates the reductionist approach to development. It is based on an economic interpretation which equates production with the ability to earn money in the market place. Because of the relationship between work and power as conveyed by this model, 'life' is reduced to that period of existence in which we earn an income and establish ourselves as individuals in the labour market. In other words, what is done on the job is production and work- what is done away from the job is consumption and leisure. Given these distinctions it becomes obvious that 'life' for many people in our society is contracting. In formative years of development, many young people are being forced to stay on in 'education' although they are no longer guaranteed a job, and at the other end of the continuum, people are pensioned off into redundancy, despite the fact that they have so much to offer society. Thus the concept of the 30 year life.

(Ian Shirley 1995, Keynote Speech Towards 2000,)

The RCSP has not mentioned thus far the Maori perspective on ageing. The elderly are treasured as having knowledge and wisdom and are seen as the teachers and the leaders. The potential for status and knowledge is acknowledged once the person reaches older age, and older people are traditionally viewed as a valuable resource. This is a concept that could be nurtured by the wider society.

### **(8) Continuity and Integration Perspective.**

The final perspective advocates the integration of the Elderly into society rather than identifying them as a different group due to their age.

The continuity perspective endeavours to portray the elderly as capable of being totally integrated into society, and sees old age as no different from other age-cohorts. It accepts the argument that since old age is socially defined (rather than chronologically or biologically defined), such a social construction can also be avoided.

(RCSP 1988: 647)

An approach which promotes integration of the elderly without any distinction on the basis of age is extreme and will negate some of the special needs the elderly have, to ensure continuity. Retirement will be a concept from the past and no statutory provisions for income will be made. In a sense this concept is being promoted to younger generations who are now 'saving' for their retirement through various superannuation schemes.

Underpinning this theory is developmental theory, which regards human development as a life long process.

#### **Summary:**

The link between the perspectives presented and the feminist analysis, is social policy and it's impact on the family and more specifically women. The whole notion of community care is reliant on women as the lynch pins of families to provide care for both young and old. This role is promoted throughout social policy and rests on the unseen women in the community who fulfill this need. As outlined above social researchers internationally seek to explore why women become carers and the nature/nurture debate continues.

Women seem to be the nurturers in all cultures- this is understandable when children rely on lactation to survive, but with elders the logic is lost. The gender difference in caring is presented in the literature and promotes the perspective that women spend more of their time providing direct or indirect care than men. I was challenged by feminist theory to explore how the women recipients became carers, developing the nurture component of the debate by asking whether there is a choice for women to provide this caring role. Choice also has an influence in the literature presented

surrounding elder abuse. As a social worker, this issue challenges those working with elders as it highlights injustices both for the elderly themselves and their carers and is experienced on a daily basis. When focusing on carers, the elements central to elder abuse are lack of formal and informal support, isolation from family and friends and invisibility - the lack of recognition for the difficult job they do. These themes, together with the issue surrounding choice, are explored within the interviews and are presented within chapters five and six. For some of the carers this provided their first opportunity to discuss how they feel about their role.

The demographic information presented outlines the size of the ageing phenomenon. It is important also to reflect on the roles women play in caring for older people and the other roles they are also expected to fill. Elder abuse, as stated, is becoming more known within New Zealand and pilot programmes are being offered throughout the country responding to the cases of abuse that are being referred. A new area identified in the literature is the research currently focusing on the impact of care-giving on employment. If 83% of women are going to be caring for an older person sometime in their life it will certainly affect the labour market and unless the employers in New Zealand address this issue a large pool of knowledge and resources will be lost.

Having reviewed the literature on ageing it seems important to analyse the information on the formal resources available to carers. This established the support provided to these women by New Zealand's statutory agencies.

## CHAPTER 3

### Resources:

#### Introduction:

Caregiving occurs in the private world of the family, isolated from the public sphere. It is in this public sphere that social policy is formulated and subsequently resources are allocated. The resources available to carers may provide support which reduces the caregiver stress as outlined in the previous chapter including reducing the risk of elder abuse.

Within New Zealand, there are a number of Government Departments whose purpose is deemed to provide resources to enable New Zealanders to have a basic standard of living. The three statutory agencies providing for the elderly are the Department of Social Welfare-New Zealand Income Support Service (NZISS), Accident Compensation and Rehabilitation Insurance Corporation (ACC) and the Ministry of Health. An explanation of the structures of these organizations is provided and the resources current at the time of this thesis are outlined together with the daily lived experiences of carers. Reflected are the consequences at grass roots level, of social policy affecting carers.

The opportunity arose to interview Nikki, a social worker who had been in a front line position for three weeks. Nikki was interviewed as she was in the position of having to learn what resources were available in order to fulfill her role as a health social worker whose caseload is primarily involved with advising the elderly and their carers. The orientation programme designed to provide Nikki with the resource information and networks to co-ordinate services for carers providing for an older person returning to their home is presented. The social worker also assesses the older person for residential care.

This chapter concludes with an example of the experience of a consumer, Gillian, who describes how her husband was mistreated in a residential facility. I was moved by this all too familiar story, as it demonstrated the total inability of formal services to meet the needs of those they were designed for.

#### Welfare:

New Zealand Income Support Service, provides support for people who are unable to support themselves, either because they are sick, caring for dependents or unemployed.

The elderly are able to get superannuation if they have reached the age of entitlement. The financial support from this service includes a weekly payment for the costs of living, disability allowances, accommodation support, as well as various special needs grants (loans) that have to be paid back.

The focus of this department is to provide basic necessities. Whether they do provide this is open to debate. New Zealand Income Support Service comes under the Social Welfare Vote in the Official Budget publications. The Government's strategic objectives and related outcomes as described in the 1995 Budget, are outlined below.

The services purchased by the Minister of Welfare will make a significant contribution to the Government's strategic objectives of maintaining strong economic growth, and building a cohesive society. The latter of these objectives will be an area of particular focus, with the aim of helping New Zealanders move from state assistance to greater self-reliance and various forms of social contribution, including work of all types. By contributing to the goal of building a cohesive society in this way, the opportunity for strong economic growth is enhanced.

The Government's outcomes for Social Welfare are expressed in two categories: general and specific.

#### General Outcomes

That people are encouraged to take responsibility for themselves and their families and whanau.

That appropriate services and support are available to people with special needs and disabilities, and other disadvantaged groups.

That social welfare policies and practices help the development of strong and supportive families and whanau.

That social welfare policies and practices support older people who live independently, and facilitate the participation and contribution of older people in community life.

That social welfare policies and practices support and strengthen safe and cohesive communities.

That the special position of Maori under the Treaty of Waitangi is recognised.

#### Specific Outcomes

Income maintenance policies and practices:

People receive sufficient income to prevent undue hardship.

People are well informed about their income maintenance entitlements, how to access them, and their rights and obligations.

Recipients are supported to become independent and move into paid employment to the greatest extent possible.

The particular needs and circumstances of recipients are recognised, and that appropriate services and support are available to those with special needs.

Benefit crime is deterred and detected.

Debt is appropriately managed.

(Estimates of Appropriations for the Government of New Zealand 1995, 422)

Reflected in the statement from the Department of Social Welfare is the philosophical position of the government on welfare. The primary objective is the maintenance of strong economic growth and the second is the building of a cohesive society. This is to be done by encouraging individuals to be more independent through participating in the work force.

Applying this specifically to carers of older people, how do each of these Departments supply resources to carers? NZISS will provide support in a number of ways. The most important is the living allowance provided either through superannuation or domestic purposes benefit.

New Zealand Superannuation gives a retirement income to people who have reached the qualifying age.<sup>1</sup> This has now been moved from 60 years to 65, but people born between 1932 and 1936 can receive it at an interim qualifying age. The weekly amount paid is \$189.65 nett. (A table is provided to help people calculate their qualifying age). There is a surcharge on superannuation if you earn a wage above a certain level while collecting superannuation. The Transitional Retirement Benefit is available for those who have reached the qualifying age of retirement but not receiving superannuation. This is set at \$144.32 per week for a married person and \$173.06 for a single person.

The second living allowance available for carers is the domestic purposes benefit (DPB) for carers. The caregiver must be:

16 years old or over

be caring full time for someone (not a partner) who would otherwise be in hospital.

If you are caring for a partner or someone who needs full-time care but not hospital care then the emergency unemployment benefit is available of \$142.50 net.

In summary, to receive the DPB for caring for an older person depends on how old you are, whether you live with a partner and other income you or your partner receive. One carer says...

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<sup>1</sup> The reason superannuation has been outlined is most carers over 65 will be receiving this benefit.

*The Government pay this wage, currently nett amount of \$173 and a few cents a week. There is also 28 days in a year relief care which is exactly 4 weeks which is about the average person's holiday time, the minimum holidays that people have in a normal job is 3 weeks and plus all the statutory holidays, plus 15-16 hours a day free to themselves, plus 2 days every weekend. Now my position is, theoretically, I'm paid that small wage, there's 28 days relief care when I can have a break, but that 28 days doesn't cover 2 days every weekend for the year, it doesn't cover the 16 hours a day that other people have to themselves.*

**Catherine**

There are a number of other services available:

Community services card; for a family on a low or medium income to give cheaper costs for visits to doctors, hospitals, specialists and for prescription charges.

Accommodation Supplement; designed to assist with accommodation costs and is payable to people whose income and assets are limited.

Special benefit; is for short-term help eg hire purchase of a washing machine.

Training Incentive Allowance; mostly for those on DPB, Invalids and Widows benefits to encourage them to go into training

Major Repairs Advance; a loan of up to \$2652.00 incl. GST to assist with repairs, maintenance or essential services to a persons home.

Disability allowance; supplementary allowance for people with a disability on a low income or who receive Income Support.

Home Help; up to 15 hours per week, funded through the RHA.

Special Needs Grant; a one off payment to those who need help due to an emergency.

Legal Aid; income tested to assist people who require representation.

The services mostly used by carers of older people are the Community Services Card (CSC), Disability Allowance and Home Help. The carers, and the older person being cared for, are entitled to be considered for any of the above services. The community services card is being used as the main criteria for means testing. If people hold a Community Services Card a number of services will be available without cost. The CSC is used to identify and target those on lower incomes. Holding a CSC not only provides you with discounts for prescriptions and doctors visits it also provides free outpatient treatment at public hospitals and (in Northland) dental care at \$25.00 per visit. Other health cards include the high usage card for those with ongoing illness and prescription subsidy cards for those requiring large amounts of medication.

Outlined below is the estimated published annual costs of the above services.

**Table 2: Services provided by New Zealand Income Support Service**

Service <sup>2</sup>	Estimated cost in the 95/96 financial year. (\$000s) <sup>3</sup>
Superannuation	5,063,541
Domestic Purposes Benefit <sup>4</sup>	1,100,711
Community Services Card	390
Accommodation Supplement	480,000
Special Benefit	100,050
Training Incentive Allowance	81,120
Major Repairs Advance	2,027
Disability Allowance	133,896
Home Help	1,266
Special Needs Grants	36,582
Funeral Grants	5,446
Transitional Benefit	86,473

Disability allowance is a means tested allowance to people with regular costs incurred because of their disability. Examples of this are travelling costs, special clothing and special diets. This allowance would be added to the benefit of the person with the disability.

The Home help scheme was funded and provided by NZISS, but funding has now been transferred to the local RHAs (June 1996). Home help is the provision of household tasks that the person is unable to do for themselves. This is also means tested by NZISS (who do the means testing for the RHA) if the person holds a CSC this is the criteria to be eligible for this service free of charge. Household tasks include housework, preparation of meals, shopping, washing etc. The social contact for the isolated individual is equally important to some people as the services provided.

In 1994 Ann Beaglehole from the Department of Internal Affairs published an article on income support for women from 1893-1993.

<sup>2</sup> The application forms for these benefits are contained in Appendix 1.

<sup>3</sup> This information is provided by the various votes and tabled in parliament in accordance with the Public Finance Act 1989

<sup>4</sup> This figure also includes support to single parents.

**Table 3:** Comparison of benefit rates, wages and cost of bread at key periods of survey.

Year	Benefit	Value (weekly)	Weekly Wage (female)	Weekly Wage (male)	Cost of Bread (loaf)
1898	old-age pension	6s 11d	£1 1s	£2 12s	1d
1911	widow's pension	4s 7d (widow with one child)	£1 8s	£3 6s	1d
1926	family allowances	2s per child (families with more than two children)	£2 4s	£4 17s	3d
1936	deserted wives' benefit	£1 10s	£2 2s	£4 8s	3d
1939	1938 Social Security Act		£2 10s	£5 12	3d
	widows' benefit	£1 15s (women with one child)			
	deserted wives' benefit	£1 15s (women with one child)			
	sickness benefit	£1 (aged 20 or over)			
	invalids' benefit	£1 (single rate)			
	unemployment benefit	£1 (aged 20 or over)			
	age benefit	£1 10			
	Universal Superannuation (from 1940)	£3s 8d			
1946	Family Benefit (Universal)	10s	£3	£6 3s	3d
1973	domestic purposes benefit	\$36.50	\$80	\$95	18c
	widows' benefit	\$36.50 (women with one child)			
	invalids' benefit	\$23.70 (single women aged 18 or over) \$19.75 (married women)			
	sickness benefit	\$23.70 (single women aged 18 or over) \$19.75 (married women whose husband cannot support her)			
	age benefit and Superannuation	\$23.70 (single women aged 18 or over) \$19.75 (married women whose husband cannot support her)			
1977	National Superannuation (Universal)	\$49.64 (single person) \$82.72 (married couple married rate is set at 80% of the average weekly rate)	\$76	\$93	18c
		\$41.30 (single women) \$68.84 (married rate)			
1993	(net rates)		\$474.95	\$612.75	\$2
	Family Support	\$42 per week (for first child) \$24 per week (for subsequent children aged 0-12) \$35 per week (for subsequent children aged 12+)			
	unemployment benefit	\$110.69 (single person aged 18-24) \$132.84 (single person aged 25 or over) \$218.50 (married couple)			
	sickness benefit	\$138.37 (women aged 25 or over) \$251.60 (married couple)			
	invalids' benefit	\$166.04 (single women aged 18 or over) \$276.74 (married couple)			
	domestic purposes benefit	\$190.27 (sole parent with one child) Family Support is also available			
	National Superannuation	\$230.38 (single women living alone) \$210.19 (single women sharing accommodation) \$343.36 (married couple)			

(Ann Beaglehole 1994: 86)

It was not until 1973 that the domestic purposes benefit became available. The domiciliary care benefit, used by carers to support themselves while caring for an older person does not feature anywhere. However, assuming it was paid at the same rate as the domestic purposes benefit the relative value of this benefit has decreased from 46% of the average female wage in 1973 to 40% of the average female wage in 1993, twenty years later.

### **Accident Compensation and Rehabilitation Insurance Corporation:**

The Accident Compensation (ACC) scheme came into effect in 1974 as a universal social insurance system for all New Zealanders suffering personal injury by accident. Its innovative principles attracted international acclaim but cost increases and economic downturns prompted successive governments to reform and restrict the scheme. As a consequence, the current scheme mainly focuses on those who need some support to get back into the workforce. If people are not returning to the work force and need ongoing financial support it is likely ACC will try and rehabilitate people and if this is unsuccessful they will become long-term customers of NZISS.

ACC's official title is the Accident Compensation and Rehabilitation Insurance Corporation. The underlying philosophy of this Corporation is that it is providing an insurance based, twenty-four hour, no fault cover. The funding for this insurance programme is derived from a variety of sources. The bulk of funds come from premiums paid by employers and employees to cover the costs of injuries sustained in the workplace. The second major source of funds is a premium levied on the sale of motor spirits which, together with a premium included in vehicle registration fees, meets the cost of the road toll. The balance of funds comes from general taxation derived from appropriations by Parliament.

Coverage under the ACC scheme is for personal injury

- caused by an accident
- caused by an occupational gradual process or disease
- which is a result of a medical misadventure
- which is a consequence of treatment for an existing personal injury
- which is mental or nervous shock suffered by a victim of certain offenses

Any injuries occurred by the individuals, either physical or mental, must be directly related to the individual themselves. If an accident occurs and ACC accept the claim then the following entitlements are available:

**Table 4:** Services available through ACC.

<b>Service<sup>5</sup></b>	<b>Explanation of Service</b>
Weekly Compensation	This is paid to people earning and is based on 80% of earnings over the past year.
Educational Support	Assistance is based on educational, social, medical, physical and psychological history. Assistance may be in the form of a teacher aide and/or transport between the home and school or preschool.
Independence Allowance	Compensation for not being able to perform normal activities. To qualify for payment you must have a total disability of ten percent or more.
Transport	Transport to medical treatment.
Medical Treatment	Payment for medical treatment as a result of an injury. If the provider charges a surcharge, this is not covered by ACC.
Private Hospital Treatment	Available when urgent hospital treatment is needed a contribution from ACC may be made.
Vocational Rehabilitation	Vocational and Social Rehabilitation may be provided to enable people to lead as normal a life as possible.
Attendant Care	Personal cares are provided for those with serious injuries.
Home help	If you need assistance to look after your home due to injury, then home help is available.
Child care	Help with child care if injuries prevent the caregiver from being able to attend to the children.
Aids and Appliances	Equipment is provided to help with independence
Motor vehicle modification and purchase	Assistance may be provided with purchasing or modification of a car, if as a result of injuries a unmodified care cannot be driven.
Housing Modification	To enable independent access around the home i.e. to the toilet and bathroom.
Complex Personal Injury Regulations	Special assistance is available for complex personal injuries as a result of an accident. This is defined as; a severe brain injury, an injury resulting in tetraplegia; or similar sort of injury
Training for Independent Living	If the ability to perform daily living activities, communicate, and engage in social interaction has been affected by the injuries, ACC may be able to help with training to increase independence.

<sup>5</sup> The application forms for these services are contained in Appendix 2.

The estimated costs tabled in parliament for the ACC vote the figure provided for the above benefits is \$1,404,633,000 (ACC Annual Report 1996) this figure has not been broken down to identify specific costs.

Either the person being cared for or the caregiver could have an accident and be entitled to the above. Most often, for older people who are not being rehabilitated back into the work force, the entitlements utilised are attendant care, home help, aids (for example walking frames) and housing modifications.

One caregiver recounted her experience

*I have got a broken ankle which has not healed and just recently I've torn the ligaments off my bone just up here on my right arm but I still keep going. Because I have to and that is why my ankle has not healed because after two days, when I was supposed to be off it and in plaster for a month (I had to be off my foot for a month while it was in plaster,) the first month, I was walking on it after two days because I had to attend to John. I got no help at all. It was ten days before I got ACC help and up till that I just coped on my own, walking on my plaster, looking after him and they say now that my tendons and ligaments are still torn and that they aren't healed and that's 8 months down the track, so how long that's going to be, I don't know.*

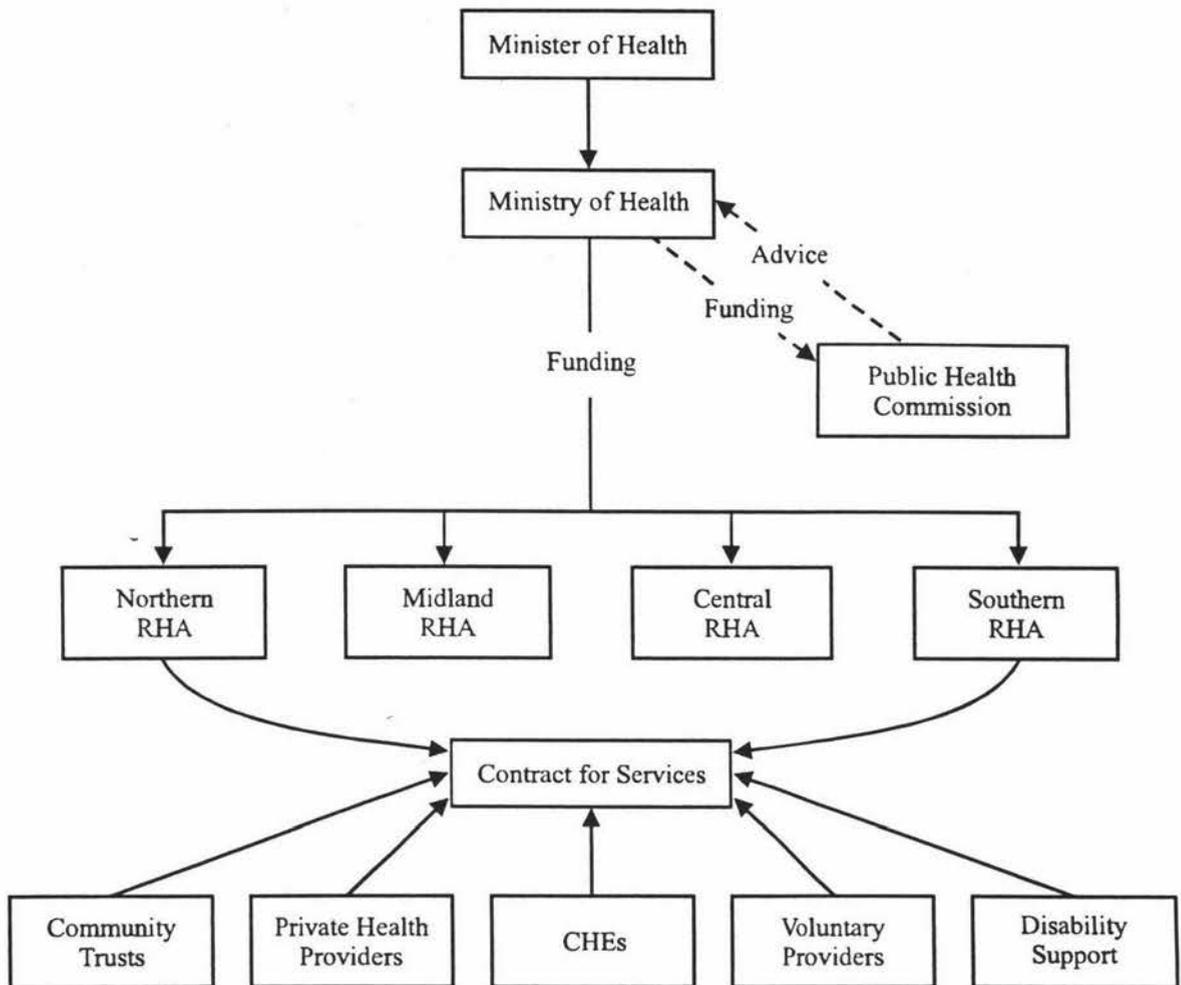
**Gillian**

### **Health:**

The Ministry of Health is given the job of defining what health needs are and the priorities for health funding. This is done through the Core Health services committee and once these decisions are made the Ministry then provides money to Regional Health Authorities (RHAs). There are four RHAs covering the country and it is their function to buy health and disability services. Crown Health Enterprises (CHEs), is the new name for a public hospital or a regional area working together with associated community services. There are 23 throughout the country and many of them have chosen new names to reflect their new identity.

The CHEs provide the services they are contracted to provide with their local RHA. This moves the hospitals from a needs driven focus (treating everybody who walks in the door) to providing the services contracted (providing services for specific health problems). An example of this is that a CHE may have X million dollars for surgery. Once that money is used by the CHE elective surgery (routine rather than emergency) can be stopped by the CHEs until the next payment is made by the local RHA.

Diagram outlining the provision of Health Services<sup>6</sup>



The funding service purchased by the RHA falls into two categories. The first is the Personal Health Need (PHN). This may be defined as short-term treatment due to accident or sickness. This refers to hospital care in the acute phase of treatment (e.g. directly after a stroke, heart attack or car accident). The second type of services purchased is Disability Support Services (DSS), referring to the long-term provision of services, examples of which are disabilities caused by arthritis, multiple sclerosis or disabilities that remain after a stroke.

In terms of the resources available to individuals, in the majority of cases personal health need services are free and provided by the hospital while the person is acutely unwell. If they have had their condition stabilised and no further treatment can improve the physical condition, then an assessment takes place.

<sup>6</sup> This information is from the Disability Welfare Manual (Health Benefits page 3) produced by the DISABILITY RESOURCE CENTRE Palmerston North and dated August 1994 however regular updates have been made.

Locally in Northland people over the age of 16 and under 65 are assessed by the Disability Resource Centre. This is a local community group that has secured the contract with the RHA for assessments of younger people.

If the person is over 65 years old the assessment contract is being delivered in Northland by Northland Health Limited (the CHE). A team of assessors work within the hospital and the community. It is important for this assessment to be completed, as no government resources can be received without it. Once the assessment is completed the assessors then discuss with the client the resources available to meet the identified needs and referrals are made to the appropriate services.

The common services discussed are<sup>7</sup>:

- |   |                                 |   |
|---|---------------------------------|---|
| 1 | Aid to Families /Carer Support* | This service is designed to give the carer up to 28 days relief, subsidised the RHA. This can be used as one day a fortnight, 1/2 day a week or as a block. The rate is \$68.00 per day or \$28.00 if a family member provides the care.  |
| 2 | Attendant Care                  | This service has traditionally only been available for people under 65. Ideally home help and attendant care will be provided together as a comprehensive service. In June 1996 Personal cares free to those over 65 holding a community services card.   |
| 3 | Day Care                        | This service has two foci. The first is to provide people with disabilities the opportunity to socialise with others and have time out from home. The second is to give the caregiver a day out at least once a week to have time to go window shopping, visiting or whatever. Unfortunately most of the time the caregivers have just enough time to rush into town, pay bills and do the groceries. There are two types of providers, either through the public hospitals (although nationally this is becoming phased out due to a change in philosophy) or private trusts that charge approximately \$15.00 per day or some schemes are subsidised by the RHA and the means testing criteria is the community services card. A local pilot scheme in Northland is providing CSC cardholder's with Alzheimer's a service of up to 5 days a week. |
| 4 | Community Nursing               | Traditionally the Community Nurses have been a great support for carers both providing a hygiene service for  |

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<sup>7</sup> Health forms for assessment and authorization of services are contained in Appendix 3.

- those unable to shower/bath themselves and a monitoring role to keep an eye on the health of both carers and carees. The focus of this service is now a personal health need response and therefore that majority of the services provided is more for acute treatment and management of the patients in their own homes. The monitoring and hygiene cares are now in separate contracts.
- 5 Home Support This service is also provided by the public hospitals and private trusts (in Northland). The service is means tested (using the community services card) and provides basic household support.
- 6 Meals on Wheels This service is primarily run through the public hospitals and the cost for the meals is sealed at \$4.95 per meal. The service is available 5 days a week and the people prioritised are those living alone or unable to prepare meals for themselves. The service relies on volunteers to deliver the meals.
- 7 Social Relief The service is to provide care for a hospital category person for up to two weeks at a time, in the local public hospital (or other residential setting that have a contract with the RHA) The service is free and is only for those who would otherwise be in hospital. The scheme usually starts with two weeks in hospital and twelve weeks at home and increases to two weeks at home and two weeks in hospital as the carer and the caree need it.

\* In 1990 Lynne Cargill and Ruth Bonita conducted a survey of the 28 day alternative care scheme. Some of the results reported were:

Carers first found out about the scheme in a variety of ways. General practitioners fared well in this study with 21 out of 24 knowing of the scheme. However in only eight instances was the general practitioner the initial source of information. Other sources of information include social workers, friends and support groups. No one first heard of the scheme from the Department of Social Welfare or by advertisement.

(Cargill and Bonita 1990: 13)

The next section will look in a more practical sense at how assessments and information is gained in terms of the resources available. Those who complete assessments are expected

to have the knowledge to be able to assess the needs of both the dependent person and the carer. It is also assumed that assessors will have a comprehensive knowledge of all resources available, both statutory and community based. I interviewed a new front line Social Worker-Nikki . She was a new social worker just returned from Europe who also has a New Zealand social work degree.

The orientation programme for Nikki is outlined below. This starts with an introduction to the team she will be working with. The social workers are based in separate service areas rather than in a specific social work department. The assessment process provides a clear indication to the social worker of the role expected in this service setting. Knowledge of resources in the community is essential for the worker to be able to provide information for those needing these supports. Orientation to the ward is needed to familiarise the worker with the protocols and procedures and to ensure information and communication to the other team members is clear and accessible. Visits to community groups is a two way process. The worker learns the resources available and the community groups can identify and meet the new staff in this area. Reading material is to ensure Nikki is aware of the organisation, its goals and direction and what is expected of her from the organisation. On the job training is to link Nikki with other social workers and enable her to learn the networks and resources from others responding to similar needs as well as having the opportunity to meet the others and see different styles of health social work. Time with other team members from different disciplines is encouraged to enable the understanding of different roles - especially important when facilitating team and family meetings. Supervision is provided as a support for the new worker and also for the safety of the clients when workers are learning new specialisations.

### **Orientation Programme**

Orientation with the Assessment and Rehabilitation Team	Learning Assessment Process Resources in the Community: Daycare Home Support Services Monitoring services (Nursing/Social work) Referral processes for Assessments and services
Orientation on the Ward	Medical Terminology and conditions Ward protocols and procedures Documentation
Visit to Community Groups	Age Concern Northland Home Support Services

Reading Material	Disabilities Resource Centre Northland Health Limited, Policies and Procedures
On the job training	Benefits and entitlements Orientation from other Social Workers Time spent on other wards Visits to residential care facilities Co-worked ward cases to identify needs of the person and families and learn resources available and how to access them.
Supervision	Provided by the Social Work Advisor

The interview below outlines the social worker's perception of the brokerage role and the first impressions of front line health social work. The interview was conducted approximately one month after the start of the job. She had just completed an orientation period of two weeks and she describes how she feels about immediate needs that have been presented and access to resources to meet them. As explained previously in the introduction the purpose of interviewing Nikki enable me to present the experience of a social worker learning the systems at a grass roots level.

#### **Interview between Viv and Nikki:**

- Viv            From your limited time here, what has been identified in terms of needs for carers? So what sorts of needs did you come up against when working with carers?
- Nikki        *The biggie seems to be the time out- they get quite stressed because there is so much on their plate but then they've got lots of feelings with that as well - they too tend to feel guilty to even admit that they want a little bit of time away from the person that they're caring for. Even in the short time that I've been there, the carer support seems to be coming up the most, especially out of all the forms that I seem to be dealing with, it's always carer support. So it's excellent that that's available, but that seems to be the only thing that's available at the moment - I suppose you've got the day care. But that to me would be the strongest one for carers is the time out.*
- Viv            How have you found the system as a whole -the health system and the welfare system since returning to New Zealand three months ago?
- Nikki        *That's an interesting question - the thing is I didn't really work in the*

*health system before so I haven't really got anything to compare it to but it seems a lot more business orientated. When I left I assumed that the hospital was a free service, a public service and a long term service particularly when it comes to the elderly. It was more you went to hospital and pretty much stayed in hospital until you die but now it's a lot more short term. For example terminal care in the last few months of life, as opposed to weeks, used to be provided in public hospitals, but now residential care in the community is provided at a cost. So that's how the health system, the hospital system's changed anyway.*

Viv So are you seeing more of a community care model coming in - community based?

Nikki *Yeah, much more so.*

Viv Do you think that's good or bad?

Nikki *I think it's a really good thing - I'm all for the community care model but there has to be something in the community - it can't be just a cost cutting exercise. I think at the moment they do need a lot more, especially when it comes to the elderly, they need more services in the community.*

Viv OK. How have you learnt about systems?

Nikki *Through my orientation - my two week orientation, but I seem to be, having to phone colleagues to just ask questions again and again. There doesn't seem to be a clear cut way of doing it, so you can ask somebody one thing and they think "Oh yeah, this, this and this" but it's not necessarily so because when you ask somebody else and - it's a little bit hazy. Whether that's because of the change that's just happened, I don't know but I'm finding it a little bit hazy. So, if I'm finding it hazy I think how poor families and the patients on the ward must feel.*

Viv What change has just happened?

Nikki *Oh, with the health change.*

Viv Is it easy to learn where resources are?

Nikki *At the moment I don't find it's too bad to learn where the resources are - the resources in the community?*

Viv In general.

Nikki *I'm not finding that a problem at the moment. I think I can honestly say.*

Viv Is it easy to get access?

Nikki *Yeah - I'm just trying to think, have I had difficulty accessing them. No I don't think I've had any problems actually accessing any services. Maybe it's too early to say because I haven't actually had to - I mean,*

*no, I've had no problems with the under 65s, both times that I've made referrals to the Disability Resource Centre they've come through. I've had to - once I've made the referral, I've had to make another phone call to say "Are they being discharged", or such and such, but actually accessing their service was no problem, but I've never actually had to do a referral for a long term home help or anything like that yet. So, I don't know whether that's going to be - but it seems accessible. The people that I'm dealing with make it quite accessible.*

Viv Do you think carers would find it easy to know what is available and how to get it?

Nikki *Not on their own. No, because there doesn't seem to be like a central person or service for them to go to ask for the information. They could get little bits here and there but if they had their family on the ward, I feel like I would be the person that could actually give them - well, eventually once I've been there for a few more weeks, but a well rounded view of what's available in the community, what they're entitled to, how to go about getting it but that's only because I've had to deal with it - that's my job, that's what I'm doing, you know, day by day, but if I was a carer I don't think - I think I would find it quite difficult - I'd find it quite confusing. I wouldn't know where to start I don't think.*

Viv Have you got any other general comments?

Nikki *Yes! Just the one thing that I've been having difficulty with is that I'm sure that if I was - and I'm only starting to come to grips with it - is just the whole system of doing an assessment, referring onto either one of the home support services, if not, short term home help from the hospital. Government doesn't provide attendant care - all that sort of thing. When I've been dealing with some of the families they've just looked at me bamboozled - absolutely bamboozled -they feel like I'm talking a different language and yet I feel like I'm being actually quite clear. From the responses I've had from families - it's confusing, yeah. That's the biggest thing.*

In summary the new social worker found the process of finding resources and then accessing them not too difficult but felt that she had had some time to adjust and learn the system and if she was a carer the process would be very confusing.

The forms are themselves daunting, the NZISS forms relevant to benefits or subsidies for older people and their carers collectively total approximately 139 pages. To illustrate the

red tape, a selected sample of benefit and subsidy forms connected to the three statutory organisations will be attached in appendixs 1,2 and 3.

When interviewing the carers about resources, Gillian told me her experience of having her husband in a hospital when she felt she had reached the point when she could cope no longer.

*I've already complained to the Licensing Department of the Health Department in Auckland and they are looking into him. He was put into private hospital permanently because the family were getting a bit worried that it was getting too much for me and it was the hardest decision I'd ever made in my life, it caused me a lot of heartache and everything but I could see that I was getting very, very tired, because at that stage I was coping on my own, I had no help at all except for my neighbours and so the family said, they felt that it was time he went into care.*

*I had been up to the hospital, it was a lovely sunny day and everything looked very nice and also it had the two small lounges and I thought, it's far better than the other hospital with the big, huge lounge which gave me the creeps and I thought, oh well, this seems to be very nice so we put him in.*

*Well, as soon as I got him there I objected strongly to the room he was put in, it was like a little, wee cell with torn wallpaper and I'd been shown some lovely, sunny rooms, it said, oh all the rooms have views, but when we got there he was stuck in what I call the bad side, and underneath eaves so there was no sun getting in that room and it was so tiny, you barely had the bed and then a chair and that was it and I was very upset over that and objected strongly to that and was told that it was only until he was assessed which I couldn't believe anyway and he was there 6 days and I brought him home.*

*My sister was with me, luckily she was up at the time and she could say everything that happened.*

*There was a net curtain on the window and it was absolutely black so I climbed up and I got it down and I washed it in the hand basin in his room and it took seven rinses to get that clean, OK, it was only a small hand basin but it was black, the water was black and so I rehung it back up on the window and there were just little things, and I thought, oh I'm not happy and I thought, oh I'm just a bit emotional you know, with Mr G...*

*I went in every day, spent about 4 hours with him and I just wasn't happy, I don't know, I just wasn't happy and the final straw came on the Sunday night. Oh just before that, about 3-4 days back, I went to get a pair of underpants out of the drawer and they were faeces stained and I said to the girl, who does the washing? And they said, oh they do it here and I said well in future I'll be taking his washing home and so I got a bag and they were to put his washing in it. Well, this Sunday I went to get his washing, no washing, nobody could find his washing, and he was running out of pants, long pants because he was on a Uridome at night but, oh they had him on a Uridome in the daytime I think but for some reason he was running out of long pants, so I took them home, washed them and dried them...*

*That evening we went in about ten past six, well during the week it had been lovely and sunny and then one day we went in and it had been all shut up and I said to my sister, what a dreadful stench in here, I said this is shocking and I said to one of the nurses, how do you cope with this smell? She said, oh you don't notice it after a while, you only notice it when you go outside and come back in again and I said, well my husband's not used to these smells and that really upset me. Well this night we came in, it was about ten past six, everything was locked and barred, we had to knock loud and they came and let us in and as soon as I walked in, look I just retched and I'm not kidding, my sister and I just stood, and I said out loud, What a putrid smell. It was shocking...*

*We went down and saw Mr G and this young girl wheeled him in a chair and she said, in a wheelchair, they never had him walking, I'd asked for him to be walked, he was never walked, I know because when we brought him home he couldn't even walk so I knew he hadn't been walked 'cause we ever only saw him in a wheelchair and she came in with him and she said, oh I'm here to sponge him down before he goes to bed. Anyway, she started to undress him in the wheelchair and wash him down and she said to me, oh I'm new to this, she said, I've only been called back, I'm really a cleaner. That shocked me a little bit because, I mean, I sort of thought, he's in there for hospital care not for a cleaner's care and I knew she was a cleaner because I'd actually seen her in cleaning uniform...*

*...so anyway, I said do you realise he's got a Uridome on? Oh, she said, I know nothing about that. I said, well will you go and get a nurse please? And while she was away I took the Uridome off and found that he had an infected*

*penis and I went berserk so when the nurse came back I said, Look he's not having a Uridome on again. I said, he needs something on this infected penis. I had had him on a Uridome for over a year, never had an infected penis so she went away and she came back, I said he'll need a pad of some sort, she went away and she came back and she flopped down this Ungvita and the spatula and a pad and she turned to the girl and she said, I'm busy. and she said to me, make sure that you use the spatula when you put the ointment on. I mean, I was paying, you know I mean he was to be paid for being looked after, I mean that was what he was in there for.*

*Anyway, we stood him up and I went for the pad to put on and it was all faeces stained. Oh look I was nearly sick, I was so angry. I put it on, I showed it to my sister and I put it on because there was, I was just about in tears, I was really so upset and he was getting agitated because he could sense how agitated I was getting and my sister just shook her head at me because she could tell that I was really going to, absolutely go berserk, and we put him back in the bed and the girl said to me, can you help me put him on the bed so she climbed on the bed and the two of us lifted him back on the bed while she climbed on the bed and we pulled him back up onto the bed, because there was nobody to help her, there was nobody there to help her you see.*

*I just couldn't stand any longer, I was so upset and I could see he was upset because he could tell that I was upset and I just said to him, we'll go, and we went and I just cried the whole way home, I was so upset. I said, he's not staying in there any longer, I just can't stand it.*

*On the Monday I got on the phone and rang everywhere I could think of, I rang my friend, Margaret at another Home and I begged her to have him and she said, we can't, Ruth, he's a 5 and they can only go to 4's and she said, we've got no rooms so it would only be temporary. I rang everywhere I could think of and then I rang the Licensing people at, they said they'd send me a form...*

*I went in on the Monday and stayed there about 4 hours and I noticed he had a pad on and we were there 4 hours and nobody came and checked him to see if that pad was wet or dirty or anything...*

*On the Tuesday my ACC lady said to me, I was in tears in telling her and I said I'd take her up to see my husband because she's very fond of him and she said to me, look my daughter's 21, she hasn't got a job, she will come and live with you Monday to Friday, she said, and help you look after your husband.*

*When we went in he was in what I call the bad lounge, which was the real smelly lounge, he was there and some woman was banging flat tack on a piano and he was sitting there with his eyes nearly sticking out of his head, he can't cope with noise now, he's hopeless, so I wheeled him into his room and he just took one look at me and he just started to cry and he said, home. Ruth, home and I said, I'll take you home, dear.*

*I raced out and luckily my son, he's a fireman, he's the senior station officer here, he was home, it was his day off and I raced up to him and I said, we're taking Dad home so he got one of his other fireman and they brought him home and carried him up the stairs and if you'd seen his face when he came up the stairs, it was worth every penny of it.*

*When we got him home that night, when I came to change his clothes and everything, from here to here was completely scalded, all the skin was hanging off between his toes, every single toe, between his toes was all peeling off, not being dried, you know how it goes and his hands were like that and under here, all of that was all peeled off and he also had a septic mouth because he said he wasn't eating very well and I said, have you got a sore mouth? And he said yes so I had a look at him and it was all inflamed so we took a swab, he had thrush in his mouth so I had to get ointment from the doctor for that, I had to get ointment from the doctor to heal this and heal his feet.*

*Just before I left I said to them, can I have his tablets? Because I had rung my doctor in the mid-week and because my husband has got a urinary tract infection near enough to all the time now, they just can't get rid of it, and my doctor had said, he'd given me a thing to take into the hospital for them to take up tests and send away and then my doctor's nurse rang me and said, "yes he still has the urinary tract infection. I have phoned through antibiotics for him for urinary tract infection" and I said, well look while you're going to do that, please could you send through some ointment for his infected penis because it was the day after that, you see, and she said "yes, OK we will"*

*The day I was leaving I said to them, please may I have his medication and she came out with them and I opened it and I said, oh there's no antibiotics here and the Charge Sister said, "he's not on antibiotics". I said, he is, my doctor rang yesterday, that was the Tuesday and rang on the Monday to send, and I said, look here's the tube of stuff for his infected penis, so I said, it must have come through. No, she said, "he's not on antibiotics". And I said, well he*

*must be because... And she said, "oh well, probably, she said, it was sent with everything else and we didn't know it was for him". I nearly died, he should have had 4 doses of antibiotics by that time because this was lunchtime on the second day and that was just the final straw so as I say, when we came home it took me about a fortnight to get him right again, the 6 days in there.*

*I've sent it all away, it's all gone to them (Ministry of Health). I've had a phone call back, she said that "they're looking into it" and she said, "of course, your version and their version differs" and I said, well I had my sister there the whole time and I said, did you expect it not, I mean of course it would differ, I mean I didn't expect anything else but as I say, as I put in my note, I am complaining about this.*

*I know it won't help my husband but maybe it will help some of those other poor souls because there would be at least 20 of them that are in the bad lounge, which I call the bad lounge, which he wasn't in, he was in the other one.*

*One of the nurses said to me, "it's just so wonderful to have somebody that comes in here that cares about their partner, she said, most of them just dump them in here and that's it" and she said, "I care but she said three quarters of them don't care, she said, they're just here for the money and she said, I care and it breaks my heart to see how these poor souls are treated."*

*So if it doesn't help anybody else, it didn't help my husband but maybe it might help some other poor soul but I've since heard that there's been quite a few moved from there.*

*If he ever has to go into care, we'd book him into Wesley Methodist one in Mt. Eden Road in Auckland, a proper hospital, and he'll go down there.*

*I hope he doesn't ever have to go into care but that was the only time, so now I wouldn't put him anywhere on this 28 day thing. That's why I get somebody in here. It's going to be a bit hard because the lady that has come in to help, she's pregnant, so that means that that's the end of her after September so I don't quite know what I'll do for my 28 days.*

*It's pretty miserable, if it's somebody out of the family, they get \$71 a day and if it's part of the family they get \$24, I can't see the difference. To me, I can't see any difference, they're still doing exactly the same work so why not? It just*

*beats me so I don't quite know what I'm going to do for my 28 days now. I just don't know, unless I just have my break by if he goes into Ward 15, if he goes, and perhaps just go up there 2 or 3 times, you know, like not go away, just stay at home and sort of rest at home.*

*I don't quite know what I'm going to do because I don't really know, unless I take him to Auckland, down to Wesley and put him in there for a couple of weeks. I might even have to do that but again, it's such an effort to get down there and you know, it's just hard.* **Gillian**

### **Summary:**

The wealth of information provided within this chapter has been gleaned from the formal publications from each department, or in the case of health, from experience of working within this system. It could be considered most people would be in a position to receive formal support from one of the numerous benefits or services. However as outlined by Catherine, commenting on her 'income support', felt under valued by the government due to the financial recognition (or lack) given to the grinding tasks required by her role. Gillian commented on ACC and the frustration and self damage which occurred because the formal services did not allow her broken ankle to heal as she still had to provide care to her dependent husband.

Cargill and Bonita (1990) highlighted the lack of information provided by (the then) Department of Social Welfare. In the surveyed results not one of the research respondents heard about the 28 day alternative care scheme through the Department of Social Welfare. This was also experienced during this research by my father who, on my request, approached NZISS asking for forms appropriate to the elderly. He was asked his name, then the staff insisted on assessing his entitlements and did not provide the forms requested, which are public information. The forms were obtained through my social work networks with management at the local NZISS branch.

The information provided by Nikki indicates that a working knowledge of all services available to older people and their carers is required to perform the brokerage role, a fundamental part of health social work. Nikki had little difficulty accessing resources as she was orientated to the formal services available but felt it would be difficult for a carer to access services themselves.

The interviewing process with Nikki was also utilised with the research recipients. An aspect of the feminist method used within this study is reciprocity, and this took the form of

presenting formal services to the women carers. In Gillian's case (following her account of the above story) this involved reviewing all formal services available with her as at June 1995. This presented her with an opportunity to define her own needs when she was not in a period of crisis.

## CHAPTER 4

### Hearing And Understanding The Stories.

#### Introduction:

It is important when conducting research into intimate areas of peoples lives that certain ethical standards are met to ensure that those being interviewed are not disadvantaged or abused in any way. The ethics that have guided this thesis have been drawn from the Massey University's "Code of Ethical Conduct for Research and Teaching involving Human Subjects" 1990. Methodology is central to any thesis presented and, as in most feminist research, the design of the study is moulded by the women participating in the research. Information was gathered through the use of a questionnaire and interviews. The method was underpinned by Smith and Noble-Spruell's (1983) principles for feminist research. I wanted to hear from carers of the elderly what the reality of their life was like in order to record and present their stories; enabling them to tell of their experiences. Feminist method provided me the vehicle to do this. In feminist research the researcher is present and active in the study. I introduced myself and my interest in working with carers of older people, and the part this experience played in the research process.

Data was collected in two forms: as transcripts from interviews and time-use diaries collated by the women themselves. The latter were records of activities over two twenty four hour periods. This was used to establish how much work is done by the carers and what proportion of time is work and what is leisure. This method enabled the carers to evaluate for themselves the care work they do and enlightened them to the extent of their care-giving task. It also allowed me as a researcher a clearer vision of the impact of caregiving on their lives.

As outlined in the previous chapter, Catherine clearly defined her caring role as work and this gave me the opportunity to validate their caring work and contextualise this in relation to the feminist analysis of paid and unpaid work. This is further discussed within the theory chapter.

Several themes emerged from the carers stories. These provided a basis of comparison and evaluation, and highlighted the similarities of their experiences and feelings.

### **The Research Question:**

Brenda Smith and Carolyn Noble-Spruell (1983) point out that research has in the past been conducted in the framework of the male perspective of the subject concerned, while a female perspective brings about a different framework and perspective. This concentrates attention on issues that concern women, and women are the majority of caregivers. In this presentation the feminist view of the nature of caregiving was adopted.

The principles for feminist research outlined by Smith and Noble-Spruell (1983) are as follows:

1. Feminist research should be for women, to improve their daily lives (Stanley and Wise, 1983; Duelli Klein, 1983).
2. Feminist research should be based on feminist theory (Stanley and Wise, 1983)
3. Feminist research is premised on the oppression of women and is committed to changing it (Stanley and Wise, 1983, Roberts 1981).
4. Feminist research emphasizes a non-exploitative relationship between researcher and researched which is based on collaboration, co-operation and mutual respect (Oakley, 1981; Mies, 1983; Reinhartz, 1983; Stanley and Wise, 1983)
5. Feminist research recognises the open presence of the researcher as intrinsic to the process (Stanley and Wise, 1983; Light and Kleiber, 1981; Oakley, 1981).
6. Feminist research questions the ownership of the research outcome (Spender, 1981; Spender L., 1983)
7. Feminist research attempts to develop a specific methodology congruent with feminist ideology (Stanley and Wise, 1983)

(Brenda Smith and Carolyn Noble-Spruell 1983: 139)

This research was based on hearing and recording the experiences of eleven women, all of whom were carers of older people. The objective was to obtain an understanding of the needs of these women from social, cultural, and financial perspectives. A qualitative research method was used to present as much of the information provided by the carers as possible and to encourage the respondents to recount their own experiences, rather than condensing the data to reveal patterns as required by quantitative methods. I wanted to politicise the position of women as carers by providing them with an opportunity to have their voices heard. The stories exemplified the carers experiences

within New Zealand family, social and cultural frameworks. These frameworks may have influenced their decision to become or remain in the role of caregivers.

Factors such as ethnicity, age, religion of the carer and the caree often dictate the societal expectations of the participants and provide a setting for understanding these particular familial systems. The length of time the carers have been providing the care, the patterns of care within the maternal line and the paid and unpaid caregivers' history of work were established to enhance the awareness of contributing factors to kinship care. Relationships of the caregiver to the dependent caree, to their partners and to their friends have been discussed to identify the informal networks that are available and the isolation (if any) as a result of being in full-time unpaid work

This issue of unrecognised contribution of women has been at the centre of feminist research for some time. "Superwoman Where are you?" (1992), written by three women working in the Social Work and Social Policy department at Massey University Palmerston North explored New Zealand womens' position in terms of the social policy of New Zealand. These women define the general concept of critical social policy (CSP)

*"...is an assumption that 'social problems' are mainly the result of social inequality, particularly class inequality, and of unequal distribution of societal resources."*

The authors then respond...

Nevertheless, except for a small number of writers such as Fiona Williams, race and gender have still been relatively marginalised ... compared with class in the C.S.P. tradition. In order to focus upon the effects of social policy on women's lives, and upon various ethnic groups, it is necessary to look at other policy perspectives.

(Briar, Munford and Nash 1992: p15)

A feminist social policy analysis was considered as an important aspect of this research as women were the largest group of providers and users of social services, both paid and unpaid. Women live longer, therefore form the majority of the 'old' population and also have the children. These two groups are high users of the welfare and health systems. In terms of the women in this study, the perspective presented by Briar et al (1992) directly related to them, as the assumptions made in social policy documents affects the resources and support made available by the government. Unfortunately, the awareness

of women providing care for older people has not been highlighted and 'family' is defined as two parents and young children, not adult children caring for older people. This was even more reason to encourage women caring for older adults to speak out and share their experiences. This was referred to by Smith and Noble-Spruell (1983) as the first principle of feminist research and was also reflected by Briar, Munford and Nash when they stated...

One task of feminist social policy research and analysis has been to describe the effects of social policy upon women's daily lives, and to put women at the centre of the picture.

(Briar, Munford and Nash 1992: p16)

Although Briar, Munford and Nash concur with Smith and Noble, there is a distinct New Zealand cultural influence reflected in "Superwoman where are you?." which presents information which relates to women on a localised level.

The services available to these carers were limited and the financial support was provided by NZISS, at a subsistence rate, therefore indicating that caring was viewed by the state as a secondary role and not identified as paid employment. NZISS clearly has the philosophy that they provide 'Income Support' and were not employers, therefore defining caring for older people as unpaid and unrecognised work. The majority of women interviewed however were not receiving any specific support as carers but were receiving superannuation or were supporting themselves.

The pragmatic goal of the researcher was to identify resource gaps for carers and provide this information to the local RHA who purchase services on behalf of this group.

### **Ethics:**

The ethical approach to this research has been underpinned by Massey Universities "Code of Ethical Conduct for Research and Teaching involving Human Subjects" 1990. This was the code provided in the set readings and was current when this research was initiated.

The principles of the code have dictated the methodology of this thesis. Informed consent was obtained from the recipients and written information was provided about the researcher, purpose of the research and possible use of the research. This was contained in a letter (Appendix 4) presented to the research respondents before

interviews were conducted. One carer was approached to participate in the research and she did not feel comfortable to do so therefore she was not included. Written consent was sought from each respondent (Appendix 7) and the transcriber signed a declaration of confidentiality.

Confidentiality was discussed with my supervisor before an interviews and considerable editing (where appropriate) has been done to protect the identities of the respondents. The information is now kept in a lockable cabinet and passwords used to prevent access to computer files. All the women carers have been given pseudonyms to prevent the identities of the older person and their carers.

Three main 'watch dogs' have been utilised to minimise harm to the respondents. Age Concern was involved in the selection of the 'carers' and have been in contact with a majority of research respondents throughout this research period.

The carers themselves have been actively involved in guiding the research and have controlled the interviews. They have clearly stated when tape recorders etc. are to be switched-off and have also chosen not to provide responses if they have felt uncomfortable in doing so.

Regular supervision has provided a monitoring of the research methodology and created safe boundaries for the respondents to ensure their safety and discussions surrounding any possible harm so that the information is not used for my own ends outside of the research process.

The open process as outlined in the methodology of providing written information and answering questions from the respondents has instilled truthfulness into this thesis. In the majority of cases the carers have asked about what I do and what I hope to achieve from the research. A number have maintained contact since the interviews to see the progress of the thesis. A copy of the research has been requested by all involved and will be provided.

The issue of social sensitivity was given much consideration within supervision as the selection of the carers was made. The age of the respondents varied. Both the ethnic origin and gender was specific. The respondents identified themselves as European, the decision was made to work with this group as it reflected the researcher's ethnic origin and therefore a better understanding and analysis and could be made. As stated previously the group selected for interview were women.

A cultural difference would best be identified when considering religion. Some of the carers were Closed Brethren. This was a specific subcultural group with unique support networks. Although not originally identified to be included within the sample group, the women carers themselves were keen to be involved and those first interviewed contacted others to include them in the research.

The respondents have had an active part in the research and continue to do so. Since the beginning of the study I have no longer been in the role as social worker which has prevented any difficulty in the professional/researcher roles.

### **The Role of Feminist Methodology in this Study:**

The basis of all social work is 'listening' to peoples' stories and responding to the needs presented within them. It is a natural progression therefore to use 'peoples' stories' as a foundation for research. The caring role was one prescribed to women by most societies and feminist theory identified and provided the framework to uncover these issues where other methodologies did not. This also concurs with principle three from Smith and Noble-Spruell (1983).

Fiona Williams summarises the advantage of feminist methodology:

Practically, personally and politically, feminism reached those parts that other theories couldn't.

(Fiona Williams 1989: p16)

The methods used to achieve these objectives were primarily qualitative. The underlying perspective informing this method was feminist and therefore the information from the women needs to be relevant to them and spoken by them. The information requested contains personal feelings and thoughts relating not only to caring in a broad sense, but also in response to the personal relationships they had with the person(s) they were caring for. Therefore the data collected by the questionnaire, should not be treated in a quantitative fashion.

Robyn Munford in 'Superwoman: Where are you?' focused on 'Caregiving The Invisible Work of Women'. Presented were thirty women's caregiving experiences. Half of the caregivers were mothers of people with intellectual disabilities and fifteen were paid workers, also caring for people with intellectual disabilities. Munford (1992) describes feminist theory and the influence it had on the research.

Feminist theory informed the way the research was carried out. The very essence of feminist theory embodies a process that demands that not only existing theoretical perspectives and methods for carrying out research are examined, but that alternative ways for understanding the world are also developed. In so doing, women can develop strategies for bringing about change both in their experiences and in ways in which these are interpreted. Feminism has a commitment to making sense of current conflicts in the daily experiences of women and this, I argue, is the first stage in the change process. (Munford 1992: 83)

The philosophy within Munford's research was also reflected in this thesis- the desire to uncover what was hidden and devalued in terms of women caring for older people. The hidden includes the amount of unpaid work the caregivers have been doing all their lives without recognition and the lack of assistance provided by 'the community' and by 'the family', and the good and bad things about caring. These issues are never discussed because they are hidden within the private world of the family home. Hidden also were the reasons why women become carers in the first place and carers feelings about this.

The methods chosen were face-to face interviews and time use diaries. The interviews were an opportunity to discuss the role of the carer. They also provided a forum to share information about resources for the carers and refer them for further services. This enabled the research to provide a positive result for the carer. The time use diaries were used to identify the nature of the care given and establish a benchmark for the number of hours the carer worked.

Prior to the commencement of the interviews pilot studies were done to ensure that the questions were clear and the equipment worked well. Both interviews went well and as a result of these some questions were modified and a directional microphone used to increase the clarity of the voices on the tape.

When I first started conducting the interviews it became apparent that the study was not going to be as directional as first anticipated. The research took on 'a life of it's own' as the women raised issues and concerns relevant to their own situation. The questionnaire provided a framework not initially designed to test a hypothesis but in a sense the assumptions behind the questions were a range of hypotheses. The respondents answered the questions in the manner they wanted to and although the information I required was provided, the respondents extended and developed anecdotes describing their experiences. An example of this was the story from Gillian explaining her husbands experience in a private hospital.

This led to reflection on whether this research was inductive (having already decided that I was following feminist methods) or deductive. Babbie describes deductive research in a study he was conducting “...*having framed this general hypothesis, we set about testing it.*” (Babbie 1989: 40) The theory had been developed and the research was designed to prove or disprove it. I found that although I had developed a questionnaire to provide a framework for interviewing it was presenting as deductive research.

The questionnaire was a product of my assumptions and the answers were a test of these. However, by encouraging the women respondents to interpret the open questions and respond to them without directing or controlling the interviews, this moved the research from a deductive to an inductive process. Babbie describes an inductive process he used

...A questionnaire was designed to collect information from parishioners that might shed some light on why some participated in the church more than others, but questionnaire construction was not guided by any precise deductive theory.

(Babbie 1989: 42)

The stories were told by each respondent and the process of finding themes and areas of commonality from the information then emerged.

### **The Researcher:**

Placing yourself as the researcher into the work and identifying yourself as part of it is central to feminist research (principle 5 from Smith and Noble-Spruell (1983)). My interest in the study evolved from both personal and professional perspectives. On a personal level, being the youngest daughter, living closest of all the children to my parents, I am most likely to provide support to my ageing parents. Having chosen not to have children, and part of that decision was about rejecting the ‘caring role,’ it may be difficult to sidestep this role when I feel the assumption is made by society and some members of the family that I should fulfil this role.

Professionally, I had been working as a social worker on the Assessment and Rehabilitation Ward at Whangarei Hospital. Some of the carers in this study had been on my caseload. As the job developed (I started there in 1991) the resources available to help carers seemed to be reducing. Before the “Health Reforms” a number of

agencies could provide resources and social work had a brokerage role. Now with the "Health" funding being centralised under the Regional Health Authority it was difficult to obtain funds. For example, in regard to social relief, previously the Department of Social Welfare would have provided money to pay a carer or alternatively the money would cover the cost of residential care. Hospital care was also available for short periods of time. Alternatively a patient could be admitted purely because the carer was not coping.

The scheme from social welfare was transferred to the Regional Health Authority. Hospital beds were no longer available for anyone who was not at a highly dependent level and they were not admitted to help the carer unless the appropriate assessments and forms had excluded all other options.

Social work became principally a gate keeping function, through formal assessments, which prevented patients/clients from receiving inappropriate services. Previously, agencies provided a range of resources but, with the introduction of specific contracting, the number of services has declined, rather than, as may have been expected, provision of more services through competition. Financial considerations are limiting help to the point where the priority for most is the individual living alone and those with carers are seen as fortunate. I wanted to hear from the carers what they felt were the gaps in resources that they needed for support.

### **The Participants:**

The participants in this study were eleven women (who were self defined as European) living with, and caring for, older people with varying degrees of dependency. The majority of women interviewed were known to me through my relationship with them as a hospital social worker. Others were contacted by Age Concern and one of the participants was known to a respondent who brought her into the study. As I have already identified, cultural perspectives strongly influence kinship care. Therefore I have attempted to limit the study to women from a similar cultural base; namely white, middle-class. It is acknowledged that religion has also a strong cultural prescription and three Closed Brethren participants bring a new flavour to the mix. The respondents were willing to be participants in the study and it was coincidental that they define themselves as Exclusive Brethren. Closed Brethren are also known as Exclusive Brethren, because the community culture is very strong and socialising is restricted to other members of the group. A non-Maori perspective has been selected for two reasons - firstly that I had limited understanding of this kinship system (and the culture as a

whole) and secondly I believe that Maori should research Maori rather than be exposed to further exploitation under the heading of research (Stokes 1985).

The eleven carers came from different age groups and their relationships to the caree were also varied. The majority were urban based mainly from Whangarei, and therefore do not represent all carers in Northland as most of the northern region is rural.

Having identified those carers to be interviewed the first contact was a phone call outlining my research and asking if they wished to participate. This was followed by a letter (Appendix 4). My phone number, both work and home, and address were provided on the letter. This was to provide the carers with an opportunity to contact me should they require further information. All but one of those approached, agreed to be interviewed.

The eleven carers consisted of seven blood relatives - five of those were daughters, two sisters shared the care of their aunt and the remaining four were wives. All caregivers lived with the caree, five women have others also living in the house (the carer maintaining them as well) and six were main caregivers with nobody else living with them. Three women were working outside the home, two are self-employed and the third has a part-time position. Another three have the financial support of a husband working in full-time paid employment. There were three carers who had children living at home and one who also lives with the grandchildren.

The length of time that carers had been in this role ranged from three months to three years.

At the time of the first interview all but one carer had been the main caregivers and the person needing care had never received 'formal' care. One had been in residential care for a short time (under a week) and had returned home.

**Table 5:** Age, in years, of Carers and Carees.

	Alice	Barb	Cath/ Claire	Dawn	Eliz	Fay	Gill	Helen	Irene	June
Age of carer	59	58	55/54	65	62	52	67	61	46	58
Age of caree	81/ 84	63	82	73	78	77	70	95/93	72	79

The ages of the carers are presented above to illustrate that women continue to nurture in the second half of their lives. Most of these women have been carers of children, two still have children at home. The age of those being cared for is also significant, the majority of these people are past the average life expectancy.

### **Data Collection:**

The main method of data collection was an interview based on a questionnaire (Appendix 5). Although the questionnaire was used as a base, most of the interviews were directed by the respondents. The questionnaire was designed to be a framework and was often sidelined by the women as the real issues for them emerged; this was important in order that the women feel they could own the research (principle 6, Smith and Noble-Spruell, 1983)

Section one included demographic information such as ethnicity, religion and marital status etc. The focus of this section was also to establish the relationship between the carer and the receiver of care, as well as others living in the home. Information on where parents came from, and religion, was to establish some understanding of cultural context within which the older people and their carers functioned. Questions revolving around paid employment and length of time in this caring role were to identify both the financial situation and the degree of marginalisation from the work force. The last part of this section identified trends in women being the main carers in their family systems and a feel for how the participant came to be in the situation of caring for an older person.

The second section was more quantitative as it was a list of services and support groups available in the Whangarei area. These questions had a dual focus. Firstly to establish the support networks currently being utilised, and secondly to provide information on services and refer carers on to receive further help.

The theme of support networks continues in section three. Here the focus is more on the type of care provided and where the informal support comes from. It also explores how the caring role had affected the relationship between the carer and the older person. The carer was also asked how the situation had affected their relationship with others. The intent of this section was to explore further the change in family relationships and to provide the carer an opportunity to discuss issues of isolation.

The final section of the questionnaire reflects on the good and bad parts of being a carer. 'Good' and 'Bad' are value laden concepts so the question was reworded to identify when the carer had found caring easy and when they had found it difficult. The interview was then opened to discuss advice that the woman respondents would give another woman, who was contemplating becoming a carer, which reflected the respondent's same situation. This gave the carers an opportunity to discuss some of the preconceptions that they had, and contrast this with the reality they found in providing the care.

The questionnaire itself was piloted and some of the questions were re-worded, however a few areas could have had further modification. This refers to exploring with the carers what life would be like for them if they were not in the role of carer.

Following the interview the carers were asked to fill in a time use diary. This was designed to provide structured information on the amount of unpaid work needed by those they are caring for (Appendix 6). This was based on a design from Deidre Shaw 'The Rural Work of Farming Women in New Zealand (1993) who used this method to determine the work done by farming women.

The interviews were held primarily with the women caregivers and, although asked, the majority (all but two) chose to be interviewed alone. One of the caregivers was interviewed with her partner (receiving the care) the others were nieces sharing the care of their Aunt. The women were invited to have a volunteer provide alternative care while they were being interviewed, but the offer was declined. It was interesting that only one caregiver had her husband (the person receiving the care) present and although he had difficulty communicating, it was important to the carer that she was being open and honest in his company. The interviews lasted between 45 minutes and one and a half hours. The information was taped, once permission was received, and transcribed at a later date. The majority of interviewees offered refreshments and these were accepted either during or after the interviews. The information requested about resources utilised by the carer gave the interviewer an opportunity to share information about what was available in the local area. A number of referrals were made as a result of this interaction. I found a similar response with the interviewees as did Oakley:

In terms of my experience in the childbirth project, I found that interviewees very often took the initiative in defining the interviewer-interviewee relationship as something which existed beyond the limits of question-asking and answering. For example, they did not only offer the minimum hospitality of accommodating me in their homes for the duration of the

interview: at 92 per cent of the interviews I was offered tea, coffee or some other drink.... there was also a certain amount of interest in my own situation. (Oakley 1981: 45)

The interviews gave the women an opportunity to discuss a role that was mostly unrecognised and undervalued. This provided an atmosphere to canvas subjects that had previously been taboo and several participants were emotionally overwhelmed by this. In the majority of cases the women didn't want any formal intervention but in some cases available resources were mentioned and referrals made as a consequence of the issues raised.

### **Time Use Diaries:**

The time-use diaries were completed after the interviews had taken place. The diaries were based on a twenty four hour period and people were asked to complete two of these. The days of the week were allocated to different carers so ensure that shopping days and weekends were covered. The response to the time use diaries was that 6 people completed and returned the documentation. The diaries were time consuming and required regular completion and the six returned have provide interesting information. The purpose of the diaries was not only to provide information about the activities and work done by these carers but also to give the carers themselves an opportunity to evaluate the activities they do.

Robyn Munford discusses this in terms of methodology..

Our methodological orientation must of necessity match the value stance we adopt. If we are to make women's unpaid and paid work visible, we must work with women to empower them.

(Robyn Munford 1990: 31)

The primary reason for asking these women to participate in the time use diaries was to identify the areas of paid and unpaid work. The women themselves found this an interesting exercise.

*"You know, it might be to our advantage in the long run because, you've got to learn from somebody that's in this situation, don't you?"*

**Irene**

### **Data Analysis:**

The process for analysing the qualitative information emerged through the interviewing phase. The interviews themselves provided trends and themes. The information was mostly recorded, but field notes were taken after the interviews if information was shared once the tapes were turned off. The process of transcribing the notes and later reading them reinforced the essence of the material that was gained. To enable this to be passed onto the reader excerpts taken from the transcripts have not been altered apart from names and addresses to maintain confidentiality. Unfortunately only a small portion of the information gained can be encapsulated within this thesis. I have not had a great deal of experience with analysing interviews it was comforting to read that Anne Opie also shared this dilemma in relation to her work:

The caregivers' text were too long to be published as they stood ... While there were some obvious passages that could not stay (because of issues of confidentiality), I wanted to ensure that I did not interrupt the flow of the account and lose the range of tones and emotional positioning accessed by each caregiver. (Anne Opie 1993: 13)

This was highlighted within this thesis, for example the story from the women who had the bad experience with the private hospital. I decided to include this with only light editing changing mostly the identity of the individuals concerned. It does not read easily but does encapsulate the essence of the carers story.

### **Summary:**

This study was designed to follow feminist method and be guided by the works of Brenda Smith and Carolyn Noble-Spruell and Robyn Munford. Underpinning this research is a desire to change the lives of caregivers by highlighting who the caregivers are, what they do and how they feel about it. This research should have an impact on caregivers lives because social workers will be challenged to change their practice and this will be developed as the final chapter of this thesis. One aspect of this study was to reveal the oppression of the women concerned and the lack of support given to those performing this informal unpaid work.

The research was based on interviews and these were guided by a questionnaire. The respondents were able to (and did) respond to the questions in which ever way they felt appropriate and therefore controlled the interviewing relationship. Time was taken to

evaluate the resources used by the respondents and provide information about resources not known to the carers. The process therefore required that I was an active participant in providing information and I was open about my experience as a social worker and this was used as appropriate. Essential to all feminist research is that it is based on feminist theory. The development of this study has been drawn from the respondents experiences. Following are these responses provided by the women.

## CHAPTER 5

### Introduction To The Interviewees.

#### Introduction:

The interviews were conducted with carers living in the Whangarei area. Whangarei is a small city located two hours north of Auckland. The population size of the district was 62,000. This city provides goods and services to a wider farming and horticultural community. The demographics of Northland include a large rural Maori population of people living in isolated areas.

Due to the size of this community all the women in the study have been given a pseudonym. The study included interviews with eleven women, two of whom were caring for the same person. The women interviewed fit into three groups. The first group are those that were caring for their husbands, Barbara, Dawn, Elizabeth and Gillian. Dawn, Elizabeth and Gillian all care for husbands who can not even roll over in bed independently and all need help to get in and out of a chair.

The second group comprises of women with partners, all caring for their mothers. These women all have partners, who work away from home, and as the majority of the hands on caring is done during the day, these women do not have anyone around to help.

Finally the single women without partners - these four women are blood relatives to the dependents.

The questions asked of the carers revolves around their role and the job they provide. These include:

What were the lives like for these women before they took on this particular caring role?

How did these women come about being a carer for an older person?

What care is provided by the carers?

Informal support networks.

Although the interviewees had the commonality of all caring for older people as individuals their lives and experiences were very different and I would like to introduce you to these amazing women.

Alice is a qualified teacher and was initially teaching in different rural communities around the North Island.

*More recently I worked in. ... a supermarket as a delicatessen manager and a food supervisor at the ... Hospital and sort of different odds and ends like that, after a long time as a teacher I just thought I'd like a change and then after that I went back to teaching. I went to Vanuatu and taught there for a couple of years then to the Solomon Islands as well, teaching.*

#### **Alice**

The church has greatly influenced Alice's life and a lot of her social activities have centred around it. A single life has suited Alice and she has enjoyed this freedom. The confines of becoming a carer for her parents in their home has been quite a lifestyle shock for her.

Self employed as a farmer, South African born, Barbara lives on a 188 acres and enjoys the outdoor seasonal lifestyle. The solution to a frustration or woe is to chop a mountain of firewood or tackle a fencing job.

*If I can get in amongst the cows, I'm a different person when I come away because it just takes my mind off everything and you do, your mind's a total blank and you're dealing with these animals that don't demand anything of you and you come away and you feel as though you, you know that advertisement, take your sinuses to Arizona? Well, I feel like that when I'm working with my animals but for such a long time, since 22nd January, I haven't been able to get there and really do anything that you can say is a physical effort, that I could release my tension.*

#### **Barbara**

As the result of a stroke 7 months ago which has affected Mr B's independence he has been cared for by Barbara. It has also effected Mr B's ability to think and Barbara has found the man she knew before the stroke is not the same person today. Before they would make decisions together, now she carries this burden alone.

Dawn has been caring for Mr D for three years after he became a paraplegic as a result of an operation going badly wrong. Dawn is a woman of few words, she impresses as a, hard working woman, who gets on with the job. When asked what advice she would give others she said

*I don't know. Just tell them that they'll be doing it all the time.*

#### **Dawn**

Providing care that would usually require two nurses to move a patient who cannot take their own weight. Dawn copes on her own. She lives next door to family and has regular visits from her two grandchildren. Ian, was a rugby player in his youth and rugby has featured strongly in their lives. The rugby club is one of the main groups that Ian and Dawn are involved in.

The two sisters, Claire and Catherine, work together to provide care for their Aunt. Both of these women are single and have spent many years in clerical positions. Being closed Brethren the church is the centre of social activities and support networks...

*We are in the fortunate position of having a lot of people we can call on to come and stay with her, we have no trouble finding someone to come.*

#### **Catherine**

The caring role for these women is a challenge. Catherine clearly states that she is naturally not a nurse and finds the personal care tasks 'unpleasant'. Although both sisters acknowledge the restrictions due to their Aunts heavy dependence they feel that they would be very sorry if they had not taken on this role.

Elizabeth is also an Exclusive Brethren. She married nine years ago, later in life. (Referred to this research by Claire and Catherine.) Mr E is now her main focus and Elizabeth felt it was important to include Mr E in the interview.

Being Mr E's second marriage, Elizabeth has found herself relying on the support of her husband's daughter. It has been difficult for Elizabeth living with extended family. Although she appreciates the support from her step-daughter there is nothing quite like having your own home. Mr E is also heavily dependent and the strong culture of family support within the Closed Brethren society is reflected in Elizabeth's words....

*...our daughter, that we're living with. She mostly helps with the showering and everything else that we need help with but her husband does too. Like when Mr E goes out, his son in law puts him in the car and gets him out. The other boys help him, their sons help... three generations. Two more*

*generations of help. Apart from the District Nurses twice a week, that's all the help we have.*

### **Elizabeth**

Northland born and bred, Fay is married and cares for her Mum and has been since she brought her home in December 1994. Fay's mother went into hospital for a hip operation (to repair a fracture) and subsequently lost her power of speech. The change in Fay's mother was dramatic.....

*It's very hard because it's not my Mum, if I can put it like that, because Mum was always the goer and be off here and doing this and we used to always, you know, go to the movies or have lunch or things like that. We always have had a good relationship but of course, she's just a complete different person now. But I do enjoy caring for her and I couldn't bear her when she was in the home, it just wasn't me. I went to her every day and then it just took over, the fact that I could get her to be mobile enough to bring her home and then I brought her home and it just went from there.*

### **Fay**

However Fay gets great satisfaction out of providing care for her mother.

Gillian has been caring for her husband for three years and has watched him rapidly lose his independence and both mental and physical abilities due to a degenerative disease - Parkinson's. So committed is Gillian to caring for her husband that she has been walking around on a broken ankle....

*What are we now, June. I broke my ankle in October and it's still no good. He was no good before that so it's been about the last year, that's been very, very, hard, extremely hard.*

### **Gillian**

Mr G can no longer communicate - his yes and no response is not reliable, Gillian still feels she has a very close relationship with her husband.

Being a Baptist is important to Helen, she believes caring for her parents - aged 93 and 95 is a calling from God and she is happy to respond to it. Helen describes her first marriage a disaster and the second as not much better.... *"before I married the second time,"*...The church remains a big part of Helen's life. She has enjoyed visiting and caring for others in a voluntary capacity and seems to be a born carer, previously looking after a 91 year old friend until his death. Both parents have all their needs met and when discussing the possibility of rest home care Helen says to them....

*Who is going to massage your feet like I do and rub your back and put the cream all over you?.. Every year I think it is a bonus that they've had.*

### **Helen**

Having a background in caring for older people assists Irene in caring for her mother. Although her mother is reasonably independent she is, never the less, quite demanding. Irene has been establishing herself in a business - book-keeping for other people and typing. As if this isn't enough Irene continues to study... *"You've got to have another interest as such. I've got to do it at home, so I mix the two together"*. The mother daughter relationship at times is strained with Irene acknowledging that it is difficult juggling everything and providing her mother with the attention she demands.

Having worked with several carers under stress and 'trapped' in this role as no other paid live-in carers are available it was important to find out more about their lives and what the caring role means for them.

### **What were the lives like for these women before they took on this particular caring role?**

All the women interviewed had been in paid employment prior to becoming carers. The majority had been in the position of having both paid work during the day as well as providing and maintaining others in their home environment. This is based on the fact that the majority are married and/or have had children. This is further complicated by those women who have gone into business with their partners. It is interesting that the two roles have not been identified by the women themselves, however, Gillian states.....

*I was a bank teller until I got married and then after that I was a buyer for Auckland Farmers Union and I also worked in the main Post Office in the*

*box lobby on the counter for 5 1/2 years. Just looking after the family. I had 4 children so, you know, in between doing those, that was what I did. Oh, then Mr G and I had a Foursquare Store and I worked there and we had that for 3 years in the first one and I think it was about 4 years in the other one ... That was while we still had the children at home. While they were little, you know, going to school and what not...* **Gillian**

Claire in fact, was asked whether she had done any unpaid work to which she replied "no". Claire is single and therefore does not have children, however, she states there was a time when... "I kept my parents". Claire identified her main work history as working for the fire service for ten years. Her sister Catherine has done clerical work for 37 years only having had two jobs in that time.

Helen discussed her work history and intertwined this with her closest relationships - namely the three children and her partners...

*I was 15 and I worked at Corban Mills and then they turned it into Holeproof, then I was married. Had 3 daughters, marriage broke up, ... I was living in Auckland then, from Hikurangi off a farm, to Auckland at 15 and then I came back to Whangarei, probably the very early 30's. Yes. Oh I used to do housework and all that sort of thing, you know, to help out in the marriage and also I did work in a grocery shop, a greengrocers at one time ... That was my first marriage and then I married again after about 9 or 10 years which actually was another disaster, I stayed with him for 13 years and I've been here on my own for the last, I've been here nearly 9 years so about 11 years I've been, over 11 years I've been on my own. In the second marriage I ... used to work up at Lookout Hill, you remember they used to sell oranges up there? ... I did a job for probably 2 years and that was pretty heavy work, you used to load up and pack and all that kind of, mainly fruit, mainly oranges from Kerikeri. I worked at the laundry and also did housekeeping, I used to go to an old man's home and do all their washing and ironing and cleaning and bred Siamese cats.*

She further described the unpaid work...

*I got involved with the church and things like that. I used to do a lot of visiting, I really loved doing that, especially when I was in my second marriage, I used to do a lot of that. Even in my first marriage I was actually a Deaconess really but visiting people and helping and that kind of thing,*

*doing ironing and babies and all that sort of thing. Yeah, I have done that so I never think about those things. You don't really think about that, no. And I sort of was, when I was on my own, out Abbots Way, before I married the second time, I used to be at home but I used to have lots of visitors, people that were single that were in a situation like myself and having problems and all that kind of thing. Solve others but not my own.*

### **Helen**

The only carer who received tertiary education when they were younger was Alice. This identifies her life as different from the others as she has been more of a 'career' person. Her skills in teaching pervade both her paid and unpaid work history. The reason why the description of Alice as a career person is because she has moved for her employment (not her partners) and because she has clearly indicated her energy was centred around her employment.

*I started off when I left school as a dentist's receptionist nurse and then I trained as a Kindergarten teacher and then I retrained as a home economics teacher and worked in places like Rotorua and in the North, Kaikohe and Taurua. It's quite a long time ago.*

Currently Alice's unpaid work centres around ESOL, which stands for.....

*English Speakers of Other Languages. Sort of just a bit of tutoring. At the moment, I'm doing a SPELD course so I guess some of that is certainly voluntary work. It's hard to think back. I suppose one's always involved in some sort of voluntary work you know, especially through churches and things like that, 40 hour famines and all sorts of, does that count, that sort of thing?*

### **Alice**

All of these women have been in responsible positions, this is recognised by society and these women are given credit for this.

### **How did these women come about being a carer for an older person?**

The interesting aspects of this question revolve around the cultural expectations of those receiving the care and other family. The carers fall into three groups, the wives who tend to view caring for their husbands as part and parcel of marriage, the daughters who

have been carers before and have actively chosen to care for their parents; the last group is compromised of the single women who have never been in the caring role and, although they believe that the person they are caring has a better quality of life at home than in residential care, the decision has a high personal cost because the caring role is not one they feel comfortable with.

The married carers were very clear about their position. Gillian highlights this when she was asked how she came about caring for Mr G...

*Well, what other choice was there? I mean, he's my husband and what did I say, in sickness and in health, didn't I? We were just discussing that today actually at the table, you know, we were joking and my son said something about sickness and in health and I said to him, how true that's turned out to be, hasn't it? and he said yes, it has Mum.*

**Gillian**

Elizabeth's response is very similar. Dawn states she became carer because she was living in the house and it was the logical choice...

*Yes. Hospital said he was coming home so I thought, oh well, that's it. I was a bit nervous to start with when he did come home because I didn't know what to expect, eh. It took a long while to sort of settle down.*

**Dawn**

The next group are those who have been in the caring role before and are now caring for their parents. Fay is caring for her mother - "Well, I'm the only daughter." This reflects an expectation whether it be by the family or herself. Why would it not be possible for one of the sons to fulfill this role? June was in a similar position.

*My mother's husband died in May last year and she came up here to live because ... the house she was living in was to go back to the family, it was her husband, it wasn't his home but he was there until he died and it had to go back to his family's side and Mum only had a certain time to stay there before she had to find somewhere else to live so she came up here and we brought a little home unit for her and then she had the stroke about a fortnight after, so we had to get out of all that. So I've had her here ever since.*

**June**

Irene clearly outlined how she became a carer..

*Before she came here, I was going in and out from town while she was still in her own unit but I watched her slowly get to the stage where she just couldn't look after herself so, I never pressured her to come here, I sat my sisters around the table and we discussed it because I made them aware of what was happening. They're a lot younger than I am and I said, there will be a day coming up very soon where we're going to have to take care of her because she didn't want to go into a rest home. Because of my training, we've always said ... I would care for her. They had agreed to be on hand but well, one's taken off, decided to live in Greytown which is near Masterton and the youngest one is farming in Okaihau and she can't always be on hand. So here we are in the middle and I'm the oldest and I know what I'm doing they say, but there are times when it would have been quite nice to say ... for one of them to come in for the day and just let me get out, ... Please myself, but oh well, you get around these things. So I've had her here since February and it's full-on now, it's full-time.*

**Irene**

It appeared from this that Irene had been the one in the family that had been constantly aware of her mothers needs and had taken on the responsibility. The issue for Irene seemed to be not that she was the carer for her mum but that she was not getting ongoing support from the rest of the family. Helen is a born carer and has embraced this role all through her life, this was reflected through her account of her unpaid work history.

*Because I felt personally myself I always wanted to, I don't know why but I did. I felt it was what God would have me to do. My sister that, well my parents lived at the Heads and my Mum was sort of more or less crying out for help then, you know, the things she was saying. I felt I couldn't do much about it because she always said she'd live with my younger sister and she did live with my younger sister for 12 months but she had to keep coming up here off and on because she was too sick and I'd get her better and she'd go back and start all over again. She used to cry when she left too, I don't really understand that, but anyway it happened that Mum was really ill and I said to my brother that I would like to look after my parents but there was a little bit of unhappiness and disharmony in the whole family because I wanted to look after them and my sister had a part-time job and she couldn't really do the job and she was married in a short time but she never had children and she sort of didn't have the knack, if you know what I mean.*

*Things that weren't getting done that should have been done. I'm not criticising her because she did a good job to what she thought but to me she wasn't going far enough, you know what I mean, there was a greater need there and it caused a bit of upset in the family and we had a meeting and in the end they left it up to my parents. They were here then, I'd only just got Mum back, she had pneumonia and she was really ill and she got on her feet again and Dad's not 100% half the time either, but he's not too bad. Neither of them are but you've got to be careful with them, you know, they get sick very quickly. Anyway, they had a meeting and they decided that they'd ask the parents where they wanted to live and my father said that he wanted to stay here with me because he thought he couldn't get better attention, you know, that's what he said.*

**Helen**

The final group is those that have not ever been in a caring role and find it difficult. The carers who expressed this were Alice, Catherine and Claire. This typified by Alice's account of how she became a carer.

*Well, I guess my sister did for a few months in her home in Opua. They, my parents had their home here in Whangarei and I guess they felt attached to it, so I came back to enable them to live in their own home, to stay there as long as possible and enjoy the space it offers and the privacy it offers, which maybe is not available in a retirement home. I don't know that I realised at the time, you know, I'm one of those people that kind of leaps into things, you know, it could be quite demanding and quite a tie and that kind of thing and of course things happen where it becomes more and more of a tie.*

**Alice**

The interesting aspect of this account was that Helen's parents seem to be the ones who have made the decision to live with her. None of the other carers have indicated that the ones needing care had made a choice. Apart from Helen none of these carers have clearly stated that they wanted to be a carer but there seemed little choice in the matter.

### **What care is provided by the carers?**

When asked who helped with providing the care the immediate reaction from all carers was 'either I do it myself' or 'nobody helps'. The consistency of the response reflects that, as a main carer, this was done by one person or that the responsibility was taken on

by one. This response also indicated how they feel about the role they provide and the support they receive.

The care provided by Gillian, Dawn and Elizabeth was equivalent to private hospital care in the community. The assessments done by the health professionals (support need assessment protocols) would indicate that these husbands require 24 hour care and cannot mobilise independently in any way. This means they cannot roll over in bed without assistance. I make this point to illustrate not the inabilities of those being cared for but the degree of dependence they have on their wives. It is not safe for them to be left alone in the house in case of fire etc. as they could not get out, and in some cases were unable to call for help. This was reflected in Elizabeth's comments

*Well, he's, as I say, he's completely disabled. We have to really do everything for him. It takes two of us to get him onto the commode in the morning to shower him. I feed him, the first thing I suppose I do is feed him, shower him, put him back to bed, do all his little cares, bits and pieces. Then I can dress him by myself and get him into the wheelchair by myself and get him back to bed again. Somebody else usually helps me into a Lazyboy and they help me out of it and back into bed again. Lift him up. I do all the dressing and undressing and feeding.*

#### **Elizabeth**

As a former assessor I can say that all those being currently cared for by these women would be eligible for residential care, either because they were unable to fend for themselves by preparing meals, or due to an inability to provide their own hygiene cares. There were three types of care - those that were providing assistance due to a physical problem and the person being cared for was unable to do things for themselves because they physically can't do them. The next group were caring for people with invisible problems and those were the ones who have a degree of dementia. These people were physically able to do tasks (generalisation of this particular group) but were unable to mentally make the links. For example, a person may be asked to go and brush their teeth. The person may pick up the tooth brush, they may even put the tooth paste on the brush but were unable to complete the task. In fact soap may be put on the tooth brush because they think they are cleaning the teeth therefore they use soap.

The last group of carers, as outlined previously are those who were able to do neither - that is think for themselves or physically care for themselves. It was not just the wives who were coping with this Fay a daughter stated.

*Everything. Like to get her out of bed in the morning, you've got to get her out, she can't get out of bed of course. You have to do the toileting, you have to dress her, you have to shower her of course, feed her, she's got to have help to stand and walk and everything. Just everyday functions, she needs help.*

**Fay**

When explored most carers could identify someone who helps, not with hands-on care, but more of a supportive role. Those with support in the home gave examples of this i.e.

*..my husband will help me sometimes get her up the stairs"*

**Fay**

*I have a daughter at home ... she will cook ... she doesn't do anything for my parents*

**Helen**

*He'll do the odd thing ... if he's passing..*

**Irene**

All the carers indicated they received moral support from others living in the house but did not tend to have hands-on help. There seemed to be two reasons for this. Firstly that the other person in the house was working outside the home, and the carer did not want to burden them with more work and secondly those people being cared for did not like having their personal cares provided by anyone else. The former was reflected in Helen's comments

*I can't expect her to do much because she's really over-worked as it is at work.*

**Helen**

Those that have help in the home were those who need two people to move the person being cared for. For example Gillian, has an arrangement with a woman to help care for her husband and receive free board. Catherine and Clare have combined their efforts to care for their Aunt. Elizabeth also needs help moving her husband and at the time of the interview was living with their daughter's family who provided help.

The church seemed to be the organisation which helped the majority of carers the most. This organisation was not included as a service or support group but is obviously a support for a number of women. Not surprisingly Catherine, Claire and Elizabeth felt supported by their Brethren church. Alice, Gillian, Helen also discussed the church as being important in their lives. When asked to identify the help that was provided by others, the general response was a social visit - moral support. Alice mentioned that her sister filled in with the 28 day relief, but stated .. *"in general they seem to just pop in*

*and pop out again.*” This was also reflected in Barbara’s comments “*My daughter pops out*”... “*just comes for a visit, she’s never really helped.*” The general perception of these comments is that the carers would appreciate more help but that either the person being cared does not want personal care from someone else or that the family do not realise the support needs of the carer. Certainly the social support by others is very important to the carers. “*He’s good moral support.*” June said of her husband.

### **Informal support networks**

The carers were asked to identify where their own personal support came from. The responses indicated that there was a lack of support available in this area. Alice expressed this “*I’ve been quite angry because I’ve felt I haven’t had a lot of personal support*”. Barbara, Dawn, Fay and Irene also cannot identify any personal support what so ever. However, both Dawn and Barbara work as a way of coping with the stresses that arise, while Irene drew on her own personal resources to cope preferring to work through and problems on her own. Half of the carers stated that they have no personal support of any kind. Family, once again, featured as support and mostly children. The other half of the carers talked regularly to their children.

### **Summary:**

This chapter has been an attempt to disclose the private world of carers. Making visible the day to day experiences of the research respondents as alluded to in the literature review. Throughout the interviews the loudest cry was from those who had no choice about becoming carers. I heard this clearly and repeatedly. It stemmed from a combination of familial expectation and gender socialisation.

The carers discussed the grind of providing care day after day without relief. The increasing dependence of those cared for and the psycho-social and emotional cost of this was important rather than the unbundling of the care tasks. However task definition was a valuable tool for the women themselves to shed light on the nature of their unpaid work. The interviewing process developed into exploration of the inherent personal cost of caring: the withdrawal from the public to the private sphere.

## CHAPTER 6

### How Has Becoming A Carer Affected Your Life?

#### Introduction:

Becoming a care-giver involves major changes in lifestyle; relationships change dramatically and social interaction is also affected. This chapter was born out of an interest in the effects of becoming an unpaid carer, a role that is little recognised by society and families. I have particularly focused on how relationships have developed with the person being cared for, other family and friends. These areas are traditionally unspoken of by carers and unasked about by health professionals, who often assume psycho-social aspects of a carers life are fulfilled through their caregiving role. As outlined in the literature review, the medical model encourages focus on the person being cared for and actively discourages the health professionals to step into the private world of the carer and their relationships. It is because of this that carers are silenced. Silence is presented by Marilyn Waring (1996) as survival.

I agree with Adrienne Rich that 'lying is done with words, and also with silence', but silence is also the tool of the political prisoner, an element of informed passive resistance. Silence is often survival. The silence of a battered woman is a wall of resistance. It is often effective protection, but it also keeps other women removed from truth. (Waring 1996: 2)

Opportunities were given to discuss both the 'good' and 'bad', 'easy' and 'hard' aspects of the caring role. This technique encouraged respondents to acknowledge and name their daily lived experience of caring. Consequently the women interviewed were given the opportunity to voice the 'uncut version': the negative aspects of caregiving without any guilt, - articulating feelings that would usually be taboo. The benefits of caring were also expressed, some found the deepening of the relationship with those they cared for a fulfilling reward, giving them meaning to their lives.

To evaluate the information provided by the carers, it may be useful to once again divide the carers into three groups, the wives as their relationship with their husbands is uniquely intimate, the daughters who have had experience in caregiving and the women who have never been in a caregiving role before.

Having identified the wives as different as they have had a relationship of a different nature, the roles that they had in the marital relationship changed as a result of one being so dependent on the other. This has clearly been difficult for Barbara to cope with ...

*That I found really hard because Mr. B is a self-thinking person, he's always been able to think on his feet and do things and all of a sudden he stopped doing that and you had to do it for him. Mr. B, he's the one that before he had the stroke, gets up in the morning and gives me my medication and here I was, even before I started medicating him, saying "Did you take your pills?", "No", "Well, I think it's time you take it". "Did you take your medication?", "No, I don't think I have", you know, and this is the type of thing, all of a sudden he stopped thinking and stopped doing and I had to step in, I was quite happy to step in because I was scared with his double vision and with his forgetfulness that he might over-medicate himself or whatever. Or not medicate himself, so I was quite happy to do that but just trying to do everything on the farm so that things didn't deteriorate in the short space of time I had to do it, look after him and everything, it just sort of got to the stage where you felt it wasn't too much but if you could only have a half a day break, somebody take your problems for a half a day and you can be free of it.."*

This is also shared by Gillian. Gillian found suddenly having to take over responsibility of all aspects of life difficult.

*Having to, you know, completely run the place, but then if he'd died I'd have had to have done that too so, but it's been the extra stress, it's been very stressful.*

**Gillian**

Dawn has had to learn to do things around the home that her husband would usually have done, this included changing tap washers, spraying grass and all the other odd jobs.

Role change has also affected the daughters that were caring for their parents but on the whole this group reported that their relationships with their parents had improved. Helen reflected this in her comments when discussing how being her parent's main caregiver had affected her relationship with them.

*I would say that especially towards the both of them but mainly my father, closer, much closer. I've always got on well with my parents, you know,*

*90% well with them and I would say when you are showering people and all that, Dad and I always talk in the shower, he's pretty deaf so I don't know if they all hear down here but I've got my mouth right up next to his ear more or less so he can hear most of the time, if he knows what we're talking about he can kind of get the gist of it all and so I would say it has drawn us closer than anything else and I don't get angry with them or anything. No, I choose not to. I could, sometimes when I'm tired, I think, oh deary me and then I says no, that's not the right way, forget it, you know and carry on. It's a job you asked to do and you've got to do it well, as unto the Lord, so that's it. It certainly has it's rewards. No, I'd say we're closer really but I wouldn't say that I'm favourite or anything like that, as far as the family go. They're all treated the same, me included.*

### **Helen**

However, Irene has previously been in a paid caregiver role and she has struggled with her mother. This was reflected in her reply.

*Oh yeah, with Mum, that's right. It's a bit strained at times because it's hard for her to understand fully that I am a working person too and I have to remind her every now and again that I do have to come in here, I do have books to do, I have accounts to get out, I am needing new software and it's an advantage thing, I don't come in here to escape her or anything, it's something she has to understand and it's very difficult sometimes because, you know, like now for instance. You're in here and she knew the fire was out before we came in here but she had to call, you know. I can be up and down, up and down and I say, look I am busy, can it wait or is it urgent or I won't be long, you know, trying to think of something and sometimes, like mind you right now, I am tired and I know that I need a break, you know, to get this break so I've got to bite my tongue. She knows too. I mean Mum's very aware of this and she says, as she realises, she's rattled me a little bit, "oh sorry dear, I don't mean to be a nuisance." But she's very good at passing the guilt trip too. Yes, she'll rattle me and then because I've not got cross with her but because I've got a bit stern with her, she'll say, "oh I wish I wasn't a burden on you" and all this, you know, and then I think, oh God, what have I said. And I'll say, Mum you're not a burden, I love you to bits and I'm here to help you. "I'm just a burden and I shouldn't be here, fancy living like this" because she never got a life till Dad died. It's very*

*difficult for her to have to put up with what she's got, you know. She had no life what so ever, she was bullied, she was ill-treated, he was violent and I actually nursed him in the private hospital till he died, 7 years, 6 years ago and then suddenly Mum had a life. At a very old age, she's off bowling and doing things that she's wanted to do. We went for an air trip, she and I went to Australia to visit the younger sister that was over there at the time and got off the aeroplane and boomf, she had collapsed on me and since then she's been ill, not been able to do all those things so I can see how frustrating it is for her.*

**Irene**

Culture shock occurs through a drastic change in lifestyle, Alice described moving from being single to caring for both of her parents.

*I think that's been quite hard to adjust to because it's their home and I've also got my home and I want to do things a certain way ... also there is a generation gap and a difference of interests ... I can't have any continuity of interests, I feel.*

**Alice**

When people become dependent to the point where they need a caregiver a change in the relationship is unavoidable. The nature of the relationship before becoming a carer has an impact on whether the relationship develops positively. The change in the person being cared for also has an impact, the ability to do things together changes and that also affects the relationship. This is reflected in Fay's comments.

*Mum was always a goer and be off here and doing things like that. We always have had a good relationship but of course, she's just a completely different person now.*

**Fay**

The next set of relationships explored was the effect on relationships with people outside of the carer-caree situation. A strong theme of isolation came through. Catherine said:

*...regular entertaining we can't go now, we've just recently done less and less of that because we are finding it's too stressful with Aunt.*

**Catherine**

Fay also reflected these feelings

*... we used to be in a Friday night group where everyone used to go to somebody's house and of course we are out of that now as well.*

**Fay**

These comments were mirrored by Alice, she couldn't keep up with things so never felt she could keep up with friends. Helen indicated that it is not just friends that stay away.

*I've got a friend in Dargaville that I never see ... actually my eldest daughter and everyone else, they keep away now. They don't come like they used to which has been a big hurt in my life.*

**Helen**

The other responses reflected a sense that the friends have changed. Some people, Irene and Dawn, felt that friends made more of an effort than before, while Elizabeth has noticed that they are more dependent on friends.

#### **How has becoming a live-in caregiver affected your relationship with others?**

The responses to this were varied. The dependency of the person being cared for seemed to be a factor in social interaction with others. The inability to leave people alone or for the carer to be able to transfer/mobilise people alone in and out of vehicles was a big problem. Elizabeth found this

*I guess it's made us more dependent on others, I mean, where as before I could get him into the car and we could go places and do everything by, you know, just on our own. Now it's made us more dependent on other people.*

**Elizabeth**

Catherine and Claire also talk about not being able to attend daily church meetings or do regular entertaining in the home, this is an important part of their membership in the church.

Alice and Fay discussed the feeling of being 'cut-off' from others. For Alice being cut-off referred to her frustration of being unable to visit a friend in Dargaville - the distance (45 minutes by car) seemed too far for her to go and keep up this relationship.

Fay was finding that the social scene continues without her.

*It has affected them. Friends don't seem to come around, I don't know whether they're, I can say to them on the telephone if someone rings up, well you know we haven't got the plague. I'm only looking after my Mother but no, I have noticed that, they just, and because we used to always be in a Friday night ones where everyone used to go to somebody's house and of course we're out of that now as well.*

**Fay**

This was identified as the main gap in terms of resources for Fay. Social relief and carers' support were discussed with her to provide options for Fay to maintain her social contacts.

June communicated the change in relationships with others by outlining statements made by her husband. The ability for them to socialise together as a couple was not always possible...

*My husband feels a bit restricted at times, with not being able to do what we want to do, you know, because we've got to think of Mum first before we can sort of go and plan anything. That does affect him at different times. He's always saying, we should do such and such, oh if only we didn't have Mum*

**June**

### **What are the 'good' things about being a carer?**

It was decided to try and look at both sides of the caring coin. Therefore carers were asked to identify the good aspects of being a carer and the benefits that came from it. As stated previously by Alice, her main reward was seeing her parents in their environment. This was expressed by most of the carers, they believe they were giving the older person the opportunity to stay out of residential care.

Barbara claimed that the increased closeness of the relationship with her husband had been a reward, also the feeling of being needed.

*After all these years, we're closer together than what we were say 10 or 15 years ago because you drift apart, each do their own little thing and this has brought us very much closer together. Feeling that again, like when we*

*were younger, I was needed, as far as he was concerned. And that was really good.*

**Barbara**

Catherine and Claire believed if they hadn't taken the opportunity to be carers they would have regretted a missed opportunity. Another 'spin-off' expressed by Catherine was that she no-longer had to go out and work. Finishing up work was a bonus for June as well.

Caring for older people was an accepted reason for women to move out of the workforce and back into their private worlds. This is an environment that several women enjoy.

The relief that her husband was still alive after his stroke was Elizabeth's response. The good thing for her was the opportunity "*I just like caring for him.*" Gillian and Helen expressed a satisfaction in a job well done. For Gillian this was reflected in the standard of care she provided

*All my friends say he is the best kept, looked after person in Whangarei and I really take pride in looking after him great and the fact that he hasn't got bedsores or anything like that. He is really looked after well and even though I say it, I take great pride in making sure he is looked after and the place is kept nice and everything kept nice and clean and everything, I'm real fussy."*

**Gillian**

Helen believed being a carer brought the best out in her.

*I guess it makes you feel a richer person, I don't know. You feel as though you're doing something anyway.*

**Helen**

Some carers couldn't think of any good things about being a carer at all.

### What are the 'bad' things about being a carer?

While many aspects of being a caregiver were positive, obviously there were things which were negative. This question was not meant as a value laden statement, but to once again give carers the opportunity to reflect on the job they do, an opportunity to discuss the 'down side' of caring which is often not discussed because of the guilt that can be felt for not selflessly providing this care. This is usually self imposed, but is also generated by families and the one receiving the care. This 'guilt-tripping' has previously been discussed by Irene.

The answer given most often was the feeling of restriction. This was expressed in two ways. The first was that the carers no longer have the freedom to jump into the car and go where they please. The second, once again, the feeling that you lose contact with others. This was reflected in Helen's comments.

*It's just that you lose your friends and family, you know, you can. That's about the only thing I can say, looking from a selfish point of view that I've had to sacrifice a lot of my time, all my time, I've given my life to them at the moment, my life's not my own, it isn't. Doesn't matter what you say, it's not, not my own so therefore I guess the family could feel neglected.*

#### Helen

Interesting that Helen refers to the family as being neglected when she has been caring for family (both young and old) for years. Why was it that Helen had lost contact with the family? (her two children who have left home) Irene has also previously commented that her family have left her to it once she took responsibility for the care of her mother.

The change in relationship was once again raised. This was attributed to two factors, a change in the person receiving the care and having to change your behaviour by speaking sternly to get co-operation from the person receiving the care. In this case from being 'mothered' to becoming the 'mother'.

The jobs that go with being a carer are difficult for some. Catherine stated that she was not naturally a nurse. Fay also finds this aspect difficult...

*And the bowel thing is not the most pleasant things to be having to clean up and also wonder if it's hard on her dignity, I don't know. It's something*

*that has to be done but it's certainly not a pleasurable thing.*

**Fay**

**When do you find it easy?**

When do you find it easy? This question was asked to try and change the focus of the question away from a moral context. The main themes running through this was that some carers never found it easy. This was perhaps summed up by Dawn's ambivalence.

*It's never really easy, eh. But it's easy going, you know, none of it is difficult or hard.*

**Dawn**

The reason this comment was chosen was because those that didn't find it easy coped by developing routines.

The opposite of this was that some always found it easy because the person being cared for was always grateful and because the carers love the person they were caring for. Barbara in fact has found her husband easier to get along with.

*He is a very easy person, he never made demands and I think he wasn't moody or aggressive like he was when he was younger or before he had the stroke. If he had a headache, he was moody, he was short tempered but he wasn't with the stroke. He was really very good and he would rather just sit in his chair and wait for me to find the time to do things for him than demand anything.*

**Barbara**

Sometimes the time of day made a difference. This was reported as when the person being cared for is in bed, at night time or after lunch. Irene found she didn't relax till her Mum has gone to bed, however she is constantly on alert for any problems her Mum might have. Irene has also looked after her mum so well that when she first arrived she was in bed by 7.30 now it's 10.30. When does Irene find it easy?

*When she has gone to bed at night. And I can really put my feet up and just completely try and unwind and I don't unwind some nights until 1,2 in the morning"... "But she sits up late now, she never used to, she's so well at the*

*moment that she sits up till 10.30 at night and before, when she first came here, she was in bed at 7.30, 8 o'clock, it's a big jump.* **Irene**

Also reflected is the physical state of both the carer, "when I'm not tired" and caree "when he is bright" **Elizabeth.**

If the carer is feeling rested and the dependent person is bright it makes sense that caring would be easier. The time when the dependent person is in bed was echoed by several carers as this was a time when minimal care demands were made and there was space for the carers to have time to themselves and connect with partner or friends.

### **When do you find it hard?**

Converse to the previous question is - when do you find it hard? The responses have been grouped together. The first relates to the carer knowing the person they are caring for when they were fully independent. There has been a change in the person or their behaviour. These issues have surfaced before however the subject is discussed with a lot more emotion. Barbara states..

*Just Mr. B being the way he is. It's (**crying**) you know, it was like being married to the same person that I got married to 42 years ago. The body was there but the person inside was lost.*

**Barbara**

Gillian also has finds the difference in Mr. G difficult.

*Well, I find it difficult, as I said to you, there's no communication.*

**Gillian**

The carers physical health featured as a component. Being tired, having a sore back, namely when the carer herself is not feeling well, things become difficult. Fay discusses how it was for her at the time of the interview.

*Well, at this point it is very difficult because my back is killing me. And it's a case of having to lift her and trying to ask her to hang onto something just so you're not taking all the weight, that really is difficult.*

**Fay**

Gillian had previously outlined her story of how she had broken her ankle but it took a few weeks for ACC to provide support so Gillian had to continue to care for her fully dependent husband.

Helen also conveyed how things were for her.

*When I'm not a 100% and I feel I'll be honest here, when I'm not up to A1 and the family will come and they'll go on about what they're doing, they've been here and there and everywhere and sometimes I feel a little bit resentful that they're rubbing it in a bit and I feel kind of hurt, you know."*

**Helen**

Helen almost sounded like she was apologising for feeling resentful towards her family. This women had not had a break since she started caring for both of her parents two years ago.

Irene's greatest difficulty was the inability to attend to matters pertaining to the new business she was trying establish.

*Difficult when I have to got lots to do, like appointments, if I've got to meet with my, Accountant or the Bank Manager, I've got things to sort out business-wise and it might be the morning we have a shower, ... you can guarantee if I've got my day sort of semi-planned and then of course she'll come out with her shopping list and that's hard, to try and get everything in and not be away too long because she's learning in the respect of, how long are you going to be? And I tell her how long I'm going to be but I try to be as quick as I can so that she's not left on her own too long ... You can't sort of plan, I can't ring my Bank Manager and say, well I can't come and see you until this date because I have to get someone to sit with my mother, it doesn't work like that. You've basically got to work around other people too, you know, that can be difficult.*

**Irene**

Finally changes in lifestyle directly related to becoming a live-in full time unpaid carer. This related to the routines necessary to cope with providing care. Waiting for the start of the day indicated an anticipation of the heavy hands-on care of getting the person up showered and dressed. In some cases this took most of the morning.

Meal times could also be especially trying for two reasons; the effort of preparing the meals and the time commitment needed to feed the person needing the care. June explained..

*In the mornings when I'm waiting for her to come out for breakfast. She takes a long time, I sit and wait, I do all my little jobs and I sit and I wait.*

**June**

*Living in somebody else's house, having to allow for others likes and dislikes rather than suiting yourself.*

**Alice**

This was Alice's greatest difficulty and she reflected on how things are for her

*I suppose there are times when perhaps, the things that I probably find difficult are things like a loud TV when I don't like it loud and that kind of thing I find quite hard and quite a strain.*

**Alice**

In summary the three areas expressed as difficulties were the changes in the abilities in the loved-ones that altered the relationship between the carer and caree, the carers' having to continue caring even when they do not feel 100%, and finally the lifestyle change, having to constantly putting your own priorities behind those of the person(s) being cared for.

**What would you advise others to do if they were thinking of becoming a carer in exactly the same circumstances as yourself?**

The answers to this question really provided a summary from each person as to how they viewed their circumstances and therefore the information will be presented as it was given.

**ALICE**

*To think about it carefully and think about how they're going to get their resources ... make sure that they get their time to themselves to do what they want ... their respite care, make sure to take full advantage of all those things ... that are available and for*

*them, because even though maybe you think, like when I first got respite care, I thought, well, I wonder how my parents are getting on with this person and all these things but actually people are resilient and they adapt quite well and they're usually worrying unnecessarily. And to take full advantage of all the things that are available and to think fairly carefully about how they're going to sort of recharge their own batteries in a way. You know, and how they're going to fulfill their needs, what they feel they need out of life and as my sister said, it won't get better, it will get worse as they might have accidents or they might become less mobile and so there is going to be that sort of tendency of things to sort of wind down a bit so they need to think in those terms. That it won't be static, it won't be exactly as it is at this moment, there are going to be changes. The person you knew as a parent I suppose when you were 10 or 20 is not the same person at 80 or 90. So there's a role reversal probably.*

#### **BARBARA**

*The advice I would give them, stick to that person and be patient, that's all ... don't pass your burden onto another person because you lose contact with that person when you start. When Mr. B comes into hospital, I lose contact with him, he's not with me, we're not sharing anything, he's living in a different environment, I'm living in a different environment. It's very easy, it's very lovely, but you lose that person somewhere along the line. If you can put up with that burden, don't shove your burden onto anybody else, don't let anybody else care for him, love that person and care for him yourself because I love Mr. B dearly. Even after 40 years of married life, he hasn't become a habit and if he should ever have another stroke and be put in the same position, I'd rather have him die because I can't see Mr. B, the person that he was, being the person he has been in December, January and February, that tore me to pieces and I know many a time he would rather have been dead than been in the situation where he was. So if anybody gets into a situation where their partner is anything like Mr. B, just care for him, that's all. And if anybody says, put him in a home, tell them where to go in no uncertain terms. It's different if they are mentally affected, ... I even*

*think then that if that person has got a little bit of his own faculties, if you can care for him you are helping him through that. But by shoving him into a home or shoving him onto somebody else to look after him, you're not helping that person at all because they do know and they do feel neglected and I think this is when my daughter phoned and said she'd have him, is that I felt ... I'm neglecting him. If I gave him to his daughter to look after, I mean, she's not a stranger but I would have been neglecting him and I couldn't do that, no way.*

### **CATHERINE/CLAIRE**

**Catherine**      *Try and do the best they can, wouldn't you? If you can possibly do it, do it for your own people.*

**Claire**            *Yes, I think when it comes to your own responsibility, or if there's anybody that needs caring for, if you look ahead to when they've gone, you'd be sorry if you hadn't done what you could to care for them. I wouldn't like to be left out in the cold and think that nobody wanted to look after me.*

**Catherine**      *That is one thing that we all have to consider too, that maybe someday we'll be old, we may need caring for. The earlier in life that you realise that, the easier it will be for both yourself and others doing it. It's much easier to adjust yourself when you're young, adjust your ideas, than when you're old.*

**Claire**            *No matter what situation you're in, unless you're going to be a hermit and live on your own in the bush, you've got to get on*

*with other people no matter what arises so you've got to, this is one reason why we've stopped entertaining like we were, is that because it's too much stress. Sure as we want to do something extra, something will happen that will give us extra work that we hadn't counted on and that's not easy to cope with because we can't say, look run and get cleaned up or whatever like you can with children, you can't do that. We've got to spend our time when we've perhaps got extra to do because we've got visitors about to walk in the door, we've got to stop in our tracks and go and do something we hadn't counted on and it's very stressful when it comes to coping with a grown person, it's not like picking up a baby. Some friends of ours were saying their two sisters, one of them's a widow and her sister, they care for their elderly mother here in Whangarei, and one of them was telling me a few months ago that the married ones daughter said to the children, look it's time to go to bed, get your nighties on, brush your teeth and this, that and the other thing and then it just came across, wouldn't it be lovely if you could do that. They can't do that when it comes time to put their mother to bed, they've got an hours work. It's a totally different thing to caring for children. But whatever you're doing you've got to consider other people and learn to fit in with them."*

#### **DAWN**

*I don't know. Just tell them that they'll be doing it all the time. I don't know what I'd tell them. I'd just tell them it's a tie, I think. Like they'd be tied to it.*

#### **ELIZABETH**

*I don't know really. I would probably say, well don't be too quick to pack up home and go and live with your daughter. See if it's possible to do*

*something so that you can stay in your own home. But on the other hand, it's probably been the best way to go for us, to go this way because, I mean I've got used to caring for him and all the things that need to be done and probably been the best way to go. I don't know what else I could say really. Certainly there's a lot to be said for being able to care for your husband in your own, or in a home, even if it's not your own home. Far preferable to having him in an institution of any kind.*

#### FAY

*Advice. That's a tricky one. Perhaps forget sometimes that it's your mother, that you have to be a little stern for their own good and that is hard. But just give them plenty of love ... In my case it's probably different because Mum's not talking, she's not demanding and other people could be quite demanding. Whether Mother wants something or not, she's not really demanding. If someone was a real demanding person every 5 or 10 minutes, well it could be a different story altogether.*

#### GILLIAN

*What advice would I give them? To try and get as much help as they can because it's too much on your own, it really is. I did it on my own and I really ran myself right down. Get as much help as you possibly can and keep them at home as long as you can because there's no getting away from it, they love being at home. Familiar things are far better and I know if I took sick, I know where I'd rather be and if you can keep them at home, do it, but not to the detriment of their health. OK, that's easy advice for me to give, when I get that advice given to me all the time but that is the case ... but if they are put in a home too quickly, I always feel I'd have had a dreadful regret, that I hadn't looked after him as well as I could have and I know how much I'd hate to be put in a home, and I can always remember Mr. G and I, we used to go on things with the Sallies up at the local rest*

home, and as we drove away I can remember him saying to me, "Ruth, if I ever need to go into a home, shoot me."

... he's less trouble than somebody that's got Alzheimers' and that's running around like a rabbit. ... he's just accepted it and that makes a world of difference because I think if he was a grumpy, niggly old beggar, maybe it would have been alot easier to have put him into care but not while he's like he is now, he's no trouble. ... I get a sense of pride looking after him, I suppose, and I would hate to have to put him away. I know it will probably eventually come to that because I won't be able to lift him or anything but while I can, I'm going to keep him here. Who knows? -

## IRENE

What would I suggest, what would I say or suggest? What advice? Just have lots and lots of patience and love and care. When all's said and done, they've given you the best part of their lives, which is what she does remind me every now and again, she'll say, well I gave you 16 years of my life before you left but you've only got one lot of parents, one lot of uncles, ... you've only got one shot at it and there is nothing nicer than at the end of the day to have said, well I gave it my best shot and that's rewarding. So I guess that's probably about all that I could suggest and just treat the situation as accordingly.

## JUNE

Go for it ... I'll have to think about that too. I think there are pleasures in looking after them when they're older. We have more ups than we do downs with looking after Mum. ...Mum's a fairly happy go lucky sort of a person, I think that sort of helps with caring for her. Not all people are easy to look after, I know that, but I think if you've got a good relationship to look after them rather than have them looked after anywhere else.

Helen summarises the main themes of the majority of interviewees.

## HELEN

*Go for it. I would. ... You've got to be prepared to do it. I knew when I was taking them on that it was going to be hard and I knew it wasn't going to be easy, that it's alot harder than what you think. You don't realise it's a 24 hour job, like when they're not well and you've got one ear open all night and every cough you're waiting to see what's going to happen from there on, it's a 24 hour thing if you're going to do it properly. You have to love your parents to do it. I mean, otherwise I think you'd get angry with them, you hear all those things, like granny-dumping and all that. No, depends on the person.*

*I've got a girlfriend who looks after her Dad but her sister is a nurse and everyone says to, she was telling me this, the nurse one telling me that hasn't got the father with her. "I thought you would have Dad," this is what they say. "Oh no," she said, "I haven't got him, I can't get on with Dad," ... so you see it didn't work out for her. You've got to get on with them.*

*The youngest sister, there's only two of the girls, and she's got her Dad and she manages very nicely. She's tolerant and you've got to be cut out for it to a point.*

*You've got to love them too and you've got to be very forgiving at all times. But it's certainly worthwhile to do. I think it's a real privilege, I always tell people it's a privilege and it is really, to look after them ... it's honourable to God as well. It's a Godly thing to do and it's a job that you get blessings from that nobody else will ever have. You shared your life with them and when they've shared it for you, but there's something you get back, it's hard to say what it is but it's a satisfying type of thing. There's more for it than against it. Again you have to be the right person and it's not easy. I'd tell them that they need to think about it. See I couldn't bear the thought of my parents going into a home.*

*It'll be a different story when the Lord takes one and leaves the other. I think it's be even harder. It's alot more work with two but it's going to be more demanding in another way when it's one. Do you know what I mean? I can see that, I've been thinking about it occasionally, I think, oh dear, you know, I hope I'll cope but anyway with all these aids and things, I should.*

**Summary:**

The advice giving to other carers provides these women with an opportunity to explain how they would provide care if they had the chance to start again. The themes that came through were that providing care for 'their own' is very important and an act of love. To give it your best and enjoy the time in this caring role was balanced with the caution to other carers to look after yourself and not be scared to ask for help when it is needed. The following chapter explores some of the theoretical concepts that have been developed out of the themes presented by the women respondents.

## CHAPTER 7

### The Theory Behind All Of This.

#### Introduction:

This chapter brings a conceptual focus to the issues raised by the writer and the women in the study. A theoretical position is needed to provide a tool to analyse, challenge and enhance the position of women in the caring role. I used feminism as the philosophical vehicle to do this and as a theory it demands that the political exploitation of women be challenged. Annie Opie outlines this ...

Feminism is synonymous with working for an improvement (and therefore change) in women's status and for their participation in their society while also questioning the current grounds on which that participation is permitted. Feminism calls for a persistent foregrounding and articulation of the continued social and political exclusion and suppression of women and of the issues relevant to them.

(Opie 1994)

Most researchers present theory earlier in the study and use this as a framework to guide their hypothesis and data collection: this is known as deductive research as described by Babbie (1989). The progress of the research involved the development from deductive to inductive research through the women recipients describing their experiences.

Although feminist method provided the framework of this study the theory was drawn from the themes exposed by the women .

In this context feminism provided the most useful framework to analyse the position of women as carers of older people, the difficulty was finding supportive literature. The key reason for this is that the feminist literature reviewed in this study, has had little specific relevance to the stories presented by the women interviewed. It would appear that ageing is only now being recognised as a concept and has yet to be addressed by the literature. Brid Featherstone and Barbara Fawcett, in a presentation to the 27th IASSW Congress (1994), outline the difficulty for social workers of integrating the theories of post-modernism and what is presented to them on a daily basis through the experiences of clients. Featherstone and Fawcett discuss the safety for social work students that are unwilling to "*let go of categories which they find helpful*". (Featherston and Fawcett

1994) Like the social work students to which they refer, I have been hesitant to 'let go' and therefore this study is based on a structured socialist feminist perspective. The key aim of the study was to identify resource gaps to present information for internal change within the system in order to create a greater degree of equality.

As outlined earlier, the majority of resources are available through statutory agencies. The government systems are structured and the philosophy used to promote the restructuring of resources was that a competitive environment would be developed which would enable those wanting services to have a choice. The assessments for people under 65 in Northland have been contracted to community based agencies away from the hospital system. The ideological reason behind this was to enable the individuals to define their needs and develop these outside of the medical model. For example one carer felt it would be useful to be able to take her parents to organised swimming and another needed someone to help mobilise her mother, as the carer was unable to take her out in the car alone. The difficulty in applying this philosophy, however is that the assessors involved may not have an understanding of the long-term implications of a disease process and therefore will not put in appropriate supports for the person with the disability or for the carer and will therefore need regular review. Another problem has been that the health professionals do not recognise these assessors as competent.

The opportunity I had to spend time with the study respondents and provide them with an opportunity to define needs themselves, was unique. Most research into statutory resources stems from a quantitative methodology and therefore the individual's responses are limited by the structure presented by those doing the research. The premise is that those with the decision making power will want the most effective system and have an underlying desire to provide resources to those that need them in the most effective way. To enable this to happen they will have to take seriously the needs as presented by the carers, however, this may be seen as idealistic and impractical as it is not the most efficient method of 'capping' resources for carers.

### **A Socialist Feminist Perspective.**

The recent writings of those who refer to themselves as socialist feminists take the position of two separate but interlocked spheres of oppression: (1) class oppression, which is rooted in production of things; and (2) sex oppression, which is rooted in the production of people.

(Janet Nes & Peter Ladicola 1989: 14)

Sex oppression is discussed in relation to the production/reproduction of people. The interest is in the socialisation of women to become active in the reproduction or maintenance of family members in a carers role, and to leave the productive or public sphere. The socialisation of the social relationships of families, and in particular women as carers, is central to the analysis of the information provided by the women carers in the study. The material outlined further in this chapter, expands these concepts and selects themes from a range of different feminist perspectives. These have been used to answer the questions surrounding the caregiver role. Families and marital systems are analysed to address the question of why women become carers? This is expanded into gender roles with the public and private worlds explored which then leads into discussion about paid and unpaid work.

Central to the role of women as carers is production and reproduction. Production (of goods and services in paid employment) is a role that all women in this research have played at some stage in their lives and some continue to do so. For some there has been an active decision to choose production or 'career' over marriage and children. Information was not sought or given about women's marital choices, however it was clear that women chose to be in paid work and identified themselves as the occupation i.e. "I'm a teacher". Reproduction has also had influence in the carer role in the majority of cases as the 'mothering' role continues the biological relationship to partner and family. The conflict between these two roles is evident in the information provided and, based on the choices the women have made, i.e. the role of production or reproduction, has affected their ability to cope as carers. Those that have previously been in a caring role in the private or public sphere, namely mothers themselves or hands-on carers in a formal care situation, had a better idea of the lifestyle change and role demands than those with no previous caregiving experience. This study has to a degree challenged the assumption that women see themselves naturally in the caring role. A number of women did not enjoy the 'hands-on' care and found this very unpleasant. However as stated previously the majority of women did not hesitate or question the fact that they would provide this role and this will now be explored further.

### **Public and private worlds.**

The sexual division of labour is inherent in the theory of public and private worlds. Shelagh Cox and Bev James (1987) demystify public and private worlds. They present the two as being aligned to the different sexes, men to the public world outside the family home and women inside the family home, the private world. The concepts of

production and reproduction are aligned also - men to production in an economic sense and women to reproduction connected directly to child bearing and nurturing the next generation of workers.

This false consciousness was reflected most strongly in a pilot interview. When the carer was asked what *her* paid work history was, she recounted her husband's employment history. The work done by her in the public and private sphere was not considered (by her) as important, reflecting the invisibility of her contribution. However she also saw herself strongly as supporting her husband and it was seen as a team effort - his achievements were her achievements. To isolate her from her husband's public success would have devalued the contribution she had made even through raising children were unrecognised.

The carers within this research are doubly invisible. As previously stated the elderly themselves tend to become invisible at the time of retirement and those who care for this group are further removed from recognition. There are expectations from both the state and society that women will naturally take on the role of being a carer. This is reflected in Robyn Munford's accounts of working with carers. She found...

Power relations pervaded the most intimate spheres of women's lives. The men they loved and lived with were part of the relations of oppression. When women did attempt to enter a 'public world' and make some changes, they would be criticised and ostracised for upsetting the status quo. The myths about caregiving which controlled and gave meaning to their lives were so entrenched that at times it is almost impossible to image another reality.

(Robyn Munford 1990: p42)

From my experience, men as carers are seen by family and society as heroes and they attract more support. Formal and informal resources become available, the formal tends to recognise the time-out that men need to socialise with others and the informal is meals provided or domestic tasks done by other women. The need for women to socialise seems unrecognised.

Alienation is a concept which is explored through the research and presented as one identified consequence of becoming a carer. This is not questioned directly in relation to patriarchy but in terms of why families and society leave the women carer alone to fulfill a roll that is demanding and socially isolating? However it is the writer's strong belief that this sex-gender system is rooted in patriarchy. Women still make up the

majority of carers and there is an expectation that the daughters, wives and nieces will fulfill these roles and provide domestic labour.

### **How do women fall into the role of carers?**

'Familiar Exploitation: a new analysis of marriage in contemporary western societies' written by Christine Delphy and Diana Leonard (1992) expands on the sexual division of labour in the home by focusing on the roles within the family setting. Though the writing stems from a Marxist feminist analysis, it presents the argument by evaluating the economic relationships within the family, rather than comparing with others in the market place. The explanation is as follows:

..in asking if wives get more or less for their work in the family than they would on the labour market, it gets forgotten that the 'wage rate' is not the point at issue in family labour. Family oppression is about family subordinates being personal dependents. It is about their not being able to change to another husband/father easily (or their not being able to change at all), and their having to do whatever their husband/father requires rather than specific tasks, and his being able to be violent or sexually abusive towards them with relative impunity. Family dependents do not own their own labour power in the same way as heads of households own theirs, and if dependents sell labour they do so under different conditions from heads. Dependents either do not have the money at all except what their heads 'gives' them, or if they earn money, they do not own it in the same way as their household head earns what he earns.

If the bad things about family labour keep getting forgotten, the bad things about wage work, on the other hand, are nearly always recalled. Hence not surprisingly, people end up saying that the family labour is not as bad as wage labour. They then cannot understand how the family contributes to the continuing subordination of women generally, or why women, when given the choice, generally opt for paid employment rather than for being a 'kept women'.

(Delphy and Leonard 1992: 1-2)

One of the striking responses from the women that were caring for their ageing husbands was the lack of conscious decision making when it came to becoming a carer for their spouses. It was a given that they would provide this care and fulfill this role. The carers who are caring for their husbands, in the main, are past the age where they

are able to work in paid employment, as they qualify for superannuation, however the concept of - "*their not being able to change to another husband/father*" (Delphy and Leonard 1992) is interesting. Dawn, when asked how she became a carer stated that it was because she was living in the house when her husband was to be discharged from hospital. The hospital did not question if she was prepared to be a carer and she accepted her fate.

Barbara and Irene persevered with the caring role and struggled to maintain a business at the same time. Two of the women interviewed felt that one of the benefits of becoming a carer was that they moved out of the paid employment arena and were able to stay at home. Catherine had been working in an office and although she expresses leaving paid work as a benefit, also states that hands-on care is difficult for her. The financial costs for Catherine receiving the domiciliary care benefit have previously been outlined. Family labour to Catherine must have had a great deal of value if the termination of paid employment is a bonus in taking on the carer role. June was the other carer to express leaving paid employment as positive. She indicated that she enjoys being at home and enjoys family labour.

Becoming a carer provided a legitimate reason to leave work. Most carers do not view the family or the carers role as one where they are oppressed by the family, but the lack of support from family and friends was expressed as a disappointment and frustration. The cultural beliefs of families seem to manipulate some women through family expectations and emotions to prevent discussions of other options available, or whether the option of becoming a carer is the right one. Most social workers in dealing with families find that men, however, do not attract the same familial expectations.

Mary Daly has researched in some depth the relationship between women, the church (Catholic) and the impact it has had on marital relationships. She evaluates the clerical mainstream writers. Monsignor Kelly is one.

"Sometimes, self-appointed marriage authorities of this breed will write of the wife as a man's 'reward' at the end of a hard day's work. It is characteristic of these marriage counselors that they oppose work outside the home on the part of the wife, since this fosters 'undesirable traits', such as independence.

Since it is chiefly as mother rather than as partner that the Eternal Woman is envisioned, the maternal role tends to be exaggerated into grotesque proportions which have pathological implications for sexual relationship.

Devotees of the mystique often proclaim that the wife should be a mother not only to her children but also to her husband.

(Daly 1975: 175)

This section of Daly's work is part of her analysis of how the Church has continued to oppress women. Although it would be inappropriate to generalise that this perception of women has been accepted by all the carers in this study, however an element of the institutionalised sexism grounded in church doctrine is apparent in the information provided.

To explore further the comments presented by Mary Daly, that women are to be totally dependent on their husbands, would not totally be supported by the women in this study. The concept of dependence needs to be further evaluated. Several women in the research discussed the difficulty for them of having to take over the money and business side of the relationship. None of the women indicate a total dependence on their partners or any other male, but reflect more on how they feel about another person becoming totally dependent on them. Barbara reflected on the loss of a mutuality of the marital relationship. Once they would discuss everything together and jointly make decisions, now she has to make them all on her own.

The Christian doctrine was evident in the responses from several women. Those that identified themselves as Closed Brethren reflected this in different ways. Elizabeth talked about her work history and was clear that once she was married her paid work finished. Social Workers who work with this group recognise that men have the responsibility of decision making within families. Examples of this have been family meetings to arrange care for a person needing hands-on help and only the men in the family (unlikely to provide hands-on care) come to the meeting.

When Helen was asked how she came about caring for her husband she said ..

*I felt it was what God would have me to do, reflecting an expectation that on a spiritual level Helen fulfills this role.*

### **Unpaid work.**

In analysing the 'unpaid household work' done by women, the definition of housework remains unclear because the concept of housework is accepted without question. Work, within the context of this thesis, includes everything that is in conjunction with maintenance of the home and those who live within it. This is clarified within the results of the time-use diaries where personal time and care is excluded

In the late 1960s and 1970s the domestic activities of women was recognised by the women's movement, as work (Delphy and Leonard 1992). It was acknowledged that women were not unproductive because they were at home, however housework, childcare and meeting the emotional and sexual needs of the man of the house were still unrecognised.

The 'value' of womens' contribution to the productivity and how this is excluded by the economists is exposed by Marilyn Waring in her book 'Counting for Nothing - What Men Value and What Women are Worth'. Economic definitions of production are challenged as, it is revealed by Waring that womens' contribution is excluded by the economic equations.

The skewed definitions of work and labour that are used by economists result in equally skewed concept of production. As we have seen, economists usually use labour to mean only those activities that produce surplus value (that is, profit in the marketplace). Consequently, labour (work) that does not produce profits is not considered production.

(Waring 1988: 22)

Relating this to carers of older people the work done by this group is viewed as economically worthless and unproductive. A value for this work has been established in the market place by residential homes that are charging between \$22,000 pa for the lowest dependency care and \$45,900 pa. for the highest. Like all unpaid work caring for older people does get recognition if anyone but the carer provides this role. For example the District Nurse who provides hands on care either by treating wounds and showering the person, the worker at the day care centre who provides care from 10 am till 3 pm. The list goes on and on. The issue is not to quantify this and put a dollar value on the care but to have recognition for the importance of the role and the acknowledgment of the fact that it is hard work.

The 1970s and 1980s brought out the consciousness of women and the definition of women's work was broadened. This included domestic tasks - housework, sexual and emotional servicing of men, the caring for children, the elderly and the sick. (Delphy and Leonard: 1992)

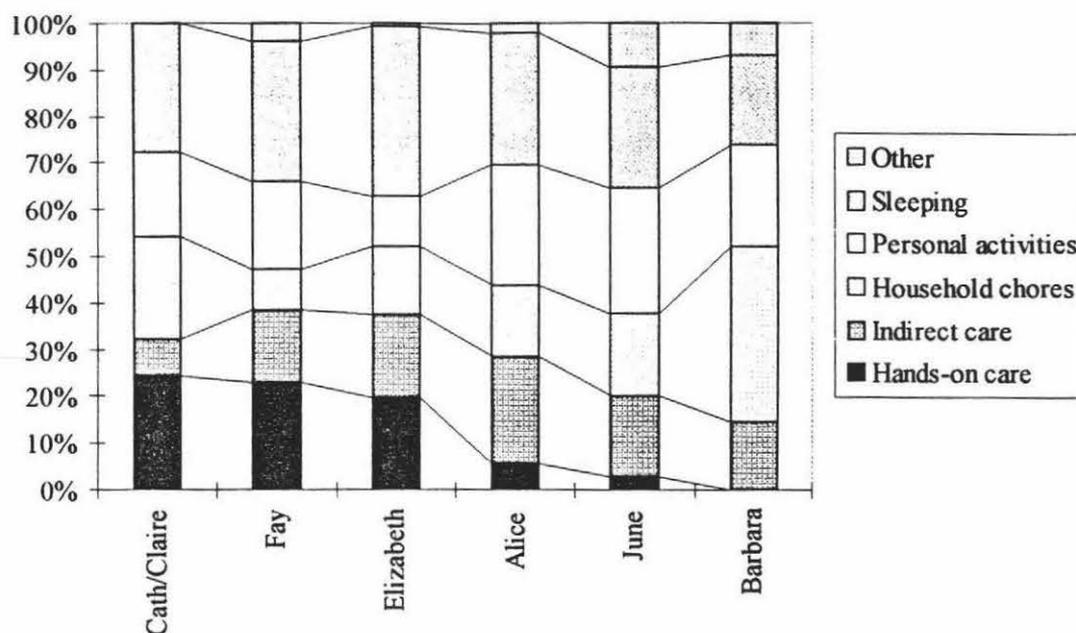
Throughout the feminist literature, the work of women was finally recognised and the reproductive role of women given value. This role is the nurturing and maintenance of both children and the men who then provide the means of production. This acceptance of the sexual division of labour was shown through the continued socialisation of children. The majority of these carers would have been socialised into their caring roles

before or during the 1960s and would have socialised their children during the 1970s and 1980s.

It is no great surprise that women are choosing to participate in the 'paid' work force rather than choosing 'unpaid' work. Several women now, however, are left in the uncompromising position of having to cope with both going to work and providing all the unpaid responsibilities as well, although there are some changes occurring in this area. This was reinforced by a popular myth that the home environment is the 'best' option for an individual. In my experience of working with older people and their families, if a carer considers alternatives, especially residential care, there is a heavy cost in guilt and the feeling of having failed the person they were caring for. In some situations quite the opposite effect occurs in that both people have a higher quality of life, both have their own interests and when the carer and caree get together they enjoy their time, rather than both being stressed due to remaining in an unsatisfactory situation.

#### **Time use diaries.**

A section of the information collected was recorded in a quantitative form to enable an analysis of the unpaid work provided by the carers. The graph on the following page is a visual illustration of how the care tasks are spread within a day.

**Figure 1:** Time use diary analysis

This graph illustrates the breakdown of the time use diaries. The majority of carers spent an average of 47 percent of their time providing caring duties, namely hands-on care (which applies to the time spent physically caring for the caree), in-direct care (this includes all other care tasks for example checking a person at night) and household chores which applies to housework. The rest of the time was defined as sleep, personal activities and other. The majority of paid workers spend 30 percent of the working day working and have two days off per week. Generally most people would still do household chores and may also provide in-direct care for others but this graph does reinforce the time and commitment provided by carers when fulfilling a carers role. One of the most important aspects of the time-use diaries has been providing the carers with an opportunity to reflect on the work they do and have it defined in this way.

### **Poststructuralism.**

The challenge now is to evaluate the above information from a poststructuralist's perspective. This is described by Roberta Sands and Kathleen Nuccio

... Poststructuralists look at meaning in relation to the particular social, political, and historical contexts in which language is spoken or written.

They view discourse (bodies of language or “texts”) and “readers” as situated, rather than neutral.

(Roberta Sands and Kathleen Nuccio 1992: 491)

The appeal of poststructuralism lies in its ability to deconstruct the information by looking at the social, historical and political contexts of the women involved. One example of this was when the women were asked their ethnic origin. The majority of the women were European, this term was chosen over pakeha as most women described themselves as European and several came from other colonial areas for example Australia and South Africa.

Foucault through the concept of ‘genealogy’ draws on historical information on struggles and suggests that these can be utilised in developing strategies for present day events. Genealogy is the research into historical struggles.

What it really does is to entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchise and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects.

(Foucault 1980: 83)

The relevance to this study of this concept is that carers have traditionally been marginalised and have not been recognised as having legitimate opinions surrounding their knowledge or struggle.

Jacques Derrida’s presentation of binary oppositions is an interesting theory when applied to carers and caregivers. The term ‘caregivers’ when deconstructed revolves around a binary relationship, one being the caregiver the other the receiver or taker of the care. It has been difficult within this research to avoid this implication. Attempts have been made to use terms like ‘caree’ and ‘older person receiving the care’. However when talking to the carers the relationship is based on rewards received from providing the care. The motivation is to provide a better quality of life and the rewards are to see the ‘loved one’ responding to the attention given. There are many other rewards and costs. Further deconstruction could occur.

Another factor of poststructuralism is to look at the juxtaposition of the global view and the localised scene. In the context of the women in this study, the global view taken is that of the monetarist philosophy. In an examination of the health system in New

Zealand, this has been chosen because most of the financial resources for carers are funded through this system and this system has been adopted from the United Kingdom. The United Kingdom system was introduced as the National Health Service on 1st April 1991 and in New Zealand in 1993. The names of the administrative organisations are the same; - Regional Health Authorities. The hospitals have the same names; - Crown Health Enterprises. The community funding systems are the same with General Practitioners becoming fundholders.

These reforms were based on regulated competition driven by the market philosophy. The reason for separating funders and providers was to give the funders the option of purchasing services from several providers. The flow on effect of this was that individuals would also have the option to choose from a range of providers. Another advantage of separating the funder from the provider is to enable a 'capping' to be placed on the health dollars spent.

Boston and Dalziel (1992) discuss this system..

“access to health care as a part of society reward system, so that those with higher incomes should be permitted to purchase more and better quality care if they so desire. Market liberals generally argue that health care is no different from other commodities in terms of the expected responses to market mechanism. Even when ill, individuals are the best judges of their own welfare and should therefore accept responsibility for their own health care. Strengthening market mechanisms through private funding and provision should improve the efficiency of health services.

(Jonathan Boston & Paul Dalziel 1992: 147)

The implication of this approach for carers and those cared for is that services are available because the market will see the need and supply them to those that can afford them.

The localised situation for these carers is affected by their political, social and cultural contexts. The needs expressed by them are localised and although there may be some similarities with the United Kingdom caregivers, the needs can only be met on a local level. It is for this reason that a structural socialist feminist approach has been taken to identify the themes expressed by the women and an opportunity for their voices to be presented to the health service stakeholders. The resources gaps identified by the women are the need for contact with families and other people to counteract isolation.

**Summary:**

This chapter draws together the feminist theory woven throughout this thesis. The fundamental theoretical perspective underpinning this research has been drawn from the socialist feminist school of thought. This ideology is reflected in discussions surrounding production and reproduction in terms of caring for the elderly. Production is explored through the evaluation of womens' roles in society and the link between work in the private world as influenced by social policy developed in the public realm. The concept of reproduction refers to womens' place in the home and their role as nurturers. Socialist feminist analysis explore womens' role of reproducers of labour and this nurturing role is extended to include care of the elderly. These expectations of reproduction are expected to affect women in the fist half of their lives, what has been highlighted by the literature and theory is that socialisation of women as carers and nurturers will place them again in these roles in the second half of their lives.

## CHAPTER 8

### Implications For Social Work Practice.

#### Introduction:

This research has provided me with a luxury that most social workers do not have. A time to stop and appraise the situation for a group of people who received a service that I had provided.

The implications for social work practice will relate more specifically to social work within a hospital setting, in a multi-disciplinary role and under service management. To explain this, the social work scene was mostly based on a hospital ward not based in the community. The social worker was in a team of other health professionals, namely occupational therapists, physiotherapists, nurses, doctors and speech language therapists as the main players. Finally under service management refers to the social worker being accountable to the above team and to a clinical manager who may not have a social work background. This was a direct reflection of the position I held within the health system which was duplicated not only locally but nationally.

The information provided by the carers constantly brought new information and surprises. Although, through experience, a lot of the responses were expected, it was the continual challenges to the assumptions I held about carers and the consequences of providing the care that brought the surprises.

The literature provided some information on assumptions being tested by researchers globally. Several of these revolved around the role of carers and the role of women. The majority of the literature written on social work within New Zealand excludes elder care. The implication of this for social workers was that those working in health and community organisations find that a large client group held by these workers have little information and research available to draw on.

As previously stated social work with older people is a separate specialisation due to the complex nature of inter-generational dynamics. Social work training is critical as a foundation on which to develop this specialist knowledge.

The majority of social workers, although they may draw on different philosophical positions, are bound by issues of social justice. When working with elder care issues, elder abuse is one of the areas of social injustice that speaks the loudest. The links between lack of resources, carer stress and elder abuse are constantly remembered in every social work assessment.

The literature reflects education as the best prevention of abuse and that this needs a multi-agency approach. The implication on practice is that carers and older people start by receiving education about the existence of abuse. Having identified that abuse is occurring, the proactive response is to clarify with the carer (who may or may not be the abuser) and the older person which safety measures can be implemented. The appropriate intervention should be provided within the social work role, taking into account that other agencies are available to assist in this area. A local example was the Elder Abuse Co-ordinator employed through Age Concern. The Co-ordinator receives referrals from any person or agency, passes this onto the most appropriate agency to respond to the concerns raised. These agencies include Age Concern, Police, local Iwi groups, health professionals, Women's Refuge and Lawyers. Unfortunately, to date a clear policy has not been established within the hospital system, however this should be completed in the near future.

Also outlined in the literature review was the RCSP summary of different theoretical positions. When reflecting on these it appears that the one most utilised by health social workers was medicalisation. This was not the situation when I first started in this position five years ago. It appears to be a combination of several factors. The institutionalisation of social work through service management has reduced the flexibility of community based practice to the point that follow up visits by that social worker are rare. Separating a social worker from a social work focus centralised the social worker under a medical model. The consequences of this are that the social worker is reduced to responding to clients within a short time frame - from days to a week at the most. This reduces intervention options. The social work role becomes defined by the team and the management (usually these people have no social work training). Therefore the role is defined through the medical model as the majority of the team members trained under this model. The occupational therapists are the exception - they work from a socio-ecological model. The team also refer to social workers, everyone with a social problem, or who is behaviourally in the "too hard basket" and expect them to be 'treated' and 'cured' instantaneously.

Another factor within the current environment for health social work is the gate keeping role. This has been created through the assessment process outlined previously in the resources chapter. Social workers have become assessors, the main reason for this is that the traditional brokerage role cannot be performed unless the assessment function is completed and then the referrals for resources can be made. This function has dominated the social work role and restricted other intervention methods such as individual, group, family or community work. The range of recognised social work skills is limited and therefore the service received by the client and families becomes one of brokerage rather than therapy.

Anne Opie (1995) evaluates the effectiveness of social work intervention and, in doing so, interviewed caregivers.

The caregivers I interviewed felt supported by most of the social workers, who acted as their advocates, advised them of the available services and of their eligibility to access them, arranged family meetings to discuss care plans and to keep other significant family members informed of what was happening, responded to crisis and tried to provide a listening, empathetic ear. That caregivers valued those dimensions of support came through very clearly in the warmth of their comments. Yet simultaneously nearly half of the 25 caregivers whose transcripts I analysed indicated a significant limitation to the support work carried out by the social workers. They spoke of how their knowledge of the social workers' pressure of work meant that they had consciously to justify a decision to contact them, and they referred to the absence of support or counseling, especially at key transition points in their caring career, such as the admission of their relative or spouse to care, times when caregivers were likely to be experiencing high levels of guilt and anxiety about the rightness of their decision at critical points, then, the support to deal with the emotional consequences of their decisions or of the events was absent.

(Annie Opie 1995: 222)

The consequences of the above have led to a reduction in effectiveness when working with carers and the institutionalisation of social work and the subsequent assumptions made by social workers was the major realisation for me.

The resources chapter raised a number of questions in relation to social work practice. Currently some social workers refuse to provide information on New Zealand Income Support Service benefits or subsidies because they feel it is the responsibility of the

client to find out this information from NZISS. As stated earlier the forms themselves are extremely daunting especially if the client has any problems with literacy, an illustration of this is in Appendix 1,2 and 3. This does enable NZISS to deal with the financial matters. However when considering options for older people (mainly the caree), should not financial costs be discussed as a consideration in making informed choices? Certainly the respondents have indicated that domiciliary care benefits provide a very basic standard of living.

### What services are utilised by the carers?

The carers were asked if they were using the following services. At the time they were interviewed carer support-aid to families was being issued through NZISS.

**Table 6:** Formal services used by the carers

	Alice	Barb	Cath	Dawn	Eliz	Fay	Gill	Helen	Irene	June
Aid to Families	✓		✓				✓		✓	✓
Attendant Care										
Day Care						✓				✓
Community Nursing		✓	✓	✓	✓	✓	✓			
Home Support Services										
Meals on Wheels										
Social Relief				✓						

Aid to families (28 days) or carer support together with community nursing were equally the most popular services used. The reasons for this are not provided, however, it may be because neither of these services are income tested and both can be provided in the carers home.

Attendant care, although now included in home support contracts, was at the time of the interview, unavailable to those over 65 years of age, therefore it is not surprising that this service was not utilised. Day care is designed to provide an opportunity for socialisation for the person receiving the care and time out for the carer. This service was available to people diagnosed as having dementia at no cost if they hold a community services card.

Home support services and meals at the time of the interview were provided by the local CHE. The criteria for this would exclude the carers from receiving this service, because those living on their own or with carers who themselves have disabilities, would be the

first to receive the service. The need to prioritise these services usually results in those living alone receiving what funding is available.

**Table 7: Voluntary Groups used by Carers**

	Alice	Barb	Clair	Dawn	Eliz	Fay	Gill	Helen	Irene	June
A.D.A.R.D.S.						✓				
Age Concern	✓			✓				✓	✓	
Arthritis Foundation										✓
Advocacy Service										
Blind Foundation										
Cancer Society										
Civilian Maimed Association	✓									✓
Diabetic Society										
Disabled Persons Assembly								✓		
Grey Power							✓			
Hearing Association		✓								
Home Line										
Hospice Society	✓									
National Heart Foundation										
DRC	✓			✓		✓				
Order of St. John	✓								✓	
Ostomy Society										
Parkinson's Society							✓			
RSA				✓		✓				
Salvation Army Social Services							✓			✓
Stroke Support Group										

As Age Concern provided the names of some of the respondents it is not surprising that as a support group they are the one that was used by more carers than any other group.

Disabilities Resource Centre (DRC) Northland, as outlined previously in the resource chapter, has been providing an assessment service for people under 65. This assessment acts as a gate keeper for resources. This service also provides information and advocacy for people with disabilities and has a range of aids for people to purchase.

The majority of remaining support groups are specific to particular disease processes or disabilities, for example Parkinson's Support Group. The advantage of this is an opportunity to receive support from others in a similar situation who may have useful practical experience which can be shared.

The under utilisation of resources was a surprise. The situation is that carers get one main opportunity to receive referrals for resources. This is when the person they are caring for is assessed, either in the community or in the hospital. It is usually at a time of crisis and therefore the carer has not had the opportunity to think through the implications of the care situation. By asking which resources were used gave the carers an opportunity to ask about those not heard of before and placed the majority in a position (not in crisis) of knowing where the resources are most needed. It appears logical then that a visit to carers, sometime down the track to explore the available resources to enable them another opportunity to define their needs once they know the caring situation better. At the time of interviewing carers this was not possible as the managerialism of social work prevented the workers from leaving the assigned areas of responsibility as this work is not contracted and therefore unpaid by the service concerned.

I started the methodology section by stating that it was natural for social workers to develop a relationship with a client by asking them to "tell their story". However when I asked carers to do this in a research setting the information I received was different from the information provided in a working relationship. Being captured by the medical model results in a diagnosis-treatment process. The carer indicates she is taking the older person home, then the social worker assesses the client using a prescriptive assessment form and a list of services available which the elder person may receive or not, depending on the income of the applicant. This research has suggested another assessment process, enabling the carer to do a self assessment and present their needs, not restricted by a prescribed assessment or a list of resources.

The ideal would be for a the method adopted within this research to be utilised by social work practitioners. For this to become part of social work practice several changes in work patterns would need to occur. Currently the focus is on the needs of the older person, who is defined as the client. Although the carer usually receives the majority of the social worker's time, the focus is not on the carer's needs (although they are explored). Social workers would also need to be able to visit carers in their own homes at a time when the crisis of the initial stages of caring have passed, to re-evaluate the

needs identified within the home and maybe the client at this point should become the carer.

The importance of support agencies in the community are not always acknowledged and it may be appropriate to refer to these groups rather than cling to the concept of being the 'key' worker.

The most significant information provided by this research is that given by the respondents themselves. The job performed by carers is not widely known by society, or even by those working with health needs on a daily basis. The level of care provided by the women in this study reinforced the level of dependency of those receiving care. It has been highlighted on numerous occasions that the wives in this study, particularly, are providing hospital level care.

For the first time I have been asking carers how they became carers and the response indicated that in the majority of cases it was not a matter of choice. This challenges a fundamental assumption made by social workers. It is taken for granted that wives want to care for their spouses, unless they specifically state otherwise. Residential care is discussed in terms of long-term care but this assumption is highlighted in Barbara's response. She became a carer because she lived in the house and he (her husband) was returning home. In one case the family rallied around and discussed, not only who was providing care, but what the dependent person(s) wanted. It is also assumed that the older person would prefer to be dependent on family than in an institution.

Residential care is viewed by respondents as a last resort. The majority of carers believe they can provide a better quality of life for the individual than an institution. In Mr. G's case, presented at the end of the resources chapter, this is certainly the situation. However, in a number of residential care facilities the care is good and improving due to the competitive nature of the industry. Mrs. G has a broken ankle that has not healed because she is walking on it to look after her husband. If he had been to a facility where his needs were met then both of them would have benefited. The residential care situation does not restrict the carer from being able to leave and return home for periods of time. In my experience, and this is reinforced by some of the carers, the quality of life for both the carer and the caree is not always explored.

Once again these issues can be raised at a later date once the implications of the caring becomes a reality for those involved.

Although it is assumed that carers, particularly wives, will provide care for a heavily dependent person, it also follows that the role is enjoyed even though it is a hard job. There is a great deal of benefit in providing care for another person and this was expressed by carers. As stated before, the satisfaction comes from believing they are providing a higher standard and better quality of life for those receiving the care. Social workers, when exploring with carers the choice they are making, should discuss the motivation expressed by the person contemplating the carer role. It was clear that those women who have previously been a carer, either through recognised paid or unpaid carer roles, knew the implications of their decision to care for an older person. Certainly those who had never provided the role before found it very difficult.

The themes that were strongly voiced by the carers were the lack of real choice (when reflecting on how they became carers), the isolation which develops through lack of opportunity to continue personal interests and the isolation from other family and finally the job is one with no visible end.

The challenge to social work is to respond to these issues that for this practitioner were being heard for the first time. It is important for social workers to explore with the carers the choices they are making in taking on the carer role - even if they are wives.

Isolation is an issue which social workers are aware of but the degree of family isolation was a revelation. The resources provided by statutory agencies have an underlying assumption that family are willing to support carers. This may need to be explored with families and carers to formalise what support is available and what is needed. This needs to be reviewed at a later time as with the statutory resources once the carer is familiar with the role, and has a better idea of what resources are needed.

Michael Belgrave and Loretta Brown (1996) recently completed an evaluation of the cost of informal care. This was incorporated into a review on the effectiveness of case management. Following are the recommendations of the report in relation to supporting informal carers.

These recommendations recognise a particular role undertaken by women as carers and are aimed at improving the self-esteem and status of informal carers as essential providers of care and of sharing the burden of care more evenly by:

- providing more timely and effective formal services in the home to reduce the non-financial and financial costs of care to informal carers;
- by ensuring adequate and flexible care is available;

by ensuring that carers have access to information from professionals on the services available and on the consequences of them undertaking the role of carer;

by encouraging other family members to provide care;

by providing training in care where this is required and by ensuring that carers maintain their own support networks and have the emotional support to allow them better to cope with their situation.

(Belgrave and Brown 1996: iv)

In summary social workers working with carers and older people tend to work from a model which focuses on the needs of the dependent person and is detached from the carer. The carer is asked at a time of crisis to define their needs before they really know what they are. The interviewing methods used by social workers, which are directive, need to become non-directive to enable the carer to define their own needs. Non-directive interviewing provides the setting for the development of the working relationship to enable the carers to talk about the issues for them in fulfilling the caregiving role.

As this research focuses on carers needs and was conducted at a time when they were not in crisis, many were able to identify resource gaps and indicated that social isolation is a big issue. This includes isolation from both friends and family. It is the problem social workers need to be clear about. In this study the respondents challenge social workers to address carers needs and isolation created by the caregiving lifestyle.

Finally the medical model does not address the ongoing nature of providing care for another person. Social workers need to move from a dependence model to one where the needs of both people are continually considered and carers feel they have choices.

## APPENDIX 1: FORMS ISSUED BY NEW ZEALAND INCOME SUPPORT SERVICES AND BENEFITS:

The following forms are from New Zealand Income Support Service. The total number of pages totals 139. Those marked with an asterisk are the most likely to be used by elder carers, and are presented in full in the Appendix:

- Accommodation supplement
- Accommodation supplement application
- Appointment of an agent
- Change of address/accommodation costs
- Change of bank account
- Community services card application - National Superannuation\*
- Domestic purposes benefit application - *Caregiver*\*
- Funeral grant application
- Home support services subsidy\*
- Increased payment while in hospital
- Living alone payment application
- New Zealand superannuation application\*
- New Zealand superannuation application - *Partner*
- New Zealand superannuation/Veterans pension review
- Personal details
- Residential care subsidy\*
- Review of decision
- Special benefit application
- Support needs grant
- Tenure protection allowance review
- Veterans pension application
- Veterans pension application - *Partner*
- Veterans pension - transfer from New Zealand superannuation

# Community Services Card Application - New Zealand Superannuation



CUSTOMER NUMBER

Please fill out this Application form if you are currently receiving New Zealand Superannuation (previously known as National Superannuation or Guaranteed Retirement Income). If you need help with this form please call our toll free number 0800 805 494.

## Name

1. What is your name?

First names

Surname or family name

Give any other names that you use now or have used in the past (including your maiden name).

2. Are you known by or have you ever used any other names?

No  Go to Question 3

Yes  Please give details below

Maiden name:

Any "other" names:

3. Are you: Male  Female

Please tick one box to show the title you want to be known by.

4. What do you wish to be called?

Mrs  Miss  Ms  Mr  No title

Other

## Birth Date

5. What is your date of birth?

Day Month Year

## Address

Give your house number, street, suburb, and your town or city.

Give your mailing address if different from where you live.

If you do not have a telephone, please give a friend or relative's number so we can contact you.

6. Where do you live?

7. Where do you want your card sent?

8. What is your contact telephone number?

Home / work

Friend relative

My number is

## Tax Number

9. What is your Inland Revenue tax number?

### Ethnic Group

You don't have to answer this question if you don't want to.

This information is for statistics only.

#### 9. To which ethnic group do you believe you belong?

- |                 |                          |              |                          |        |
|-----------------|--------------------------|--------------|--------------------------|--------|
| New Zealand     | <input type="checkbox"/> | Other        | <input type="checkbox"/> |        |
| European/Pakeha | <input type="checkbox"/> | European     | <input type="checkbox"/> | Samoan |
| Tokelauan       | <input type="checkbox"/> | Cook Islands | <input type="checkbox"/> | Tongan |
|                 | <input type="checkbox"/> | Maori        | <input type="checkbox"/> |        |
| Chinese         | <input type="checkbox"/> | Indian       | <input type="checkbox"/> |        |

New Zealand Maori  To which tribe(s)/iwi do you belong? Give details below

Other (please state) \_\_\_\_\_

### Living Alone

You are "living alone" if:

- you live in one place of residence most of the time, and
- you are not sharing your accommodation with another adult.

#### 10. Do you live alone?

Yes

No

### Overseas Pension

Give amount in New Zealand dollars.

#### 11. Do you get paid an overseas pension?

No  Go to Question 15

Yes  Please answer questions below

#### 12. What country pays the pension?

\_\_\_\_\_

#### 13. What is the name of the pension?

\_\_\_\_\_

#### 14. What is the annual rate of pension? \$ NZ

\_\_\_\_\_

### Spouse

A spouse is a wife or husband, or someone you are living with in a relationship similar to marriage.

#### 15. Do you have a spouse?

No  Go to Question 19

Yes  Please answer questions below

#### 16. What is your spouse's full name?

\_\_\_\_\_

First name \_\_\_\_\_ Surname \_\_\_\_\_

#### 17. What is your spouse's date of birth?

\_\_\_\_\_ 19\_\_\_\_\_  
Day Month Year

**18. Is your spouse getting National Superannuation payments?**

No  Yes  Please give your spouse's customer number below

--	--	--	--	--	--	--	--	--	--

Ask your spouse to complete the Spouse section

### Income Details

*Please only give your own share of any income. We may ask you to show proof of your income.*

*We will use half of any amounts you show in Question 19 or 20 when calculating your entitlement to the card.*

*Do not include any lump sum payments or your National Superannuation in the amount as Question 19.*

*Examples of money from other sources:*

- wages or salary before tax
- taxable accident compensation
- net taxable farm or business income
- interest from savings or investments before withholding tax
- dividends from shares or debentures before withholding tax
- net taxable income from rents
- redundancy or termination-type payments
- private overseas pensions
- any other taxable income, eg. family trusts

*Do not include*

- NZ Registered Superannuation schemes
- annuities from NZ Life Insurance offices
- National Superannuation.

**19. What money did you get as a pension from any New Zealand Registered Superannuation scheme or as an annuity from any New Zealand Life Insurance offices during the last tax year?**  
(Do not include any lump sum payments or your National Superannuation in the amount below).

\$  Enter the full amount or "nil"

**20. Are you still receiving the same amount as shown in Question 19?**

Yes  Go to Question 21

No  How much do you expect to get this year?

\$

**21. What money did you get from any other source during the last tax year?**

Where did it come from?

	\$
	\$
	\$
	\$
	\$
	\$
<b>Total</b>	<b>\$</b>

**22. Do you think you will get the same amount as shown in Question 21 during this tax year?**

Yes  Go to Question 24

No  How much do you expect to get this year?

\$

**23. What is the reason for the difference?**


**Rest Home**

24. Are you a resident of a rest home or hospital?

Yes  No

**Statement**

Under the terms of the Privacy Act 1993, we are required to inform you that:

- the information you have provided is being collected under the authority of The Health Entitlement Card Regulations 1993
- the information is needed to assess your entitlement to a Community Services Card and will be used for the functions and purposes of New Zealand Income Support Service
- you have rights of access to the information held about yourself and you have the right to request corrections to this information
- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department, Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

The information I have given in this application is true and correct and I have not left anything out.

*If this form has been filled out by someone else on your behalf, that person needs to complete the agent's details.*

*New Zealand Income Support Service must have written confirmation if you have appointed an agent.*

**Please sign here**

CUSTOMER'S SIGNATURE

19  
Day Month Year

**Please sign here**

AGENT'S SIGNATURE

19  
Day Month Year

AGENT'S NAME

**Agent's address**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To get your Community Services Card please complete this application form and send it to New Zealand Income Support Service, P.O. Box 5054, Wellington.

**Office use only**

GRANT  DECLINE

RECOMMENDING OFFICER SIGNATURE

19  
Day Month Year

AUTHENTICATING OFFICER SIGNATURE

19  
Day Month Year

CHECKING OFFICER SIGNATURE

19  
Day Month Year

# Partner Details



## New Zealand Income Support Service

Please ask your partner to complete Questions 1-20.

CUSTOMER NUMBER
PARTNER CUSTOMER NUMBER

### Customer's Name

First name Surname

### Name

1. What is your name?

First names

Surname or family name

Give any other names that you use now or have used in the past (including your maiden name).

2. Are you known by or have you ever used any other names?

No  Go to Question 3

Yes  Please give details below

Maiden name:

Any "other" names:

3. Are you: Male  Female

Please tick one box to show the title you want to be known by.

4. What do you wish to be called?

Mrs  Miss  Ms  Mr  No title

Other

### Birth Date

5. What is your date of birth?

Day Month Year

### Address

Give your house number, street, suburb, and your town or city.

6. Where do you live?

Give your mailing address if different from where you live.

7. Where do you want your card sent?

If you do not have a telephone, please give a friend or relative's number so we can contact you.

8. What is your contact telephone number?

Home work Friend relative  
My number is

### Tax Number

9. What is your Inland Revenue tax number?

**Customer Number**

8. Do you know your customer number?

Yes  › What is your number?

--	--	--	--	--	--	--	--	--	--

No  › Go to Question 9

**Ethnic Group**

*You don't have to answer this question if you don't want to.*

*This information is for statistics only.*

9. To which ethnic group do you believe you belong?

New Zealand European/Pakeha	<input type="checkbox"/>	Other European	<input type="checkbox"/>	Samoa	<input type="checkbox"/>
Tokelauan	<input type="checkbox"/>	Cook Islands Maori	<input type="checkbox"/>	Tongan	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Indian	<input type="checkbox"/>		
New Zealand Maori	<input type="checkbox"/>	To which tribe(s)/iwi do you belong? Give details below			

--

<input type="checkbox"/>	Other (please state)	
--------------------------	----------------------	--

**Living Alone**

*You are "living alone" if:*

- you live in one place of residence most of the time, and
- you are not sharing your accommodation with another adult.

10. Do you live alone?

Yes

No

**Overseas Pension**

11. Do you get paid an overseas pension?

No  › Go to Question 15

Yes  › Please answer questions below

12. What country pays the pension?

--

13. What is the name of the pension?

--

14. What is the annual rate of pension? \$ NZ

--

*Give amount in New Zealand dollars.*

## Income Details

Please only give your own share of any income.

We may ask you to show proof of your income.

We will use half of any amount you show in Question 15 or 16 when calculating your entitlement to the card.

Do not include any lump sum payments or your National Superannuation in the amounts at Question 15.

Examples of money from other sources:

- wages or salary before tax
- taxable accident compensation
- net taxable farm or business income
- interest from savings or investments before withholding tax
- dividends from shares or debentures before withholding tax
- net taxable income from rents
- redundancy or termination-type payments
- private overseas pensions
- any other taxable income, eg. family trusts.

Do not include

- NZ Registered Superannuation schemes
- annuities from NZ Life Insurance offices
- National Superannuation.

15. What money did you get as a pension from any New Zealand Registered Superannuation scheme or as an annuity from any New Zealand Life Insurance offices during the last tax year?

(Do not include any lump sum payments or your National Superannuation in the amount below.)

\$  Enter the full amount or "nil"

16. Are you still receiving the same amount as shown in Question 15?

Yes  › Go to Question 17

No  › How much do you expect to get this year?

\$

17. What money did you get from any other source during the last tax year?

Where did it come from?

<input type="text"/>	\$
<b>Total</b>	<b>\$</b>

18. Do you think you will get the same amount as shown in Question 17 during this tax year?

Yes  › Go to Question 20

No  › How much do you expect to get this year?

\$

19. What is the reason for the difference?

<input type="text"/>
<input type="text"/>
<input type="text"/>

## Rest Home

20. Are you a resident of a rest home or hospital?

Yes  No

**Statement**

Under the terms of the Privacy Act 1993, we are required to inform you that:

- the information you have provided is being collected under the authority of The Health Entitlement Card Regulations 1993
- the information is needed to assess your entitlement to a Community Services Card and will be used for the functions and purposes of New Zealand Income Support Service
- you have rights of access to the information held about yourself and you have the right to request corrections to this information
- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department, Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

The information I have given in this application is true and correct and I have not left anything out.

*If this form has been filled out by someone else on your behalf, that person needs to complete the agent's details.*

*New Zealand Income Support Service must have written confirmation if you have appointed an agent.*

**Please sign here**

▶	CUSTOMER'S SIGNATURE	19		
		Day	Month	Year

**Please sign here**

▶	AGENT'S SIGNATURE	19		
		Day	Month	Year

▶	AGENT'S NAME
---	--------------

**Agent's address**


**Office use only**

GRANT	DECLINE
-------	---------

RECOMMENDING OFFICER SIGNATURE	19		
	Day	Month	Year

AUTHENTICATING OFFICER SIGNATURE	19		
	Day	Month	Year

CHECKING OFFICER SIGNATURE	19		
	Day	Month	Year

# Domestic Purposes Benefit Application-Caregiver



CUSTOMER NUMBER

--	--	--

## Who can get this benefit

*If you need help filling in this form, please ask at your nearest New Zealand Income Support Service office.*

*Mehemea e hiahia me awihina a koe ki te whakahi i tenoi panui, haere patai ki te poari o te New Zealand Income Support Service tata tonu kia koe.*

*Afai e te mana'omia se fesoasoani i le faasumuina o so'o se pepa talosaga e uiga i penefiti, faamolemole faafesoota'i le ofisa o le New Zealand Income Support Service.*

## Domestic Purposes Benefit for Caregivers

To get the Domestic Purposes Benefit for Caregivers you must:

- be 16 years or over  
**and**
- be caring full time for someone (but not your partner or child) who would be in hospital if you weren't caring for them  
**and**
- usually live in New Zealand.

If you are caring for your partner or child, you may be able to get an Emergency Benefit. Please ask us about this.

*This is an income tested benefit.*

## What to bring

*Please ask Income Support Service staff for help if:*

- you do not have any of the documents we have asked for
- you would like to know about extra help.

**When you apply for the Domestic Purposes Benefit for Caregivers, you need to bring the following information:**

1. Bank account details.
2. A birth certificate or passport, and one other form of identification, eg. driver's licence.
3. Inland Revenue tax number.
4. Income details.
5. Full birth certificates for your children.
6. Marriage certificate.
7. Verification of any name change.

### Your partner's details

If you have a partner, you need to bring in the following information about him/her:

1. Bank account details.
2. Inland Revenue tax number.
3. Income details.
4. A birth certificate or passport, and one other form of identification, eg. driver's licence.
5. Verification of any name change.

**This form should be taken to your New Zealand Income Support Service office as soon as possible. The date you apply affects the date you are granted your benefit.**

# Customer's information

## Privacy & Social Security Act

*Under Sections 11 and 12 of the Social Security Act we are authorised to collect necessary information in order to establish entitlement.*

### The Privacy Act 1993 requires us to inform you that:

- the information you have provided is being collected under the authority of the Social Security Act 1964
- the information is needed to assess your entitlement to a benefit and will be used for the functions and purposes of New Zealand Income Support Service and Social Policy Agency
- you have the right to request access to the information held about yourself and to request corrections to this information
- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department, Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

## Warning

### I understand that:

- if I have made a false statement,  
or
- if I have failed to answer all the questions in full,  
or
- if I do not tell New Zealand Income Support Service about changes in my life that might affect my entitlement or rate,  
then
- my benefit may be reviewed and cancelled,  
and
- I may have to pay back the total amount of any overpayment that I have received,  
and
- any overpayment that my partner has received,  
and
- New Zealand Income Support Service may impose a penalty, (up to three times the value of the overpayment)  
or
- I may be prosecuted and fined or imprisoned.

## Obligations

*Work situation changes include starting part-time, casual or full-time work, whether paid or unpaid.*

*Changes to your living situation include:*

- starting or ending a relationship similar to marriage
- change in the number of children supported
- change in accommodation costs
- marriage or separation.

### I must tell New Zealand Income Support Service immediately if either my partner or myself:

- have a change in work situation
- become self employed/start to run a business
- have changes to my/our income or financial circumstances
- intend to travel overseas
- start/finish part-time or full-time study
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our benefit entitlement or rate.

## Additional Information

Contact name \_\_\_\_\_

Information required by \_\_\_\_\_

19

Day Month Year

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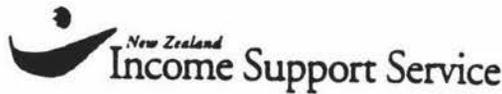


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# Domestic Purposes Benefit Application-Caregiver



CUSTOMER NUMBER

--	--	--

*Please complete all questions; if not applicable write 'nil'.*

## Name

1. What is your name?  
First names

Surname or family name

2. Are you known by or have you used any other names?

No

Yes  Please give details below

1.

2.

3. Are you: Male  Female

4. What do you wish to be called?

Mrs  Miss  Ms  Mr  No title  Other:

*Give any other names that you use now or have used in the past (including your maiden name).*

*Please tick one box to show the title you want to be known by.*

## Birth Date

5. What is your date of birth?

<input style="width: 90%; height: 20px;" type="text"/> Day	<input style="width: 90%; height: 20px;" type="text"/> Month	<input style="width: 90%; height: 20px;" type="text"/> 19 Year
---	---	---

## Address

*Give your house number, street, suburb, and your town or city.*

*Please give us your mailing address if different from where you live.*

6. Where do you live?


7. What is your mailing address?


8. What is your contact telephone number?


## Past Benefits

9. Are you currently receiving any type of benefit?

No

Yes  What type of benefit?

10. Have you ever received any type of benefit before?

No  Go to Question 12

Yes  What type of benefit?

11. What was your customer number?

--	--	--



Give gross (before tax) amount.

Give the name, telephone number and address of the firm or person you worked for.

Give gross (before tax) and net (after tax) amounts.

Give gross (before tax) amount.

Give type of payments, eg. long service leave, payments in lieu of notice, etc.

Give the name and address of your employer, and the start and end dates of your employment.

24. How much is your gross weekly wage? \$ \_\_\_\_\_

25. Have you had any other employment in the last 52 weeks?

No  Go to Question 33

Yes  Please answer Questions 26-32

26. Who did you last work for and what sort of work did you do?

27. What was your weekly wage in your last job?

Gross	Net
\$ _____	\$ _____

28. How long did you work for?

Start date	Finish date
Day _____ Month _____ Year 19____	Day _____ Month _____ Year 19____

29. Why did you leave your last job?

30. Did you get holiday pay when you left the job?

No  Yes  Give gross amount \$ \_\_\_\_\_

31. Did you get any redundancy/termination-type payment in the last 26 weeks?

No  Yes  Give net amount \$ \_\_\_\_\_ Payment type \_\_\_\_\_

32. Have you had any other employment in the last 52 weeks?

No  Yes  Please give details below


**Other Income**

Examples of income from other sources:

- wages or salary
- accident compensation
- farm or business income (include drawings)
- self employment
- interest from savings or investments
- dividends from shares
- income from rents
- redundancy or termination type payments
- Child Support
- maintenance payments
- any other income, eg. family trust.

33. Did you get income from any other source in the last 52 weeks?

No  Go to Question 34

Yes  Please give details below

Source (eg. bank account number)	Income (eg. interest)
	\$ _____
	\$ _____
	\$ _____

34. What income do you expect to get in the next 52 weeks?

Source (eg. bank account number)	Income (eg. interest)
	\$ _____
	\$ _____
	\$ _____

### Details of the person you are caring for

*You must be caring full time for this person. You must also provide a Medical Certificate from your doctor.*

35. What is the name of the sick or frail person in your full-time care?

36. What is their relationship to you?

37. Is there anyone else in the house able to care for this person?

No  Yes

38. What date did you start caring for this person?

\_\_\_\_\_ 19\_\_\_\_\_  
Day Month Year

### Payment

- Give details of:
- your cash assets
  - what expenses you have to meet
  - whether you can change these expenses.

39. There is a two-week stand-down before your benefit can be granted. If you need to apply for earlier payment, please explain why below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Partner

*A partner is a spouse who is a wife, husband, or someone with whom you have a relationship similar to marriage.*

40. Do you have a partner?

No  Are you: Single  Living apart/separated  Divorced  Widowed

Go to the Accommodation Supplement or Obligations section

Yes  Are you: Married  In a relationship

41. What is your partner's name?

\_\_\_\_\_

42. What is your partner's date of birth?

\_\_\_\_\_ 19\_\_\_\_\_  
Day Month Year

▶ Please ask your partner to fill in the Partner Details section (Questions 1-22)

# Medical Certificate



CUSTOMER NUMBER		

Customer's Name

First name

Surname

The customer named above has applied for the Domestic Purposes Benefit for Caregivers for ..... who is your patient.  
Please provide medical details as requested below.

## Medical Details

*Please get the doctor of the person you are caring for to fill in this section.*

1. Doctor's name and address:


2. What is the patient suffering from?


3. How long is the care required?


4. Is the care required full time?

No  Yes

5. Would this person be admitted to hospital if not cared for?

No  Yes

## Doctor's Statement

*This information is required under Sections 11 and 12 of the Social Security Act 1964.*

I certify that I have examined this person, and confirm the information given above.

Please sign here

DOCTOR'S SIGNATURE
--------------------

	19	
Day	Month	Year

# Partner Details



PARTNER CUSTOMER NUMBER		
CUSTOMER NUMBER		

Please ask your partner to complete Questions 1-22.

## Customer's Name

First name	Surname

### Name

1. What is your name?  
 First names \_\_\_\_\_  
 Surname or family name \_\_\_\_\_

2. Are you known by or have you used any other names?  
 No  Yes  Please give details below  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_

3. Are you: Male  Female

4. What do you wish to be called?  
 Mrs  Miss  Ms  Mr  No title  Other

Give any other names that you use now or have used in the past (including your maiden name).

Please tick one box to show the title you want to be known by.

### Birth Date

5. What is your date of birth?  

		19
Day	Month	Year

### Past Benefits

6. Are you currently receiving any type of benefit?  
 No   
 Yes  What type of benefit? \_\_\_\_\_

7. Have you ever received any type of benefit before?  
 No  Go to Question 9  
 Yes  What type of benefit? \_\_\_\_\_

8. What was your customer number? \_\_\_\_\_

### Tax Number

9. What is your Inland Revenue tax number? \_\_\_\_\_

### Residency

Tick one box.

10. Indicate which describes your residency situation:  
 Born in New Zealand  Go to Question 14      Permanent resident  Go to Question 12  
 New Zealand citizen  Go to Question 12      Other  Go to Question 11

11. What is your immigration status?  
 \_\_\_\_\_

12. When did you arrive in New Zealand? \_\_\_\_\_ 19\_\_\_\_  
Day Month Year

13. Where were you born? \_\_\_\_\_  
Day Month Year

14. Do you normally live in New Zealand?

No  Yes

15. Have you lived in New Zealand for any 12-month period?

No  Yes

### Employment

*Give the name, telephone number and address of the firm or person you work for.*

*Give gross (before tax) amount.*

16. Are you working?

No  Go to Question 20

Yes  Is the job: Full time  Part time  Casual  Seasonal   
 Voluntary  Self employment

17. Who are you working for?

1. \_\_\_\_\_  
 2. \_\_\_\_\_

18. How much is your gross weekly wage? \$ \_\_\_\_\_

19. Have you had any other employment in the last 52 weeks?

No  Yes  Please give details below

\_\_\_\_\_  
 \_\_\_\_\_

### Other Income

*Examples of income from other sources:*

- wages or salary
- accident compensation
- farm or business income (include drawings)
- self employment
- interest from savings or investments
- dividends from shares
- income from rents
- redundancy or termination type payments
- Child Support
- maintenance payments
- any other income, eg. family trust.

20. Did you get income from any other source in the last 52 weeks?

No  Yes  Please give details below

Source (eg. bank account number)	Income (eg. interest)
_____	\$ _____
_____	\$ _____
_____	\$ _____

21. What income do you expect to get in the next 52 weeks?

Source (eg. bank account number)	Income (eg. interest)
_____	\$ _____
_____	\$ _____
_____	\$ _____

### Bank Details

22. What bank account do you want the benefit paid into?

Name of your bank (eg. Postbank) \_\_\_\_\_

Name of your branch (eg. Lower Hutt) \_\_\_\_\_

The account is in the name of: \_\_\_\_\_

The account number is: \_\_\_\_\_  
Bank Branch Account number

Office use only

Verified by \_\_\_\_\_

II# / / I# / # II#

# Partner's obligations Staff Copy

*Please read this statement carefully and sign.*

I must tell New Zealand Income Support Service immediately if either my partner or myself:

- have a change in work situation (such as starting part-time, casual or full-time work, whether paid or unpaid)
- become self employed/start to run a business
- have changes to my/our income or financial circumstances
- intend to travel overseas
- start/finish part-time or full-time study
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation (such as starting or ending a relationship similar to marriage, change in the number of children supported, change in accommodation costs, marriage or separation)
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our benefit entitlement or rate.

I have completed all the questions in this *Domestic Purposes Benefit for Caregivers* application, or this application has been completed for me, and the information I have given is true and complete. The conditions for receiving a benefit have been explained to me and I understand these conditions.

NAME (print)	PARTNER'S SIGNATURE						
	<table style="margin-left: auto; margin-right: 0;"> <tr> <td style="border-bottom: 1px solid black; width: 20px;"></td> <td style="border-bottom: 1px solid black; width: 20px;"></td> <td style="border-bottom: 1px solid black; width: 20px; text-align: center;">19</td> </tr> <tr> <td style="font-size: 8px;">Day</td> <td style="font-size: 8px;">Month</td> <td style="font-size: 8px;">Year</td> </tr> </table>			19	Day	Month	Year
		19					
Day	Month	Year					

<p><b>Office use only</b> <i>Only if partner is present.</i></p>	<p><b>Statement by Interviewing / Interpreting Officer</b> I have explained the conditions for receiving a benefit and explained what the partner's obligations mean and the reason for them. The partner has indicated that he/she understands and accepts responsibility to provide true and complete information and to advise immediately of any changes in circumstances. All questions have been completed.</p>						
NAME (print)	INTERVIEWING OFFICER SIGNATURE						
	<table style="margin-left: auto; margin-right: 0;"> <tr> <td style="border-bottom: 1px solid black; width: 20px;"></td> <td style="border-bottom: 1px solid black; width: 20px;"></td> <td style="border-bottom: 1px solid black; width: 20px; text-align: center;">19</td> </tr> <tr> <td style="font-size: 8px;">Day</td> <td style="font-size: 8px;">Month</td> <td style="font-size: 8px;">Year</td> </tr> </table>			19	Day	Month	Year
		19					
Day	Month	Year					

# Partner's obligations Your Copy

*The following information is for you to take away.*

I must tell New Zealand Income Support Service immediately if either my partner or myself:

- have a change in work situation (such as starting part-time, casual or full-time work, whether paid or unpaid)
- become self employed/start to run a business
- have changes to my/our income or financial circumstances
- intend to travel overseas
- start/finish part-time or full-time study
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation (such as starting or ending a relationship similar to marriage, change in the number of children supported, change in accommodation costs, marriage or separation)
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our benefit entitlement or rate.

### Additional Information

Information required by

		19
Day	Month	Year

Contact name

**Additional information***Staff Copy*

PARTNER CUSTOMER NUMBER

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**Office use only**

Decision


PROCESSING OFFICER

19

Day Month Year

AUTHENTICATING OFFICER

19

Day Month Year

CHECKING OFFICER

19

Day Month Year

LETTER REFERENCE

10%	100%	CRITICAL DATA
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Bring up

S F

19

Day Month Year

**Warning***Your Copy*

PARTNER CUSTOMER NUMBER

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**I understand that:**

- if I have made a false statement, or
- if I have failed to answer all the questions in full, or
- if I do not tell New Zealand Income Support Service about changes in my life that might affect my entitlement or rate, then
- my partner's benefit may be reviewed and cancelled, and
- I may have to pay back the total amount of any overpayment that I have received, and
- New Zealand Income Support Service may impose a penalty, (up to three times the value of the overpayment) or
- I may be prosecuted and fined or imprisoned.

**The Privacy Act 1993 requires us to inform you that:**

- the information you have provided is being collected under the authority of the Social Security Act 1964
- the information is needed to assess your entitlement to benefit and will be used for the functions and purposes of New Zealand Income Support Service and Social Policy Agency
- you have the right to request access to the information held about yourself and you have the right to request corrections to this information
- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department, Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

Under Sections 11 and 12 of the Social Security Act we are authorised to collect necessary information in order to establish entitlement.

## Customer's obligations

*Please read this statement carefully and sign.*

I must tell New Zealand Income Support Service immediately if either my partner or myself:

- have a change in work situation (such as starting part-time, casual or full-time work, whether paid or unpaid)
- become self employed/start to run a business
- have changes to my/our income or financial circumstances
- intend to travel overseas
- start/finish part-time or full-time study
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation (such as starting or ending a relationship similar to marriage, change in the number of children supported, change in accommodation costs, marriage or separation)
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our benefit entitlement or rate.

I have completed all the questions on this *Domestic Purposes Benefit for Caregivers* application, or this application has been completed for me, and the information I have given is true and complete. The conditions for receiving a benefit have been explained to me and I understand these conditions.

NAME (print)	CUSTOMER'S SIGNATURE	19
		Day    Month    Year

### Office use only

**Statement by Interviewing / Interpreting Officer**

I have explained the conditions for receiving a benefit and explained what the customer's obligations mean and the reason for them. The customer has indicated that he/she understands and accepts responsibility to provide true and complete information and to advise immediately of any changes in circumstances. All questions have been completed.

NAME (print)	INTERVIEWING OFFICER SIGNATURE	19
		Day    Month    Year

**Additional information**


**Decision**


LETTER REFERENCE	PROCESSING OFFICER	19
		Day    Month    Year
10%    100%    CRITICAL DATA	AUTHENTICATING OFFICER	19
		Day    Month    Year
	CHECKING OFFICER	19
		Day    Month    Year
	Bring up    B    F	19
		Day    Month    Year

## Home Support Services Subsidy



CUSTOMER NUMBER

--	--	--

### Who can get this benefit

*If you need help filling in this form, please ask at your nearest New Zealand Income Support Service office.*

*Mehemea e hiahia me awhina a koe ki te whakaki i tenei panui, haere patai ki te poari o te New Zealand Income Support Service tata tonu kia koe.*

*Afai e te mana'omia se fesoasoani i le faatumuina o so'o se pepa talosaga e uiga i penefiti, faamolemole faafesoota'i le ofisa o le New Zealand Income Support Service.*

### What to bring

*Please ask Income Support Service staff for help if:*

- you do not have any of the documents we have asked for
- you would like to know about extra help.

### Home Support Services Subsidy

The Home Support Services Subsidy is available to people who have been needs assessed as requiring home support services.

The Subsidy is financially assessed by New Zealand Income Support Service but is funded by the Regional Health Authority.

### When you apply for the Home Support Services Subsidy, you need to bring the following information:

1. Regional Health Authority authorisation form for financial assessment (from your service coordinator).
2. Details/verification of income, assets, expenses and commitments.

### Your partner's details

If you have a partner, you need to bring in the following information about him/her:

1. Details/verification of income, assets, expenses and commitments.

*Please complete all questions; if not applicable write 'nil'.*

**Name**

1. What is your name?  
First names

Surname or family name

*Give any other names that you use now or have used in the past (including your maiden name).*

2. Are you known by or have you ever used any other names?

No  › Go to Question 3

Yes  › Please give details below

1.

2.

*Please tick one box to show the title you want to be known by.*

3. Are you: Male  Female

4. What do you wish to be called?

Mrs  Miss  Ms  Mr  No title

Other

**Birth Date**

5. What is your date of birth?

		19
--	--	----

Day                  Month                  Year

**Address**

*Give your house number, street, suburb and your town or city.*

6. Where do you live?


7. What is your contact telephone number?

**Past Benefits**

8. Are you currently receiving any type of benefit or New Zealand Superannuation?

No  › Go to Question 9

Yes  › What type of benefit?



**14. What is their customer number?**

--	--	--

**Family Members**

**15. Do you have any other family members living in the home?**

No  Yes  Please give details of the family members below

Family members name	Relationship to you	Income per week
		\$
		\$
		\$
		\$

**Assets**

*Examples of assets:*

- money in a bank or savings organisation
- money lent to other people or organisations
- money in Bonus Bonds, shares, debentures or government stock.
- other

*You may be required to show proof of these details.*

**16. Do you or your partner have any assets?**

No  Yes  Please give details below

Type of asset	You	Your partner	Jointly owned
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

**Income Details**

*Examples of money from any other sources are:*

- wages or salary
- accident compensation
- farm or business income
- self employment
- income from rents
- redundancy or termination type payments
- boarders
- any other income.

**17. Did you and your partner (if you have one) get money from any other source?**

No  Yes  Please give details below

Where does it come from?	How much to you?	How much to your partner?
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$



**Statement**

**I understand that:**

- if I have made a false statement, or
- if I have failed to answer all the questions in full, or
- if I do not tell New Zealand Income Support Service about changes in my life that might affect my entitlement or rate, then
- my benefit may be reviewed and cancelled, and I may have to pay back the total amount of any overpayment that I have received, and
- any overpayment that my partner has received, and
- New Zealand Income Support Service may impose a penalty, (up to three times the value of the overpayment) or
- I may be prosecuted, fined or imprisoned.

**The Privacy Act 1993 requires us to inform you that:**

- the information you have provided is being collected under the authority of the Social Security Act 1964
- the information is needed to assess your entitlement to a benefit and will be used for the functions and purposes of New Zealand Income Support Service
- you have rights of access to the information held about yourself and you have the right to request corrections to this information
- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department and Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

Under Sections 11 and 12 of the Social Security Act we are authorised to collect necessary information in order to establish entitlement.

The information I have given is true and I have not left anything out.

**Please sign here**

	CUSTOMER'S SIGNATURE	19
		Day Month Year

**Office use only**

			<b>Decision</b>		
<b>LETTER REFERENCE</b>			<b>PROCESSING OFFICER</b>		
<b>10%    100%    CRITICAL DATA</b>			<b>AUTHENTICATING OFFICER</b>		
<b>CHECKING OFFICER</b>			<b>Bring up</b>		
			<input type="checkbox"/> <b>B</b> <input type="checkbox"/> <b>F</b>		
			19		
			Day Month Year		

# New Zealand Superannuation Application



CUSTOMER NUMBER

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## Who can get this benefit

*If you need help filling in this form, please ask as your nearest New Zealand Income Support Service office.*

*To check if you are eligible for New Zealand Superannuation, or if you wish to have your partner included, please ask New Zealand Income Support Service staff.*

To get New Zealand Superannuation, you must have reached the qualifying age.

You must also:

- be a New Zealand citizen or have been granted permanent residence in New Zealand and
- have lived in New Zealand for a "certain period of years" and
- be living in New Zealand when you apply for New Zealand Superannuation.

If you have a partner who does not qualify for New Zealand Superannuation, you may want to include them in your payment.

*If your partner is included your New Zealand Superannuation will be income tested.*

## What to bring

*Please ask Income Support Service staff for help if:*

- you do not have any of the documents we have asked for
- you would like to know about extra help like the Living Alone Payment.

When you apply for New Zealand Superannuation, you need to bring the following information:

1. Bank account details.
2. Inland Revenue tax number.
3. A birth certificate or passport, and one other form of identification, eg. driver's licence.
4. Verification of any name change.

## Privacy & Social Security Act

*Under Sections 11 and 12 of the Social Security Act we are authorised to collect necessary information in order to establish entitlement.*

The Privacy Act 1993 requires us to inform you that:

- the information you have provided is being collected under the authority of the Social Security Act 1964
- the information is needed to assess your entitlement to a benefit and will be used for the functions and purposes of New Zealand Income Support Service and Social Policy Agency
- you have the right to request access to the information held about yourself and to request corrections to this information

This form should be taken to your New Zealand Income Support Service office as soon as possible. The date you apply affects the date you are granted your benefit.

## Customer's information

- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department, Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

### Warning

#### I understand that:

- if I have made a false statement, **or**
- if I have failed to answer all the questions in full, **or**
- if I do not tell New Zealand Income Support Service about changes in my life that might affect my entitlement or rate, **then**
- my benefit may be reviewed and cancelled, **and**
- I may have to pay back the total amount of any overpayment that I have received, **and**
- any overpayment that my partner has received, **and** New Zealand Income Support Service may impose a penalty, (up to three times the value of the overpayment) **or**
- I may be prosecuted and fined or imprisoned.

### Obligations

*Changes to your living situation include:*

- *starting or ending a relationship similar to marriage*
- *change in the number of children supported*
- *change in accommodation costs*
- *marriage or separation.*

#### I must tell New Zealand Income Support Service immediately if either my partner or myself:

- intend to travel overseas
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our New Zealand Superannuation entitlement or rate.

#### If my partner is included in my New Zealand Superannuation entitlement then I must tell New Zealand Income Support Service immediately if either my partner or myself:

- have a change in work situation (such as starting part-time, casual or full-time work, whether paid or unpaid)
- become self employed/start to run a business
- have changes to my/our income or financial circumstances.

### Additional Information

Contact name

Information required by

Day Month Year


# New Zealand Superannuation Application



CUSTOMER NUMBER

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*Please complete all questions; if not applicable write 'nil'.*

## Name

**1. What is your name?**

First names

Surname or family name

*Give any other names that you use now or have used in the past (including your maiden name).*

**2. Are you known by or have you ever used any other names?**

No  › Go to Question 3

Yes  › Please give details below

1.

2.

**3. Are you:** Male  Female

**4. What do you wish to be called?**

Mrs  Miss  Ms  Mr  No title

Other

*Please tick one box to show the title you want to be known by.*

## Birth Date

**5. What is your date of birth?**

	19	
Day	Month	Year

**6. What is your Country of birth?**

*If not New Zealand please supply proof of residence.*

## Address

*Give your house number, street, suburb, and your town or city.*

*Please give us your mailing address if different from where you live.*

**7. Where do you live?**


**8. What is your mailing address?**


**9. What is your contact telephone number?**

### Past Benefits

10. Are you currently receiving any type of benefit?

No  Go to Question 11

Yes  What type of benefit? \_\_\_\_\_

11. Have you ever received any type of benefit before?

No  Go to Question 13

Yes  What type of benefit? \_\_\_\_\_

12. What was your customer number?

--	--	--	--	--	--	--	--	--	--

### Tax Number

13. What is your Inland Revenue number?

--	--	--	--	--	--	--	--	--	--

14. At what rate do you want tax to be deducted from your New Zealand Superannuation payments?

Primary rate (if the New Zealand Superannuation is your only income)

Secondary rate (if there is other income)

A special rate (Inland Revenue can calculate a special rate)

### Ethnic Group

*This information is for statistics and will be used for research and future development work.*

15. To which ethnic group do you believe you belong?

New Zealand Maori (a) To which tribe(s)/iwi do you belong? Give details below

\_\_\_\_\_

New Zealand (b) European/Pakeha  Other (c) European  Samoan (d)

Cook Islands Maori (e)  Niuean (f)  Tokelauan (g)

Tongan (h)  Chinese (i)  Indian (j)

Other (k) (please specify) \_\_\_\_\_

### Bank Details

16. What bank account do you want your New Zealand Superannuation paid into?

Name of your bank (eg. Postbank)

\_\_\_\_\_

Name of your branch (eg. Lower Hutt)

\_\_\_\_\_

The account is in the name of:

\_\_\_\_\_

Office use only
Verified by

The account number is:

Bank	Branch	Account number

**Residency**

*Please provide details of your absences from New Zealand.*

*Please provide your passport(s).*

*If you answer no to either question 17 or 18 please discuss with Income Support Service staff as you may be entitled to New Zealand Superannuation; if you have resided or paid contributions in a country which New Zealand has a Social Security Agreement with.*

*If you have lived in Australia for an aggregate of 10 years or more, more information is required. Please ask Income Support staff for Australia and New Zealand residence details form.*

17. Have you lived at least 10 years in New Zealand since age 20?

Yes  No  Please give details below

18. Have you lived at least 5 years in New Zealand since age 50?

Yes  No  Please give details below

1. Date of departure	Date of return/Immigration date
<input type="text"/> <input type="text"/> <input type="text"/> 19	<input type="text"/> <input type="text"/> <input type="text"/> 19
Day Month Year	Day Month Year
Period away	Name of country lived in/visited
<input type="text"/> <input type="text"/>	<input type="text"/>
Months Years	

2. Date of departure	Date of return/Immigration date
<input type="text"/> <input type="text"/> <input type="text"/> 19	<input type="text"/> <input type="text"/> <input type="text"/> 19
Day Month Year	Day Month Year
Period away	Name of country lived in/visited
<input type="text"/> <input type="text"/>	<input type="text"/>
Months Years	

3. Date of departure	Date of return/Immigration date
<input type="text"/> <input type="text"/> <input type="text"/> 19	<input type="text"/> <input type="text"/> <input type="text"/> 19
Day Month Year	Day Month Year
Period away	Name of country lived in/visited
<input type="text"/> <input type="text"/>	<input type="text"/>
Months Years	

19. Give names and addresses of two people (other than relatives) who can confirm your residence in New Zealand?

Person 1	Phone
Person 2	Phone

**Children**

20. Do you have children in your care?

No  Go to Question 21

Yes  Please give details over the page

*Please give the names of any children that you support and are living with you, including:*

- stepchildren
- children at boarding school
- adopted children
- grandchildren
- mokopuna.

Child's full name	Date of birth
1	/ /

Relationship to you	Other parent's name

Child's full name	Date of birth
2	/ /

Relationship to you	Other parent's name

### Overseas Social Security

**21. Have you made any contributions to an overseas Pension Scheme?**

No  → Go to Question 22

Yes  → Please discuss with Income Support Service staff.

### Partner

*A partner is a spouse who is a wife, husband, or someone you are living with in a relationship that is similar to marriage.*

**22. Do you have a partner?**

No  → Are you: Single  Living apart/separated

Divorced  Widowed

Yes  → Are you: Married  Living with a spouse

### Partner's Name

*Give any other names that they use now or have used in the past (including their maiden name).*

*Please tick one box to show the title they want to be known by.*

**23. What is their name?**

First names

Surname or family name

**24. Are they known by or have they ever used any other names?**

**25. What do they wish to be called?**

Mrs  Miss  Ms  Mr  No title

Other

### Partner's Birth Date

**26. What is their date of birth?**

	19	
Day	Month	Year



5. Does the Disability Allowance need to be paid to an outside organisation?

No  Yes  Please give details below

### Medical Insurance

6. Is the disability covered by ACC, private medical insurance or War Pensions?

No  Yes  Please give details below

Organisation scheme/ name  Weekly amount  \$

### Statement

The information I have given in this application is true and I have not left anything out.

Please sign here

CUSTOMER'S SIGNATURE  19  
Day Month Year

### Disability Certificate

*Please get your doctor to fill in this section.*

1. Doctor's name and address:

2. What is the nature and extent of the disability?

3. What is the expected duration of the disability?

4. How often does the patient need to see you, and what is the cost per visit?

5. Do you agree that the expenses claimed by the customer are as a result of their disability?

No  Yes  Please give details below

**Doctor's Statement**

*This information is required under Sections 11 and 12 of the Social Security Act 1964.*

I certify that the information I have given is correct from the records held in this office.

Please sign here

DOCTOR'S SIGNATURE

		19
Day	Month	Year

**Office use only**

Decision

PROCESSING OFFICER

		19
Day	Month	Year

LETTER REFERENCE

AUTHENTICATING OFFICER

		19
Day	Month	Year

10%	100%	CRITICAL DATA
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CHECKING OFFICER

		19
Day	Month	Year

Bring up  B  F

		19
Day	Month	Year

## New Zealand Superannuation Application - *Partner*



CUSTOMER NUMBER

--	--	--

### Who can get this benefit

*If you need help filling in this form, please ask at your nearest New Zealand Income Support Service office.*

If you do not qualify for New Zealand Superannuation in your own right, you may be included in your partners payment.

To check if you are eligible for New Zealand Superannuation, please ask New Zealand Income Support Service staff.

*This is an income tested payment.*

### What to bring

*Please ask Income Support Service staff for help if:*

- you do not have any of the documents we have asked for*
- you would like to know about extra help like the Living Alone Payment.*

When you apply for New Zealand Superannuation, you need to bring the following information:

1. Details of your income and assets (payslips, bankbooks, share certificates, etc.)
2. Details of your partner's income and assets (payslips, bankbooks, share certificates, etc.)
3. Your birth certificate.
4. Your marriage certificate.
5. Your bank account details.
6. Your Inland Revenue tax number.
7. Your passport.
8. Verification of any name change.

### Privacy & Social Security Act

*Under Sections 11 and 12 of the Social Security Act we are authorised to collect necessary information in order to establish entitlement.*

**The Privacy Act 1993 requires us to inform you that:**

- the information you have provided is being collected under the authority of the Social Security Act 1964
- the information is needed to assess your entitlement to a benefit and will be used for the functions and purposes of New Zealand Income Support Service and Social Policy Agency
- you have the right to request access to the information held about yourself and to request corrections to this information

**This form should be taken to your New Zealand Income Support Service office as soon as possible. The date you apply affects the date you are granted your benefit.**

## Customer's information

- the information you have provided may be compared with information held by the Ministry of Education, Inland Revenue Department, Justice Department, Customs Department, Department of Labour and Accident Compensation and Rehabilitation Insurance Corporation.

### Warning

#### I understand that:

- if I have made a false statement,  
**or**
- if I have failed to answer all the questions in full,  
**or**
- if I do not tell New Zealand Income Support Service about changes in my life that might affect my entitlement or rate,  
**then**
- my benefit may be reviewed and cancelled,  
**and**
- I may have to pay back the total amount of any overpayment that I have received,  
**and**
- any overpayment that my partner has received,  
**and**
- New Zealand Income Support Service may impose a penalty, (up to three times the value of the overpayment)  
**or**
- I may be prosecuted and fined or imprisoned.

### Obligations

*Changes to your living situation include:*

- *starting or ending a relationship similar to marriage*
- *change in the number of children supported*
- *change in accommodation costs*
- *marriage or separation.*

#### I must tell New Zealand Income Support Service immediately if either my partner or myself:

- intend to travel overseas
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our New Zealand Superannuation entitlement.

### Additional Information

Contact name

Information required by

Day Month Year


# New Zealand Superannuation Application - Partner



CUSTOMER NUMBER		

Please complete all questions; if not applicable write 'nil'.

## Name

1. What is your name?

First names

Surname or family name

Give any other names that you use now or have used in the past (including your maiden name).

2. Are you known by or have you ever used any other names?

No  Go to Question 3

Yes  Please give details below

1.

2.

3. Are you: Male  Female

Please tick one box to show the title you want to be known by.

4. What do you wish to be called?

Mrs  Miss  Ms  Mr  No title

Other

## Birth Date

5. What is your date of birth?

<input type="text"/>	<input type="text"/>	19
Day	Month	Year

If not New Zealand please supply proof of residence.

6. What is your Country of birth?

**Address**

*Give your house number, street, suburb, and your town or city.  
Please give us your mailing address if different from where you live.*

7. Where do you live?

\_\_\_\_\_  
\_\_\_\_\_

8. What is your mailing address?

\_\_\_\_\_  
\_\_\_\_\_

9. What is your contact telephone number?

\_\_\_\_\_

**Tax Number**

10. What is your Inland Revenue number?

□ □ □ □ □ □ □ □ □ □

**Past Benefits**

11. Have you ever received any type of benefit before?

No  Go to Question 12

Yes  What type of benefit? \_\_\_\_\_

12. What was your customer number?

□ □ □ □ □ □ □ □ □ □

**Ethnic Group**

*This information is for statistics and will be used for research and future development work.*

13. To which ethnic group do you believe you belong?

New Zealand Maori (a) To which tribe(s)/iwi do you belong? Give details below

\_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> New Zealand (b)<br>European/Pakeha | <input type="checkbox"/> Other (c)<br>European | <input type="checkbox"/> Samoan (d)    |
| <input type="checkbox"/> Cook Islands<br>Maori (e)          | <input type="checkbox"/> Niuean (f)            | <input type="checkbox"/> Tokelauan (g) |
| <input type="checkbox"/> Tongan (h)                         | <input type="checkbox"/> Chinese (i)           | <input type="checkbox"/> Indian (j)    |
| <input type="checkbox"/> Other (k)<br>(please specify)      | _____  |  |

## Bank Details

14. What bank account do you want your New Zealand Superannuation paid into?

Name of your bank (eg. Postbank)

Name of your branch (eg. Lower Hutt)

The account is in the name of:

The account number is:

Bank			Branch			Account number		
1	2	3	4	5	6	7	8	9

Office use only

Verified by .....

## Residency

*Please provide details of your absences from New Zealand.*

*Please provide your passport(s).*

*If you have lived in Australia for an aggregate of 10 years or more, more information is required. Please ask Income Support staff for Australia and New Zealand residence details form.*

15. Have you lived at least 10 years in New Zealand since age 20?

Yes  No  Please give details below

16. Have you lived at least 5 years in New Zealand since age 50?

Yes  No  Please give details below

1. Date of departure Date of return/Immigration date

Day	Month	Year	Day	Month	Year
		19			19

Period away Name of country lived in/visited

Months	Years	
--------	-------	--

2. Date of departure Date of return/Immigration date

Day	Month	Year	Day	Month	Year
		19			19

Period away Name of country lived in/visited

Months	Years	
--------	-------	--

3. Date of departure Date of return/Immigration date

Day	Month	Year	Day	Month	Year
		19			19

Period away Name of country lived in/visited

Months	Years	
--------	-------	--

17. Give names and addresses of two people (other than relatives) who can confirm your residence in New Zealand?

Person 1
Phone
Person 2
Phone

### Assets

Assets may be:

- Investments
- Shares
- Any other property from which income could have been earned.

18. Have you or your partner sold or gifted any asset over the last 12 months?

No  Yes  Please give details below

1. Description of asset 1:


Name and address of person it was sold or gifted to


Date it was sold or gifted

Value

		19
Day	Month	Year

\$	
----	--

2. Description of asset 2:


Name and address of person it was sold or gifted to


Date it was sold or gifted

Value

		19
Day	Month	Year

\$	
----	--

### Other Income

*Examples of income from other sources:*

- wages or salary
- accident compensation
- farm or business income (include drawings)
- self employment
- interest from savings or investments
- dividends from shares
- income from rents
- redundancy or termination type payments
- Child Support
- maintenance payments
- any other income, eg. family trust
- Private Superannuation.

19. Did you get income from any other source in the last 52 weeks?

No  › Go to Question 20

Yes  › Please give details below

Source (eg. bank account number)	Income (eg. interest)
	\$
	\$
	\$
	\$

20. What income do you expect to get in the next 52 weeks?

Source (eg. bank account number)	Income (eg. interest)
	\$
	\$
	\$
	\$

### Employment

*Give the name, telephone number and address of the firm or person you work for.*

*Give gross (before tax) amount.*

21. Are you or your partner working?

No

Yes  › Is the job: Self-employment  Casual

Full time  Part time  Seasonal  Voluntary

22. Who are you/were you working for?

You	Your partner
1.	
2.	

23. How much is/was your gross weekly wage?

\$ \_\_\_\_\_

24. What was last date at work?

\_\_\_\_\_ 19  
Day Month Year

25. Have you had any other employment in the last 52 weeks?

No  Yes  › Please give details below


## Customer's obligations

*Please read this statement carefully and sign.*

I must tell New Zealand Income Support Service immediately if either my partner or myself:

- have a change in income
- have a change in work situation (such as starting part-time work, casual or full-time work, whether paid or unpaid)
- intend to travel overseas
- have changes to personal details (such as name, address, or bank account number)
- have changes to my/our living situation (such as starting or ending a relationship similar to marriage, change in the number of children supported, change in accommodation costs, marriage or separation)
- are imprisoned/held in custody on remand
- are admitted to or discharged from hospital
- have any other changes that may affect my/our New Zealand Superannuation entitlement.

I have completed this *New Zealand Superannuation* application, or this application has been completed for me, and the information I have given is true and I have not left anything out. The conditions for receiving *New Zealand Superannuation* have been explained to me and I understand these conditions.

NAME (print)	CUSTOMER'S SIGNATURE	Day	Month	Year
			19	
NAME (print)	PARTNER'S SIGNATURE	Day	Month	Year
			19	

## Residential Care Subsidy



CUSTOMER NUMBER

--	--	--	--	--	--	--	--	--	--

### Who can get this subsidy

*If you need help filling in this form, please ask at your nearest New Zealand Income Support Service office.*

*Mehemea e hiahia me awhina a koe ki te whakaki i tenei panui, haere patai ki te poari o te New Zealand Income Support Service tata tonu kia koe.*

*Afai e te mana'omia se fesoasoani i le faatumuina o so'o se pepa talosaga e uiga i penefiti, faamolemole faafesoota'i le ofisa o le New Zealand Income Support Service.*

### What to bring

*Please ask Income Support Service staff for help if:*

- *you do not have any of the documents we have asked for*
- *you would like to know about extra help.*

### Residential Care Subsidy

The Residential Care Subsidy is available to older people who have been needs assessed as requiring long term rest home or hospital care.

The subsidy is income and asset tested by New Zealand Income Support Service but is paid by the Regional Health Authority.

If you do not qualify, you can apply to receive the subsidy in the form of a loan.

### When you apply for the Residential Care Subsidy, you need to bring the following information:

1. Bank account details.
2. Income and asset details.
3. Receipt of prepaid funeral expenses.

#### Your partner's details

If you have a partner, you need to bring in the following information about him/her:

1. Bank account details.
2. Income and asset details.

This form should be taken to your New Zealand Income Support Service office as soon as possible. The date you apply affects the date you are granted your subsidy.

*Please complete all questions; if not applicable write 'nil'.*

**Name**

1. What is your name?  
First names

Surname or family name

*Give any other names that you use now or have used in the past (including your maiden name).*

2. Are you known by or have you ever used any other names?

No  Go to Question 3

Yes  Please give details below

1.

2.

3. Are you: Male  Female

4. What do you wish to be called?

Mrs  Miss  Ms  Mr  No title

Other

*Please tick one box to show the title you want to be known by.*

**Birth Date**

5. What is your date of birth?

		19
Day	Month	Year

**Address**

*Give your house number, street, suburb and your town or city.*

6. What was your address before entering residential care?

7. What is the name and address of the rest home or hospital?

8. What date did you enter the rest home or hospital?

		19
Day	Month	Year

9. What is the total weekly amount of fees payable to the rest home or hospital?

\$

10. What date have the fees been paid up to?

19		
Day	Month	Year

### Past Benefits

*For example:*

- New Zealand Superannuation
- Invalids Benefits

11. Are you currently receiving any type of benefit?

No  Go to Question 12

Yes  What type of benefit? \_\_\_\_\_

12. Have you ever received any type of benefit?

No  Go to Question 14

Yes  What type of benefit? \_\_\_\_\_

13. What was your customer number?

--	--	--	--	--	--	--	--	--	--

### Ethnic Group

*This information is for statistics and will be used for research and future development work.*

14. To which ethnic group do you believe you belong?

New Zealand Maori (a) To which tribe(s)/iwi do you belong? Give details below

\_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> New Zealand (b)<br>European/Pakeha | <input type="checkbox"/> Other (c)<br>European | <input type="checkbox"/> Samoan (d)    |
| <input type="checkbox"/> Cook Islands<br>Maori (e)          | <input type="checkbox"/> Niuean (f)            | <input type="checkbox"/> Tokelauan (g) |
| <input type="checkbox"/> Tongan (h)                         | <input type="checkbox"/> Chinese (i)           | <input type="checkbox"/> Indian (j)    |
| <input type="checkbox"/> Other (k)<br>(please specify)      | _____  |  |

### Bank Details

15. What rest home or hospital bank account do you want your benefit paid into after personal spending has been deducted?

Name of their bank (eg. Postbank)

\_\_\_\_\_

Name of their branch (eg. Lower Hutt)

\_\_\_\_\_

The account is in the name of:

\_\_\_\_\_

The account number is:

Bank	Branch	Account number
	:	***



**Children**

*Please give the names of any children that you support and are living with you, including:*

- *stepchildren*
- *children at boarding school*
- *adopted children*
- *grandchildren*
- *mokopuna.*

**20. Do you have children in your care?**

No  Go to Question 21 Yes  Please give details below

Child's full name	Date of birth
1 _____	_____ / ____ / ____
Relationship to you	Other parent's name
_____	_____

Child's full name	Date of birth
2 _____	_____ / ____ / ____
Relationship to you	Other parent's name
_____	_____

**Next of Kin**

**21. Who is your next of kin?**

Name \_\_\_\_\_

Address \_\_\_\_\_

Contact telephone number \_\_\_\_\_ How are they related to you? \_\_\_\_\_

\_\_\_\_\_

**Agent**

*An agent is someone who is authorised to act on your behalf.*

**22. Do you have an agent?**

No  Yes  Please give details below

Name \_\_\_\_\_

Address \_\_\_\_\_

Contact telephone number \_\_\_\_\_

\_\_\_\_\_

## Assets

**Examples of cash assets:**

- money in a bank or savings organisation
- money lent to other people or organisations
- mortgage investments
- money in Bonus Bonds, shares, debentures or government stock.

**Examples of non-cash assets:**

- leisure boats
- caravans
- land or buildings other than your home, eg. holiday homes.

*You may be required to show proof of these details.*

**Examples of services not received are:**

- pre-paid funeral expenses
- any bond or 'key money' paid to a rest home or hospital.

**23. Do you or your partner (if you have one) have any cash assets?**

No  Yes  Please give details below

Type of asset	You	Your partner	Jointly owned
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

**24. Do you or your partner (if you have one) have any non-cash assets?**

No  Yes  Please give details below

Type of asset	Total value	Money owing
	\$	\$
	\$	\$
	\$	\$
	\$	\$

**25. Have you paid money to any person or organisation for services not received?**

No  Yes  Please give details below

---



---



---

**26. If the payment was to prepay your funeral expenses please advise the following:**

What was the amount prepaid?

\$ \_\_\_\_\_

State the name of the organisation these were paid to

---



---

### Other Income

Examples of money from any other sources:

- wages or salary
- private superannuation
- contributions from relatives
- annuities
- estate trust income
- mortgage trust income
- farm or business income
- interest from savings or investments
- dividends from shares
- income from rent from properties
- any other income

27. Did you or your partner (if you have one) get money from any source over the last 5 years?

No  Yes  Please give details below

Where did it come from?	How much to you?	How much to your partner?
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$

### Own Home

28. Do you or your partner (if you have one) own your own home?

No  Go to Question 30

Yes  Please give the address below

Give your house number, street, suburb and your town or city.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

29. Who will be living there while you are in the rest home or hospital?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Gifting

Examples of money gifted could be -

- money
- property

30. Have you and your partner (if you have one) sold or gifted any assets to anyone over the last 5 years?

No  Yes  Please answer Questions 31-34

31. What was the asset?

\_\_\_\_\_

32. Who bought or received the asset?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please give the name and address of the person who bought or received it.

**33. When was it sold or gifted?**

19		
Day	Month	Year

**34. What was it worth?**

\$
----

**Helper's Statement**

*To be completed by any person who helped the applicant fill in this form.*

**Helper's name:**

--

**What is your address and telephone number?**

--

**How are you related to the person applying for the Subsidy?**

--

I completed this form at the request of the person applying.

The information I have given is true and I have not left anything out.

**Please sign here**

 HELPER'S SIGNATURE	19	
Day	Month	Year

**Statement**

**I understand that:**

- if I have made a false statement, or
- if I have failed to answer all the questions in full, or
- if I do not tell New Zealand Income Support Service about changes in my life that might affect my entitlement or rate, then
- my subsidy may be reviewed and cancelled, and
- I may have to pay back the total amount of any overpayment that I have received, and
- any overpayment that my partner has received.

**The Privacy Act 1993 requires us to inform you that:**

- the information you have provided is being collected under the authority of the Social Security Act 1964
- the information is needed to assess your entitlement to a subsidy and will be used for the functions and purposes of New Zealand Income Support Service and your local Regional Health Authority
- you have rights of access to the information held about yourself and you have the right to request corrections to this information.

**Under Section 11 of the Social Security Act we are authorised to collect necessary information in order to establish entitlement.**

**The information I have given is true and I have not left anything out.**

**Please sign here**

	CUSTOMER'S SIGNATURE	_____		
		Day	Month	Year

19

**Office use only**

Decision

LETTER REFERENCE			PROCESSING OFFICER	19		
			Day	Month	Year	
10% 100% CRITICAL DATA			AUTHENTICATING OFFICER	19		
			Day	Month	Year	
			CHECKING OFFICER	19		
			Day	Month	Year	
			Bring up	B	F	19
			Day	Month	Year	



ARCI  
Application for entitlement

**Claimant details**

Claimant's name .....

Name of parent or guardian (if claimant is under 16) .....

Address .....

Phone number ..... Claim number (if known) .....

What is your ethnic background? .....

*(This information is collected for statistical reasons only. You don't have to answer this question.)*

**Payment details**

Name of bank .....

Branch and address .....

Bank account number

Bank                      Branch                      Account number                      Suffix

**Claim details**

List any expenses, allowances, or other entitlements that you are claiming for and the costs (if known). Attach any medical certificates, accounts, receipts or other proof that you have to support your claim.

.....

.....

.....

.....

.....

.....

.....

**Weekly compensation details** *(Complete this section if you are applying for weekly compensation.)*

Give details of employment or self-employment for the 12 months before your injury. (If you are self-employed please indicate this, and note the name of your company). Include all periods when you were not working, and specify why (for example, unpaid leave, study leave, or unemployment).

Name and address of employer (or identify any gap in earnings)	Period covered
.....	...../...../..... to ...../...../.....

<b>Weekly compensation details (continued)</b>	
IRD number <input type="checkbox"/>	Tax code .....
If you receive taxable income from another source, the pay as you earn (PAYE) tax deductions from your weekly compensation may be too low, resulting in liable tax. If this is the case, consider arranging a special tax code with the Inland Revenue Department (IRD).	
If you did not receive earnings for the full 52 weeks before the injury, answer the question below.	
If it were not for your injury, would the earnings from your job at the time of injury have continued for another 52 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Consent for the collection and release of information</b>	
<i>If you are unsure of your rights and responsibilities regarding this consent, contact your nearest ACC Branch Office for a copy of your rights and obligations under the Privacy Act 1993 and the Health Information Privacy Code 1994, before signing this.</i>	
I authorise the collection and release of any information about me, by ACC, to the extent that it is needed to assess my entitlement to compensation, rehabilitation assistance, medical treatment, grants and allowances.	
I understand that this authority relates to all aspects of my claim, and includes any external agencies or service providers (such as general practitioners, specialists, assessment agencies, employers and IRD).	
I understand that this information will only be used to meet the requirements of the Accident Rehabilitation and Compensation Insurance Act 1992.	
I understand that in the collection, use, and storage of this information, ACC will at all times comply with the guidelines of the Privacy Act 1993 and the Health Information Privacy Code 1994.	
I understand that I have the right to access, and ask for the correction of, any information that ACC holds about me.	
This authority is valid from ..... /..... /..... to ..... /..... /..... (You'll need to complete a new consent at the end of the dates stated above.)	
<b>Claimant's declaration</b>	
I declare that the above information is true and correct and I have not withheld any information likely to affect my application.	
Claimant's signature .....	Date ..... /..... /.....
<b>Representative's declaration (if appropriate)</b>	
Representative's name .....	
What is your relationship to the claimant? .....	
Why is the claimant unable to sign this form? .....	
I declare that to the best of my knowledge, the above information is true and correct, and that I have the authority of the claimant to sign this form.	
Representative's signature .....	Date ..... /..... /.....
<i>The information collected on this form will only be used to fulfil the requirements of the Accident Rehabilitation and Compensation Insurance Act 1992. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.</i>	



CLAIM FOR COVER AND TREATMENT EXPENSES

M 867978

To lodge a claim with ACC you need to fill in the first part of this form or ask someone to fill it in for you. The health professional who sees you will fill in the rest of the form and send it to ACC. ACC will use the form to register your claim, and to assist in making a decision on whether your claim should be accepted. The collection of this information is necessary to make a decision on your claim and failure to provide it may mean that your claim will be declined. The information will only be used by ACC for the purpose of performing the functions of the Accident Rehabilitation and Compensation Insurance Act 1992, in accordance with the provisions of the Privacy Act 1993 and the Health Information Privacy Code 1994.

PATIENT COMPLETES  
PERSONAL DETAILS  
EMPLOYMENT DETAILS  
INJURY DETAILS  
DECLARATION  
REFUND  
MEDICAL CERTIFICATE  
DOCTOR COMPLETES  
REFERRAL  
DOCTOR'S DECLARATION

PERSONAL DETAILS

Mr  Mrs  Māori  Māori  Māori

Male  Female

SURNAME FIRST NAMES

DATE OF BIRTH / / IF KNOWN BY OTHER SURNAME PLEASE STATE

ADDRESS

HOME PHONE NUMBER WORK PHONE NUMBER Are you in paid employment?  Yes  No OCCUPATION

Do you normally live in New Zealand?  Yes  No IF NO, WHERE DO YOU NORMALLY LIVE?

EMPLOYMENT DETAILS

NAME OF EMPLOYER (IF SELF-EMPLOYED WRITE "SELF" OR NAME OF COMPANY)

ADDRESS OF EMPLOYER

Have you claimed for this injury before?  Yes  No Give previous claim number if known and sign the declaration.

COMPLETE THIS SECTION ONLY IF THIS IS YOUR FIRST CLAIM FOR THIS INJURY

INJURY DETAILS

HOW WAS YOUR INJURY CAUSED - WHAT HAPPENED TO YOU? (EG. CLIMBING A LADDER, FELL, AND HIT HEAD ON GROUND)

DATE OF INJURY / / NAME OF DOCTOR/HOSPITAL/DENTIST YOU FIRST SOUGHT TREATMENT FROM DATE OF FIRST VISIT / /

Was a vehicle involved?  Yes  No Did the injury happen at work?  Yes  No IF A SPORTING ACCIDENT, NAME SPORT.

Did the injury occur in New Zealand?  Yes  No Please name city or town nearest to where injury happened

DECLARATION

I declare that to the best of my knowledge the above information is correct and I authorize (I have the patient's authority to authorize) ACC to collect information about me that is required to decide cover and my entitlements I may have to compensation, rehabilitation and treatment, and I authorize (I have the patient's authority to authorize) the disclosure of information by any health agency which holds health information about my injury for the purpose of deciding cover and my entitlements by the ACC.

SIGNATURE OF PATIENT/AUTHORISED SIGNATORY DATE / /

WHAT IS YOUR RELATIONSHIP TO THE INJURED PERSON? WHY IS THE INJURED PERSON UNABLE TO SIGN THE FORM?

REFUND

PLEASE ATTACH ITEMISED ACCOUNT(S) AND ORIGINAL RECEIPT(S). WHAT IS THE TOTAL AMOUNT YOU ARE CLAIMING? \$

DOCTOR TO COMPLETE

MEDICAL CERTIFICATE

DIAGNOSIS AND/OR DESCRIPTION OF INJURIES

Able to resume full work duties  Yes  No Unable to resume any duties at work from / / for / days

IF ONLY ABLE TO PERFORM SELECTED WORK DUTIES, PLEASE DESCRIBE DUTIES

IF IMMEDIATE ASSISTANCE OR SUPPORT IS REQUIRED (E.G. HOME HELP) PLEASE INDICATE WHAT ASSISTANCE

BY A GENERAL PRACTITIONER ONLY

REFERRAL

TO: DATE OF REFERRAL / /

CURRENT THERAPY/INVESTIGATIONS

SUGGESTED TREATMENT OR OBJECTIVE OF TREATMENT

DOCTOR'S DECLARATION

Provider's Name Address Account Number

I certify that I treated the patient for the injuries described above.

SIGNATURE DATE / /





**Claimant consent for the collection and release of information**

Claim Number: .....

Injured person: .....

Address: .....

.....

.....

.....

Date of Birth: .....

Injury: .....

**PLEASE RETURN THE COMPLETED FORM TO YOUR ACC CASE MANAGER**

Your ACC Case Manager is:	Name: .....
	P.O.Box: .....
	Town: .....
	Phone: .....

*I ..... authorise the collection and release of such information about myself (or the injured person) by ACC that is required to assess any entitlement that I (or the injured person) may have to compensation and rehabilitation assistance, or to facilitate treatment. I understand that this authority includes all aspects of the claim and extends to appropriate service providers, including General Practitioners, specialists, assessment agencies, and employers; but only to the extent required by the circumstances of the claim.*

*I understand that this information will only be used to fulfil the requirements of the Accident Rehabilitation and Compensation Insurance Act 1992 and that in the collection, use, and storage of this information ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994. I understand that, within the provisions of the Privacy Act and the Code, I have the right of access to, and that I may ask for correction of, information that the Corporation holds about myself (or the injured person).*

This authority is valid for the period ..... to .....

Please refer to the reverse of this form for more details about your privacy rights.

Signed ..... Date .....

(if you are signing on behalf of the injured person please indicate your relationship to that person)

**THE PRIVACY ACT 1993,  
THE HEALTH INFORMATION PRIVACY CODE 1994  
& ACC**

To help you get any assistance from ACC that you may be entitled to we need certain information from you. This will include personal biographical and health related information, accident details and, if you are claiming weekly compensation, details of your earnings.

ACC will collect as much information as we can directly from you. However, it will sometimes be necessary to get this from others. Depending on the nature of your claim this may include getting medical details and information about your earnings from people such as your employer or health professional. To do this we need your consent for those people to release information to us. Without that consent we cannot collect the necessary information and as such we may not be able to assess your entitlement to compensation or other assistance that you may otherwise have. This means that you could miss out on funding or assistance.

It will sometimes be necessary for ACC to release information about you in order to obtain details about assistance that you may be entitled to. Depending on the circumstances of your claim this may include releasing information to agencies which carry out assessments on our behalf, treatment providers, and employers.

ACC is bound by the Privacy Act 1993 and the Health Information Privacy Code (HIPC) 1994 in handling personal information collected in relation to a claim. As such, information may only be collected or released by ACC to carry out our functions under the Accident Rehabilitation and Compensation Insurance Act 1992.

The Information Privacy Principles of the Privacy Act and HIPC ensure that, with certain exceptions:

- the least possible amount of personal information must be collected to meet ACC's need;
- the individual concerned must know of, and consent to, ACC collecting personal information;
- information is kept securely;
- any person has a right of access to, and correction of, any information about themselves which ACC obtains;
- information is only used for the purpose that it was collected;
- there are limits on what information can be released by ACC.

If you have any concerns about the way in which ACC has handled your personal information, you should discuss the matter with your ACC Case Manager. If you still have concerns you have the right to lodge a complaint with the Privacy Commissioner.

If you have any questions about what information will be collected, or how it will be used, please discuss the matter with your Case Manager whose contact details are shown on the other side of this form.

**ACC** CLAIMANT RESPONSIBILITIES FORM

CLAIMANT .....  
 CLAIM NUMBER .....

*I am currently in receipt of ACC entitlements, ACC now requires me to sign this document indicating I have read and understood each of the following statements:*

1 I am aware, that while in receipt of weekly compensation, I must declare any other income received, to ACC immediately.

1 SIGNATURE .....  
 DATE ..... / ..... / .....

2 I am aware, it is my responsibility to notify ACC immediately, if I return to work in any capacity. I understand that under Section 18 of the 1992 Act, rehabilitation back to work is my responsibility and therefore I should not resign from my current employment without first discussing this with my Case Manager. I am also aware that I should not move away from my current township without first discussing this with my Case Manager.

2 SIGNATURE .....  
 DATE ..... / ..... / .....

3 I am aware, that I am obliged to notify ACC immediately, if I participate in any activities (other than those for which I have my doctor's advice in writing confirming I am entitled to participate in), which could be seen to aggravate my injuries or effect my entitlement to compensation.

3 SIGNATURE .....  
 DATE ..... / ..... / .....

4 If I wish to return to full work duties I must first obtain a clearance medical certificate and send this certificate to ACC immediately..

4 SIGNATURE .....  
 DATE ..... / ..... / .....

5 I am fully aware that I can be liable for prosecution, should I not comply with the above.

5 SIGNATURE .....  
 DATE ..... / ..... / .....

*If you have any queries regarding this form, please contact your Case Manager. Please sign EACH SECTION of this document and return within 14 days. Failure to return this form may result in a suspension of weekly compensation under Section 73 (2)(a) of the 1992 Act.*

RETURN THIS FORM TO : ACC , PRIVATE BAG 9032, WHANGAREI



**EARNINGS QUESTIONNAIRE  
SELF-EMPLOYED PERSON**

CLAIM NUMBER \_\_\_\_\_

**C4**

MAY 1-9-95

**PERSONAL DETAILS**

1. Mr  Mrs  Miss  Ms  First Name \_\_\_\_\_  
Last Name \_\_\_\_\_

2. Home address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Date of incapacity \_\_\_\_/\_\_\_\_/\_\_\_\_

**OTHER BUSINESS OR OCCUPATION**

13. Are you engaged in any other business or occupation (other than that listed below) either as a self-employed person or employee:

YES  NO

If "YES" give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you are also working as an employee it will be necessary for your employer to give details of your earnings on a ARC 3 Form

**THE BUSINESS**

4. State trade or business in which you are self employed: \_\_\_\_\_  
\_\_\_\_\_

5. Give name of business or trade (if any): \_\_\_\_\_  
\_\_\_\_\_

6. Are you in business:  
Alone  In Partnership

7. If in a partnership, state:  
(a) number of partners \_\_\_\_\_  
(b) your percentage interest in the business \_\_\_\_\_

8. How many employees are engaged in the business (including proprietors): \_\_\_\_\_

9. How long have you been engaged in this business as a self-employed person: \_\_\_\_\_ years \_\_\_\_\_ months

10. State number of days and hours you normally work each week as a self-employed person:  
(a) days per week  (b) hours per week

11. Give name and address of Accountant or Financial Adviser: \_\_\_\_\_  
\_\_\_\_\_

12. Please provide:  
(a) ACC number              
(b) Levy class number

**AFTER THE INCAPACITY**

14. Since the incapacity have you been: -

(a) able to do normal work

(b) unable to work at all

(c) able to do light or partial work

(i) Give details of duties you are unable to do: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(ii) How many hours did you work each week following the incapacity:

WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5	WEEK 6	WEEK 7

15. Is the business:  
(a) continuing to function YES  NO   
(b) continuing to earn income YES  NO

Give details: \_\_\_\_\_  
\_\_\_\_\_

16. Have you any other relevant details to this claim on your entitlement to compensation: \_\_\_\_\_  
\_\_\_\_\_

**DECLARATION**

I declare that to the best of my knowledge the above particulars are true and correct and I have not withheld any information

Signature of the injured person or authorised agent \_\_\_\_\_ Date Signed \_\_\_\_\_

If not injured state relationship to injured person: \_\_\_\_\_



# EARNINGS QUESTIONNAIRE . . SELF-EMPLOYED PERSON

Telephone
If enquiring please ask for . . .
Date

This form is to be filled in **ONLY** if you are a self-employed person and have lost income due to personal injury by accident. Complete this form if you wish to claim for compensation related to your loss of earning capacity as a result of the injury.  
Note: You are not entitled to earnings related compensation for the day of the incapacity and the following six days.



ACCIDENT COMPENSATION CORPORATION

### Treatment Expenses Claim

- This form is to be used when claiming treatment expenses from the Accident Compensation Corporation
- If you think you have suffered personal injury by accident this form needs to be completed by you or someone who has your permission to do so.

M46 a

**Personal Details**

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss	Surname		First Names	
	Address			
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Phone Number	Are you in paid employment?	
	/ /		<input type="checkbox"/> Yes → Occupation <input type="checkbox"/> No	

Have you claimed  Yes → Give previous claim number (if known)  for this accident before:  No → and sign the Declaration  
**Complete this section only if this is your first claim for this accident.**

**Accident Details**

How was your injury caused - what happened to you		
Date of Accident	Name of doctor/hospital you first sought treatment from	Date of first visit
/ /		/ /
Was a vehicle involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did the accident happen at work?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
If a sporting accident, name sport		

**Declaration**

I declare the information above is correct and I also authorise any treatment provider to release information regarding the injury.

Patient Signature	Date
	/ /

**Refund**

Please attach itemised account(s) and original receipt(s).  
 What is the total amount you are claiming? \$

## APPENDIX 3

Northland Assessment Service

NORTHLAND HEALTH

WHANGAREI



## NORTH HEALTH DISABILITY SUPPORT SERVICES

AUTHORISATION FOR FINANCIAL ASSESSMENT FOR  
HOME SUPPORT SERVICES

To be completed by Service Co-ordinator

## CLIENT:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## ASSESSMENT OF NEED FOR SUPPORT SERVICES:

Date of Needs Assessment: \_\_\_\_\_

Date of Support Needs Review: \_\_\_\_\_

Signature: \_\_\_\_\_

## SERVICE CO-ORDINATION:

Name of Person Responsible for Service Co-ordination: \_\_\_\_\_

Organisation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Either

Maximum Number of Hours Per Week:

\* Total Hourly Rate: \$

Or

\* Total Negotiated Cost of Care Per Week: \$

Date of Commencement of Services: \_\_\_\_\_

Signature: \_\_\_\_\_

\* Where applicable includes Holiday Pay, ACC Levy, Administration Fees and GST.  
Information for use by New Zealand Income Support Service.  
To be attached to Home Support Services Subsidy Application.





# North Health

Northern Regional Health Authority  
 Mana Hauora A Rohe O Te Raki  
 Private Bag 92526, Wellesley Street, Auckland

North Health Copy

## Service Authorisation / Change

To be completed for Carer Support, Day Care and Residential Support

### 1. Client Details

Please complete all questions

- (a) Is this the first assessment for this client?  Yes **Go to (b)**  No **Go to (c)**
- (b) Has the client completed a Client Details Form?  Yes **Go to (c)**  No

Client Details Form:

**Before a service will be paid by North Health, a Client Details form must be returned. This form can be obtained from North Health Operations. If any details have changed, please submit another Client Details form.**

- (c) Enter client's NHI number if known

First Names

Surname/Family Name

Date of Birth

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

### 2. Service Approval

To be completed by authorised Assessor only. (G.P's and Community Health Social Workers go to (c)).

- (a) Residential Support

This client has been approved to receive (tick one service and one level):

- |                         |                       |         |                       |
|-------------------------|-----------------------|---------|-----------------------|
| Alcohol & Drug          | <input type="radio"/> | Level 1 | <input type="radio"/> |
| Intellectual Disability | <input type="radio"/> | Level 2 | <input type="radio"/> |
| Psychiatric Disability  | <input type="radio"/> | Level 3 | <input type="radio"/> |
| Physical Disability     | <input type="radio"/> |         |                       |

If Residential Support approved, go to 3. Facility Details. If not, continue to (b)

- (b) Day Care

This client has been approved to receive Day Care:

For a Period of: \_\_\_\_\_ days per week until \_\_\_\_\_ (end date)

Tick the circle which best describes the Person's disability and complete the level of need.

Dementia  Frail Aged  Level \_\_\_\_\_ (1-5)

Continue to (c)

- (c) Carer Support

This client has been approved to receive Carer Support:

for \_\_\_\_\_ days per \_\_\_\_\_ year(s)

Tick the circle(s) which best describe the Person's disability.

- |              |                       |                 |                       |
|--------------|-----------------------|-----------------|-----------------------|
| Physical     | <input type="radio"/> | Age-Related     | <input type="radio"/> |
| Psychiatric  | <input type="radio"/> | Sensory         | <input type="radio"/> |
| Intellectual | <input type="radio"/> | Personal Health | <input type="radio"/> |
|              |                       | Terminal Care   | <input type="radio"/> |

If Carer Support is approved, go to 4. Full Time Carer Details  
 If only Day Care is approved, go to 5. Assessor Details

**3. Facility Details**

**Residential Support Only**

Client will be entering:

Facility Name

Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *Number* \_\_\_\_\_ *Street*

\_\_\_\_\_ *Suburb* \_\_\_\_\_ *Town/City*

**go to 5. Assessor Details**

**4. Full Time Carer Details**

**Carer Support Only**

Full Time Carer Name

Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *Number* \_\_\_\_\_ *Street*

\_\_\_\_\_ *Suburb* \_\_\_\_\_ *Town/City*

**Continue to 5. Assessor Details**

**5. Assessor Details**

NON-CONTRACTED ASSESSOR STATEMENT AND DETAILS (i.e. G.P's, C.H.E. Community Health Social Workers)

I certify that ..... requires full time care and attention and is unable to live independently or safely at home without support.

Signature

Date

Name

Address

\_\_\_\_\_

\_\_\_\_\_ / /

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *Number* \_\_\_\_\_ *Street*

\_\_\_\_\_ *Suburb* \_\_\_\_\_ *Town/City*

Contact Number

\* ACC is responsible for those people disabled by accident after 1.4.74

**CONTRACTED ASSESSOR SERVICE CO-ORDINATOR DETAILS**

Signature

Date

Name

Position

ASC Team Name

Address

\_\_\_\_\_

\_\_\_\_\_ / /

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ *Number* \_\_\_\_\_ *Street*

\_\_\_\_\_ *Suburb* \_\_\_\_\_ *Town/City*

**CLIENT AUTHORISATION**

I hereby authorise \_\_\_\_\_  
(Name of Residential Care Facility Administrator)

to collect payment on my behalf from date of entry until the date of exit from their services. Please pay any personal allowance due to the residential care facility's bank account held on NZISS's records unless I specify otherwise.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**SUPPORT NEEDS ASSESSMENT**  
**NORTHLAND ASSESSMENT SERVICE**

New assessment	Reassessment	Appeal	Client referred by:
Referral date:	1st contact:	Assessment date:	
Reason for referral:		Previous Assessment Date:	
Place of assessment:		Previous SNL level:	

**PERSONAL DETAILS**

Surname:	First names: <small>(attach sticky label)</small>	Hospital Number:
Mr/Mrs/Miss/Ms:	DOB:	General Practitioner:
Address:	Postal address: (if different)	
Phone:		Male    Female
Marital status:	Ethnic Origin:	Occupation:

**IMPORTANT CONTACTS**

Name:	Phone or address:	Relationship:
-------	-------------------	---------------

**PERCEIVED NEEDS AND SOLUTION**

Source of information:

Personal care:	<b>PHYSICAL</b>	<small>(enter a,b,c,d or e in box)</small>
----------------	-----------------	--

Transfers/Mobility:

Environment:

Hearing/Vision/Speech/Communication:

Nutrition:

Continence:

Sleep pattern/night time needs:

Mental Function:

.....

(PHYSICAL CONTINUED)

Medical history:

Medication:

Four horizontal lines for text entry.

Medication management:

SOCIAL

Current services:

Domestic function:

Household members:

Safety:

Transport needs:

Social/cultural/spiritual/recreational needs:

OUTCOME

Services discussed:

Referred to:

Date referred:

LIST OF PEOPLE CONSULTED

Name: Designation: Date: Signature:

ASSESSED BY

Name: NORTHLAND ASSESSMENT SERVICE  
Address: NORTHLAND HEALTH LTD  
PO BOX 742  
WHANGAREI

Designation:  
Phone: 430-8021

CONSENT(assessors to sign)

I have discussed this assessment, its recommendations and appeal procedures with the client/caregiver.  
The client/caregiver agrees/disagrees with the recommendations.  
I have/have not obtained consent to discuss the information on this form with the client's service provider/ G.P.  
I have obtained consent to send a copy to.....

Signature.....

Date.....

SNL



**MEMORY TEST SCORE**

1. Age (allow 1 year error)
2. Time (allow consultation of clock or watch and error up to 1 hour)
3. Address for recall at end of test - this should be repeated by the patient to ensure it has been heard correctly:-  
201 Bank Street
4. Year (allow previous year)
5. Name of Hospital or home address
6. Recognition of two persons (doctor, nurse, etc)
7. Date of birth (day and month only)
8. Year of first World War
9. Name of present Prime Minister
10. Count backwards from 20 - 1 (no errors, no clues)

DATE	SCORE
TOTAL	

**GUIDELINES FOR PHYSICAL AND SOCIAL ASSESSMENT**

- A = No apparent problems  
 B = Problems present but independent  
 C = Requires minimal assistance  
 D = Requires moderate assistance  
 E = Heavily dependent

**GUIDELINES FOR SNL LEVEL**

- 0 = No problem, no support needs
- 1 = Has some disability but copes independently.  
Regular monitoring may be required by voluntary or professional agency.
- 2 = Manage personal care activities although may need some assistance to set up.  
Generally may need assistance with domestic functions (eg meal preparation, housekeeping).  
May have mild memory impairment.  
Includes those managing their own incontinence devices (IDC, Colostomy) with occasional supervision.  
Should require regular monitoring.
- 3 = Should require regular input of one person for personal care activities ( at least daily).  
Requires help with domestic functions.  
May have mild to moderate memory impairment but without behavioural problems or wandering tendency.  
May require assistance with transferring and initiating mobility.  
May require assistance with maintaining continence (eg prompting for toileting, supervision of appliances)  
Infrequent incontinence.  
Does not usually require assistance at night.
- 4 = Needs constant supervision/assistance from one throughout personal care activities on a regular basis (more than once a day).  
Carer may be routinely needed to provide bowel/bladder care.  
Generally require night time assistance or supervision.  
May require constant presence of one to mobilise.  
Includes older people with age related psychiatric disability which requires constant supervision to ensure the person's safety.
- 5 = Requires frequent input from two people to provide cares day and night.  
This group of people are very dependent requiring a high level of input.  
Includes those with severe behavioural problems needing presence of two people to manage.

13 July 1995

Te Hape Rd

R.D.9

Whangarei

Dear ,

Hello, you may remember me. I am employed as a social worker at Whangarei Hospital (currently, I am working in another area). During the past three years I have been studying towards a Masters in Social Work and I have now reached the interview stage of research. The area I have decided to study relates to resources for carers. In the past four years I have noticed that carers have less access to resources than previously. In order to identify where the gaps in resources are, I am interested in speaking to women who are currently caring for an older person at home

There is no obligation for you to be involved in this research. However if you choose to participate and then later decide you do not want to continue you can withdraw at any time. If you participate, your comments will become part of my study, however your identity will be kept confidential at all times.

You will be interviewed by me and this will be taped to ensure the information is recorded correctly.

The questionnaire will take approximately 1 hour and a volunteer from Age Concern will provide alternative care while you are involved in the study, if you want this. There are four areas of questioning, the questions in section one are to give me an understanding of the relationship between you and the person you care for. Second two identifies the service and support groups you are involved in, section three asks about the type of care that you are providing. Finally the last section identifies what the good and bad things are about caring for another person and provides an opportunity to discuss the gaps in resourcing.

Along side the interview will be a time in motion survey. What this means is that I will ask you to record what you do during the day for two days.

Thank you for considering this study. I will be contacting you the week of the 10 July 1995 to discuss an interview time.

Yours sincerely

Viv Patterson.

8-9-95

Te Hape Road  
Maunu  
Whangarei

«address1»  
«address2»  
«address3»  
«address4»  
«address5»

Dear «name»,

Hi, I am sorry I haven't contacted you again sooner. As you will be aware from my original letter the first phase of the research was the interviewing. This is now complete and I am currently collating this information.

The next phase is the time-use diaries which I may have given you at the time of the interview. Please find enclosed another form as I may have forgotten to hand one to you, I would appreciate it if you could return the form in the self addressed envelope by the 22 September 1995.

Thank you once again.

Vivienne Patterson

## APPENDIX 5

**Questionnaire**

The beginning of the interview process will be an introduction of the research and further information about what the process will be and general discussion about caring etc. Also covered will be confidentiality and the method of data collection ie taping the interview.

**SECTION ONE****Name****Age****Ethnicity****Religion****Address****Marital Status**

What does your partner do?

Where do your parents come from?

Where does name's parents come from?

What was their religion? (yours and his / hers)

What is your work history? (paid / unpaid)

What else were you involved in at the same time?

When did you last have a wage?

What have you done since then?

How long have you been caring for name?

Has any other women in your family been a main carer?

How did it come about that you are caring for name ?

## LIST OF SERVICES section 2

Do you receive any of the following services?

	Yes	No
Aid to families (28 days)		
Attendant care		
Day care		
Community nursing		
Home support services		
Meals on wheels		
Social relief		

Are you involved in the following support groups?

	Yes	No
A.D.A.R.D.S		
Age Concern		
Arthritis Foundation		
Advocacy Service		
Blind Foundation		
Cancer Society		
Civilian Maimed Association		
Diabetic Society		
Disabled Persons Assembly		
Grey Power		
Hearing Association		
Home Line		
Hospice Society		
National Heart Foundation		
Northland Disabilities Resource Centre		
Order of St John		
Ostomy Society		
Parkinsons Society		
RSA		
Salvation Army Social Services		
Stroke Support Group		

Other groups?

**section 3**

What tasks do you provide for this person?

Who else helps you?

What do they do to help?

Where does your support come from?

How has the situation affected your relationship with Name?

How has the situation affected your relationship with others?

**section 4**

What are the good things about caring for name?

What are the bad things about caring for name?

When do you find it easy?

When do you find it difficult?

What would you say to some one else who is considering caring for an older person?

INSTRUCTION MANUAL

To: \_\_\_\_\_

The purpose of the time use diary is the analysis of the activities performed by you over 48 hours. So you are clear on what is required I have put together a few points on some areas that might not be clear to you.

- 1 The objective is to keep a daily record of your activities in such a way as it will present a continuous chronological account of events as they occur, therefore it is important to try and fill in the diary as you go, not every 15 minutes, but at regular intervals, and not at the end of the day.
- 2 You have been asked to record not only your main activity, but also any second, third, or fourth activities you are doing. It is possible to be doing three or four things at once. (or even more)
- 3 It is important that you try not to overlook activities, and do include such things as watching the person you are caring for (or children), supervising activities, watching television, listening to the radio, eating a snack, having a drink.
- 4 If you go to town for three hours for example, include the travelling time, and time spent paying bills, going to the bank, buying goods etc.
- 5 Sensitive activities, such as toilet or sexual activity may be recorded as 'personal' or you may wish to combine the duration of the activity with another associated activity such as 'shower'.
- 6 If it is possible, and if you wish, another household member (over 14 years) can observe your activities and fill in a diary. If this involves an older schoolchild, then this might best be done in the school holidays.
- 7 If an observer is to fill in the diary, the observer is not to assist in duties s/he would not normally do.
- 8 Please state if an observer is filling in the diary.
- 9 I realise that the time use diary is very detailed, but I would be grateful if you could record every single activity that you perform. You may find it interesting to see exactly how much time you do spend on certain things.

Thank you, once again, for helping me with the research, and I look forward from receiving the time use diaries in the future.

Viv.

<b>Time Use Diary Day 1</b>		
	<b>What are you doing? (Main activity)</b>	<b>What other activities are you doing at the same time?</b>
1	00:00:00	
2	00:15:00	
3	00:30:00	
4	00:45:00	
5	01:00:00	
6	01:15:00	
7	01:30:00	
8	01:45:00	
9	02:00:00	
10	02:15:00	
11	02:30:00	
12	02:45:00	
13	03:00:00	
14	03:15:00	
15	03:30:00	
16	03:45:00	
17	04:00:00	
18	04:15:00	
19	04:30:00	
20	04:45:00	
21	05:00:00	
22	05:15:00	
23	05:30:00	
24	05:45:00	
25	06:00:00	
26	06:15:00	
27	06:30:00	
28	06:45:00	
29	07:00:00	
30	07:15:00	
31	07:30:00	
32	07:45:00	
33	08:00:00	
34	08:15:00	
35	08:30:00	
36	08:45:00	
37	09:00:00	
38	09:15:00	
39	09:30:00	
40	09:45:00	
41	10:00:00	
42	10:15:00	
43	10:30:00	
44	10:45:00	
45	11:00:00	
46	11:15:00	
47	11:30:00	
48	11:45:00	
49	12:00:00	
50	12:15:00	
51	12:30:00	
52	12:45:00	
53	13:00:00	

<b>Time Use Diary Day 1</b>	
	What are you doing? (Main activity)   What other activities are you doing at the same time?
54	13:15:00
55	13:30:00
56	13:45:00
57	14:00:00
58	14:15:00
59	14:30:00
60	14:45:00
61	15:00:00
62	15:15:00
63	15:30:00
64	15:45:00
65	16:00:00
66	16:15:00
67	16:30:00
68	16:45:00
69	17:00:00
70	17:15:00
71	17:30:00
72	17:45:00
73	18:00:00
74	18:15:00
75	18:30:00
76	18:45:00
77	19:00:00
78	19:15:00
79	19:30:00
80	19:45:00
81	20:00:00
82	20:15:00
83	20:30:00
84	20:45:00
85	21:00:00
86	21:15:00
87	21:30:00
88	21:45:00
89	22:00:00
90	22:15:00
91	22:30:00
92	22:45:00
93	23:00:00
94	23:15:00
95	23:30:00
96	23:45:00
97	00:00:00

(Repeated for Day 2)

**CONSENT FORM:**

I have read the information sheet for this study and I have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researcher on the understanding that it is completely confidential.

I agree/do not agree to the interviews being audio taped.

I wish to participate in the study under conditions set out on the information sheet.

Signed \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Declaration of Confidentiality

I hereby declare that as transcriber of the recorded conversations between the interviewer and the participants, that any information contained in tapes will not be divulged to any party what so ever. The tapes and transcriptions will be handed to the researcher immediately after the transcription process.

Signed \_\_\_\_\_

Transcriber

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