RETIREMENT VILLAGES IN PERSPECTIVE

A Study of Service Provision for Older People in the Waitakere Region

A thesis submitted to fulfil the requirements of the degree of Master of Philosophy in Public Policy

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ABSTRACT

This research was prompted by over a decade of personal experience in dealing with older people in hospitals, rest homes, in Retirement Villages and in the community. The focus of the study was about people living in Retirement Villages. This research has been contextualised within the available literature by discussing some prior research regarding informal service provision in New Zealand and by referring to prior international research regarding the role that information dissemination has on service provision for older people. Service provision by the New Zealand Government and others is well documented throughout the literature.

A qualitative method of research: observation, discursive interviews and a focus group discussion, was used to determine what older people know of health and other government services that are available to them. The research was conducted in three Retirement Villages in the Waitakere Region of Auckland, New Zealand. The results of the individual interviews were confirmed after a focus group discussion. Generally all the residents were very happy with life in a Retirement Village and felt empowered to express their views and requests to the manager of the Retirement Village in which they resided. A few of the respondents (all women) said that although they knew that they had the right to, they did not venture to communicate their needs to management because they had been raised in an era when women had no 'voice'. The research confirmed that there is a need for information dissemination to older people about support services that are available to assist them to live independently to facilitate optimum use of these services. The respondents who were solely dependent on financial support from the government were better informed about available services and how to access it than were the respondents who were financially independent.

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Older people have always been a source of joy and inspiration to me. Through my daily interaction with them I am constantly reminded of their courage in the face of the inevitability of gradual dependence and ultimate death. They give generously of their time in helping each other as well as doing voluntary work. This thesis would not have been possible without their enthusiastic participation.

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Finally, I would like to thank God who has given me the strength to persevere with this thesis in spite of many personal challenges during the period of adjustment to living and working in Aotearoa New Zealand.

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ABBREVIATIONS

ACC	Accident Compensation and Rehabilitation Insurance Corporation
ADHB	Auckland District Health Board
ADL	Activities of daily Living
AHB	Area Health Board
AT&R	Assessment Treatment and Rehabilitation
CCMAU	Crown Company Monitoring Advisory Unit
CDHB	Canterbury District Health Board
CHE	Crown Health Enterprise
CSC	Community Services Card
DHB	District Health Board
DN	District Nurse
DSS	Disability Support Service
DT	Dietician
G P	General Practitioner
GMS	General Medical Services Benefit
GRI	Guaranteed Retirement Income
HSS	Home Support Services
IADL	Instrumental Activities for Daily Living
ILE	Independent Life Expectancy
IPCS	Integrated Primary Care Services
MSD	Ministry of Social Development
NZS	New Zealand Superannuation
OECD	Organisation for Economic Co-operation and Development
OPCS	Office of Population, Census and Surveys
OT	Occupational Therapist
PHARMAC	Pharmaceutical Management Agency
PT	Physiotherapist
RHA	Regional Health Authority
PWG	Project Working Group
SCD	Self-care deficit
SLT	Speech and Language Therapist
SNL	Support Need Level
SW	Social Worker
TTE	Taxed Contributions
WINZ	Work and Income New Zealand

INTRODUCTION AND OVERVIEW

As a recent immigrant, with over a decade of experience in service provision for older people, my own experience when entering the aged care industry in New Zealand has been that there is a paucity of information about the available resources for older people, as well as how to link with other service providers. This is borne out by the Te Pumanawa Hauora (1997), report that cites lack of appropriate information and the need for integrated services as barriers to accessing services. A desire to increase my own understanding (in order to provide a more efficient service for older people who are in my care) and to create a source of reference (body of knowledge) for my colleagues, including those whom have been recruited from overseas, was the catalyst for this study. The study was conducted in Retirement Villages situated in the Waitakere Region. Prior to the commencement of this study, the Ethics committee of Massey University Albany campus scrutinised and approved the research protocol.

The Context of the Study

Older people in New Zealand are growing in numbers and as a percentage of the total population (Statistics New Zealand, 2000). This trend will continue to raise the profile of older New Zealanders as a group of critical importance for politicians and for policy makers because of their voting power. A common refrain in research reports spanning the last twenty years, about service provision for older people in the community and elsewhere, has been to point out the involvement of several government departments, voluntary, church and private providers (Scharf, 1995; Jansen, 1997). The lack of any identified organisation with an overall responsibility has been seen as contributing to a lack of co-ordination and focus in community care (Scharf, 1995; Jansen, 1997). While this may have been true in the past, the Ministry of Social Development is now co-ordinating policy development, implementation and evaluation of strategies to improve the quality of life of older people (Ministry of Social Development, 2002a).

The Office for Senior Citizens, a unit within the Ministry of Social Development, advocates for older people at Cabinet as well as in other government policy forums. The increasing proportion of older people means that issues within the portfolio are becoming prominent and are subject to greater political debate and public interest. The scope of the portfolio is broad, incorporating positive ageing, health, retirement income, housing, security, transport and other issues (Ministry of Social Development, 2002a). The Office for Senior Citizens has received correspondence related primarily to the matters of retirement income including New Zealand Superannuation and supplementary assistance, health services, the Retirement Villages legislation, older driver licensing and the residential subsidy (Ministry of Social Development, 2002a). As a result of this correspondence, and as a consequence of escalating cost of institutional care for older people and the ideology of the reigning political party, the government made a decision to promote ageing in place. Members of a reference group appointed by the Ministry of Social Policy developed a Positive Ageing Strategy and Action Plan, which is revised in July of each year. The Positive Ageing Strategy provides a strategic framework for government policies and services through an agreed set of positive ageing principles (Ministry of Social Development, 2002a).

The Positive Ageing Strategy represents a paradigm shift from encouraging institutionalisation of older people, to promoting independent living in the community. Self-care would be supplemented by informal community (unpaid) care by relatives or other primary carers and would be complemented by formal (paid) services and/or facilities supplied by government appointed agencies and others. The growing proportion of people aged 85+ has given rise to an increased number of older people becoming frail and physically dependent (Cantor and Brennan, 2000). The proportion of two-generation older people is increasing, with a concomitant decrease in carer support being provided by relatives. Policy issues about carer support and respite care have been areas that have been a focus for research in New Zealand (Belgrave and Brown, 1997, Patterson, 1997).

There is a social need for appropriate housing and services for those older people who want to remain in the community but look for a 'home-away-from home'. In New Zealand there are many different types of housing options for people generally,

as well as for older people specifically. These include ordinary housing, serviced flats and Retirement Villages. As the baby-boomers enter retirement age, there is a new trend among older people. They tend to be physically active, involved in the community, seek a socially satisfying environment and look for living conditions that suit their lifestyle. Some of them are looking for a transitional lifestyle. The Retirement Village industry fulfils this market niche.

From 1998–2000 there has been a growth of 13% in the Retirement Village industry from 205 Retirement Villages in 1998 to 303 in 2000 with an estimated population of 21,000 people over the age of 65 in 2000 (Ministry of Social Development, 2002a [1]). It is reasonable to assume that while the industry is profitable, it will continue to grow. An aspect of concern is that the ageing population is predicted to continue to grow overall but especially among the old-old (those aged 85+).

The Retirement Village industry caters for the needs of physically active as well as physically dependent older people. One direction the Retirement Village industry has taken is towards providing medium to low density, low maintenance, secure housing that has communal areas for in-house social activities. It also provides transport for shopping or community activities and has a progression of services. Some of these services are part of the contractual agreement between the older person and the village management and some are provided (by the village or others contracted by the village) on a user-pay basis. Provision of care may become a contentious issue in Retirement Villages that have facilities to provide continuity of care on a user pay basis, if the older person has not fully understood this aspect of the contract or took it for granted that continuity of care would be part of the contractual package. Age Concern New Zealand and others have expressed concerns about the need for legislation to govern the management of Retirement Villages in New Zealand (Age Concern New Zealand, 2000). The response of the Ministry of Social Policy has been to develop the Retirement Villages Act 2003 No 112. The aim of this Act is to protect older people who enter into legal contracts when they purchase a unit in the Retirement Village.

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[1] Ministry of Social Development, 2002a, Chapter 7: 3.

'The very old and the very young are high users of health services. Per capita health costs increase and accelerate significantly from age 65. While people over 65 make up 12% of the population, they use 37% of total public health expenditure' (Ministry of Social Development, 2002a). The Ministry of Social Development has confirmed the increased use of health services by people aged 60+. 'Since 1997/1998, the proportion of Disability Allowances granted each year which covered people who were aged 60 years or over has increased from 30% to 36%, while the proportion covering people under 15 years has shown a corresponding decrease' (Ministry of Social Development, 2003b: 77). The increasing healthcare requirement of older people clearly is a significant policy issue. It also has cost implications and can impinge on the Retirement Village industry's willingness and/or ability to expand in the area of health care of older people (Scott, 2001). It is essential that New Zealand health services be structured to make the best use of health funding to meet an increasing demand for these services.

Problem Statement

The increasing number of older people in New Zealand has led to a growing demand for long term living facilities in the form of Retirement Villages. Older people living in a Retirement Village may be independent now, but within several years they may not be able to walk without assistance and require other support to remain independent. The state does make provision for services and financial support for those older people who have been assessed to need long-term assistance due to a disability, and who cannot afford to purchase such services. On average, levels of disability and need for support increases with age yet many older people with a disability or who are ill do not access formal support services at all (Ministry of Social Policy, 2000). Support services are under-utilised for a variety of reasons one of which is cited to be the fact that General Practitioners who are in most cases the Primary Health Provider, may not be aware of the range of benefits that such people are entitled to (Williams, 1989). Another reason is that older people face barriers to accessing services themselves due to the lack of publicity about existing services (Ministry of Social Policy, 2000).

Hypothesis

There is a difference between the availability of government-funded services, and knowledge and use of such services, by people who live independently in Retirement Villages.

Ethical Issues

Consent was obtained from the Ethics Committee of Massey University prior to conducting the research. The nature of the research was explained to the residents' committees and the managers of the participating Retirement Villages. The manager of each participating village gave written consent for me to have access to the village to conduct the research and provided me with a list of names of residents who had expressed interest in taking part in the research. Each participant was contacted to explain the study, answer any questions and to give them an information sheet detailing the research process. They were informed of their right to withdraw from the study (Addendum Two). Appointments for the interviews were then set up. In the case of the focus group the participants were asked to sign a form stating that they would honour the confidentiality of the information received during a group session. They were informed that I could not guaranteed anonymity within the group.

Overall Purpose of The Research

The purpose of the research is to establish whether there is a difference between the availability of government-funded services, and knowledge and use of such services, by people who live independently in Retirement Villages. An exploratory descriptive research design was chosen because it meets two of the three basic purposes of this type of research:

1. To satisfy the researcher's curiosity and desire for better understanding,
2. To test the feasibility of undertaking a more careful study, and

3. To show the path of prior research and how the current project is linked to it (Babbie, 1992: 90).

In addition, this research is breaking new ground: it evaluates the perceived service needs and usage of services provided by the government and others to older people who live independently in Retirement Villages. Breaking new ground is appropriate for exploratory research (Babbie, 1992: 91).

The objectives of the study were:

1. To do a literature review in order to:

- Analyse demographic trends in to obtain a clearer understanding of the composition and dynamics of the older population in New Zealand, and to obtain a snapshot of what the population in Retirement Villages was likely to be like.
- Explain the nature of public policy, the Positive Ageing Strategy and its relation to ageing in place in Retirement Villages.
- Review prior knowledge of services and facilities for older people, including formal and informal support service delivery in the community and Retirement Villages, in order to integrate and summarise what is already known in that area.
- To review prior relevant research to establish the current thinking of service provision for older people in New Zealand and elsewhere.

2. To establish why some older people choose to live in a Retirement Village rather than remain in their own home.
3. To establish whether older people are engaged in doing formal and/or informal work.
4. To determine which services the independent living older people in Retirement Villages expect the government to provide through individual and focus group discussions.

5. To explore the dissemination of information to older people, especially those who live in Retirement Villages.
6. To raise policy issues based on the literature review as well as the research report.

The Research

The study is about people living in Retirement Villages. In its focus on older peoples' knowledge of, and use of support services that are provided by the New Zealand Government and others, this research is designed to use qualitative methods of study (observation, discursive interviews and a focus group discussion) to determine what older people know of health and other government support services that are available to enable them to live independently for as long as possible.

Individual interviews were conducted on sixteen people who lived in three Retirement Villages in different locations in the Waitakere Region. An interview guide schedule based on the objectives of the research was used. The questions were open ended in order to give the respondents the opportunity to answer in as much or as little detail as they wanted to. In order to keep the respondents focused during the interview, probing questions were asked relating to comments they made. Any line of enquiry that arose during the interview was followed up by further questions. If the questions were not clear enough, an adaptation was made to the question before the next interview. The question relating to whether the respondents worked, for example, was misconstrued by the first person that was interviewed, thus a working definition of what could be classified as 'work' was developed and incorporated in subsequent interviews. The interview schedule was refined as the research progressed with the view of making the information that was obtained from the research more credible.

It was decided to use a focus group of eight people to verify the information obtained from the individual interviews. They were selected from the original sample group of sixteen people who participated in the individual interviews. This approach was selected so that the focus group was then able to take ownership of the results of the individual interviews. By presenting them with information in a summarized form it stimulated them to debate issues, ask questions for clarification, add to what people

said, verbalize anecdotes about their own experiences of service provision by the government and other service providers that served to affirm or add to the topic that was being discussed.

This methodology allowed for demystifying the discrepancy that appears to exist between the availability, knowledge and usage of services that are available to assist older people to live independently for as long as possible.

Organisation of the Thesis

The literature and policy review is dealt with in Chapter One to Chapter Six and the research project is dealt with in Chapter Seven to Chapter Nine.

Chapter One provides a snapshot of the scale and demographic structure of the older population of New Zealand. It identifies some of the consequences of current demographic changes and links it to the growing demand for Retirement Villages with the concomitant need for policy development to ensure that older people have access to appropriate services that will enable them to age in place.

Chapter Two explains the nature and purpose of public policy. It highlights that social policies affect the welfare of citizens but that there is tension between the responsibility of the state, the individual and the community to ensure that older people are enabled to contribute to appropriate policy development. The Positive Ageing Strategy is identified as an enabling policy that strives to assist older people to age with dignity while remaining active community members. The need for suitable houses and appropriate healthcare are identified as cornerstones of the Positive Ageing Strategy.

Chapter Three describes housing options for older people who live in New Zealand and links it to the Positive Ageing Strategy that emphasises that 'for older people to maintain independence, it is important that they have housing appropriate to their needs' (Ministry of Social Development, 2002a, Chapter 4: 2). It provides an international perspective on housing as well as the development of the concept of a continuum of care. The strategy for a continuum of care is linked to the Retirement

Village industry in order to analyse strategies/policies that have been put into place to encourage older people to live in their own homes for as long as possible.

Chapter Four describes Retirement Villages in general and examines Retirement Villages in the Waitakere Region. It analyses advertisements and other public information about these Retirement Villages[2]. It reports on the services offered by the villages and reviews the legislative aspect and the governance of Retirement Villages. The chapter concludes that older people who live in Retirement Villages are no different to those older people who live in the community. They have the right to access the same health and other support services to enable them to age in place. In order to do this they need to have access to information about the relevant services.

Chapter Five addresses the importance of formal and informal healthcare because the need for and usage of health services increases with age. The significance of informal care is explored as well as trends and policy developments in healthcare provision for older people who live independently. The problem of access to healthcare is discussed in order to emphasise that people need to be aware of what healthcare services are available and should be kept informed by means of appropriate information dissemination in order to make informed decisions.

Chapter Six expands on community services for older people within a community context. It identifies and describes the roles of some of the key role players in the provision of care services: the doctor, social worker, the Ministry of Health, and the Ministry of Social Development. The fact that the Ministry of Health has identified (and is addressing) the issue that there is a paucity of information about government and other resources, and that older people need to be empowered by making information available and accessible, is discussed.

Chapter Seven links the problems identified by the literature review in relation to access to services, to the research question. These questions also form the basis of the interview guide that was used as an instrument to do qualitative research to focus

[2] Described in Addendum One

on how the respondents experience and perceive service provision in Retirement Villages and what they think the role of the government and others are with regard to service delivery.

Chapter Eight documents the research results. Common themes were identified in the responses of the individual as well as the comments of the focus group. This allowed the responses to be quantified. Some responses were quoted verbatim which allows one to gain insight into the attitudes that some older people have toward being labelled by society as 'beneficiaries', and why some older people are reluctant to make use of support services provided by the government.

Chapter Nine is an analysis of the research results and links it to research objectives as well as to the literature review. The findings of the study are weighed against the research hypothesis and some issues that may impact on future policy direction are raised.

Prior Research in New Zealand.

New Zealand is recognised as being innovative in the field of social policy development. Prior to commencing with the research I endeavoured to establish what relevant or related research had been done in New Zealand to avoid repetition, and also to build on the body of knowledge that is available. Older age (85 years and older) is associated with disability, therefore particular attention was paid to research related to the care-provision that may be needed by this age group.

The 1996 Household Disability Survey recorded 66% of women and men aged 75 and over, as identifying having a disability (Health Funding Authority and Ministry of Health, 1998). From a national sample of 3000, Abbott and Koopman-Boyden (1996), found that over one-third of the total adult population is providing regular informal care to older people, with people who are retired, unemployed and homemakers providing the largest amount of care (Ministry of Social Policy, 1999: 10). The key factor influencing family care is agreed to be not family size but having a spouse or daughter (Ministry of Social Policy, 1997: 30).

In 1996, Waitemata Health carried out the most substantial New Zealand study to date of home-based services as an alternative to institutional care (Richmond and Moore, 1997). This Case Management Study of 186 clients, conducted by Belgrave and Brown found that carers in the home suffered considerably more non-financial cost, such as stress and social isolation. The drudgery of providing day-to-day care was significant and ongoing. Often this was compounded by the level of disability of the person being cared for (Belgrave and Brown, 1997). The study found no statistical difference in activities of daily living or support needs between those receiving care at home and those in institutions. Those in the home care group who made use of support services were more satisfied with their living arrangements (Ministry of Social Policy, 1999: 11). In a survey done by Patterson (1997), not one of the research respondents had heard about the 28-day alternate care scheme funded the Department of Social Welfare. This scheme aims to provide relief for caregivers.

Barker (2000), demonstrates that beneficiaries share the same diversity of views regarding the provision of welfare as could be expected from the general population. There are barriers to accessing support services such as lack of culturally appropriate services, lack of information and the need for integrated services (Te Pumanawa Hauora, 1997).

Prior Research In Other Countries

Prior research in other countries was explored in order to glean information about international trends in information dissemination about services for older people. Representatives of organisations run by and for older people in Slough formed a Project Working Group with the University of Reading research team (Quinn, Snowling and Denicolo, 2003). The study examined the needs and problems of various communities of older people in Slough in relation to information, advice and advocacy. The study found that:

- older people experienced barriers in accessing information in three stages by:

1. **becoming aware** that there was advice or advocacy that could help in their situation,
2. **gaining access** to appropriate and comprehensive information and advice, and
3. **receiving practical assistance** to act on information and achieve a solution.

- They welcomed advice that helped relate information to their particular circumstances and how to obtain services they needed.
- Older people valued information that was topic based rather than agency based.
- They wanted timely information, often at a point of change or crisis in their lives. They desired continuity of contact to avoid having to retell their story to new people. A follow up service was also appreciated, ensuring a solution was achieved, rather than simply being referred on to yet another potential source of information.
- The study also found that services struggled to provide accurate and comprehensible information to other people, in the absence of resources to develop and maintain information databases. Older people's preferred solutions included: an information bank to provide a comprehensive and updated source of information, and an information centre to provide a point of contact for older people (Quinn, Snowling and Denicolo, 2003).

In 1998, the Health Education Authority in the United Kingdom commissioned the Policy Studies Institute to carry out qualitative research among professionals that explored the barriers that prevented them from conducting health promotion activities among older people. Interviewees said that older people needed better and more accessible information, in the form of a national campaign, well designed material and innovative ways of dissemination. Older people needed information on home safety, health promotion, benefits and services (Health Education Authority, 2003).

According to Bodie (1997), some older people taking part in a series of focus groups felt that there was not enough information available about health and social care.

One suggestion was that it might be more appropriate to provide information verbally to older people, allowing for questions and discussion. This is supported by the findings of Tinker et al (1994), who found that word of mouth was cited as the most important source of information about services. Toffaleti (1997), found that older people in a survey were more likely to turn to their friends and family for advice and information than to professionals. Only one in ten thought that they would turn to the local authority. In another piece of focus group research (Beattie, 1997) a group of older Irish people suggested that a health visitor focusing on older people could act as a source of advice and assistance.

CHAPTER ONE

Demography and Population Ageing

1.1. Population Growth

'New Zealand's estimated resident population was 3.98 million at the end of December, 2002 and reached four million on 24 April, 2003. During the 2002 year, the population grew by 63,400 or 1.6 per cent, a rate of growth that was higher than the average for the decade and comparable to a previous peak in 1995' (Ministry of Social Development, 2003a: 17).

1.2. Age and Sex Structure of the population

Population ageing in New Zealand, as in other developed countries began over a century ago, with the onset of transition in fertility from relatively large to relatively small families (Statistics New Zealand, 2000). New Zealand is experiencing a maturing population characteristic of most economically developed countries. 'The median age of the population is currently 35 years and is expected to rise to 38 years by 2012 and to 40 years by 2023. Males outnumber females among children and youth, but females are predominant among adults, particularly from the late twenties to the mid-forties, and from the late fifties onwards' (Ministry of Social Development, 2003a: 21).

At the end of March 2002[3], over half (54%) of all older people were aged 65-74 years, over one third (35%) were aged 75-84 years and just over one tenth (11%) were aged 85 years or older. The rate of growth in the older population (currently just over 1% per year) will increase over the next decade, accelerating to over 3% per year after 2011 as the oldest members of the post-war baby boom generation begin turning 65 (Ministry of Social Development, 2002a). The people born in the

[3] Refer to Table 1.1

post war 'baby boom' will start to retire around 2010 and the number of 'young olds' will start to increase again at that time (Williams, 2001).

Because women have longer life expectancy than men, they make up the majority of the older population and their predominance increases with age. In March 2002, while women accounted for more than half of all those aged 65 and over, this proportion varied from 52% among 65-74 year olds, to 28% among 75-84 year olds, and 70% among those aged 85 and over (Ministry of Social Policy, 2001b: 15). The gender imbalance will continue to lessen at the older ages in future because males have made greater gains in longevity than females in the last two decades (Ministry of Social Policy, 2001b: 15).

Table 1.1: Age and Gender Distribution of 65+ Population, March 2002

Age in years	Males	Females	Total	% Female	
				Female 2002	Female 2020
64-74	59	50	54	52	52
75-84	33	36	35	28	55
85+	8	14	11	70	63
Total 65+	100	100	100	56	54

Source: (Ministry of Social Policy, 2001b: 15) Statistics New Zealand, Estimated Resident Population

1.3. Life Expectancy

Life expectancy is the number of years a newborn could expect to live on average, based on the mortality rates of the population in a given year. Life expectancy at birth is a key summary of population health outcomes, specifically fatal outcomes, improvement in overall life expectancy reflect changes in social and economic conditions, lifestyle changes, medical advances and better access to health services (Ministry of Social Policy, 2001b: 15). An increase in mortality (for example an increased death rate of infants at birth or up to the age of one year), with a stable birth rate over the same period, will cause a decrease in the life expectancy of those people born within the same period.

In the period 1999-2001, life expectancy at birth was 76.0 years for males and 80.9 years for females (Ministry of Social Development, 2003b: 28). With the fall in infant mortality rate (from 11.2 deaths per 1,000 live births in 1986 to 5.6 per 1,000 in 1999), the impact of infant death on life expectancy has fallen. Between 1985-87 and 1997-99, life expectancy at birth increased by 4.1% for males and 3.3% for females (Ministry of Social Policy, 2001b: 16).

The increase in life expectancy and increase in the number of older people has resulted in many two-generation 'older' families. The emergence of two generations of older people will cause changes in the mutual support network among family members. In some cases people will enter old age and still have surviving parents (Spoonley, Pearson and Shirley, 1990). The implication is that a person aged 80+ may well have a son or daughter who is expected to assist in the care of their parent, yet they themselves may need assistance.

The older group itself is ageing. The old-old (85 years and over) are expected to increase six-fold during the projection period (1951-2051) from 39,000 to over a quarter million by 2051. It is this group of older people aged 85 years and over that has experienced the greatest proportional growth. In 1965 there were only 9,534 people in this group and they accounted for 4.8% of the total older population. By 1996 their number had quadrupled to 38,463 and they accounted for 9.1% of the usually resident older population (Statistics New Zealand, 1998).

1.4. Independent Life Expectancy

Independent life expectancy (ILE) is the number of years a person could expect to live independently, that is, without any functional limitation requiring the assistance of another person or complex device (Ministry of Social Development, 2002a: 26). It is an integrated measure of health expectancy, capturing both quantity and quality of life dimensions of health. It is a positive measure, capturing expectations of life free from disability requiring assistance. On average, females can expect to live around 68 years independently while for males the figure is around 65 years. In 1996, males

had an independent life expectancy at birth of 64.6 years. The figure for females was 67.9 years. These figures mean that males can expect to live independently for 87 per cent of their lives and females for 85 per cent (Ministry of Social Policy, 2001b).

Table 1.2 Independent Life expectancy (ILE) in Years by Gender and Ethnicity

Age	Maori		Non-Maori		Total Population	
	Male	Female	Male	Female	Male	Female
0-14	57.3	58.7	65.6	68.9	64.6	67.9
15-44	44.8	45.4	52.3	55.1	51.4	54.2
45-64	20.0	20.0	25.4	28.0	24.9	27.3
65	7.5	7.5	9.9	11.9	9.8	11.7

Source: (Ministry of Health, 1999: Table 54, 55 a).

Because the impact of disability greatly intensifies from middle age, the ratio of ILE to life expectancy declines sharply from around age 45. However, at age 65 almost two-thirds of remaining life expectancy will be spent independently. Females spend a higher proportion of their lives needing assistance than males. In absolute years, females can expect to live longer, both independently and in a state of dependency, than males (Ministry of Health, 1999).

The Maori population aged 65 and over numbered approximately 18,000 in March 2001, an increase of 61% (6,700 persons) from 1991. Older Maori people made up 3.4% of all Maori in 2001, an increase of 2.5% from 1991. The number and proportion of older Maori is projected to increase over the next three decades (Ministry of Social Development, 2002a). 'There is little information about people's experience across a range of indicators' (Ministry of Social Policy, 2001b: 11). There are no statistics for the number of Maori people who live in Retirement Villages, but in view of the fact that the representation of Maori decreases with age: in 2001, they accounted for 6% of all 65–74 year olds, 3% of 75–84 year olds, and just 2% of those aged 85 years and over, it can be assumed that Maori will subsequently be under-represented in Retirement Villages (Ministry of Health, 1999).

The Ministry of Social Policy, (2001b) stated that Maori spend more years requiring assistance than non-Maori, both in absolute years (females) and as a proportion of their shorter lives. While this does not have implications for short-term planning or policy formulation, it has long-term implications. The question that needs asking is whether older Maori will continue to be taken care of in the community or will more choose to live independently in a Retirement Village setting? According to Statistics New Zealand (2001), in 2001 the majority of older people were English speaking, 40,000 older people were able to speak two or more languages and Maori was the most frequently language spoken after English (11,232). In 1996, ILE at birth for Maori males was 57.3 years, 8.3 years less than for non-Maori males. Maori females had an ILE at birth of 58.7 years, a gap of 10.2 years compared to non-Maori females.

1.5. Ageing and Dependency

Analyst primarily concerned about aged care services are more inclined to use the proportion of people aged 85+ when making predictions about the extent of age related dependency and the type of services that will be required. Physical and mental disabilities are two obvious potential causes of dependency, as are psychological or emotional inadequacies (Gibson, 1998). Day (1993), reminds us that circumstances may change rapidly as people get older, and that the capacity of any of us to cope may not be as great as we would wish. Successive problems such as ill-health, the death of a partner, change in personal fortune and the moving away of a son or daughter may be contributory factors in causing some older people to perceive themselves as becoming dependent on outside agencies for assistance.

1.6. Ageing and dependency ratios

A dependency ratio compares the size of the working population with the size of the populations of younger and older people. It makes the assumption that the non-working age population is dependent on the working age population for support (Ministry of Social Development, 2001b: 11).

Table 1.3. Dependency Ratios 2001 to 2051

Per 100 people aged 15-64				Per 100 people in labour force			Older people aged 75 + and *persons* aged 45-64 not in the labour force
Year	Children 0-14	Older people 65+	Total (Children + older people)	Children 0-14	Older people 65+	Total (Children + older people)	
2001	35	18	53	44	23	66	1.0
2006	32	19	51	40	24	64	1.0
2011	29	21	50	37	26	63	1.0
2016	28	24	52	35	30	65	1.0
2021	27	28	55	35	35	69	1.2
2031	29	38	67	36	47	83	1.8
2041	28	43	71	36	54	90	2.3
2051	27	44	71	35	56	91	2.3

Source: (Ministry of Social Development, 2001b: 11)

In 2001 there were 18 people aged 65 and over for every 100 people aged 15-64 years. By 2011, the older dependency ratio is expected to be 21 per 100, rising rapidly to reach 38 per 100 in 2031. However the projected declining youth dependency from 35 per 100 people aged 15-64 in 2001 to 29 in 2011, means that the total dependency ratio (youth plus older people) will decline over the same period. The total dependency ratio is expected to rise to 67 per 100 by the year 2031 (Ministry of Social Development, 2001).

1.7. Conclusion and Policy Issues

Some of the demographic trends that reflect the consequences and changes that occur in New Zealand and have implications for social and economic changes are well described well described by Cook and Khawaja, (1991). Some of the changes are:

- The effect of the increasing longevity of the population is compounded by the greater longevity of women compared to men. A direct consequence of this is that there will be fewer women who may be able to supply informal care for their ageing parents.
- The situation will be exacerbated by the fact that the ratio of children to older people is projected to decline from 35 per 100 in 2001 to 27 per 100 in 2051. This means that the working population will decrease. Older people will fill the gap left by the decrease in birth rate because they tend to work for more years since the age for eligibility for New Zealand Superannuation changed from 60 to 65 years in 1992. This will decrease the pool of older people doing voluntary work as well as providing informal care.
- People providing services for older people will themselves be older, therefore policies need to be developed and implemented to maintain *their* safety in the workplace for example the non-lifting policy that has been introduced in some institutions that provide a continuum of care for older people focuses on safe practice.
- The trends toward later childbirth means that many of those who support their aged parents would be mothers whose dependants have barely left the nest, thus the level of support they *can* give will be limited.
- Increased life expectancy will result in two-generation older families: traditionally daughters have provided care for their ageing parents but in years to come they themselves will need care. A daughter or son aged 65+ cannot be expected to care for their parents.

The increased numbers of older people in New Zealand and the growing demand for longer term living facilities such as Retirement Villages have policy implications.

Policy issues are:

Demographic trends suggest that the pool of informal carers will dwindle. This means that there will be a greater need for formal (paid) care such as homecare provided by various approved agencies. The Ministry for Social Policy (1997), estimated that the cost of in-home care alone was $440 million per week.

- Structures or processes need to be put into place to ensure that older people receive adequate care regardless of whether a family member can provide care or not.
- Mechanisms need to be put into place to ensure cost-effective ways of needs assessment and provision of appropriate services to enable older people to continue to live independently in spite of disabilities associated with ageing.
- Services need to be accessible. This means that people should be aware of the range of available services so that they can make an informed choice, and they should have information readily available of how to access these services.

CHAPTER TWO

Public Policy and Older People

2.1. The Nature and Purpose of Public Policy

The term 'policy' covers the intention, the activity, and the result of governmental actions. Policy formulation involves a process of decision-making that results in selecting a course of action. It involves the identification of alternative strategies or *means* to achieve these goals, and the identification and application of criteria judged useful in choosing among the strategies. It is a dynamic activity that is open to modification when conditions change (Moroney and Krysik, 1998). Public policies are the actions of governmental bodies that result in law. It is concerned with the processes by which policies are designed, evaluated, implemented and managed, and the monitoring of policy outcomes (Koff and Park, 1999). Public policies that affect the welfare of citizens are known as social policies (Midgley, Martin and Livermore, 2000).

Social policy is concerned with the ways in which the distribution of opportunities and resources available in society influences well being (Cheyne, O'Brien and Belgrave, 2000: 3-6). Social policy does not always enhance welfare but may in fact cause *ill fare* (Midgley, Martin and Livermore, 2000). For example, social policy writers of quite different ideological persuasions have argued that public assistance or 'welfare' does not have a benevolent impact on the standards of living of poor families but rather it stigmatises them, controls them, or traps them in a cycle of dependency (Abramovitz, 1988; Murray, 1984).

Leading politicians have declared that broad beliefs and values guided their policy and practice and, governments seek to apply their principles not just to one area of policy, but to apply it to an entire programme (Drake, 2001). A number of key issues are concerned with rationales for government intervention: under what conditions and for what purposes should the government become involved in the lives of its citizens (Moroney and Krysik, 1998)? Crick, (1984), is of the opinion

that every government (and opposition party) claims adherence to a very similar set of values. Where some stress freedom, others emphasise equality, but most argue that reciprocity exists between the state and the individual in which freedoms are counterbalanced with social responsibilities, and communal equality with respect for individual privacy and autonomy.

The tension between individual responsibility and community responsibility for poverty, and the effects of a pension on people's character have been the focus of much debate. Opponents of state pensions have emphasised the despicable qualities of poverty and dependence, while supporters of pension argued the diversity of a colonial experience and accept hardship and failures as a common fate, not a cause for blame.

Koopman-Boyden stated that the Old Age Pension Act has contributed to the social construction of ageing as an illness. She expresses the opinion that the state quantified the concept of older age by defining legislatively that access to pension support would be at the age of 65 years. The state has continued its role in the quantification of old age throughout the 20th century by legislating retirement ages. This was done partly in its capacity as an employer and its involvement in a variety of occupational and sector based superannuation funds. Following the introduction of the Police Provident fund in 1899, an optional contributory fund was established for railway workers through the Government Railways Superannuation Fund. This gave contributing members the option to retire at the age of 60 years and made retirement mandatory at 65 years (Koopman-Boyden, 1992: 84-85).

The nature and extent of government support has been influenced by the ideology and moral values of the reigning political party. If we accept the idea that social policy not only reflects values, but that it can *shape* values and enforce behaviour, we must reflect on the values that are implied by our current social policy approach to older people. Social policies are important in that they humanise the potentially harmful consequences of economic policies (Moroney and Krysik, 1998). For example, the position of older people in the welfare state in New Zealand has changed from a marginalized position of targeted (means-tested) social security to a position that older people, on the basis of chronological age have a *right* to receive

benefits and entitlements. Interestingly, while older people accept the right to receive superannuation, many are reluctant to accept other forms of assistance. This might be because in the past, state and charitable provision was seen to be inadequate and humiliating (McClure, 1998).

The terminology used to describe assistance given to older people is reflective of the political will of the political party in power and may influence older peoples' self-perception as well as community perceptions about older people. Terminology used to describe assistance given to older people and others are: pensions rather than 'benefits', superannuation rather than 'handout,' social security rather than 'welfare' (Thomson, 1998).

Dependency means different things to different commentators, but includes the notion that large, and probably increasing, numbers of people receive cash benefits for long periods (Walker and Ashworth, 1994). The social welfare definition of dependency is being 'unemployed for a period of more than 26 weeks and receiving a benefit' (Barker, 2000: 55). This definition of welfare dependency *excludes* superannuitants, yet those who retire at the qualifying age continue to be *welfare recipients* for the remainder of their lives and for some, the benefit is their sole source of support (therefore they do depend on welfare to sustain them). The contradiction in terms of the use of 'welfare dependency' in relation to superannuitants can be understood if analysed within the historic context of the development of the policies in relation to retirement provision. Cheyne, O'Brien and Belgrave (2000), argue against unemployed people being labelled as welfare dependent and describe dependency as being the paths in and out of welfare. This implies that for some there is an element of changed circumstances: they work when a job is available, and when unable to work, they go on a benefit. This can be described as *intermittent dependency*[4].

Probably the most common treatment of dependency in the gerontological and disability literature has been, however, as a virtual synonym for disability. The term commonly used is *dependent disability*. This is in a sense a clinical usage of the

[4] My own definition

term, associated with physical dependency, although the extent to which it is characteristic of the individual or of the level of care needed by the individual has remained an unresolved tension (Gibson, 1998). In New Zealand older people are more likely to be dependent due to physical or mental conditions rather than due to a financial need.

2.2. Policy Intent of the Positive Ageing Strategy

The cornerstone of the ageing policy in New Zealand is the Positive Ageing Strategy. The New Zealand Positive Ageing Strategy aims to promote ageing in place across a broad range of portfolio areas' such as housing and health (Ministry of Social Development, 2003b: 5). The Positive Ageing Strategy establishes a set of principles as a framework for integrating policies and programmes across the government sector. The New Zealand Positive Ageing Strategy aims to improve opportunities for older people to remain at home for as long as possible and to participate in the community in the ways that they choose. This will be achieved through identifying barriers to participation and working with all sectors to develop actions to address these, while balancing the needs for older people with the needs of younger and future generations. The underpinning premise is that the years of older age should be both viewed and experienced positively (Ministry of Social Development, 2002a).

2.2.1. Positive Ageing and Housing

Many components are involved in ensuring a positive quality of life for older people. These include suitable housing, existence of meaningful relationships *and* adequate income and healthcare. For older people to maintain independence, it is important that they have housing appropriate to their needs. Housing options should be affordable and appropriate. It should take an account of their infirmities and disabilities and should permit regular contact with community facilities and younger families. Integration of housing for the older people with the rest of the community should be planned and not left to chance (Ministry of Social Development, 2002a).

'Housing options for older people are undergoing a period of change. For example, within the last 10 years there has been a four-fold increase in purpose-built housing for older people, such as Retirement Villages, within the commercial sector' (Ministry of Social Development, 2001b: 44). The trend for younger people (55+ years) buying into Retirement Villages is becoming a feature of providing housing for older people in New Zealand. Social services authorities will need to work closely with housing authorities, housing associations and other providers of housing of all types in developing plans for a full and flexible range of housing. Housing needs should form part of an assessment of care needs. This is a crucial element in service provision for the older people, including those living in Retirement Villages (Ministry of Social Development, 2001).

2.2.2. Positive Ageing and Health

Strategies for health care provision for (older) people have fluctuated between minimal state provision and responsibility to universal provision. The Health of Older People Strategy sets the policy frame for health sector action to 2010 to support the health and independence goals of the Positive Ageing Strategy. These two strategies provide the vision and policy framework for developing an environment where older people can maintain capacity, contribution and participation for as long as possible but can also receive assistance when it is needed. It has as its health goal equitable, timely, affordable and accessible health services for older people. Positive Ageing defines older age as a time for continuing contribution to and participation in society (Minister of Social Development, 2001a: 5).

Ideological, financial and pragmatic factors have acted as catalyst for health sector reforms. Changes have fluctuated from a minimalist approach and from a paternalistic approach to a market-oriented approach. Health care for older people takes up a considerable amount of the health budget (Ministry of Social Policy, 1997). The focus of health planning for older people is to assist them to live independently for as long as possible by empowering them through involvement in decision making that will impact on their health and well-being.

A major concern that affects the ability of older people to live independently has been identified as access to health and disability services (Dwyer et al, 2000). Older people identified the need for more funding for field officers and home visitors, having health equipment available for hire, and having meals-on-wheels available at weekends. Older people also saw early intervention for cataracts, hip replacements, and help with buying hearing aids as being important (Ministry of Health, 1999).

The Ministry of Health has identified three key drivers for change:

- Concern about the lack of strategic policy development and planning for health and disability support services for older people;
- The desire to implement the New Zealand Positive Ageing Strategy within the health sector;
- The rapid increase in the number, and ethnic diversity, of older people (Ministry of Health, 2001b).

2.3: Barriers to Positive Ageing

Positive Ageing is closely aligned with the ability to 'age in place', that is, to be able to make a choice in later life about where to live, and to facilitate the receipt of the support needed to do so. Patterson (1997), considers that satisfaction in old age is related to the extent to which there is a match between the resources people have and the expectations that are held by themselves and significant others. Thus, two people with similar resources in terms of housing and health will vary in the extent to which they feel satisfied in their lives with their own and others' expectations of how they ought to be living (and about the choices they make). The choices people make are influenced by personal experiences, expectations, and resources and by the person's physiological and psychological state. According to the Ministry of Social Policy (2001a), 'older people face barriers to accessing services themselves due to the lack of publicity about existing services'. Older people and their families should be empowered to identify and overcome these barriers.

Empowerment refers to the process of helping people increase the degree of control they have over their lives. It involves:

- Challenging stereotypes of dependency: a focus on empowerment seeks to ensure that older people are not made dependent on workers or services. The concept of 'interdependency' (Phillipson, 1989) is a useful one insofar as it acknowledges that older people have not only needs but also positive strengths to offer;
- Giving people choices: instead of acting as the 'expert' who has all the answers, a more appropriate approach is one in which we help to identify choices, and support the older person through the process of deciding upon options and carrying them through;
- Focusing on self-esteem: the negative stereotypes of ageism tend to be internalised by older people. This internalised oppression can then have a detrimental effect on confidence and self-esteem. Empowerment can counter the potential negative effects of ageism on self-worth ; and
- Recognising oppression: it needs to be recognised that older people are vulnerable as individuals and could be subject to oppression or abuse. If this point is not acknowledged, practice may reinforce ageist stereotypes and thus negate the opportunity for them to having a positive quality of life (Drake, 2001, Payne, 1997, Burch, 1999).

2.4: Policy Issues

The New Zealand Positive Ageing Strategy is of particular importance when older people want to continue to live independently for as long as possible, especially in Retirement Villages, some of which provides a continuum of care. The Retirement Village Act 2003 No 12 that was promulgated 30 October 2003 has been into place to protect older people when they buy into Retirement Villages.

Policy emphasis has shifted from non-regulatory (registration and licensing of older care facilities) to regulatory (compliance with quality standards leading to certification which is compulsory, rather than accreditation which is optional). The

Health and Disability (Safety) Act 2001 replaces licensing and registration with certification of people or organisations that provide hospital or rest home care or residential care for people with disabilities. All hospitals and old people's and homes for people with disabilities will need to meet the following standards:

- Health and Disability Sector Standards NZS8134, 2001
- Infection Control NZS8142, 2000
- Restraint Minimisation and Safe Practice NZSS8143, 2001

This may lead to the closure of some facilities but it should have the desired effect of raising the standards of care for older people. Suitable education programmes have been developed and incentives for health and other professionals to up-skill should encourage specialisation in the area of care of older people.

2.5. Conclusion

The Ministry of Social Development leads social development in New Zealand. The Office for Senior Citizens is concerned with policies that affect the well being of older people. The New Zealand Positive Ageing Strategy provides a framework within which all policy with implications for older people can be commonly understood and developed. The need for suitable housing and healthcare has been identified as being essential if older people are to be enabled to age in place. The Ministry for Social Development promotes and monitors the Positive Ageing Strategy but there are barriers to the successful implementation of the concept of ageing in place. A significant barrier is lack of or insufficient information about the services that the government and other agencies offer that can assist older people to age in place.

CHAPTER THREE

Older People and Housing

3.1: *Introduction*

World wide there is a move to enable older people to age in place. Research suggests that the concept of 'home' has greater meaning for the current generation of older people and encapsulates their sense of self, independence and sanctuary (Commonwealth Department of Health and Aged Care, 2000; Williams 1989; Richmond et al 1996; Gibson, 1998).

3.2: Home Ownership

As a nation, New Zealanders have a high rate of home ownership. At the time of the 2001 Census, 76% of all older people owned their own home with or without a mortgage (Statistics New Zealand, 2001). Home ownership or equity in a home continues to be one of the more important assets that older people may possess although there is a downward trend in this regard (Ministry of Social Policy, 2001a).

Table 3.1: Distribution of Homeownership for 1618 Single Respondents and 1442 Couples

Single Respondents	Couples
68% owned their own homes: 94% owned it freehold 16% accommodation owned by a relative or family trust 17% rented their accommodation from a private landlord, local authority, Housing New Zealand or other sources	86% owned their own homes: 93% owned it freehold 8% accommodation owned by a relative or family trust 6% rented their accommodation from a private landlord, local authority, Housing New Zealand or other source

Source: (Ministry of Social Policy, 2001a)

According to a study undertaken by the Ministry of Social Policy (Table 3.1), almost all of the single respondents and the couples, who own their homes, do so freehold. For single respondents owning their own home, the median value of the property was $125,000 compared to $175,00 for a couple owning their own home (Ministry of Social Policy, 2001a). Single people were also more inclined to rent accommodation than were married couples.

The Ministry of Social Policy (2001a), reported that both direct and subjective measures of economic standard of living suggest that the retired population do not generally have low living standards. This is not true of *all* older people. According to Robinson: 'Although research shows that the type of older person most likely to be interested in living in a Retirement Village is an older woman, living alone, or on a low to moderate income, this group is least likely to have the available income are assets to do so' (Robinson, 1994).

3.3: Living Arrangements of Older People in New Zealand

According to Statistics New Zealand (1998), older people differ in their living arrangements from the general population. At the 1996 Census about 54% of older people lived with a spouse or partner. Among those aged 65-74 years, three out of ten lived in one-person households. Among the old-old group the proportion was twice as high, that is, three out of five. Women aged 85 years and over are twice as likely to be living without a spouse or partner, as men of the same age. 'Despite the fact New Zealand's population overall is ageing, and that there are more people living to over 85, the proportion of older people living in the community has remained largely the same for the past 10 years' (Ministry of Social Development, 2001b: 43).

The proportion of older people living alone has steadily increased over the past 30 years, from 19.1% in 1966 to 30.4% of all older people in 1996 (Table 3.2). This increase can be attributed to the combination of increased life expectancy and the structural ageing of the New Zealand population. The changing nature of the family

and the increased divorce rates, suggest that there will be more, single older people living by themselves in the future (Ministry of Social Policy, 1997).

Table 3.2: Living Arrangements Of Persons Aged 65 Years And Over, 1966-1996

Living Arrangements	1966	1976	1986	1991	1996
Living alone	19.1%	24.7%	29.0%	29.8%	30.4%
Total family or Relative	72.4%	66.0%	62.1%	61.3%	53.8%
Retirement home	1.9%	2.6%	3.7%	4.7%	4.8%
Hospital	4.3%	4.0%	2.2%	1.5%	1.9%
Not Specified	2.3%	2.7%	3.0%	2.7%	9.1%

Source: (Ministry of Social Policy, 1997).

There are more people living alone in Retirement Homes (Table 3.2), but fewer in hospitals. This trend may reflect an increasing inability or unwillingness of families to care for older relatives, because of the factors discussed above. It may also be that there is a growing preference among older people to live alone and maintain their independence (Statistics New Zealand, 1997). All signs point to the social care needs increasing exponentially, particularly with respect to the most difficult types of assistance required by the functionally and cognitively impaired older people (Cantor, and Brennan, 2000).

'The need for housing has usually been given a narrow interpretation in terms of the provision of shelter from the elements, and the maintenance of physical health' (Bland 1996: 80). According to Bland it is this narrow interpretation that is at the heart of state housing policies and which is in danger of being perpetuated in the context of community care. In the past the response of the State has been all too often to remove them (the infirm and disabled) from their existing environment and place them in one occupied by others similarly disadvantaged.

3.4:Housing for Older People

3.4.1: Housing Options

The main causes for dissatisfaction with housing are distance from family, distance from shops, banks, post office and transport stops, as well as the size of the house and garden. Cantor (1991), states that older people want to move home for the obvious pull of a new place and for the equally obvious wish to avoid problems of looking after a house and garden that may be larger than needed. Some hope to purchase cheaper property so that they might use some of their capital. The potential mobility is hugely greater for owners than tenants and there is thus a big class bias as to who is able to make these sorts of choices.

Recent trends have moved away from standard solutions to more flexible approaches geared to suit individual needs and their desire to remain independent with occasional episodes of dependence followed by rehabilitation, until their final illness (Davis and Dew, 1999). Services based on this model would not differentiate so clearly between 'ordinary' and 'specialised housing', but allow for more flexible use of all types of housing or residential care provision, so that progression was not always towards greater dependence. Day (1993), describes three types of housing: ordinary housing, special housing and residential institutions.

Ordinary Housing

This refers to the types of housing which is generally available to the whole population whatever their age. It consists either of small units intended for older or single people, or of housing for the general population (Day, 1993). Such housing may become unsuitable through need for repairs or improvements, or because the older person may have developed disabilities. With advancing age they may not be able to cope with maintenance and repairs they used to do themselves. Money may be a problem. Some, because of illness or boredom, may become apathetic about their homes and just not bother. This is a particular problem for older women living on their own.

Day (1993), also expresses the opinion that few older people with home maintenance problems seem to be aware of the provisions under the Social Security Act 1941 whereby $800 may be advanced for home maintenance purposes and charged against the estate of the beneficiary. Ways of helping people who prefer to remain in their housing includes adaptations, such as widened doorways or ground floor bathrooms, or the provision of home alarm services for emergency cover. If needs are mainly for care, intensive home-care services may be provided.

Special Housing and Residential Institutions

Special housing is frequently known as sheltered housing. This includes access to alarm systems and care support. Residential institutions include residential homes, nursing homes and hospitals. The main type of options for moving into grouped housing that provides support for older people are service flats, sheltered housing, or congregate housing. In some cases such housing is specially designed for people with disabilities.

In France sheltered housing *(logoment foyer)* is mainly a social provision offering housing with communal areas and services such as restaurant, laundry, domestic and care services. Congregate housing in the USA also offers meals and communal facilities such as a library or hairdresser (Butler, 1987).

Grouped housing of this type, usually intended for fairly independent people, may itself become unsuitable for residents who become more dependent. To avoid downward progression to institutional care, such settings are increasingly made more specialised to allow frailer people to remain there. For example *very sheltered housing* in the UK provides 24-hour cover and extra facilities (Tinker, 1994). Nursing facilities may be added to congregate housing provision in the USA (Butler, 1987) and a medical care section may be included in sheltered housing in France. By increasing the care elements of such housing to avoid institutional care, the institutional character of the housing may increase, again blurring the distinctions between types of housing.

Institutional long-term care is the other main type of moving option, with a traditional distinction between residential homes, nursing homes and hospitals, for different levels of dependence, although it is often funding sources that determine the category of institution used.

Accommodation is usually provided by housing departments, but sometimes by housing associations. On occasions, sheltered-housing units have been built near a residential home that caters for people who are dependent and require care, thus enabling the tenants to receive the benefit of support and attention from the highly qualified staff of the residential home, and yet maintain a more satisfying state of independence. If increasing age brings about a general deterioration, then the move into the residential home can be far less traumatic than is often the case.

The need for flexibility and movement between types of housing has also led to innovative forms of provision combining different types, such as sheltered housing, nursing homes and communal facilities on the same site so that people do not have to move as their needs change.

In the US this approach is highly developed in the *Continuing Care Retirement Community* (CCRC). CCRC is usually, a small village with a range of housing, residential and support services, nursing home and leisure facilities. Wealthier older people buy into the CCRC early in retirement, pay monthly service fees and are assured of any nursing home care they need in later life (Day, 1993). CCRCs are the future solution for providing a continuum of care for older people in a manner that will provide the means for them to age positively. In New Zealand some of the newly established Retirement Villages can be classified as Continuity Care Retirement Communities and many others are moving in this direction.

3.4.2: Housing Availability and Affordability

Housing assistance by the Government, while divided between state housing and mortgage subsidies, is also aimed at enabling affordable accommodation for all, by means of financial support (Cheyne, O'Brien and Belgrave, 2000). For those older people who do not own their own homes, or who do not live with an extended family, there is a range of rental accommodation options. These include Housing New Zealand Corporation, local authorities, social service and community organisations, and private landlords. In 1996, 10% of older people of the total older population (singles and couples), lived in rental accommodation. Among older people renting, 36% were living in houses rented from Housing New Zealand or other central government agencies. A further 31% had a private landlord, while 29% were renting from local authorities and the remainder from businesses, real estate agencies and other organisations (Ministry of Social Development, 2002a).

Overall reductions in public housing stock over the last decade, lowering home ownership rates and an ageing population, mean that in the future more older people are likely to rent from the private sector. If affordable and suitable housing is not available to older people, this will impact on their ability to remain independent (Ministry of Social Development, 2002). Since 1967 there has been a steady decrease in the number of pensioner-housing units built each year. According to McClure (1998), New Zealand's housing stock was low. High rents eroded the standard of living of older people. 'Previous problems with affordability of rental housing have largely been resolved by a return to income-related rents.... Those people on low incomes who are renting can access the Accommodation Supplement, which is subject to an income and asset test' (Ministry of Social Development, 2001b: 46).

Craig, Briar, Brosnahan and O'Brien (1992), referred to submissions made to the government that emphasise the importance of the role of the State in housing provision. They expressed the opinion that when it becomes commercially viable, state houses are privatised by selling off what used to be a publicly owned, taxpayer-funded asset to self-interested business. They said: 'The only winners are the new owners; the losers are the tenants, homeowners, and the people of Aotearoa New

Zealand' (Craig, Briar, Brosnahan and O'Brien, 1992: 52). While this may have been true in 1992, the state is currently adopting a 'whole government' approach to housing assistance, incorporating health services and the state housing sector, in order to improve the ability of older people to age in place (Ministry of Social Development (2001b: 49).

'Housing options for older are undergoing a period of change. For example, within the last ten years there has been a four-fold increase in purpose-built housing for older people, such as Retirement Villages, within the commercial sector' (Ministry of Social Development, 2001b: 44).

3.4.3: Housing and Health

Older people are susceptible to pneumonia therefore appropriate heating is important especially in winter 'Houses built prior to 1974 are not legally required to be insulated. New Zealand houses as a whole tend to have inside wintertime temperatures that are lower than that recommended by the World Health Organisation' (Weinstein, 2002: 2). Some live in houses that are damp, cold, and overcrowded, are not healthy environments for the occupants and are also not conducive to feelings of security and well being. A New Zealand survey described the association between poor quality housing and ill health (Davis and Dew, 1999).

3.4.4: Accessibility of Information

'While choices are expanding for those on higher incomes, there may not be so many options available for those on lower incomes' (Ministry of Social Development, 2001b: 44). It is important that older people are aware of housing options available to them. Information relating to the options should be easily identifiable, widespread and readily available in formats appropriate to people's linguistic and physical capabilities (Commonwealth Department of Health and Aged Care, 2000). Older people have access to the same information about ordinary housing as have the rest of the population. Information specific to housing for older people is also freely

available however, it depends on whether they are aware of who to contact or where to find the information.

Some sources of information are: notice boards in hospitals, doctors surgeries, local community centres and via social workers at Residential information Services, the Retirement Village Association, Elder Net, Age Concern New Zealand to name but a few. Local newspapers generally have advertisements as well as news pertaining to some services for older people. Information can also be obtained from the Internet, and from Housing New Zealand. Case managers at WINZ also assist in directing people to sources of information.

3.5: Policy Trends

In New Zealand, according to the Ministry of Social Development (2002a), while most of the older people wish to remain in their own home, this can become problematic if the home is hard to maintain or becomes unaffordable. The Accommodation Supplement is available for low-income people who are renting in the private sector housing market or from a local authority, or for those who own their home. Eligibility is subject to an income and asset test and an assessment of weekly accommodation costs. As at 30 June 2002, 3.6% (16,084) of the people in receipt of New Zealand Superannuation were receiving an Accommodation Supplement. This low percentage reflects a combination of factors such as lack of knowledge of the availability of welfare benefits related to older people, and the stigma associated with being a welfare beneficiary (Ministry of Social Development, 2002a).

The New Zealand Positive Ageing Strategy Annual Report 2001-2002 informs us that 'During the last 6 months of the financial year, 286 tenants aged 65 years and over were housed, 190 in the highest category of need (Ministry of Social Development, 2002b). According to the Ministry of Social Development between July, 2002 and June, 2003 rents were reduced for 1,200 older tenants and a new 51-unit complex specifically designed mainly for older tenants, opened in Lynfield, Auckland, March 2003 (Ministry of Social Development, 2003c: 27).

The Ministry of Housing stated in relation to housing assistance in the budget for 2004/2005 that 'the Ministry will also administer payments and receipts under the appropriation as follows:

- Benefits and unrequited expenses for housing assistance payments of $15.528 million;
- Non-departmental other expenses payable to Housing New Zealand Corporation for the community housing rent relief programme of $4.500 million;
- Capital contributions to Housing New Zealand Corporation of $231.830 million' (Ministry of Housing, 2004).

Housing New Zealand has formed partnership with Local government to develop proposals for home ownership assistance for low and medium-income earners. Although older people are not a specific target, they will be eligible for assistance. 'Partnership agreement has been developed with Abbeyfield New Zealand for an ongoing relationship and specific development for older people's housing' Ministry of Social Development, 2003c: 13).

Partnership with local authority is in line with the strategy adopted by the Commonwealth Department of Health and Aged care. They say 'As local government has responsibility for building control and land use, a coalition of community groups, the building industry and governments could encourage and investigate various models of innovative housing that could be adapted throughout the lifecycle as required' (Commonwealth Department of Health and Aged Care, 2000: 19).

Housing New Zealand is responsible for the implementation of the Social Housing Strategy (now New Zealand Housing Strategy). They work with community representatives and stakeholders to identify short, medium and long-term goals in social housing for tenants including older people. Some goals and key actions are:

- Maintaining an income related rents policy for state housing

- Working with local government to increase the supply of universal design and energy efficient low-rental housing, including supported pensioner housing complexes
- Develop policy options that facilitate ageing in place (Ministry of Social Development, 2003c: 27).

They say that the success of the New Zealand Housing Strategy will be measured against whether older people receive a range of suitable housing choices that enable them to remain in the community.

3.6. Conclusion

Access to affordable and suitable housing is a critical factor in the quality of life of older people. In New Zealand there are many different types of housing options for people generally, as well as for older people specifically. These include ordinary housing, serviced flats and sheltered housing including Retirement Villages.

Overall reduction in government housing stocks by the New Zealand Government impacted on the ability of older people to maintain their independence since some of them found that they could not afford to pay the increased rent. The reduction of rents in 2003 for 1200 older tenants as well as the construction of a 51-unit complex in Lynfield, Auckland was the response of the Government to this need. Another response has been capital contributions to Housing New Zealand Corporation of $231.830 million (Ministry of Housing, 2004).

The trend for younger people (55+ years) buying into facilities that provide a continuum of care is becoming a feature of providing housing for older people in New Zealand. The Office for Senior Citizens is an agency of the Ministry of Social Development and deals with inter alia, legislation regarding Retirement Villages. This aspect will be dealt with in the next chapter.

CHAPTER FOUR

Retirement Villages

4.1: Retirement Villages: What they are

The term *Retirement Village* covers an ever-increasing variety of services. New look villages are aimed at younger third-lifers who may not be fully retired and are seeking a more balanced lifestyle. Third–lifers are people who have reached the age of 65 years but choose to devote 'the next third of life' to community and volunteer work. Some third-lifers continue to work part-time. The popularity of village-style accommodation is feeding growth in this area, and providing people with choice and is very much to the fore in modern service provision (Kinnaird, 2001).

The definition of a Retirement Village is contained in the Retirement Village Act 2003 No 112 of October 2003. It states that a 'Retirement Village means a complex of residential units and ancillary facilities predominantly or exclusively occupied, or intended to be predominantly or exclusively occupied, by retired persons under an occupation right which is conferred by a lease or licence, or is conferred by ownership of a share in a company, or forms part of or is subject to a contract under which a right or option to purchase the occupation right or the residential unit is conferred on another person or by which the subsequent disposal of the occupation right in the residential unit is restricted, but does not include such a complex where in respect of every unit, no consideration has been' (Retirement Villages Act, 2003).

This thesis adopts the definition of the Ministry of Social Development. It states that Retirement Villages are 'collections of houses or flats within a defined area that usually offer additional services such as communal facilities, social activities,

security, maintenance and gardening. Some also have residential care and continuing care facilities on site and offer personal and care services such as meals and laundry'

(Ministry of Social Development, 2001b: 47). Residents need to be independent (Residential Information Services, July 2001).

Twenty one thousand (4.65 percent) of the older population live in Retirement Villages (Ministry of Social Development, 2001b: 47). The Retirement Village Association, residents, and a range of senior citizen interest groups have raised concerns about the rapid growth in the number of Retirement Villages. The Ministry for Social Policy, the lead agency, with support from the Senior Citizens Unit, engaged the services of a solicitor with considerable experience in this field to assist in the process of addressing the collective concerns of older people (Age Concern New Zealand: July-August, 2001). The expressed concerns of these pressure groups contributed to the identification of a need for legislation to govern the management of Retirement Villages in New Zealand.

Retirement Villages are being built by the private as well as by the voluntary sector. It is an attractive option for a growing number of older people. It offers security, companionship and access to services they consider important (Ministry of Social Development, 2002a). Initially Retirement Villages were typically run by religious and welfare groups but to an increasing extent over the last 15 years or so commercially motivated developers and operators have entered, and now dominate, the industry (Law Commission, 1998).

4.2: Types Of Home Ownership

Older people seeking communal housing in a Retirement Village must be able to meet the costs themselves, and this is a barrier to some. Residents purchase a 'License to occupy.... In addition, there are weekly or monthly charges for maintenance, and additional charges for use of other services such as laundry or meals' (Ministry of Social Development, 2001b: 47).

4.2.1: Licence to Occupy

Fifty-seven percent of villages operate under a contractual licence structure. In this scenario, the developer or his or her successor in title will own both the units and the community facilities, licensing the occupation of units to residents and either retains management of the community facilities or installs an operator. A disclosure statement relating to ownership, management and supervision of the Retirement Village must be given to the resident (Retirement Villages Act 2003: Schedule 2).

According to a pamphlet issued by Age Concern New Zealand in March 1994, licence to occupy gives you the unqualified right to use the unit/house for life and full access and use of all village facilities. You do not own any land or buildings and your name does not appear on the title deed to the property. However, occupation is secured by a legally binding document (contract). Villages of this type must offer a prospectus. Difficulties arise in the complexity of the legal relationship people enter into when they make an investment in a Retirement Village unit (Age Concern New Zealand, 1994). They (Age Concern New Zealand) say licenses to occupy, service agreements, and a prospectus are not the stuff of everyday life in New Zealand. The Ministry of Social Development stated that the financial complexities of the purchase of a licence to occupy arrangement, the fee and the services regime that operates within a village, and the way this is presented to intending residents, can expose some older people to unanticipated costs or complicated, misunderstood or harsh financial terms and conditions (Ministry of Social Development, 2002a).

While many older people enter a Retirement Village believing that they are purchasing a unit, this is not the case. Approximately 65 percent are secured by a licence to occupy and even the villages that offer title, do so with an encumbrance on the title or condition of sale that vests control of sale to the village operator (Ministry of Social Development, 2002a).

4.2.2: Unit Title

'A village development based on a unit title structure established under the Unit Titles Act 1972 follows a similar pattern to an ordinary residential unit title development. There will be a separate unit title for each unit (including apartments). There may be a separate title for the community centre and facilities, or alternatively, these may be treated as common areas' (Law Commission, 1998: 2). The Body Corporate Rules will provide for the appointment of a manager and will usually nominate who that manager is to be. The manager must make known to the resident in its code of practice minimum requirements in relation to:

- Staffing (qualifications, experience, arrangements for training and ongoing supervision);
- Safety and personal security of residents including those with disabilities;
- Fire protection and emergency management (the act does not specify what other emergencies are);
- Transfer of residents within Retirement Villages: the code of practice must specify agreements about transfer of residents from independent self-care units to care facilities in the Retirement Village as well as any financial implications;
- Meetings of residents with the manager and the scope for involvement of the residents in decision making affecting the Retirement Village;
- Complaints procedures and the form of notification of the decision about the complaint;
- Requirements to ensure that accounts are presented in a format that can be readily understood;
- Requirements relating to the periodic review of maintenance agreements and the role of the resident in respect of those reviews;
- Termination of occupation right agreement by the manager or resident with regard to:

1. The grounds on which an occupation rights agreement may be terminated by the manager or resident;
2. The process that must be followed by the operator or resident before exercising any right to terminate an occupation agreement;
3. The requirements relating to payments due when an occupation right agreement is terminated and the manner in which these amounts are calculated;

- Communication matters relating to residents or intending residents for whom English is a second language or whose ability to communicate is limited (Retirement Villages Act, 2003).

4.2.3: Freehold Title[5]

The name of the resident is on the title deed. The resident owns the unit as well as a share of the common areas.

4.2.4: Cross Lease

Where the structure employed is a cross-lease, the lease will include an undivided interest in the community facilities or such facilities will be leased to the village operator. You own your unit and a share of the common property, but no particular part of the property is specified in the title deed. What you can do with your property is restricted to the conditions of the lease and must be agreed to by all other leaseholders (Law Commission, 1998).

4.2.5: Registered Lifetime Lease

The lease for life schemes differ from the contractual licence schemes only by reason of the fact the leases, if the appropriate resources consent and survey steps are taken, are registrable under the Land Transfer Act 1952 (Law Commission, 1998). The

[5] Information about types of ownership was obtained from an Age Concern New Zealand Incorporated brochure.

budget for 2004 allows for residents of a Retirement Village who have a separate deed of transfer to apply for an accommodation supplement from July, 2005.

4.3: Risks

The provisions of the Securities Act 1978, with its focus on disclosure at the time at which an investment is made, does not adequately address the risks that people face when buying what amount to habitation rights to a residential unit in a village. There is also legal uncertainty as to whether or not the Securities Act applies to a number of the different village title structures currently available in the marketplace (Ministry of Social Development, 2002a). This matter has been clarified in the Retirement Village Act 2003 that specifies the information that must be disclosed to prospective or potential residents.

Residential Information Services advises people that buying into a village is a complex decision. The aim of the list is to give a starting point. They advocate that the next step should include sending for a prospectus and seeking legal advice. In this regard Age Concern New Zealand has a newsletter and pamphlets that aim at empowering older people through information. They inform people about legal issues, what to look for and what questions to ask. They also furnish the contact details of the Retirement Village Association for further information and highlight the fact that people should always consult a lawyer before buying into a Retirement Village.

Comments from letters by older people who felt strongly enough to write to the Ministry of Social Policy reflected the fact that they did not fully understand the contracts they sign. They said:

- Residents have been lumbered with all of the Retirement Village's legal costs and expenses to secure their investment;
- Village management has changed and the new managers have set extremely high salary levels and 20-year employment contracts;

- Residents have had no avenue for lodging complaints and no power to influence decisions about non-performing managers: individuals who have complained have had notices sent to other residents about 'their poor attitude';
- Residents describe feeling that they are trapped, as they have no money to move;
- Residents cannot get a definitive timeframe for the repayment of their investment, minus the depreciation, even though it's months since they vacated;
- Residents complain of unfulfilled promises of quality support services (Age Concern New Zealand, 2001)

These comments do not reflect the opinion of the older people in general, but consideration must be given to the fact that some older people feel too intimidated to complain. Conversely, it should also be considered that people may not feel the need to *praise* Retirement Village managers who are efficient and caring.

4.4: The Retirement Village Population

In 1998 the New Zealand Retirement Villages Association Inc. commissioned a survey in order to satisfy the obligations of the Securities Acts. The survey analysed 205 Retirement Villages, 62 of these Retirement Villages being mainly in the for-profit category.

The analysis showed that these 205 Retirement Villages comprised of 6,777 units and 2,231 serviced apartments. A subsequent Retirement Villages Association survey in 2000 identified 303 Retirement Villages in New Zealand, a 13 percent increase since the previous survey in 1998. It was estimated that in the year 2000, there were 21,000 people over the age of 65 living in Retirement Villages. This represented 4.66 percent of people aged 65+ compared to 2.81 per cent in 1998 (Ministry of Social Development, 2002a).

It is evident from the statistics that the Retirement Village Industry is expanding rapidly in response to a demand by older people for accommodation where they can live independently (with assistance).

4.5: Governance of Retirement Villages

4.5.1: The Manager

The Trust or owners of the Retirement Village appoints the village manager. The powers of the manager are outlined in a job description detailing duties and responsibilities. The manager is responsible for the day-to-day management of the village. A contract is entered into between the manager and the person buying into the Retirement Village. Details of the contract are explained before the deal is signed (Law Commission, 1998). Explanations do not guarantee understanding, nor does it mean that the prospective buyer will ask the 'right' questions.

4.5.2: The Statutory Supervisor

The Securities Act 1978 has the residual function of approving prudential supervisors other than trustee corporations. The statutory supervisor monitors the Company's compliance against the documents for the village, and holds encumbrance for the residents of the village, which is registered against the title to the village land. The statutory supervisor does not guarantee repayment of any money paid to the resident. The role of the statutory supervisor is specified in the Retirement Villages Act 2003 No 112 Part 3.

4.5.3: The Retirement Villages Association of New Zealand (Incorporated)[6]

The Retirement Villages Association of New Zealand (Inc.) was established to promote the resident funded Retirement Village industry in New Zealand, and to

[6] Source: http://www.retirementvillages.org.nz/residents/benefits

protect residents of these villages. This primary objective will be maintained by maintaining high standards for all who participate in the industry. They provide guidance to all tiers of Government, Statutory Authorities, and other organisations, on all matters relating to resident funded housing and they promote the good reputations of members; by fostering the free exchange of ideas and co-operation between members. The Retirement Village Association collects and researches information on the industry and uses this information for the benefit of all participants in the Industry in order to establish and maintain public education as to Retirement Village living.

They state that as an Association, their wish to maintain high industry standards has been realised by the creation and adoption of their Code of Practice and Standards for members. Member villages are committed to standards of quality determined by the association and are subject to an accreditation process. A probationary period transpires before accreditation is considered (www.retirementvillages.org.nz).

4.5.4: Residents Committees

The management contract, which is entered into when a unit is purchased usually, stipulates that a resident committee should be established. A resident committee is a management advisory committee comprising of residents.

According to Gibson (1998), in nursing homes and Retirement Villages, the classic strategy to empower consumers is by way of residents' committees. This has been long established in the United States. Residents' committees expanded in Australia only in the early 1990s. While American evidence suggests that resident committees are active and could be viable mechanisms for providing input into nursing homes (and villages), it also demonstrated that many resident committees were ineffectual in being instrumental in raising residents' concerns, complaints or suggestions for improvement.

The Australian evidence also suggested that the majority of such committees are indeed ineffectual in the context of the present discussion. Gibson (1998), states that

at the empirical level, the presence of a residents' committee did not significantly increase the likelihood that the facility in question had higher quality care. S/he is also of the opinion that given the issues discussed and the ways in which the committees function, this is not surprising. Frequently they were more a conduit for the nursing home management to communicate with residents than a channel for complaint and requests for institutional change.

The question that we must ask is to what extent this 'failure' of residents' committees is a problem for residents themselves, or whether it is a failure in terms of the ways in which we have formulated the problem, and in its turn, the solution in terms of what our expectations are of the function of the residents' committees. Gibson (1998), states that village managers hope that the residents' committee will provide information that would be useful at a policy level and in many instances they do, but they sometimes find that residents are only interested in more mundane day-to-day issues. Gibson raises the question as to what moral force underlies the position of policy analysts or management bodies in claiming the residents committees *should* focus on the more 'serious' issues, that is, the more serious issues from their (dominant) perspective?

4.6: Retirement Homes: to Rent or to Buy

A detailed list of housing estates designed specifically for older people who wish to live independently is easily obtained from Residential Information Service. The aim of the list is to provide a starting point: it may clarify the price range, services that are offered and location. Lists are compiled according to regions. There is a separate list of Retirement Villages to Buy and Retirement Villages to Rent. Council Pensioner Housing is included under the list of Retirement Villages To Rent.

The listing of accommodation covers rental accommodation that is provided specifically for older people. It includes board, bed-sits, serviced apartments, units and cottages. There is a shortage of rental accommodation in Auckland and most rental agencies have a waiting list. The list of Retirement Villages gives the following details: contact details, owner, admission age and waiting list, rent,

accommodation cost, service fee, additional services, communal amenities and care facilities (rest home and/or hospital on site). Some of the listed villages also include their future plans.

There is no government funding for building Retirement Village accommodation. You purchase tenure and then pay an ongoing service fee. Residents of a Retirement Village can apply for an Accommodation Supplement to Work and Income New Zealand although additional information is required from them. The service fee charged by Retirement Villages usually covers rates, insurance (excluding personal insurance), security, 24-hour emergency call system, lawns, gardening, and windows and exterior maintenance. The rate for serviced apartments is higher and may include meals, housekeeping, linen and power (Residential Information Services: Auckland District Health Board, 2002).

4.7: Factors that Influences Choice

A Retirement Village offers people in a similar age group security, activity, companionship and privacy, as well as accessible health and support services (Age Concern News July-August, 2001). People enter into Retirement Villages for a variety of reasons.

Kinnaird (2001), discusses the following factors that people consider when opting for a Retirement Village.

- **Location:** proximity to shops, public transport, family and friends;
- **Size:** the size of the house in relation to number of bedrooms;
- **Independence and privacy:** some Retirement Villages place a great emphasis on privacy and independence, others focus on community living;
- **Maintenance and security**: it is important to establish whether the security and maintenance that is offered is in line with what the prospective resident expects;
- **Services:** it is important to establish the exact nature of the services being offered (and the cost involved);

- **Recreation:** the list of recreation activities needs to be scrutinised in order to establish if it suits the prospective clients need;
- **Care:** assumptions should be avoided of what level of care is being offered and the cost involved. Information should be obtained of what will happen when the individual becomes too frail to remain in the unit.

The National Strategy for an Ageing Australia: *Attitude, Lifestyle and Community Support Discussion paper* states that:

Recent consultations with older Australians found that older people want more flexible, safe, affordable, accessible and innovative housing choices to enhance their capacity to remain in familiar surroundings close to family and established social networks.... Diversity of option is essential if older people are to exercise choice and avoid the dilemma of having accommodation that is either too demanding or overly supportive (Commonwealth Department of Health and Aged Care, 2000: 14).

Choices about purchasing a unit are influenced by the information that is available through the media, residential services, the Internet and by word of mouth.

4.8: Checklist Before Making a Choice

While Retirement Villages are an accommodation option that is attractive to many older people, it is an option that carries significant financial and occupational and financial risks for them. These risks are often not well understood (Ministry of Social Development, 2002a). Kinnaird (2001), lists a number of aspects that are worth checking out. These include:

Legal contracts: It is important to consult a lawyer and check out legal contracts carefully. One should establish what services management are legally required to provide on an ongoing basis. It is also important to establish the mechanisms that are in place where one can enforce one's rights other than going to court. An example of this would be the Statutory Supervisor who will act in the interest of the village resident.

Fees: It is important to know what the ongoing charges are and what services are included in the fees.

Finances: It is important to establish the financial obligations you may have when you leave the village and how much money you will receive and how long you will wait to receive it, who will administer the sale of the unit and what assurances you will have that he unit will be sold as quickly as possible.

Care: One should establish if ones service needs can be met (currently and in the future).

Village Management: It is important to establish the management style (inclusive or autocratic). The qualifications and experience of the village managers should also be open to scrutiny.

Village membership: It should be established if the village is a member of any organisation or association and the role they play in setting and monitoring standards as well as resolving disputes.

4.9: Retirement Villages to Buy in West Auckland

Retirement Villages situated in West Auckland were chosen for pragmatic reasons. I was a new migrant to New Zealand but was familiar with the older care industry in the Waitakere Region, since I worked there. Addendum One reflects the classification of information obtained from advertisements in newspapers and on the internet, as well as from other public information relating to Retirement Villages to Buy in West Auckland. The information has been classified into themes that relates to the factors influencing choice discussed by Kinnaird, (2001).

The tenure of six of the Retirement Villages was by License to Occupy. One had tenure by Independent Unit Title and the other by Freehold Title.

The location of a Retirement Village is advertised when it has a particular feature that will boost sales: within walking distance to amenities (shopping mall, doctor), access to a private beach etc.

Service fees are also referred to as *village out-goings* which is a proportion charged weekly on a per dwelling basis of all the costs, charges and expenses, fees and other

out-goings incurred by the Company in maintaining, managing, supervising and operating the village from year to year. Seven of the villages include council/water/sewerage rates, building/fire/property insurance, security, emergency call system, and the removal of rubbish, maintenance of lawns and gardens and exterior maintenance as part of the service fee. One village mentioned that they had a security pendant alarm service. This is linked to St Johns' emergency services. This Retirement Village made no mention of care facilities or whether they have a role in an emergency response.

The fees were comparable: services mentioned varied to a small degree. One village charged a lower rate than the others have because facilities were still being developed. One had a fee structure that was different. Their fees were based on the financial resources of the prospective resident. They said that the selling price of the unit was based on individual assessment of the prospective residents' financial status. Electricity was not included in the service fee (none of the villages stated that electricity cost was covered in the service fee). The fee structure of this particular village was obtained from the same public sources as the other villages and was confirmed telephonically.

Two villages gave details of additional services and six gave details of existing or future care facilities.

Six of the villages placed emphasis on the communal facilities. These are inclusive of two villages who had not made mention of features in relation to their location.

4.10: Conclusion and Policy Implications

There are many pitfalls in legal transactions. Various organisations such as Age Concern New Zealand have information available that warns one about the complexities of the various types of tenures.

The Retirement Village Association has an important role in the setting of and monitoring of the adherence to minimum standards of practice by its members. The

Retirement Villages Act 2003 No 112 Part 2 addresses registration, occupation right agreements, and related requirements and rules.

People who live in Retirement Villages are no different to older people who live in the community. In New Zealand almost 15% of disabled older people needing assistance (approximately 23,000 or just over 5% of the total older population) are estimated to be living in residential care. This implies that 85% are living independently in the community including Retirement Villages (Ministry for Social Policy, 2001b: 8-9).

They are entitled to the same public services and financial and other support that is available. The available services can only be used effectively if the older people are able to access it. Information about these services is very fragmented and can limit the ability of older person to access such services. According to Quinn, Snowling and Denicolo, people did not always turn to formal information and advice services, but asked the people who were already helping them, family and friends as well as professionals. They express the opinion that health and social care staff are not always aware of the full range of services, only those offered within their own system (Quinn, Snowling and Denicolo, 2003).

In order to evaluate the efficacy of service delivery in relation to the expectations of older people who live independently in Retirement Villages it needs to be determined:

- What services people expect the government and others to deliver to enable older people to live independently in Retirement Villages
- What support services are available and,
- Whether information is available to older people and their families that will inform them of how to access support services.

CHAPTER FIVE

Health Care Provision For Older People

5.1: Introduction

As people age their need for and usage of health services increases and varies. Patterson (1997), considers that satisfaction in old age is related to the extent to which there is a match between the resources people have and the expectations that are held by themselves and significant others. Thus, two people with similar resources in terms of housing and health will vary in the extent to which they feel satisfied in their lives with their own and others' expectations of how they ought to be living (and about the choices they make). It needs to be recognised that older people are vulnerable as individuals and could be subject to oppression or abuse. If this point is not acknowledged, practice may reinforce ageist stereotypes and thus negate the opportunity for them to have a positive quality of life by being able to participate in decision-making that affects their lives (Drake, 2001, Payne, 1997, Burch, 1999).

The choices people make are influenced by personal experiences, expectations, and resources and by the person's physiological and psychological state. The options people choose and the individual and collective consequences of their choices depend crucially on the institutional and social structural context within which these decisions are made (Fougere, 1984). Instead of acting as the 'expert' who has all the answers, a more appropriate approach is one in which service providers help to identify choices, and support the older person through the process of deciding upon options and carrying them through. In order for people to make informed choices about healthcare services, they need to be aware of what is available and how to access it.

5.2. Types of Health Care Provision

For the purpose of this thesis health care is classified into informal (unpaid) care and formal (paid) care that is provided in residential care settings, hospitals and in the

community. This chapter deals with informal care as well as formal care that are provided in residential care and in public and private hospitals. Chapter Six deals with formal health care in the community with an emphasis on Retirement Villages.

An important and interesting stream of research has concerned itself with the distinctive features and organising principles of formal and informal care. Cantor (1979), states that formal and informal cares are points along the same spectrum of care giving. Cantor asserted that these were separate systems that did not co-exist comfortably. Indeed he implied that formal services posed a threat to organic systems of informal care. Cantor believed that the bureaucratic framework surrounding formal services brought rigidity, delay and professional domination; on the other hand, such agencies dispensed valued resources in a relatively rational and even-handed manner. Informal care was patchy and unpredictable in its impact with no mechanism for ensuring that care was given to those most in need or that the requirements of actual recipients were fully met (Cantor, 1979).

Ways of defining differences between types of care are also examined by Higgins (1989), who suggests that there is no clear distinction between institution and community, and that many care settings have elements of both. Institutional care can take place in the community, for example in hostels for people with mental illness who have moved from a large institution to a smaller one. Much community care takes place in institutions, for example, day hospital or respite care, but most care takes place in the home, provided by the family. Higgins suggests that the simplest way of categorising care is to ask where people sleep at night, in an institution or at home? Services may then be divided into those available *in a home,* in the community or nursing home-from-home, for example day care or respite care; or *at home,* such as in a Retirement Village. In this model there is no need for the concept community, which Higgins finds unhelpful (Higgins, 1989).

5.3. Informal Care

5.3.1. The Significance of Informal Care

Informal care is irrevocably intertwined with formal care, yet informal and unpaid work is not considered as production in traditional analyses (Waring, 1988). It is now recognised that by far the largest proportion of care (about 75-80 per cent) is provided by the informal sector, that is family, friends and neighbours, mainly women. Similarly, although much attention has been devoted to state-provided services, most countries have pluralist systems of care provided by governmental and non-governmental agencies, formal organisations and informal carers.

There seemed to have been a limited understanding of the extensive role of the informal care system and of the pressures being faced by carers (Scharf and Wenger, 1995). There was an assumption, so deeply rooted that it was barely articulated, that the continuing efforts of carers could be taken for granted and that the public provision should occupy itself with meeting the needs of unsupported people (Day, 1993). Literature suggests that informal care is provided mostly by women and usually in an unpaid capacity. These arrangements have traditionally been accepted as a normal part of family and community life, and as a natural part of a woman's role (Brody, 1990).

The unquestioned acceptance of informal care arrangements has to be re-appraised amidst the changing social and demographic trends. The most significant of these arrangements include the ageing population, the return to work by increasing numbers of women, and changes to the nature of the family and household structure (Belgrave and Brown, 1997). Assumptions about a woman's role include:

- The traditional notion of the nuclear family is that of the father as the breadwinner and the mother as the carer (Craig, 1992).

- Despite the presence of others in a larger carer network, a single person, usually a woman, (willingly) bears most of the burden of caring (Stephens and Christianson, 1986; Belgrave and Browne, 1997).
- The assumptions that society has about the women's roles become part of the women's understanding about themselves as well as any activities they may undertake (Craig, 1992). These common-sense assumptions are so powerful that women often do not question the activities they are required to undertake (Munford, 1992).
- The extent of informal (unpaid) care is therefore closely linked with the ability of women to provide care for dependent relatives and others in the community.

Informal carers are likely to be mainly involved in providing basic care to help with daily living, mobility and self care, although some also gives highly skilled nursing care. Generally, women identify some benefits of caring, such as satisfaction (Opie, 1992), and pride from carrying out the task to the best of their ability (Pacolet and Winderom, 1991). Munford (1992), concludes that women's experience is both restrictive, as well as rewarding.

Research indicates that younger women consider themselves less destined to provide care and all looked on the caring responsibilities of women in previous generations as excessive. The availability of women to care is also reducing as women continue to increase their involvement in the workplace (Belgrave and Brown, 1997). Carers may find themselves providing support in a time of crisis assuming that it will pass and that they will return to their previous level of contact. They may gradually discover that their care is required on a long- term basis (Bland, 1996).

5.3.2: Attitudes to Informal Care

Given the choice, people in need would prefer to receive services from those close to them rather than from formal care providers (Cantor, 1979). 'Informal care-giving efforts, while largely successful in helping the older person to avoid institutionalisation, very often place heavy demands on the caregivers, taking a toll

on their emotional and often physical well being' (Cantor, 2000). It is hardly surprising that some caregivers request services that provide respite care-help with daily household tasks. This enables them to take occasional time away from their care giving responsibilities (Pacolet and Winderom, 1991).

According to Twigg, Atkin, and Perring (1990), informal carers are part of the 'taken for granted' context within which healthcare services are provided. In contrast to this, the New Zealand Ministry of Health (1995), acknowledged that informal care is an important consideration within the disability support services area, and that it is crucial to give consideration to the sustainability of such care especially in the light of reported stress or strain by caregivers.

Both the older person and their families strongly resist nursing-home placement, and families contribute a great deal toward preventing or delaying this move (Stephens and Christianson, 1986; Shanas, 1979). Thus even though informal care can be an effective strategy for helping some impaired older people to remain in the community, Richmond et al (1996), caution us that carers are sometimes reluctant to ask for help and may need counselling to recognise the difficulty they are having and to accept outside assistance.

5.4: Formal Health Care: Policy Developments

The Positive Ageing Strategy has as its goal for health on a national level, 'equitable, timely, affordable and accessible health services for older people' (Ministry of Social Development, 2002a: 20). The Ministry of Health finalised a Health of Older People Strategy to provide a framework for the planning, funding and development of programmes and services for New Zealand's ageing population (Ministry of Social Development, 2001b: 31). Some of the achievements of this strategy for 1 July 2002 – 30 June 2002 were:

- The 2003/2004 District Health Board (DHB) annual plans reflect preparation for the devolution of disability support services funding and implementation of a continuum of care for older people

- A regular forum to provide advice to DHBs to progress preparation for disability support services funding responsibility and development of an integrated continuum of care for older people
- A web page www.moh.govt.nz/olderpeople was established in November 2002, and is regularly updated (Ministry of Social Development, 2001b: 21).

District Health Boards were established to implement new initiatives on a local level. It allows for greater integration of support services with other health services at local level and provides a clearer focus on the health needs of older people. At public hospital level the focus is on specialised services for older people in assessment, treatment and rehabilitation (AT&R) and access to other specialist services. Such services also enable a managed interface between disability support services and clinical services and the range of intervention and services that are considered to be in the interest of the person being assessed (Ministry of Social Development, 2002a, Boston, Dalziel and St John, 1999).

The DHBs are responsible for providing or funding healthcare services for the populations of their specific geographical area. This includes health and disability services, health planning, health promotion and protection, public hospitals and a range of primary, secondary and tertiary services. Budgets for the various boards are determined on a population based formula. (Positive Living, July-August, 2001: 13)

In December, 2000, the New Zealand Public Health and Disability Act was passed and a new health system was established and the Disability Strategy (2001), the New Zealand Palliative Care Strategy (2001), and the Mental Health Strategy (2001) followed suit. The Disability Strategy addresses attitudinal, policy and service issues. The Palliative Care Strategy addresses the support of people who are dying from a clinical as well as physical, social, emotional and political perspective. The Mental Health Strategy addresses the needs of older people who have mental health problems, by reflecting their needs in the planning and development of mental health services (Ministry of Social Development, 2002a).

5.5: Cost Containment Concerns

An increasing recognition of the longer-term financial consequences of caring where a disregard for the cost of caring may be a false economy has contributed to a refocus on the cost of informal care. Not only are carers proven to be financially impoverished in the short term; there are undoubtedly long-term consequences (Glendinning, 1992). Opie (1992), identified that for carers there are long-term financial disadvantages specifically to women carers, such as loss of savings and superannuation, pension rights and medical insurance.

The lack of security of income is a significant stress to these women. Almost one third of both currently and recently employed caregivers had experienced restricted working hours. Of the over 35 per cent of the unemployed caregivers who had recently left jobs in the past year in order to provide care, over 21 per cent had turned down a job, and over 28 per cent had been unable to search for a job due to their care giving responsibilities. Even caregivers that were not recently employed felt restricted in their desired employment opportunities (Stephens and Christianson, 1986).

The budget for state health expenditure for older people is affected by changes in the balance between state provision and individual responsibility over time, as does the growing costs of technology and pharmaceuticals, growing demand, and the pressures of an ageing population. State responsibility for health care has been generally accepted in the past because individuals do not have full control over their own health.

Over the past 20 years in New Zealand, health expenditure per capita (both private and public) has grown at a rate of about 1.7 % per year in real terms. The government meets 77% of New Zealanders' total national health cost, down from a high 88 % in 1980. Private insurance meets 6.8% of costs – though this remains only a small proportion of total health spending, this is still much larger than the 1.1% it was in 1980. Out of pocket expenses (mainly payments to General Practitioners and

pharmaceutical part-charges) makes up the rest, about 15.6% (Waitakere Health Planning Group, 2000).

State expenditure for long term care of older people is substantial, and is very likely to increase in the decades immediately ahead. 'Older people are high users of primary and secondary health and disability support services. In 1998/1999 General Practitioner visits averaged around six per year for people aged 65-74 years, and around nine per year for people 85 years and over. This compares with around three per year for people aged 6-64 years. Per capita expenditure for people 65-74 years was estimated to be $3,261, and $6,144 for people aged 75-84 years. This compares with $849 for people aged 15 years and under and $1,190 for people aged 15-64 years' (Ministry of Health, 2001). Per capita health cost (with the exception of high expenditure on the very young) steadily increase with age and the highest expenditure is for the 85+ group.

According to Douglas, in the 10 years preceding 1991, the Department of Health's budget expanded from $1.1 billion in 1980 to $3.8 billion, a twenty seven per cent increase over and above the increase in consumer prices during that period (Douglas, 1993). 'Demand (for health services) can easily outstrip the ability (of the Government) to pay' (Ministry of Social Development, 2003a: 5).

One of the primary motivations for health reforms is to achieve better value for money, especially in public hospitals. Concerns about the size of government expenditure, access to health care, and persistent low health status for particular groups have increased debates about the ideal way of ensuring that health services are delivered efficiently and effectively. Concerns about the ethics of treatment and the increasing cost and need for rationing of expensive treatments have also been significant (Cheyne, O'Brien and Belgrave, 2000).

5.6: Access to Health Care

'In primary care there are doctors who have little interest in older people and little training in geriatric care' (Williams 1989). Richmond et al (1996), negates this

viewpoint of Williams, (1989) by suggesting that General Practitioners and staff in the private sector such as rest homes and private hospitals, have increased awareness of needs of older people as a result of focused educational and training programmes. There is no research evidence to support the latter. Williams stated that the changes in the organization of general practice have sometimes militated against the interest of the old people.

The introduction of an appointment system has made it harder for older people to consult a doctor or get routine home visits. This may cause a sick older person to be reluctant to call a doctor. Access by older people to general practitioner and other primary health care services are subject to the same constraints of income, location and motivation as the community as a whole. However, to the extent that a high proportion of older people are reliant on fixed income towards the lower end of the income scale, affordability is a significant issue (Ministry of Social Development, 2002a). Most people needing formal, paid, long-term care services have no means of meeting the cost. In one study, for example seventy five per cent of unpaid, informal caregivers of dementia patients said that they did not use paid services because they could not afford it (Eckert and Smyth, 1988).

Sue Kedgley, Green Party spokesperson for Health said in a press release 13th July, 2001 that health service cuts proposed by the Auckland District Health Board to deal with a predicted $62 million funding shortfall would inevitably lead to more serious health problems and result in further health budget blowouts. She expressed the opinion that there would be a drastic cut in services that could affect efficient service delivery. Efficiency in the health sector is notoriously difficult to measure since the relevant data are often either not known or not comparable across organisations or regions and/or over time. Boston, Dalziel and St John also state that 'an added complication is that some data are regarded as commercially sensitive and so are not publicly available' (Boston, Dalziel and St John, 1999: 141).

The reconfiguration of area health boards into Crown Health Enterprise (CHE) revealed that there was 'a chronic revenue shortfall in the public health system that had previously been addressed through unsustainable erosion of assets' (Ministry of Health, 1994: 18). In the first year, CHE expenditure exceeded revenue by 11 per

cent. The government was forced to write off $300 million in debts and inject another $100 million in the 1994 budget. This trend continued with the resultant closure of local hospitals, centralisation of services and a decline in the number of hospital beds. It influenced the number of people on waiting lists for surgical procedures (Kelsey, 1995: 217). Hospital services, surgical waiting lists and waiting times increased steadily after 1993, until by 1996 there were almost 100,000 New Zealanders waiting for surgery. In spite of an injection of funds in 1996-1997, there was a decline of only 3 per cent in the total number of people on waiting lists (Boston, Dalziel and St John, 1999). The Government is addressing the concerns expressed by the public with regard to waiting lists as was evident from the budget speech for 2004.

The reduction in the amount of elective surgery performed in public hospitals has resulted in a growth in claims against private health insurance. This in turn has led to an increase in private insurance premiums, particularly for older people and other high-risk groups (Cheyne, O'Brien and Belgrave, 20000). Private insurance is chosen as an alternative to public provision especially by those most in need (Boston, Dalziel and St John, 1999).

Access to home-based support services and the availability of these services are at times a major concern to older people. In Canterbury, access is largely dependent on the Needs Assessment and Service Coordination provided by the CDHBs Older Person's Health Division. The presence of many funding streams (ACC, DSS, CDHB Primary Referred etc) and the duplication in the provision of these services can further complicate the process for the older person. The person needs to be assessed as to whether there is any reversible cause for the changes in their function and by a combination of appropriate assessments from secondary services and a package of care, they can continue to be maintained in their own environment if that is the most appropriate option. The key to the process is as early intervention as possible from the Coordinator of Services for the Elderly (COSE) to prevent stress for the person and their family (www.cdhb.govt.nz/media, 12/9/2003).

5.7: Policy Issues and Trends

The focus of health planning for older people is to assist them to live independently for as long as possible by empowering them through involvement in decision making that will impact on their health and well-being. Various strategies have been developed to support positive ageing. The Health of Older People Strategy has links to a number of other strategies, including the New Zealand Health Strategy and the Positive Ageing Strategy.

Two concepts underpinning the strategies are an active ageing strategy and the life course approach, which recognise that policy decisions and health system design, and lifestyle choices made by people at younger ages, have major impacts on health expenditure. The strategy provides a framework for sustainable health and disability support services to meet the needs of current and future generations of older New Zealanders.

Three key drivers for change are:

- Concern about the lack of strategic policy development and planning for health and disability support services for older people;
- The desire to implement the New Zealand Positive Ageing Strategy within the health sector;
- The rapid increase in the number, and ethnic diversity, of older people (The Health of Older People Strategy, 2000).

The Office for Senior Citizens has put mechanism for the effective planning, implementation and evaluation of health service needs and provision for older people into place. James (1989), stated that shifting the choice from bureaucrats deciding *for* people to people deciding for *themselves* meant that state provision should not be given as the only option. A mechanism for shifting the balance of state responsibility for the health of older people is by extending the range of choice in social and health services to private individuals. Choice and empowerment through information dissemination is important for older people in general and specifically for older people in Retirement Villages. There is no clear legislative direction as to what

responsibility (if any) the Retirement Village industry has for the 'wellness' of its residents.

Some Retirement Villages provide a continuum of services (including health care and 24 hour emergency response[7]), but the onus is on the resident to recognise the need for and to 'purchase' appropriate services. This presupposes that *all* older people are capable of making the decision when their health needs change. For some older people memory loss and other mental changes such senile dementia happens so insidiously that it is difficult to identify when they become incapable of making appropriate choices.

Policy emphasis has shifted from non-regulatory (registration and licensing of older care facilities) to regulatory (compliance with quality standards leading to certification which is compulsory, rather than accreditation which is optional. The Health and Disability (Safety) Act 2001 replaces licensing and registration with certification of people or organisations that provide hospital or rest home care or residential care for people with disabilities. All hospitals and old people's and homes for people with disabilities will need to meet the following standards:

- Health and Disability Sector Standards NZS8134, 2001
- Infection Control NZS8142, 2000
- Restraint Minimisation and Safe Practice NZSS8143, 2001

This may lead to the closure of some facilities but it should have the desired effect of raising the standards of care for older people. Suitable education programmes have been developed and incentives for health and other professionals to up-skill should encourage specialisation in the area of care of older people, especially in the area of community care of older people.

[7] There is no legal requirement or definition of what a 24-hour response is.

5.8. Conclusion.

Healthcare for older people take up a considerable amount of the health budget. Informal (unpaid) care forms a vital part of healthcare provision yet it is not taken into consideration in healthcare planning. The dwindling pool of informal carers has implications for the budget. Older people prefer to be cared for by their relatives but a prolonged period of providing informal care creates a great deal of stress to the carer. The increasing demand for formal care provision is proportionate to the decreasing availability of informal care. Various strategies have been implemented (Health for Older People Strategy, The New Zealand Positive Ageing Strategy and The Disability Strategy) to improve the quality of and availability of healthcare. Access to health services is reliant on knowledge of the processes such as needs assessment (for appropriate placement) by the Needs Assessment and Service Coordination team. Older people and service providers need to be well informed so as to utilise this process effectively. Community care is an important aspect of healthcare provision for older people. This aspect is dealt with in Chapter Six.

CHAPTER SIX

Community Services for Older People

6.1: Definition of Community Care

There is an increasing recognition of the special needs of older people and to meet these, many countries are developing programmes with a specific focus on care in the community. Community care is a term widely used in English speaking countries, but must be recognised as a broad concept susceptible to vague definitions. Tester (1996), considers that a definition of community care in its widest sense includes housing, domiciliary health and welfare services, health services outside the home, day care services, and the social, leisure and educational facilities that help to maintain the older person's quality of life. In other words it means simply care for people who live in their own homes, irrespective of whether those homes are in ordinary housing, carers' homes, specialised or small-scale residential settings.

6.2: Why Community Care for Older People?

The preference to remain in their own homes is the 'one clear message' that we may take from research on older people's housing needs and preferences (Tinker, 1994). Walker and Warren (1996), cite results from a Euro barometer survey that indicates a larger majority of people across Europe believe frail people ought to be helped to remain in their own homes. Older people in New Zealand have convincingly echoed the sentiment that they prefer to remain in their homes for as long as possible (Davison et al, 1993). A national survey of older people living in the community in England found that four fifths of older people wished to remain in their present homes (McCafferty, 1994).

Research in New Zealand (Salmond, 1976 and 1985; King et al, 1985) demonstrated that the support required by many of the people in institutional care was social rather than medical in nature. This implies that some older people were inappropriately

placed and could have been cared for in the community. The majority of older people in long-term hospital care did not have physical or sensory impairment (Salmond, 1976). In addition, in the early 1980s, older people placed by hospital boards in private hospital through the Geriatric Hospital Assistance scheme were spending three times as long in hospital as those in public beds – despite the low levels of disability among people in private hospitals compared with public hospitals (Hyslop et al, 1983).

Most of the older people do not need formal services to remain in their own home. Some older people have pre-existing home-based support needs that are related to *disability* not older age. Others receive support or practical assistance from family, friends or relatives and neighbours, which, while not necessarily required, can be very important in terms of maintaining networks, saving costs, or having smaller support needs met before problems become overwhelming (Ministry for Social Development, 2002a).

6.3: The Aim of Community Support Services

The concept of community care implies that the home care services in general have a more sharply defined preventative function; with levels of support changing and intensifying, where necessary, in order to prevent or delay admission to more costly and less favoured residential care (Sinclair, Leat and Williams, 1990). This means bringing about a change in the mind-set of some people who may equate retirement with infirmity. The overall aim of community care is to enable an older person to function effectively in his or her own environment. Some of the aims according to Williams (2001), are:

- to maintain and/or to improve an old person's functional performance;
- to enable older people to accept responsibility for caring for themselves;
- to foster a team approach to the provision of care;
- to foster intersectoral links between hospitals, other institutions and those providing care for older people;

- to provide support and relief to informal carers who are looking after old people and
- to provide information and education for older people in the neighbourhood.

6.4. Stakeholders in the provision of Community Care

Older people may benefit from one or more of a range of services that are not always considered to be part of community care. 'In New Zealand the Government is committed to working with communities to ensure services that respond to local needs and foster community ownership of solutions. This requires strong working relationships across government departments, community organisations, iwi, local government, rural and urban communities, and the wider society. Effective co-ordination avoids wasteful duplication of effort and shares best practice among partners '(Ministry of Social Development, 2001b: 17). Various factors determine the roles played in service provision by each sector in different political, economic and welfare systems.

The provision of care is financed through different sources and methods. The funder of services is not necessarily the provider, although this has been a common assumption (Glennerster, 1992). Glennerster places emphasis on the distinctions between public and private provision and public and private financing and shows that there are few clear cut examples of services entirely publicly or privately provided and funded. For example homes for older people are often provided by private agencies but partly funded from public sources.

The main financiers of community care services are the individual and family, the state, insurance funds, employers, trade unions and charities. The finance may have been raised or reallocated from other sources such as through taxation and can be channelled through various routes to purchase services from different providers (Glennerster, 1992). It is thus important in categorising care services to distinguish clearly between particular tasks or services, care settings, providers and financiers. Consideration of government's role in funding support services and in providing financial assistance to people on low incomes to purchase the services is an issue of

increasing urgency in planning for New Zealand's ageing population (Ministry of Social Development, 2002a).

The state may provide financial support, accommodation, health and social care, through social security, health and welfare systems organised at national, regional and local levels. Private commercial enterprises may, for example, be major providers of housing and residential care, medical services, pensions and leisure activities. The non-profit sector in various forms provides social and medical care, housing, and leisure and transport services and in some countries plays a major role in health and welfare provision. Employers and trade unions, while providing occupational welfare services mainly for current employees, may have a role in providing or administering pensions and other financial benefits and welfare services for former employees and retired members.

6.5. An International Perspective on Community Care

The key dilemma facing the organisations and management of home-care services in Britain is whether the service should provide large numbers of older people with basic cleaning and shopping on a weekly or twice weekly basis, or whether to provide fewer but more dependent people with much more intensive and frequent service and one that includes personal care such as washing. If the role is to include more personal care, then this too has repercussions on the role of the community nurse, who traditionally would carry out this task (Sinclair, Leat and Williams, 1990).

An assessment of the international situation shows that the time has come not only to reconsider traditional concepts and promises, but also to develop criteria for the prioritising and allocation of scarce service resources. With this in mind, breaking free from the traditional alternative between residualism and universalism could represent an important new objective. This could, for example, be achieved by a dual system with basic and additional support measures for care services that give priority to people who live alone and cannot rely on informal carers.

6.6. The Role of Social Workers in Community Care of Older People

Patterson (1997), stated that assessment of need for social services is fraught with problems but, if services are to be planned and resources fairly allocated, some assessment is essential. The London Community Care Action Group (1994), identified a range of problems with the Community Care Assessment System including: long waits for one-off visits, a lack of opportunity to prepare, unintelligible forms, a lack of consideration of ethnic minorities and of the right of individuals to privacy. Midgely et al (1997), held a workshop for older people to explore their attitudes to assessment. They found that the majority knew very little about the services and agencies providing care to older people. Where they had information it came from personal contacts rather than leaflets.

Social workers' overarching responsibility is to find the best solution to meet client needs. This may not necessarily mean keeping people in the community. 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 social worker to provide information to those needing support. 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 (this includes admission to hospital, rehabilitation programmes, or a rest-home when remaining independent becomes an issue of personal safety). The aim is to keep the older person in the community for as long as possible, by providing the necessary support to do so.

According to the Residential Information Service ADHB, assessment may lead to specialist advice on medical conditions, admission to hospital for rehabilitation, referral to support services so that the person can remain at home for as long as possible, an assessment of the support need level (SNL), or a recommendation for residential care specifying whether a rest home, dementia unit or hospital is required.

Some Retirement Villages have an admissions co-ordinator who liases with the doctor to make a referral to a Geriatrician to assess the SNL of the older person.

Depending on the outcome, the older person may qualify for admission to a rest home or hospital. Although the older person is given a choice of facilities, they usually prefer to transfer to an on-site facility in order to maintain contact with friends. In this way the Retirement Village that provides a continuum of care, is able to 'feed' clients to the rest home and hospital as people become frailer and their dependency levels increase.

6.7. The Role of the General Practitioner in Community Care

The Waitakere Health Plan towards 2010 states that from the 1930s community and primary services, that is, healthcare outside of hospitals in New Zealand has grown up in two distinct halves, that is General Practitioner-based primary care services, prescription medicine and laboratory tests, *and* public hospital-run community services such as district nursing, public health nurses, social work or community based therapies.

People aged 65 years and over are spending less time in hospital than in the past: the average length of stay has decreased by half, from ten to five days, over the past decade. Following an acute admission to hospital, the majority of older people are now discharged quickly back into the community (Richmond and Moore, 1997). Concern has been expressed by GPs that they do not have adequate information about ongoing care needs of discharged patients (Ministry of Social Development, 2001b: 34).

The distribution of General Practitioner services and spending on prescription medicines is very uneven across communities. This is mainly due to the variation in how many times different GP's see their patients in a given period, and the uneven concentration of General Practitioners around different areas in Auckland. In addition, the traditional separation between publicly run community nursing services and largely privately-run General Practitioner services is widely thought to contribute to poor communication and a degree of fragmentation of patient care between the two groups (Waitakere Health Plan, 2000). General Practitioners are usually instrumental in referring people to Social Workers for assessments.

6.8: Policy Issues in Provision of Community Health Services

6.8.1. Affordability

If the older person has cash assets they are usually able to remain in their own homes for longer than would those who have to rely on state assistance, because they are able to purchase additional support services. Formal assistance is usually augmented by support from friends and family.

The Health of Older People Strategy, 2001 proposes that District Health Boards and the Ministry of Health review and develop a range of service options, including support for caregivers to enable older people to 'age in place'. This will cover options to integrate panning, funding and delivery of primary, secondary, residential care and community support services to provide flexible responses to people's varied and changing needs (Ministry of Health, 2001b).

6.8.2. Social Crises

Williams (1989), describes an acute social crises as occurring when there is breakdown in the provision of basic care and action is then usually necessary by the caring services. The nature of the crisis usually depends on the underlying causes. These can be broadly divided into problems with the old person, problems with helpers, problems with the environment and failures in communication.

Patient or client problems often occur. An old person may be living alone or with relatives. Where help is available, difficulties occur when the level of care required increases to such a point that it is impossible for the helpers to cope any more. In these situations where the problem is fundamentally patient or client-centred, it is usually illness that precipitates the breakdown. This can be physical or mental and may be either major or minor, and it often does not matter which. The important point is that as a result of illness, basic (informal) care can no longer be provided. Falls and accidents may bring on sudden social crises. A fracture can easily be

treated in a hospital but once discharged, the person will find it difficult to cope. Mental illness, failing senses such as eyesight or hearing may also render the person incapable of self-care.

Older people are sometimes admitted to hospital because friends or relatives can no longer cope. In some cases it may also be because the carer experiences a social problem such as illness, family crisis etc. Family support may also be withheld because the son or daughter may be faced with the ethical dilemma of choosing a course of action in the interest of their own families, rather than that of their parent(s) (Williams, 1989).

6.8.3. Accessibility

According to Baskett et al (1999), community health services may be available but not accessible for the following reasons:

- **Lack of information:** There might be lack of knowledge on the part of the public and general practitioners about the services available in a particular area and how to gain access to them.
- **Inefficient organisation of services:** Fragmentation due to lack of co-ordination of service providers as well as the lack of integration of the public, private and voluntary sectors may result in confusion of how to gain access and in some cases contribute to the overlap of services.
- **Devolution of services:** Services previously provided by the Crown Health Enterprise have been devolved to other service providers as a result of the purchaser provider split.
- **Difficult access to services:** Services may be centralised with poorly developed public transport services, or the person may be confined to the house due to structural facets of the house.

The view expressed by Baskett et al (1999), is supported by a study described by Quinn, Snowling and Denico, 2003. This study was done in Slough, a county in the United Kingdom. The county of Slough formed a Project Working Group (PWG)

with the University of Reading research team. The abstract of this study is described in the introductory chapter of this thesis. Service providers distinguished between the provision of information, advice or advocacy. Older people more readily identified services as providing assistance or help, and were less likely to recognise information giving services in its own right. The concept of advocacy was rarely recognised amongst older service users. Older people wanted information across the range of health and social care services. Needs for information and advice about welfare benefits were frequently mentioned, as was assistance in filling in complex benefit claim forms (Quinn, Snowling and Denico, 2003).

In order to improve accessibility, an attempt was made by Waitemata District Health Board to simplify the system of referral. All referrals to Home and Older Adults services now have a single entry point. An information pack was distributed to all referrers and the manager of Home and Older Adult services in 2001. The document specifies that referrals can be made by the General Practitioners (GP), acute wards from North Shore Hospital and other hospitals and other health care professionals (in consultation with the GP wherever possible). It stipulates that self-referrals as well as referrals by family members are discouraged. The task of the District Health Board is to assess the older adult and then to purchase the appropriate care (Waitakere Health Planning Group, 2000).

6.8.4. Difficulties in Provision of Care

Williams (1989), is of the opinion that it can be difficult for an older person to access services but adds that in practice, if health care workers do not co-operate and communicate effectively, it can lead to difficulties in provision of care. A number of concerns about the limited skills of some doctors in meeting the age-related needs of older people have been identified (Richmond et al 1996: 21). This included the failure of doctors to advise on aids and refer people to specialist, and the failure of the two-way information flow between hospital and GPs. In their view, GPs are not able to judge whether or not a person really needs residential care (Ministry of Social Policy, 1999: 13). While this is true of some doctors, there are many dedicated, caring and efficient doctors who specialise in caring for older people.

According to the findings of a research project done in Slough, service providers were struggling to offer timely, accurate and comprehensive information. Not one agency could provide specialist information about all relevant topics. Updating their own information base was difficult for the majority; few had resources for this. Often information resulted from networking skills of staff members, and was kept within individuals' diaries or heads (Quinn, Snowling and Denico, 2003).

In September, 2003, the Minister of Senior Citizens and Associate Minister of Health, Honourable Ruth Dyson officially launched a multi-centred clinical trial based in Christchurch, Wellington and Hamilton that will evaluate health services to older people. The trial is being co-ordinated by the University of Auckland, and, with 880 older people participating, will be the largest study to evaluate health services to older people undertaken in New Zealand (http:/www.cdhb.govt.nz/media: 12/9/2003). Aspects of care that will be evaluated during this study are difficulties in provision of services for older people.

6.9. Policy Trends

6.9.1: Information Dissemination

Lack of information has been identified as a problem in accessing health services. In a media statement May 26, 2004, the Ministry of Health stated that 'Information-enabled health services can streamline workflow, speed up and improve the delivery of patient care, reduce errors and use resources more effectively, but it cannot do these things alone. Buy-in from clinicians and administrators will be a critical part of the equation'.

There is a great awareness of the need for information dissemination in order to make health and support services more accessible to people by the Ministry of Social Development as well. The Ministry of Social Development has introduced a regional initiative to take information about superannuation entitlements out into

homes and the community. In the Canterbury region, the Work and Income Support team provides:

- Home visits to people aged 80 years and over to ensure that they are receiving their full and correct entitlement and to increase their awareness of organisations that can assist them
- A fortnightly outreach service at Age Concern (Ministry of Social Development, 2001b: 27).

6.9.2: The Ministry of Social Development and Community Support

Current government policy encourages community support services that will enhance older people's ability to remain in their familiar community settings for longer. Generally people (including those who live in a Retirement Village) who have reached the age of 65 years qualify for pension. New Zealand Superannuation (NZS) means New Zealand Superannuation (pension) payable under Part 1 of the Social Welfare (Transitional Provisions) Act 1990. If the person does *not* qualify for Superannuation, there are other forms of support. For instance If you are nearly 65, you may qualify for a *Transitional Retirement Benefit* under section 3 of the Social Welfare (Transitional Provisions) Act 1990. In some instances the NZS is not sufficient to cover all the expenses (for essential services) the retired person may have and they find themselves in financial hardship.

Older people at risk of poor material well-being are likely to have an accumulation of factors, such as no savings and high accommodation costs. Social Welfare services are designed to enable old people to maintain a satisfactory standard of health and welfare in their homes and to remain independent and involved in community affairs for as long as possible. The Ministry of Social Development (MSD) has a range of assistance programmes and support services available for people experiencing financial hardship, including older people who live independently. This includes an accommodation supplement, access to more heavily subsidised state-owned rental accommodation, special needs grants, a disability

allowance and a higher subsidy on medical costs through the Community Services Card (Ministry of Social Development, 2001: 27).

Supplementary assistance is for beneficiaries whose statutory income is insufficient. Typically it covers lump sum grants for extraordinary expenses such as clothing and bedding, home help or rest home fees for the aged, and advances for essential repairs and maintenance on beneficiaries' homes. Supplementary assistance was introduced in 1951 and provided income for those with low means, while emergency benefit, introduced in 1968, provided for those whose circumstances were not covered by a statutory benefit. The emergency benefit is for persons in need who are not entitled to a statutory benefit. This social welfare system needs discretionary powers to meet unexpected problems, administrative or legislative delays. It involves a means test, and it places considerable discretionary powers in the hands of the social security officer. Although these powers are normally used humanely and with sensitivity, nevertheless exceptions are known.

The problem is further compounded by the ignorance of the beneficiary, and lawyers, as to the rules that govern the discretionary benefits. These rules are not available to the general public. Another factor is that not all those entitled to the discretionary benefit know their entitlement. For instance the 1973/1974 Survey of Aged Persons found that of the 301 in the sample eligible for supplementary assistance 234 (78%) did not receive (or seek) any (Easton, 1980).

A compounding factor is that General Practitioners are often the only source of advice to old people. They have themselves been ignorant as to benefits and have sometimes resisted giving certificates of illness and disability (Williams, 1989).

The government *has* made provision for welfare assistance for older people who live in the Retirement Villages (The Social Welfare Transitional Provision Act, 1990: Section 18 A). This describes the number of different situations that a person can be in when living in a Retirement Village. Residents of Retirement Village serviced apartments are considered boarders. This is because their accommodation payments include power and gas bills and services such as meals. Even if a client owns a serviced apartment they continue to be treated as boarders if they purchase these

additional services. A client in a Retirement Village who does not purchase these services as part of their accommodation payments may be considered as paying rent or as a homeowner if they own the apartment. Some older people living in a Retirement Village qualify for a Living Alone Allowance.

Clients living alone in Retirement Village units can only receive the Living Alone payment if the client owns or rents and the unit is a house or flat and they do not share any household expenses. The Social Welfare Transitional Provision Act, 1990: clause 2 Ministerial Direction: Living Alone Payment states that a client will not be considered to be sharing household expenses just because they pay a flat fee to the Retirement Village proprietor to cover electricity, laundry, meals and cleaning of common area would not be considered to be sharing expenses.

Older people who have a disability may require carer support. Carer relief is available to give the carer a break from caring responsibilities where a partner, family member or any other person cares someone for full-time. As from 1993, relatives providing respite care for up to four weeks a year for a dependent older person have been able to claim a *Family Caregiver Allowance* which incorporated a daily payment plus claims for expenses and loss of earnings. There was a cap on the maximum daily rate that could be claimed, but with full allowance in line with the average pre-tax wage. A policy change was made in September 1995, when the government announced that from the 1 October 1995, those people who had entered care on or after March 1994, would be able to gift assets of up to $25,000 to carers before they went into long-stay care. Provision was also made for an older person to backdate a gift of up to $5,000 a year for the previous five years and to continue gifting a further $5,000 each subsequent year (Cheyne, O'Brien and Belgrave, 2000).

If an older person has an immediate and essential need such as dentures, hearing aids or spectacles, and they do not qualify for an allowance, they may apply for a (Work and Income New Zealand) WINZ Advance Payment of Benefit. This can be a lump sum payment if it can be established that the older person has exhausted all other avenues first. WINZ considers Advances individually. If the older person is

receiving a benefit, this money must be repaid (Residential Information Services, July, 2001)

6.9.3. Needs Assessment and Service Coordination

Older people currently receive Ministry of Health support services following their assessment and service coordination by a Needs Assessment and Service Coordination agency. In general, when an older person is identified as having high and complex needs, they are offered either support from existing community services to enable them to remain at home, or entry, if appropriate, into residential care. As part of implementing the Positive Ageing Strategy and the Health of Older People Strategy, the Ministry of Health is supporting initiatives that will provide alternative options for older people who wish to 'age in place', in other words, older people who wish to remain in their own home. This indicates a greater focus on community-based options for supporting older people at home as an alternative to residential care (www.cdhb.govt.nz.media: 12.09.2003).

6.10. Conclusion

The Policy Intent of the Positive Ageing Strategy and the Government Strategies that supports ageing in place, is to ensure that older people are able to live in their own homes for as long as possible. A means of establishing whether the Positive Ageing Strategy is effective is by undertaking research to identify the perceived service needs of older people in general, but especially those who live independently in Retirement Villages. There may be a difference between the availability of government-funded services, and the knowledge and use of such services, by people who live independently in Retirement Villages.

CHAPTER SEVEN

The Research Process

7.1. Introduction

Being a newcomer to New Zealand, I needed to develop an understanding of the Retirement Village Industry as well as the impact of the Positive Ageing Strategy on the care of older people in New Zealand. I decided to use an exploratory descriptive research design, as this approach would serve to assist me to contextualise the findings of this research project. The following insights were gained from the literature review and from prior research in New Zealand and elsewhere:

- Rationales for policy decisions that affect the quality of life of older people is influenced by the ideology of the political power that reigns at a particular point in time. The current thinking is that older people should be allowed to age in place, and that there should be a partnership between the government, local authorities, service providers and users of health services.
- There are an increasing number of the old-old (85+) with a projected association of an increased need for formal and informal support services. Family carers provide an invaluable service and cost saving to the government but continuous and complex care giving tasks does take its toll on the carer. The pool of informal carers is dwindling due to the phenomenon of two-generation older people and due to women staying in the workforce until they are much older.
- The Retirement Village industry fills a gap in the market for housing for older people who want to live independently and age in place and may require a continuum of care. Social exclusion may arise through one or more of a range of circumstances, including a lack of access to personal, community or state resources and facilities, insufficient personal capacity and opportunity, and negative attitudes to ageing.
- The government and others provide a variety of formal support services, but it is under-utilised for reasons that may include inadequate dissemination of information.

- While care of older people has been widely researched in hospitals and rest homes, very little research has been done with regard to the quality of life of older people in Retirement Villages. The main focus of research has been in the area of informal care. There is a growing awareness of the dual focus of caring: the carer needs support but equally the cared for person has the right to be aware of the various options for care and should be involved in decision making.
- An awareness of the vulnerability of older people when they purchase a unit in a Retirement Village has culminated in the Retirement Village Act 2003 No 112.
- Internationally and in New Zealand there is a problem that there are barriers that prevent older people from accessing services and this includes lack of or inaccessible information. Older people can contribute to finding a solution to this problem.

The literature raised several questions about service provision for older people:

- What is the reason for some older people to choose to live in a Retirement Village rather than remain in their own home?
- Are older people engaged in formal and/or informal work?
- What support services do people who live in Retirement Villages use?
- Are they aware of the range of available services provided by the government and others and do they know how to access those services?
- What expectations, if any, do they have of the government in the provision of services for older people?

These questions formed the basis of the interview guideline (Addendum Seven). The research methodology that evolved as a result of the literature review is Grounded Theory as discussed in this chapter.

7.2: The Nature of Qualitative Research

Katzenvollenbogen et al (1991), state that qualitative research is subjective and that the focus is on how the respondents experience and perceive any particular situation. They say that underlying the qualitative approach is a philosophy concerning how behaviours and social processes are determined. Mark (1996), is of the opinion that a qualitative approach uses general descriptions to describe or explain. He says that qualitative researchers tend to use narrative descriptions of persons, events and relationships. Their findings may be presented in the form of categories or general statements about the complex nature of persons, groups or events.

According to Hancock (2002), features of qualitative research are that:

- It is concerned with the opinion, experiences and feelings of individuals producing subjective data.
- It describes social phenomena as they occur naturally.
- Data are used to develop concepts and theories that help us understand the social world. This is an inductive approach to development of the theory. Qualitative data are collected through direct encounters with individuals, through one to one interviews or group interviews or by observation.
- The intensive and time-consuming nature of data collection necessitates the use of small samples. Qualitative sampling techniques are concerned with seeking information from specific groups and subgroups in the population.
- Criteria used to assess reliability and validity differs from those used in quantitative research (Hancock, 2002: 2).

7.3: The Research Design

During the planning stage of the research design the intention was to adopt a phenomenological approach. Phenomenology means the study of a phenomenon. It is a way of describing something that exists as part of the world in which we live. Phenomena may be events, situations, experiences or concepts. Our lack of understanding of these phenomena may exist because the phenomena have not been

overtly explained or our understanding of the impact it makes may be unclear (Hancock, 2002: 4). For example, we know that lots of older people live independently in Retirement Villages. But what does 'independence' actually mean to them and how is that independence monitored and maintained? The phenomenologist wants to understand how the world appears to others.

Since little is known about the Retirement Village Population, I decided to use a research design that is descriptive and exploratory. The main feature is the development of a new theory through the collection and analysis of data about a phenomenon. It goes beyond phenomenology because the explanations that emerge are genuinely *new* knowledge and are used to develop theories about a phenomenon. The theory needs to be grounded or rooted in observation. This methodology is known as grounded theory. Grounded theory is a complex iterative process. This is a method used for studying complex social phenomenon (Mark, 1996). Various data collection techniques are used to develop grounded theory, particularly in-depth interviews and observation although literature reviews, newspaper reports and relevant documentary analysis make important contributions. Quantitative data can be obtained from census data, research reports and government report (Flick, 2001).

The research begins by raising generative questions that help to guide the research but are not intended to be either static or confining. As the data was collected, core theoretical concepts were identified. Tentative linkages were developed between the theoretical core concepts and the data (Trochim, 2000). A key feature of grounded theory is the simultaneous collection and analysis of data using a process known as constant comparative analysis. In this process, data are transcribed and examined for content immediately following data collection. Ideas that emerge from the analysis are included in data collection when the researcher next enters the field. For this reason a researcher collecting data through semi-structured interviews may gradually develop an interview schedule in the latter stages of a research project that looks very different to the original schedule used in the first interview. New theories begins its conception as the researcher recognises new ideas and themes emerging from what people have said or from events which have been observed. Memos form in the researcher's consciousness as raw data are reviewed. Hypotheses about the relationship between various ideas of categories are tested out and constructs formed

leading to new concepts of understandings. In this sense the theory is 'grounded' in the data (Hancock, 2002: 6).

This method was chosen because the research aimed to get an assessment of how the residents who live independently in Retirement Villages understand their social and material situation (the need for support services and appropriate information). One of the aspects that this research sought to demystify is the disparity that exists between the availability of services to assist older people to live independently and their knowledge of and use of such services. It is hoped that a theory will emerge that will facilitate the effective dissemination of information to older people who live independently in Retirement Villages about service provision and how to access it.

7.4: Procedures for Recruiting Participants

A description of Retirement Villages was obtained from available literature, public information such as newspapers, the Internet and brochures obtained from Retirement Villages. On the basis of this information three Retirement Villages that covered the spectrum of services as described by the literature were selected from a list that is provided by Auckland Health Board, to people who plan to live in Retirement Villages in West Auckland. The Retirement Villages ranged from providing no care facilities to the full range of health care facilities (serviced apartments, a rest-home, hospital and a nurse on call for 24 hours).

A description of residents of Retirement Villages was obtained by analysing and quantifying the demographical data of older people in New Zealand generally, and in Retirement Villages, specifically. Appointments were set up with the respective managers of the Retirement Villages I had selected in order to explain to them the nature and purpose of the research project. After the village managers had verbalised their willingness to grant access to their respective villages if they approved of the research, they were presented with information sheets (their own, those for the residents committee, individual and focus group consent forms and all other information pertaining to the research), and given the opportunity to clarify any issues that they did not understand. No concerns were expressed but questions of

clarification were asked and answered. After answering all the questions that they had, written permission was obtained from them to have access to residents as well as to interact with the residents committee so that they could provide me with a list of potential participants.

The managers from the three Retirement Villages all said they felt the research was needed as they themselves were not fully acquainted with service provision by the government and therefore were unable to advise residents who approached them. One manager expressed the opinion that an education programme could be developed from the body of knowledge that I was in the process of developing as their organisation had identified a need for managers to be up-skilled in the caring component of the Retirement Village industry. No members of the Residents Committee were present when I met with the respective village managers. All managers stated that they preferred to interact with the Residents' Committee themselves and said they would consult with the committee about prospective respondents. This may be because in Retirement Villages the Resident Committees have limited decision-making powers (discussed in Chapter Four).

7.5: Sampling

According to Morse (1991), the sample must be appropriate, consisting of participants who best represent or have knowledge of the research topic. This ensures efficient and effective saturation[8] of categories, with optimal quality data and minimal dross. Sampling adequacy means that sufficient data to account for all aspects of the phenomenon have been obtained. By definition saturating data ensures replication in categories; replication verifies, and ensures comprehension and completeness.

[8] Saturation: In collecting and interpreting data about a particular category, in time you reach a point of diminishing returns. Eventually your interviews add nothing to what you already know about a category, its properties, and its relationship to the core category. When this occurs you cease coding for that category (Glaser and Strauss, 1967).

7.5.1: The Sample for Individual Interviews

A list of criteria (based on the demographic analysis of older people in New Zealand as well as my intuition and experience of working with older people in Retirement Villages) was given to the manager of the respective Retirement Villages. The criteria were that prospective participants had to be over the age of 65, had to be independent living, that a couple should be included to ensure representation of males as well as to get a perspective of caring by a spouse. Patton (1990), identifies this way of sampling as a maximum variation sample.

The preferred sample was to consist of 5 people from each village (the assumption was that the residents of the villages would be homogeneous in nature: retired people over the age of 65, who lived independently and who had purchased their units in the Retirement Village). The request was directed to the village manager and I enclosed a letter to the Residents Committee, asking *them* to identify prospective participants. I wanted to capture the diversity of a phenomenon within the small sample that was to be studied intensively without influencing the choice of individuals.

A list of names was obtained from each respective village. All the managers said that they would consult with the Resident Committee, but that *they* would be responsible for liasing with me. The sample consisted of sixteen people from three Retirement Villages, and this consisted of seven men and nine women (five couples and six respondents who were single). I had planned to have fifteen participants: five from each Retirement Village but when I interviewed a male respondent his wife said in a very aggrieved voice that she did not understand why she had not been chosen to participate in the study. I explained to her that I had not made the selection but had been presented with a list of names of people who had agreed to participate in the study. I invited her to participate if she wanted to. I obtained written (informed) consent from her before I commenced the joint interview since the situation obviously required sensitive handling.

Prospective participants had been contacted telephonically and appointments set up in order to explain the purpose of the study and to obtain consent. They had been informed that they could have a support person present during the interview and that they could withdraw from the research, and could refrain from answering any questions they did not want to. Consent was obtained after explaining the nature and purpose of the research, and informing them that they had the right to refuse to participate.

7.5.2: The Sample for a Focus Group

Hancock (2002), states that you add to your sample through theoretical sampling or purposive sampling. Rubin and Babbie (2001), state that when a focus group is used for an assessment that the discussants may be a key informant, referral resources, service consumers or potential consumers, or community residents. They say that typically, focus group participants are chosen without using probability-sampling methods. Purposive sampling (as in using key informants) or reliance on available subjects is much more common. I used this method of sampling to obtain the focus group. I relied on the availability of subjects by selecting the focus group from the sixteen people who had been interviewed individually. The selection was subjective and based on my intuition and on their ability to participate in, and be assertive during a discussion. I had selected nine (three from each village) but one participant forgot that she had a prior appointment.

7.6: Method of Data Collection

Qualitative approaches to data collection usually involve direct interaction with individuals on a one to one basis or in a group setting. Data collection methods are time consuming and consequently data is collected from a smaller number of people than would usually be the case in quantitative approaches such as the questionnaire survey. According to Shaw, Gould (2001), and Byrne-Armstrong, Higgs and Horsfoll (2001), five participants studied over a relatively short period of time are a reasonable number for a master's thesis.

The benefits of using qualitative approaches include richness of data and gaining deeper insight into the phenomena under study. The main methods of collecting qualitative data are:

- individual interviews
- focus groups and
- observation

A multiple method of data collection was used for this study that included interviews, observations, a document review and field-notes.

7.6.1. Individual Interviews

Sixteen (16) face-to-face interviews were held with individuals. It was time-consuming to set up the appointments because the prospective participants seemed to lead very busy lives: they were either too busy to speak to me or, they had to check their calendar of events to establish when they could accommodate me. I had planned to do all interviews at a particular village in one day. I ended up having to go many times in order to meet at a time that suited the lifestyle of the individual participant.

The interview procedure followed a generally similar format in each case. A standard interview schedule was developed with the recognition that not all sections would be applicable in each interview, depending on the background and experience of the interviewee. The interviews were tape-recorded. After each interview, I made notes about things that I had noticed such as a respondent becoming emotional about some aspect, reluctance to talk about some issues, tone of voice and body language. Each one of the participants indicated that I could interview them in their homes.

An interview guide approach was used in order to have a uniform approach at each village and with each individual. Rubin and Babbie (2001), states that an interview guide (Appendix Seven) lists in outline-form the topics and issues that the interviewer should cover in the interview, but allows the interviewer to adapt the

sequencing and wording of questions to each particular interview. Thus, the interview guide ensures that different interviewers will cover the same material and keep focused on the same predetermined topics and issues, while at the same time remaining conversational and free to probe into unanticipated circumstances and responses. This was in keeping with what is described by Morse, Barrett, Mayan, Olson and Spiers, (2002) as methodological coherence. They say this means ensuring that there is congruence between the research question and the components of the method. Data may demand to be treated differently so that the question may have to be changed or methods modified. Sampling plans may be expanded or change course altogether. The fit of these components must be coherent, with each verifying the previous component and the methodological assumption as a whole.

Each respondent was asked whether they would prefer having the interview recorded using a tape recorder or if they would prefer that I make notes. All respondents were assured that confidentiality would be maintained, and that I would be the only person with access to the interview recordings, which would be destroyed at the completion of the thesis. All except one respondent agreed to be recorded. The one that refused said that she did not think she would sound good on tape. We agreed to sample a recording then if she was not satisfied about how she sounded, she would allow me to take notes. After this process she agreed to have the interview recorded. The maximum time taken per interview was one hour. I adopted the role that Lofland (1995), refers to as 'socially acceptable incompetent'. I offered myself as a person who was not acquainted with what services were offered to older people in Retirement Villages or what the role of the government is or should be with regard to service delivery.

This approach was adopted so that the older people should see me, as advocated by Rubin and Babbie (2001), as a person who must be helped to grasp even the most basic and obvious aspects of that situation. Another reason was that I did not want to raise the expectations of the respondents that I was able to influence service delivery by the government and other agents.

Before leaving each Retirement Village, following each interview I made notes of key issues: anything I had observed, any discussion before or after the interview

was tape recorded, whether questions had been understood, which questions had elicited good responses and which questions interviewees answered briefly. Rubin and Babbie are of the opinion that: 'You need to review your notes on informal conversational interviews, detecting all things you should have asked but didn't. Start asking those things the next time and an applicable informal conversational interview emerges' (Rubin and Babble, 2001: 406).

As I did two to three interviews per day (usually at the same Retirement Village) I compared interview to interview in order to establish if there were any patterns in the responses. As I moved from one Retirement Village to another I soon developed the habit of comparing the data of one Retirement Village to another. The results of this comparison were written in the margin of the interview guide thus using note taking as a means of coding. The codes were then used to identify categories or themes and into sub-themes. Each village had a separate code and each individual was given a numerical number. In this way I was able to keep a record of information at each village for each individual. The process of coding resulted in descriptive themes that guided the process of analysing the data obtained from the transcripts of the recorded interviews. I first identified and labelled concepts for example one concept was *subsidised services* but in table 8.4 the subcategories of subsidised services are listed. Another example is that *transport* was the concept and the categories were: *own* transport, *village* transport, transport *by a person living in the village* or a *family member*. This information was tabulated to facilitate analysis but this method also lent itself to comparison being made between the villages in respect of service usage.

7.6.2: The Focus Group

A focus group consisting of eight (drawn from the sample of sixteen) were brought together at a venue that we had agreed upon. All three Retirement Villages were represented in this focus group. I wanted to add to the diversity of the sample by putting together a group of people who lived in different Retirement Villages (multi-sites), who would have had different experiences and expectations of service provision in Retirement Villages. Since I had already had one-on-one interviews with them, I knew that some of them tended to ramble, some were excessively shy

and some were dominant in that they had been community leaders and in some cases served or had served on Resident's Committees.

The time allotted for the focus group discussion was an hour. Past experience in working with older people made me realise an informal interview with eight older people could take a very long time since it would be very difficult to limit the input to semi-structured questions. Data emerging from focus groups are likely to be more voluminous and less systematic than structured interviews.

I wanted to empower the participants to be able to contribute to the discussion. I decided to modify the interview guide approach, using tabulated data that summarised the findings of the individual interviews, to stimulate new ideas and encourage participation. This was done so as not to overwhelm the participants of the focus group with too much information. The information consisted of a synthesis and interpretation (through classifying answers) of the responses given by all those who had been interviewed. In order to minimise the risk of the respective participants being identified, a comprehensive list of *all responses* instead of per village was compiled. I printed out copies of the tabulated information (Tables 8.1. to 8.6.) so that the focus group participants could have something tangible to focus on.

Since the individuals who formed the focus group had directly or indirectly contributed to the information contained in the tables, they could take ownership of it and have a stimulating discourse about whether they agreed or disagreed or had anything different to say (Ruben and Babbie, 2001 and Patton, 1990). My role was that of a facilitator and this permitted me to make brief notes of the interaction between group members, the tone of voice, and to identify the sequence that was followed in the focus group discussion. In this way I was able to collect new data and analyse the data concurrently thus forming a mutual interaction between what is known and what needs to be known (Mores, Barrett, Mayan and Spiers, 2000: 12).

The participants were divided into two groups of four and given one theme at a time. I explained the tabulated data then asked them to discuss it in their groups. I laid down the ground rules so that everybody would have an opportunity to participate

and nobody would dominate the discussion. According to Albrecht et al. (1993), the focus group is a social event and is generally one that participants enjoy regardless of the topic. The primary benefit is that it provides valuable information on how people talk about a topic and how they respond in a situation where they are exposed to the views and experiences of others (Catterall and Maclaran, 1997). The purpose of focus groups is not consensus building but rather, it is to obtain a range of opinions from a representative set of target users about issues to hand. Each user's point of view is of interest and it is the moderator's task to encourage each user to express their unique points of view.

7.6.3: Observations

In some research observation of people is not required but observation of the environment can contribute to the development of invaluable insight about the environment where a research project is being undertaken (Hancock, 2002: 12). In this instance the environment of the three participating Retirement Villages was observed in terms of geographical layout, measures of security, level of activity of residents as well as the services that are being offered.

7.7: The Reciprocal Relationship between the Researcher and the Participants

Mark (1996), says that in the research situation, the researcher and the study participants interact and, inevitably influence one another. For example, in a follow-up interview, the researcher may suggest an explanation or a concept that was developed in an earlier phase of observation. This suggestion may affect the participants' future behaviour. When researchers conduct observations, their presence is usually obvious to participants, and they may even participate in activities along with the participants. This is also likely to affect the participants' behaviour. During each interview I tried to make sure the interviewee was at ease by introducing myself and answering any questions they had. In some instances the respondents appeared more relaxed after the recorder was switched off and spoke freely about some aspects of their lives that was relevant to the research but that they

had not mentioned while being recorded. Some of them also asked questions in relation to service provision that they had experienced and when I did not have the answers it prompted me to enquire from my colleagues or to make enquiries from various service providers and facilitators. These off the record questions and comments had some influence on the manner in which I facilitated discussion with the focus group and it also helped me to revise the format of some of the interview questions that I had had to rephrase when I did not get an appropriate response during my first interview to the question (details in Chapter Eight).

7.8: Transcribing the qualitative data

I transcribed the conversations that had been recorded on tape myself and added the field notes that I had made from memory after each interview, noting any cues such as the tone of voice or body language that might give an indication of a whole range of feelings. I listened to each recording more than once and incorporated anything interesting in the subsequent interviews. The initial interview was different to the subsequent ones that had been continuously informed and revised by informants.

7.9: Strategies for the Analysis of Data

Gordon and Langmaid (1988), in Catterall and Maclaran (1997), identify two approaches to the analysis of focus group data in market research. The large sheet-of-paper approach that involves breaking down the transcripts into texts and allocating these under themes identified inductively and/or deductively. They consider this approach to be inferior to the annotating-the-scripts approach that involves reading transcripts (and/or listening to audio-tapes) and writing interpretive thoughts about data in the margins. The benefit of this is that each transcript is considered as a whole rather than as a set of discrete responses and that it allows the analyst to re-experience the group, body language and tone of voice.

Coding was used to categorise the qualitative data and for describing the implications and the details of these categories. Initially open coding was adopted in which the data was considered in minute detail while developing some initial

categories. Later the coding became more selective where systematic codes were developed with respect to a core concept in order to develop a sub-category.

Memorandums were used to record any thoughts I developed as they evolved throughout the study. This happened after each interview and sometimes while transcribing tapes. This was useful in linking codes to core concepts.

Integrative diagrams and sessions are used to pull all of the detail together, to help make sense of data to the emerging theory (Trochim, 2002). In this instance simple tables were used as summarising devices. The tables were used in the focus groups as a means to facilitate interaction with each other and to share ideas and increase insight.

According to Trochim (2000), eventually one approaches conceptually dense theory (saturation) as new observation leads to new linkages that lead to revisions in the theory and more data collection as the core concept is identified and fleshed out in detail. When does this process end? One answer is: never! Clearly, the process described above could continue indefinitely. Grounded theory doesn't have a clearly demarcated point for ending a study. Essentially, the project ends when the researcher decides to quit. Presumably at this stage you have an extremely well considered explanation for some phenomenon of interest (grounded theory). This theory can be explained in words and is usually presented with much of the contextually relevant detail collected.

7.10. Validity of Qualitative Research

It has been argued that the conventional criteria for judging the rigour or trustworthiness of qualitative research that include internal validity, external validity, reliability and objectivity are not always appropriate (Crawford, Ken, Marnie, and Arnott, 2000). Guba and Lincoln (1989), and Lincoln and Guba (1985), described these traditional facets of validity and reliability as follows:

Internal validity: the extent to which variations in an outcome or dependent variable can be attributed to controlled variation in an independent variable.

External validity: inference that the presumed causal relationship can be generalised across alternate measures of cause and effect and across different types of persons, settings and times

Reliability: consistency of a given inquiry, is generally a precondition for validity. It refers to a study's consistency, predictability, stability and/or accuracy. Reliability typically rests on replication.

Objectivity: neutrality, a demonstration that the inquiry is free of bias, values and/or prejudice

Reliability and Validity

Verification is the process of checking, confirming, making sure, and being certain. In qualitative research, verification refers to the mechanisms used during the process of research to incrementally contribute to ensuring reliability and validity. These mechanisms are woven into every step of the inquiry to construct a solid product by identifying and correcting errors before they are built into the model and before they subvert the analysis. If the principles of qualitative inquiry are followed, the analysis is self-correcting (Creswell, (1997). Guba and Lincoln (1981), stated that while all research must have 'truth value', 'applicability', 'consistency', and 'neutrality' in order to be worthwhile, the nature of knowledge within the rationalistic (quantitative) paradigm is different to the naturalistic (qualitative) paradigm. The proposed alternative criteria in the qualitative paradigm to ensure 'trustworthiness' are credibility, fittingness, auditability, and confirmability (Guba and Lincoln, 1981). These criteria were later refined to credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985).

Credibility: the credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. Since from this perspective, the purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes, the participants are the only ones who can legitimately judge the credibility of the results.

Table 7.1: Criteria for Judging Trustworthiness of Research

Traditional Criteria for Judging Quantitative Research	Alternative Criteria for Judging Qualitative Research
Internal validity	Credibility
External validity	Transferability
Reliability	Dependability
Objectivity	Confirmability

Source: (Lincoln and Guba, 1985).

Transferability: transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. From a qualitative perspective transferability is primarily the responsibility of the one doing the generalizing, but generalization is necessarily at best limited. The qualitative researcher can enhance transferability by doing a thorough job of describing the research context and the assumptions that were central to the research.
Dependability: the idea of dependability emphasizes the need for the researcher to account for the ever-changing context within which research occurs. The research is responsible for describing the changes that occur in the setting and how these changes affected the research approach of the study.
Confirmability: this refers to the degree to which the results could be confirmed or corroborated by others.

The procedure used in this research was checking and rechecking the data throughout the study. The study sought to make the findings of the research trustworthy by applying the criteria of dependability, confirmability and credibility. Transferability was not sought because of the smallness of the sample. According to Trochim (2000), after the study one can conduct a data audit that examines the data collection and analysis procedures and make judgements about the potential for bias or distortion.

CHAPTER EIGHT

Research Results: A Descriptive Account

8.1: Results of Observation

Observations included a visual assessment of the geographic layout and the level of activity at each village. Two Retirement Villages were situated within 5 – 10 minutes driving distance of a public hospital. One was within walking distance of a shopping centre, a medical centre, public transportation and a community recreation centre. Both of these Retirement Villages were situated on flat terrain. One consisted of high-rise buildings and was consequently densely populated. This village was a hive of activity. Visitors including young children were walking around or having tea with their older relatives in the cafeteria. Some older people were chatting away in semi-private areas where they had a view of the surrounding area. Others were doing structured exercise (line-dancing) to music in an area within viewing distance of the receptionist who was very busy answering telephone calls, directing people and answering queries. The atmosphere was very tranquil and friendly. I observed this during the time I waited for the receptionist to contact the person I had come to interview, to inform them of my arrival.

The third Retirement Village had a hospital, office complex and common area as a central feature around which cottage like villas were situated. I did not see anybody walking around but a few people were talking to the receptionist and some were talking to a person that I later identified as the manager. At this Retirement Village, I noticed that the terrain was very steep and units were situated on different levels that could be accessed with a chair lift between the levels. The units were sprawled over a wide geographic area and the common areas were situated in the same complex where the manager was (within walking distance from the units). I did not see any of the older people at the receptionist area but caught a glimpse of some of them as they drove into or out of the village. I did notice that a man and woman were

working in their garden and two other people were chatting to them. I saw a mini-bus with the company logo on it parked outside the office of the manager.

At the same time I observed the visible security measures that were in place. All villages had a security camera at the main door. One village had the main door situated beyond the entrance hall so that one had to report to the receptionist first, and opposite her office was the office of the manager that had a window facing the entrance hall as another means of observing anybody that entered the village. At one village a map of all the units according to unit numbers was displayed as one entered the Retirement Village complex. One could easily identify the unit one wanted to access without interacting with the administrative staff. At another village visitors were given a visitors badge to wear. The receptionist would activate the lift that was centrally placed so that anybody who wanted to go up to an apartment could be seen.

At all three villages I had been able to drive on to the premises and park my car without being challenged by anybody. This is not unusual during the daytime since Retirement Villages strive to be as homely as possible. None of the villages had a security guard visible.

8.2. Content Analysis

The content analysis, that is, the procedure for the categorisation of verbal or behavioural data is dealt with on two levels in this thesis. This chapter is a descriptive account of what was said and the next chapter is interpretive: it is concerned with what was meant by responses, what was inferred or implied. Content analysis involves coding and classifying data. The basic idea is to identify from the transcripts the extract of data that are informative in some way and to sort out the important messages hidden in the mass of each interview. The processes followed in this research are the steps described by (Hancock, 2002):

- Taking a copy of the transcript and reading through it and making a brief note in the margin of anything interesting or relevant.

- Looking through the notes in the margins and making a list of the different types of information that was found.
- From the list develop categories for each item that will describe what it is about.
- Look at the list of categories and consider if some of the categories can be linked. If so list them as major categories (themes), and sub-categories (sub-themes).
- Look through the list of themes and sub-themes to develop the 'big picture'. Sometimes, an item seems to fit into two categories. If so, list it under both (Hancock, 2002: 17-18).

This process of content analysis involved continually revisiting the data and reviewing the categorisation of data after each interview until I was sure that the themes and categories used to summarise the findings were a truthful and accurate reflection of data. Content analysis is a feature of grounded theory and ideas that emerge from the analysis of each interview are included in data collection as the researcher re-enters the field.

The structure of the interview schedule included four elements. The first element of the interview schedule involved general questions about the demographic features of the respondents. Since it was an open question some interviewees mentioned work that they or other residents of the Retirement Village did. This aspect (work) was incorporated in subsequent interviews. The second element was establishing reasons for choosing to live in a Retirement Village rather than in the general community. The third element was to determine the services that interviewees were aware of, used, and expected the government and others to provide. The fourth element was exploring efficacy of existing as well as new ways of disseminating information to older people who live in Retirement Villages.

Data triangulation was used to establish a basis to compare the demographic characteristics of the sample against the demographic features of older people in general. The different sources of data used to triangulate are:

- Data from Statistics New Zealand for the demographic features of older people in New Zealand.
- Document analysis of relevant reports of the Ministry of Social Policy.
- Interviews with five older people from two of the participating Retirement Villages, and six from the other.

Triangulation is a method used by qualitative researchers to check and establish validity in their studies (Guion, 2002: 1). Triangulation is not simply combining different types of data, but it attempts to relate the different types of information so as to leave the validity of each type of information intact (Perone and Tucker, 2002). In this instance a comparison was drawn between the age-structure of older people nationally and that of older people in the sample.

8.3: Characteristics of the Participants

Planning of any service is largely dependent on statistical analysis to establish trends

Table 8.1 Demographic Characteristics of Sample Population (Age in Years)

Marital Status	Male (Age in Years)	Female (Age in Years)
Couple	77	73
Single		72
Couple	76	75
Single	76	
Single		73
Single		84
Single	69	
Single		85
Single		85
Couple	83	79
Couple	73	70
Single	75	

in health spending or service requirements/demands. A demographic analysis gave insight into the Retirement Village population. The marital status, sex and age are

listed in Table 8.1. There were five couples and 6 individuals. The number of participants who were aged 70-74 was equal to those who were aged 75-84 and amounted to two thirds of the sample. Of the remaining one third the ratio of 65-69 compared to 85+ was approximately 1:2.

A description of the incidence and types of disabilities among older people was obtained from:

- a literature review.
- a document review of the New Zealand Disability Strategy, the Ministry of Health and the Ministry of Health and Health Funding Authority and
- interviews that were conducted with sixteen people from three participating Retirement Villages.

Disabilities mentioned by the interviewees were failing eyesight with a nil prognosis for recovery, deafness, bad back, aphasia and decreased mobility due to a Cerebral Vascular Accident (stroke), Cardiac problems (post triple by-pass) and Diabetes Mellitus (insulin dependent). A comparison was drawn between the reported incidence of disability among older people nationally and the reported incidence of disability in the sample. In the sample group the percentage that mentioned a disability was 37.5%.

Five individuals indicated that they were receiving home help and four mentioned or referred to the fact that they were receiving some form of support (financial, transport, home-help, disability allowance). Only one person mentioned that she received superannuation. None mentioned a community service or a high user card.

Five couples mentioned that they were financially independent. One couple had expressed the opinion that they did not think they were 'suitable' to participate in the study because they did not anticipate that they would ever need government support. They said they had money and that they were covered by ACC. After reiterating the purpose of the research, this couple did consent to participate and gave valuable insights into the complaints procedure and shared their experience when they sought

information from WINZ on behalf of other residents. They were very well informed about the various aspects of village life such as social events (discussed in narrative form in this chapter).

Setting up interviews had been onerous because all prospective participants seemed to lead busy lives and were difficult to get hold of. In this instance the view that many older people are subjected to social exclusion and social isolation is challenged. It seemed as if the majority of the respondents in Retirement Villages lead very busy and productive lives.

8.4: Themes used to categorize the Data

The themes used to categorise the data were developed concurrently with the content analysis. The themes are carried through to Chapter Nine and are listed below:

- Reasons for entering a Retirement Village.
- Doing formal and/or informal work
- Service provision by the government and others and
- Dissemination of information to older people

8.4.1. Reasons for Entering a Retirement Village

Methodological triangulation, that is the use of multiple qualitative and quantitative methods, was used to add rigour to the data collected for this theme. The methods used were document analysis, literature review, observation, interviews and quantifying the number of respondents for each theme. This was done in order to account for the ever-changing context in which the research occurred and to make the research results more dependable. Gluckman and Tagg (1995), cite the main reasons for people moving into Retirement Villages as being the availability of medical care and emergency help, security, lack of maintenance worries and more importantly the option of managed care. Semi-structured interviews took place and a focus group discussion was held to test the veracity of these claims.

Question: How did you come to live in a Retirement Village?

The sub-themes for reasons for entering a Retirement Village were also developed by means of content analysis of the transcriptions of the interviews, an analysis of the advertisements of Retirement Villages (Addendum1), and views expressed by Gluckman and Tagg (1995), and Kinnaird (2001), with regard to reasons for older people entering a Retirement Village. Some of the themes arose from the analysis of memos done after the interviews for example topography was mentioned as the main reason for moving into a Retirement Village after I completed an interview with a particular respondent. He said that he had left friends and family behind in another part of New Zealand because he could not cope with the steep gradient of the area where he had lived most of his life due to a disability he had.

The primary reason, mentioned by the majority of the respondents, for entering a Retirement Village was health and safety. Health and safety was equated with the response to an emergency call for medical assistance, and with the services that were provided by the Retirement Villages in terms of the administration of medication, wound dressings etcetera. Respondents from the facility that did not provide nurse coverage said that they did not have confidence in the staff (night reception) that responded in an emergency. According to the respondents night reception(s) had only been trained in first aid. They said they would feel safer if the person was skilled in cardiopulmonary resuscitation, but a nurse-on-call would be their first choice. All of this information was placed into categories and quantified (Table 8.2) and fortified with actual quotations of what respondents had said.

Social activities, no responsibility for home maintenance and the choice of a different lifestyle were rated of equal importance, followed by a concern for security. Security was seen to consist of the measures taken by village management to prevent and control fires, as well as to prevent intruders from entering. Concerns were

TABLE 8. 2: REASONS FOR ENTRY		
Categories	Sub-Categories	Number of Respondents
Health and safety	Prospect of continuity of care No rest-home hospital (a reminder of sickness and death). 24-hour emergency response Poor prognosis from Doctor Planned it for a long time	16
Social	Combat isolation and loneliness Prospect of being with peers (people of the same age/life experience) Did not want to be a burden on the family Advised by friends and family to move Choice of having company or being alone On demise of partner would have friends and be in familiar surroundings thus making grieving easier Used to entertain. Can't cope any longer	11
Home maintenance	Home too big (empty nest syndrome) Home too hard to look after Too much maintenance Garden too much to manage	11
Lifestyle	Change of lifestyle: enjoyment without burden of responsibility of a house, swimming pool, gymnasium etc. Plenty of planned activities. Free to participate or not Availability of on-site transport Availability of on-site services (user pay): meals, cleaning, medicine administration Doctor on site	11
Security (physical safety and freedom from harm)	Alarm buttons strategically placed Presence (or absence) of security cameras Security process (cards, code numbers)	10
Location/Topography	Lived locally – familiar surroundings Live near friends and family and own Doctor Location (shop, transport, local recreation facilities, public hospital) Land is flat. Unable to cope with steep hills anymore.	6
Management style	Able to participate in decisions made by management (resident's committee and monthly meeting)	3

expressed about the possibility that people may enter the Retirement Village during the day under the pretext of visiting a resident, hide until only core staff

remained during the late afternoon or night, and then harass the residents. Some residents expressed concern that the electronically controlled security gate took a long time to close when the resident, after having entered the required code, drives through the gate. They said that someone could sneak in during this time.

For some, especially those who had relatives and/or friends in the area, location was important. Location was also important in relation to accessibility of shops, medical facilities, banks, public transport and recreation facilities. Only three mentioned management style as a reason for choice of a particular Retirement Village. Some comments made by the residents are listed below for greater clarity:

- This place is very well run. I love the services they provide. The staff members are friendly.
- It has a nice atmosphere and the décor is beautiful.
- I was able to live in a trial apartment for one week. It quickly became apparent to me that this was the place for me.
- I love taking part in decision-making. A Resident committee represents us. They take our suggestions to management so we are part of the process.
- I lived overseas for many years. My husband and I decided we would come back home to New Zealand to retire. Unfortunately he died. A friend knew I wanted a small two bed-roomed unit with a small garden. She suggested that I come and live here in this village. She and the sales manager of the village sent me information. I was just required to transfer a deposit of $1000, refundable on arrival in New Zealand if I did not like the unit. I love it here.
- I found myself walking to the shops just to say hello to someone. I was that lonely. I knew it was time to move on, so I sold my house.
- The flat terrain suits me. I moved here because of my bad back. The terrain back home had too many steep hills.
- I wanted to live in a place that has all the amenities (serviced apartment, rest home and hospital), so that this could be our last move. If anything happens to me, then my wife would have made friends here and we both think she will be better able to cope.

- My mother lived till she was 98 years. I saw the transition from a young mother to a person with a little infirmity until she became a danger to herself. Her eyesight was failing so she would put her hand into the gas stove to feel if the flame was lit. I know ageing is inevitable. I started preparing for my retirement since the age of 20 years.

8.4.2: Theme: Formal and/or informal work

Contrary to the belief that retirement age is synonymous with not working, some people who are past the official retirement age continue to work because they want to and still make a valuable contribution to society. Section 22 of the Human Rights Act 1993 stipulates that it is unlawful to discriminate against anyone on the grounds of age. This stipulation is also valid in the workplace.

Question: Tell me about any work related activities that you do.

When I posed the question to the first two respondents, their response was that they did not work. We then had a discussion about what could be perceived to be work. We decided that there was a difference between paid work and unpaid work, and that formal work could be paid or unpaid (structured voluntary work). Thereafter when I posed the question to other respondents, I also gave the working definition of what work was. None of the respondents were in full-time or part-time employment and none of the respondents received any remuneration for the work they did. One respondent commented that living in a Retirement Village was an ideal lifestyle for the young-old (55+) who wanted to continue to work, but did not want to be burdened with housework and cooking when they came home from work.

The work that they reported they were doing was divided into sub-themes (categories) and is listed in Table 8.3. The themes were: work done in their own home or for leisure (hobbies), work done for residents in the village and work done in the community. All respondents did their own housework. Three of the males indicated that they did their share of the work. Five participants received subsidised home help. They said it was for one day a week. The home-aid did vacuuming and

Table 8.3. Work Status Of Participants

Unpaid Work	Type of Work and Number of Respondents
Home or leisure	Housework (11) Gardening (6) Crafts: knitting, sewing, baking, woodwork (3)
Voluntary work in the community	Fetch older people in the community, transport them to a venue (in the community), entertain them for the day, raise funds for them, provide counselling and advice (3)
Work done in the village and/or for residents	Hostess for village show-house (1) Collect and distribute mail for friends (3) Take people for walks (3) Alive and well calls to residents in the mornings (4) Care for disabled husband/wife (4) Drive village transport for social functions (2) Drive people to hospital/ or Doctor (4) Co-ordinating garden group for allotted portion of village garden (1)

cleaned hard-to-get-at places. One respondent said that she was also taken to do her shopping. Another respondent said she did not need assistance with shopping *yet* but knew that she would soon, due to her failing eyesight.

Informal Work

Thirteen respondents were engaged in informal work in the village. The activities they were engaged in were multi-varied. Some informal activities were done for the residents and other activities were related to the management of the particular Retirement Village: driving residents for social outings and medical appointments, as well as escorting prospective residents to the show-unit etc. One of the respondents mentioned the name of a person who took her to the doctor or to hospital when she needed. It was the name of a man I had interviewed in that particular Retirement Village and he had mentioned that he provided transport for

people who needed to go to the doctor or to the hospital. I did not make her aware that I knew whom she was talking about but it did confirm the facts.

Some informal activities were:

Managing a rose garden.

A respondent said that when he first came to live in the village management had asked if he would be interested in assisting with managing a portion of the garden. He declined. He had a huge garden before and did not want the responsibility again. Since then he gradually grew into it. He said: 'I have a rose garden now. I involve the villagers in it. Some donate money. A rose will be tagged with the name of the person that donated the plant. They have a sense of ownership and go into the garden to watch over *their* rose. Some residents contribute to the purchasing of fertilizer and spray. The lady next door has a broken kneecap. She owns a rose. I take her out into the garden every day so that she can look at her rose'. Relatives and other visitors to the Retirement Village were encouraged to buy some of the roses and the money accrued was used to purchase gardening implements and fertiliser. The respondent had also published an article in the village newsletter giving an account of the progress of the rose garden project.

Assisting other residents:

A male respondent at each of two villages said: 'I volunteered my services to drive residents in the village bus when excursions have been pre-arranged'. One of the two drivers also said: 'I transport people who ask me to take them to the doctor, hospital or clinic when they need to go'. Two females said that they transported people to the doctor. One respondent said that she taught crafts and that she also baked cookies and sold them. She said; 'I let them take the finished product (crafts) to their unit for a while so that they can have a sense of accomplishment. We have a mini-market then we sell all our wares. The money we make is donated to charitable organizations'. Another respondent said 'I help in the kitchen, do shopping, and clean peoples' refrigerators. Only if they ask, of course'. The interesting thing about

this is of course the extent to which the activities of these people are becoming incorporated into the collective life of the village. This must be seen as a positive thing.

Since some of the interviewees had mentioned health and disability issues, the interview schedule was adapted to include the use and knowledge of support services during those and subsequent interviews.

8.4.3: Theme: Identification of Support Services

Question: What do you know about service provision for people who live in this Retirement Village?

Comments that respondents made about the use of current services were:

I don't make use of village services but it's comforting to know it is available. One can have meals sent up if you are house bound through illness. It is all user pay of course.

I use own my own GP. I can drive to my own doctor that I have been going to for years, and he knows my condition. If there is an emergency, I will make use of the local 24-hour emergency service in the community. The role of the doctor has changed. It is not like it used to be in the old days. I think in a few years (when we are frail) we will need to be seen by a doctor more frequently. Getting to the chemist (pharmacy) will also be a problem. At the moment we have a health check by our own doctor every 3 months.

24-Hour Emergency service: In this place you are supposed to be capable of independent living. There are call buttons in each unit for example in the bathroom, bedroom and lounge. If you ring it in an emergency the person on duty will summon an ambulance if necessary. I would like to have someone qualified in first aid and CPR (cardio-pulmonary resuscitation) preferably a nurse to respond to an emergency before calling the ambulance. The government should look at defining 24-hour care and include it in the law. There is some discussion going on in Parliament at the moment (he was referring to the Retirement Village Bill, 2001 that had its second

reading in October 2001). We are the government. People are not too aware that *we* are the government.

Table 8.4. Current services used[9]

Current services used	W1[10]	W2	W3	W4	W5	P1	P2	P3	P4	P5	P6	G1	G2	G3	G4	G5
Hairdresser Village	1							1			1					1
Hairdresser community		1														
Recreation village		1		1	1	1	1	1		1	1	1	1	1	1	1
Recreation Community				1	1											
Shopping-friend/family						1										
Transport- village				1	1	1	1		1	1	1					
Transport- villager										1						
Transport own	1	1		1	1							1	1	1	1	
Transport family											1					1
Doctor- Resident									1	1	1					1
Doctor Private	1	1		1	1	1	1	1				1	1	1	1	
Village restaurant									1							1
Member of St Johns	1	1								1	1	1	1			
Home-help (subsidised)			1			1	1		1	1						
***Help with shopping* (subsidised)**						1	1									
Transport (subsidised hospital taxi)									1							
Living Alone Allowance									1	1	1					
Hearing Aid Batteries										1						
Colostomy bags										1						
Podiatrist								1							1	1
Telephone allowance														1		
Petrol voucher														1		
Disability allowance							1							1		

Home help: I have home help once a week through income support. Doctor notifies them, then they send someone to interview you. It doesn't cost anything. He suggested it because I have arthritis in my back and neck. She can also take me shopping.

Medical Insurance: I have considered giving it up because it is so expensive. My children encourage me to keep it up while I can afford it. As soon as you stop, that is

[9] Services typed in bold were all subsidized
[10] Each village had an alphabetical code

when you will need it the most. I pay $2080 per year just for me. I pay it because I do not want to go on a hospital waiting list.

Additional Services: Some respondents said: 'We can get additional services if we want but it all cost extra money.' These additional services that they mentioned are listed in table 8.5. and followed by verbatim quotations. Some interviewees said that they had no health problems. In some instances they continued to make use of the services in the community that they had before entering the Retirement Village Complex. The interview schedule was further adapted to establish whether these respondents were aware of services that can be accessed.

Question: Besides the services that you are using, are you aware of any other services that one can make use of either in times of crisis, or if one becomes disabled due to the ageing process?

All respondents knew about St John's ambulance and six of them were paid members. Others mentioned Meals on Wheels although none of them said that they made use of this service. Generally the respondents could not apply the question to their own situation. They said: 'We have never thought about it because we have never needed any services.' When I asked whether they knew of anybody in the village or in the community that made use of support services, they responded with enthusiasm. The comments they made were:

Hospital taxi service: They pick you up at the doorstep and take you to hospital. Even to North Shore Hospital. When you want to come back you phone. They bring you back right to your doorstep. The rate is very cheap.

Work and Income New Zealand (WINZ): One respondent said: 'If you do not ask the right questions at WINZ you don't get information. I went to WINZ to ask about the living alone allowance. I don't need it but I do a lot of voluntary work driving the people in this village. WINZ would not give me the information, they said I could not ask on somebody's behalf. I asked management to enquire and they waited a long time for the response. When they got the information they published it in the village newsletter.' At a subsequent meeting when I asked a widowed respondent

whether she had heard about the Living Alone Allowance she said that she had read about it in the village newsletter and had since applied for and received this allowance.

Another respondent said: ' I think WINZ is wonderful. I have come from another part of the country. I receive the same high standard of service here, as I did there.' One other respondent said: ' In a place like this we have a mix of people. We inform one another (she was referring to a resident who had informed them that WINZ no longer subsidised hearing aids)'. She had not thought of trying to find out from WINZ whether this allegation was true and if it was true, what the basis for the decision had been.

A respondent said: 'The government departments (WINZ) do not let you know about benefits. I have several chronic medical conditions that require that I have to go to hospital three times per month. It is a 25-kilometer drive and is quite costly. The doctor told me I should keep the room warm because I have asthma, he also said I needed to have a telephone in my room. After a few years I spoke to somebody else (who is on the benefit). He told me that I should get a disability allowance, a heating allowance and petrol voucher. It was only when I confronted the GP with this information that he acknowledged that I did qualify for these benefits. We were really feeling the pinch for the past two to three years since my health had deteriorated. The allowance I now get does make a difference'.

Alarm Pendant: 'I know a visually impaired lady who had an alarm pendant before she moved in here. She gave it up because she believed she would not need it in here because there are a call buttons in her apartment. She now realises that she does need one. She can't see very well so in an emergency she might not be able to get to the call button'. She expressed the opinion that she felt it was the duty of the Retirement Village management to provide alarm pendants to those people who were physically impaired since they could have some difficulty in accessing the alarm button in an emergency such as a fall.

Hearing Aids: One respondent said: 'A single hearing aid costs $1500. I paid for mine. I think I got it cheaper (subsidy). I get a bit extra for the hearing aid batteries.'

Another respondent said: 'I have a hearing problem. I needed hearing aids that cost $3000. I could afford it because it was covered by ACC. Some here have to use their life savings to pay for the device. Others cannot afford it. It is not fair. If they can't hear they miss out on participation, then they isolate themselves and this leads to degeneration. The government should subsidize it for people who are not covered by ACC'.

Elective Surgery by means of the community services card: A respondent who had had a removal of a cataract said: 'The government can assist, but there is a long hospital waiting list especially for eyes. The government will only do *one eye* even after being on that waiting list for so long. They say you can see a certain amount: Now you can wait for the other. They *say* you can see, and that is true, but you feel so unbalanced.'

Rights of older people to lodge a complaint: This respondent was explaining the process that they could adopt if they had a complaint that was not resolved by the Resident committee or by the management of the Retirement Village. He said: 'The Retirement Village Association (RVA) is set up to control standards in Retirement Villages (that are members). I believe that people that have a financial interest in these places set up the RVA. It's set up in such a way to suit *their* financial budgets if you like, rather than be told by the Government that brings in standards. O.K. Mr RVA, you do it like this. I'd like to see outside interference by the state. The state is really *us*. We should be telling these people: This is what *we* want, and we will pay for it'.

He also said: 'When we have a complaint we go to the Resident Committee. If they cannot deal with it, we go to Management, if they don't want to deal with it, then you can go to the Statutory Supervisor and you will get redress. It is like having an ombudsman. It works very well'. This respondent had previously served on the resident committee.

A respondent said: 'Women of my generation are the products of marriages where the man was the head of the house. Husbands were domineering. Now the women won't assert themselves. I saw on the television programme 'Fair Go' about a lady

who lived in a Retirement Village who had a real problem about selling her unit. They (management) sell it for you. You can't. She did not get her money. I am not sure of the details.... I think government should set standards otherwise people will continue to get away with a lot. People do not read the finer print of the contract. When you are buying, you do not think about selling. I am not sure how we can get this information to the government. Do we have a Senior Citizen representative in government?'

In response to those respondents who saw themselves as being healthy, a question was developed to establish whether they were aware that physical changes are an inevitable part of ageing and whether they were conscious of a need to plan for this possible event.

Question: In the light of the physical and other changes that occurs inevitably as a result of the ageing process, what services do you think you may need 5 years from now. Who do you think should provide such services?

One respondent felt quite strongly that people should take more responsibility for their own health and well-being. He said: 'The government has enough on its plate. I don't think one can expect anything more from them. There should be a redistribution of services rather than formation of new services.'

Eight of the respondents said that they had not given the matter thought and could not think of any services they might need. Each one said: 'I feel very healthy. I can still help myself.' Some expressed that they *knew* they would need some services because of the deterioration of existing medical conditions. Seven of the respondents said that they knew they could purchase the services that they would need from the village. Others referred to the fact that they expected a natural progression from their units to serviced apartments, then to a rest home, then to a hospital. In this regard one respondent said: 'I wanted to live in a place that has all the amenities (serviced apartment, rest home and hospital), so that this could be our last move. If anything happens to me, then my wife would have made friends here and cope better'.

Another respondent who lived in a Retirement Village that did not provide a continuum of care said: 'I came here to *live*. I don't want to think about or be reminded about death. I think when people get to the point of needing extra assistance they should move out to a place where they cater for such people'. This respondent was aged 80+.

Some respondents made these tentative predictions about their future needs (Table 8.5).

Table 8.5: Projected service needs 5-10 years.

Category	Description	Suggested service providers
Accommodation	Serviced Apartment (8) Rest-home (7) Hospital (1)	Retirement Village (RV), Government subsidies
Health	Some nursing care (5) Delivery of meals (7) More frequent GP visits (6) Using the GP who provided a service at the Retirement Village (5) Physiotherapy (2)	RV: (user pay), Government (subsidies or welfare benefits), Private sector (NGOs): user pay and/or subsidies
Transport: unable to drive anymore	Visits to the GP or Public/ private Hospital (6) Shopping (6)	Government (Taxi vouchers), RV, St Johns Ambulance, relatives or volunteers
Activities of daily living	Shower assistance (5) Getting out of and to bed (5) Dressing (5)	RV: (user pay), Government, Private sector (NGOs)
District Nurse	Colostomy care (1) Wound Dressings (1) Palliative care (1)	Government

None of the respondents had thought about their needs ten years from now. They said: 'I don't think I will be alive by then', or 'I don't really know' or 'I'd rather not think about it.'

From the concurrent analysis of the interviews it became progressively clear that older people did not have sufficient access to information about service provision by the government and other agencies thus a question was asked to explore the methods

of communication that the respondents thought would be an effective means of information dissemination.

8.4.4: Theme: Dissemination of information

Question: What methods of communication do you think might be used by government and others to provide you with information about available services, or changes to service provision, that may occur?

The response was that a pamphlet should be mailed to each resident. The assumption was that the government had the money to do so. Since the interviews took place after the budgets for 2002-2003 had recently been released I wanted them to explore alternative means of communication. Therefore I rephrased the question in keeping with the interview guide approach, which allows the interviewer to adapt the sequencing and wording of questions to each particular interview. I asked all subsequent respondents the following question:

In the light of the past elections and the fact that we know that the health and social welfare budget has been decided, what alternate means of communication do you think may be effective?

The responses were classified and are listed in Table 8.6. All the respondents said

Table 8.6. Dissemination of Information

Source	Method
Internal *(inside the village)*	• Notice board • Reception Desk • Village Newsletter • Pamphlets printed by the village • Residents Information Book
External (outside the village)	• Grey Power • Pamphlets • Age Concern New Zealand • Community News paper • Citizens Advice Office • Field Officer (Nurse or Community Worker)

that the reception desk is a place where pamphlets are displayed and where questions can be asked. It was felt that this would be a cost-effective means of communication and new information could be obtained easily as the receptionist is usually a person able to answer queries. A summary of the responses was made and tabulated in preparation for the focus group discussion.

8.5. The Focus Group Discussion

The following events unfold in the dynamics of a focus group:

- There is a sequence to a focus group discussion that can help explain the different kinds of talk at the beginning (forming and storming), the middle (performing) and the end (mourning).
- The comments of participants can be self-contradictory. Sometimes they point out the contradictions themselves and sometimes others point it out.
- Participants change their views and opinions in the course of the discussion once they have had an opportunity to hear and reflect on the opinion of others.
- Participants expand later on experiences recounted earlier adding new information and sometimes putting this experience in the context of another participant's experience (Catterall and Maclaran, 1997).

In order to maximise participation by everybody they divided themselves into two groups of four. The two males did not join the same group. After introducing a theme I did not participate in the discussion. One interviewee, who later stated that she had been in charge of teaching crafts in the village where she resided and also was in charge of the shop where the finished products were sold, initiated and led the discussions in the one group. In this group there was one lady who sat quietly at first, but her body language (leaning forward, eyes moving from one speaker to another) said she was following every word. The leader asked her a question directly and when her response elicited a lively discussion, she relaxed and joined in all further discussions.

In the other group the male participant used his own experience (he was physically disabled) as a point of departure for discussions. Two of the ladies in the group were inclined to talk softly to each other (they knew each other and it seemed as if they were seeking approval from each other) before they responded. We discussed one theme at a time.

The focus group was presented with information I had obtained from the individual interviews and that I had summarised in several tables. They were told that they could discuss it, comment on it, indicate what they disagreed/agreed with, and they could add to or take away from the lists. Each sub-group gave feedback (the self-elected leaders did this). Everybody was given the opportunity to add further comments (I asked each person individually whether they had further comments). Some participants added new information to what had already been given and this elicited further discussion on that particular aspect. For example one person mentioned that she felt that assistance was needed with dealing with the bank and with election matters (choosing political leaders). Some of the topics such as the difficulty some older people experience with automated telephonic responses were tackled with great relish and obvious enjoyment (judging from the chuckles as well as the pace of the discussion).

They affirmed the information given by the individual participants and modified or added to it. The additional information they gave was classified into the same themes as had been used for the individual interviews. They were very concerned when talking about issues relating to banking, voting and trying to access information from service providers some of whom had automated responses.

8.5.1: Theme: Reasons for Entry

Some of the comments that were made are that:

- They did not want to be a burden on their families who had a right to their *own* lives.

- Decreased ability to move was a strong motivator for entering a Retirement Village. Many activities are arranged by the respective villages that gives one the opportunity to socialise if one wanted to.
- If one remains at home, one is often isolated from the community and one is inclined not to make an effort about your appearance or going out so you deteriorate quickly.
- One participant said she and another resident knocked on each other's walls in times of need. They said they enjoyed the sense of fellowship. In the community one often did not know your neighbours therefore did not feel free to approach them in times of need.
- The support one received from fellow residents was tremendous in times of ill-health. People would cook, clean and do whatever was needed during this period. Some would even take you to the doctor or hospital.
- One respondent said that her mother had been living in the same Retirement Village, where she was now living, for a long time. She used to visit and care for her mother there. When her mother became frail and moved on to the hospital, she decided to move into the Retirement Village to be nearer to her mother. She was 67 at the time and her mother 80+.
- Some of the respondents said that living in a village simplifies life. They said: 'You don't have responsibilities'.

8.5.2: Theme: Work Status of Participants

One participant said that she was grateful that she received a 'free' pension. Nobody verbally commented on the 'free pension' but some nodded their heads possibly signifying agreement. The respondent said that she did voluntary work in the Retirement Village and in the community because she had time on her hands, was relatively fit and wanted to give something back to the community for the 'free pension' she was receiving. Her comments generated a lively discussion with most of them saying that they did some form of voluntary work, mostly unstructured. For example fetching a resident's mail or transporting somebody that was in need. One had a hobby shop in the village and facilitated a hobby group. All the money accrued from this venture was pooled back into purchasing materials that the older people

could use in their activity programme. Nobody worked formally but they stated that a village was ideal for an older person who wanted to work. They said; 'You can come home from work, kick off your shoes, go the restaurant for a meal and get people (on a user-pay- basis) to clean the unit and do washing. You don't have to be stressed.'

8.5.3: Theme: Current Services Used

One respondent said; 'If one has a chronic condition or if an acute condition warrants attending a specialist at a hospital, one can obtain a card (from the hospital) that you display on your car. This will exempt you from paying a parking fee'.

Another said: 'I feel the people of the establishment (management) rely too much on St Johns Ambulance to give the immediate response. In the old days you could phone the GP. There is nothing wrong with St Johns of course. St Johns Ambulance charges an annual fee for membership. One can then make voluntary donations on an annual basis'. One respondent said that she was taken to hospital three times in one month.' If you are a non-member, you pay $65 per trip. If you are a member, you pay nothing',

8.5.4: Theme: Knowledge of services

Nothing new was added to the information on the list even though they did discuss and confirm that they knew about the services that the individual participants had identified.

8.5.5: Theme: Projected Service Need 5-10 years

The following comments were expressed:

- In order to remain independent your meals should be delivered, on a short-term basis when ill or recovering from an illness.
- If one has a mobility problem, you need to have at least one meal delivered on a daily basis. One cannot afford to pay for delivery and cost of all meals if you are on the benefit.

- One respondent said that she knew of some residents in her village that lived mostly on bread when they were faced by financial hardship due to unexpected expenses.
- One said: 'I think that one will need mobility aids progressively. First a walking stick, then a walker, and then a wheelchair. If one has a back problem you will probably need a raised toilet seat and a bar that you can hold on to in the shower and toilet'.
- 'Some pharmacies provide an after hour service delivery. This is important because one tends to get ill at night'.

8.5.6: Theme: Dissemination of Information

They agreed with everything the individual interviewees had said but did not want to dwell on that. One respondent said that automated telephonic responses were very confusing. This sparked off a lively discussion. They said they were not able to keep up with: 'If you want.... press one, if you want....press two etc'. They had no suggestions on an alternate solution. They also felt that a field officer person was needed to assist with filling in tax papers, and with regard to investment advice and banking. They said they knew that some banks granted exemption from interest, but they did not know which banks or the detail of it. There was some discussion about who the field officer (community liaison person) could be. They did not come up with any new ideas other than that a district nurse could fulfil this role and that her availability at a village once a month would suffice.

CHAPTER NINE

ANALYSIS OF THE RESULTS

Hypotheses about the relationship between various ideas of categories were tested out and constructs leading to new concepts of understandings were formed. The hypothesis that has been adopted is that there is a difference between the availability of government-funded services, and the knowledge and use of such services, by people who live independently in Retirement Villages. Another hypothesis was that there is a link between the expectations that older people have of service provision by Retirement Villages and the level and range of care the Retirement Village they live in offer.

9.1: Demographic Aspects

A comparison was drawn between the demographic features of people who are aged 65+ years in the general population as at March 2002 in New Zealand and the population in the sample from the Retirement Villages in Table 9.1.

Table 9.1 Age Distribution of People aged 65+, March 2002

% 65+ Population in New Zealand				% 65+ Population in Sample		
Age	Male	Female	Total	Male	Female	Total
65-74	59	50	54	12.50	25.00	37.5
75-84	33	36	35	25.00	18.75	43.75
85+	8	14	11	6.25	12.50	18.75

According to the results, the population in the sample group of people 65+ that live in Retirement Villages have a higher concentration of people aged 75- 84 (43.75%) compared to 35% in the general population of the same age group. The results showed that less people in the group aged 65-74 lived in Retirement Villages when compared to the general population of the same age group. The people in the group

aged 85+ follow the same trend: 11% in the general population compared to 18.75%. This could be linked to reasons for entering the Retirement Villages as the majority of the respondents had said that the primary reason for entering a Retirement Village was related to health[11] and safety issues (further discussed under 9.3).

From the statistics of the sample group it would appear as if more women than men tend to enter life in a Retirement Village at a younger age (65-74). It would also seem as if there are more men than women who enter Retirement Village at the age of 75-84 years. If this trend continues, it will bear out the prediction made in the Social Report, 2001 that informs us that the gender imbalance will decrease as male life expectancy rises at a faster rate (discussed in Chapter One). In the general population of older people aged 85+ there was 14% of women compared to 8% of men whereas the number of women aged 85+ in the three Retirement Villages were double the amount of men. The implication of the projected increase in the proportion of 85+ in the general population, but more so in the Retirement Villages, is that there will be a greater demand for home help and other support services.

The percentage of disabled older people living in Retirement Villages is higher than that of the general population. The high incidence of reported disabilities in the sample group may be skewed because the sample might not be representative of the health status of all the residents in a Retirement Village, but it is reflective of the rising incidence of disabilities in the old-old group of the general population. Six of the sample mentioned various disabilities. Only two mentioned that they received a disability allowance. Five indicated that they were receiving home help as a result of the disabilities and four referred to the fact that they were receiving some form of support.

An analysis of Table 8.4 (current services used) shows that the greater demand/use of the need for support services is evidenced by the fact that at village 'P' five residents used village transport, four received subsidised home-help, half of the respondents received a living alone allowance as well as subsidised devices or equipment such as a hearing aid. Although this result is significant, it is not

[11] Older age is associated with an increased incidence of disabling or chronic disease conditions.

generalisable to all older people who live in Retirement Villages due to the small size of the sample (sixteen). In village 'G' for instance, four owned their own cars and used a private GP or other forms of formal care provision. Only one resident received some form of Government support (disability allowance, telephone allowance and petrol vouchers).

One retired person (aged 65) in the focus group had entered the same Retirement Village where her 87-year-old mother was living. When she moved into the Retirement Village her mother had been assessed at SNL 5 (a very high level of physical dependency) and had been admitted to the hospital that was part of the Retirement Village complex. She could not provide the necessary caring support for her mother due to her own ill-health, but wanted to be near her. This confirms that there is an emergence of two generations of older people. This phenomenon changes the ratio of older people to potential carers outside the labour force. In the past, middle-aged adult daughters have provided care on an unpaid basis.

All the respondents owned their own units. All the couples and one individual respondent mentioned that they had made provision for their retirement. A couple mentioned the fact that they were insured and was not reliant on support from the state. Two couples mentioned that they had enough money to get by but experienced hardship when faced with an emergency (medical or otherwise). The attitude of those people who had planned for retirement and had some money was that they did not think they would be in need of government assistance. One single respondent referred to the fact that she did not require state support since she had an adequate private income.

A respondent in the focus group said that she knew that some people (in the Retirement Villages that she resided) lived mainly on bread when they were faced with an emergency that caused an unexpected expenditure. She said they were welfare beneficiaries. She did not mention whether the person had approached WINZ for assistance. Interestingly only one person had mentioned that she received superannuation and that she felt obliged to give something back to the community. The majority of the respondents did not mention superannuation. This is in line with literature that stated that people have come to regard superannuation as a *right.*

9.2: Formal and/or Informal work

Couples tended to be more active in doing voluntary work in the community than individuals who were inclined to do voluntary work in the village by providing services for people whom they considered friends. The majority of residents implied that they would not expect to be rewarded for their 'work', nor would they think in terms of quantifying their contribution in monetary terms. As one respondent had put so succinctly: she received a non-contributory pension from the state, had time on her hands, and wanted to put back something into society. None of the respondents were engaged in formal (paid) work although at one Retirement Village a respondent mentioned that they knew of one resident who had a full time, paid job. Thirteen of the respondents were engaged in informal work in the village or in the community.

This activity (informal work) was mentioned most frequently at the Retirement Village where the respondents had stated: 'We are supposed to be independent'. Some of the informal work at that Retirement Village included some aspects of care-provision: alive and well calls, taking people for walks, caring for a disabled partner, driving people to the hospital or to the doctor, as well as supervising the medication of some residents. If a monetary value could be put to the care that residents in Retirement Villages provide to their spouses and to others, it would quantify the contribution that they are making to society in keeping the cost of health care services down.

9.3.Reasons for entering a Retirement Village

The analysis of reasons for entering a Retirement Village is based on Table 8.2. Old age is associated with an increase in the prevalence of chronic disease and disabilities. It is not surprising that the primary reason for entering a Retirement Village was health (physical dependency due to chronic disease and disability) and safety (freedom from harmful actions of intruders).

There is an anomaly in the reasons relating to health and safety, since fourteen residents (more than 80% of the sample) indicated that they embarked on 'village life' because of the prospect of continuity of care. One person indicated that she had an aversion to living close to people who were physically or mentally incapacitated as they were considered to be a constant reminder of impending disability and death.

Nobody said that they expected or wanted family members or friends to provide 'care' to enable them to continue to live independently if, or when they were ill or disabled. There was a general consensus (some verbalised this opinion, others nodded their heads and nobody disagreed) that they did not want to be a burden to relatives 'since they had a right to their own lives'. There was awareness that they are '*supposed to be independent*'. This is an indication that the decision by the Government to implement the Positive Ageing strategy to support people to continue to live independently in their own home environment was timely. Successful implementation of the strategy may be influenced by whether people are aware of the available services and how to access it.

Location, according to the results, is of considerable importance when older people choose a Retirement Village to live in. Being close to their family was also mentioned as an important consideration. It enables family members who live in close proximity to visit without too much inconvenience, and in one instance a respondent said her niece could take her to hospital in an emergency or for hospital appointments. It also empowered some of the respondents to provide support for their family (after-school care for grand-children), as well as moral support to their children. Older people are thus not only recipients of care-provision; they also are an invaluable source of support for their relatives and other people in the community.

The lifestyle, which included the social aspect (recreation, being with other people from their own generation and the knowledge that a surviving partner would be in familiar surroundings and have peer group support), minimal responsibility (home maintenance, gardening), was the second most popular reason(s) for entering a Retirement Village.

The potential for combating social isolation or social exclusion using a collaborative project is very well illustrated by the account one respondent gave of how the village manager had encouraged him to assume responsibility for a rose garden. He involved the residents committee, the residents (including those who were disabled) as well as members of the community. The village manager was the motivator. The resident (who had formerly been a member of the resident committee, and had owned a large garden himself) organised and planned the 'rose garden project'.

The plan had been implemented by asking for volunteers from the village to either:

- fund a rose that would then be labelled with the name of the donor;
- contribute financially toward the purchase of fertiliser;
- share the responsibility of caring for the rose garden including the pruning of the roses;
- cut and sell some of the roses when in season (money made from the sales was ploughed back into the garden) and
- take 'the owners of the roses' and others who could not walk the distance by themselves, to enjoy looking at the garden and monitor its progress.

These options enabled a whole range of people including disabled people to participate in the implementation of the project. The resident who co-ordinated the project, periodically published a report in the village newsletter giving an account of money received, how it was spent and the progress made in the garden. He also used the newsletter as a medium to request funding or assistance as well as to advertise the sale of roses or rose cuttings. Visitors could also purchase roses if they wanted to. This project facilitated the socialisation of many of the residents who would otherwise have been lonely and in a sense existed from day to day without being an active part of village life. This idea of having a collaborative project is replicable and the results could be measured by doing a pre/ post-project survey of the social effect (if any) that the project had on people who lived in that Retirement Village.

Other projects such as arts and crafts were used to raise funds to make donations to community organisations, thus keeping those participating in the projects interested in and a valued part of the village community as well as the community at large.

9.4: Advertising and Expectations of Villagers

The analysis of the expectation of people who live in Retirement Villages in relation to the services that are advertised is based on Addendum One and Table 8.4

9.4.1: Security

The respondents associated safety with health issues such as a prompt response to an emergency call, and associated security with measures that village management had taken to minimize fire hazards and potential threats to their physical and material well being. Although ten of the sixteen respondents mentioned different aspects of security that would deter intruders, the levels of security that was provided differed at each Retirement Village, as did the expectations of what should be provided. Some respondents expressed concern that if a security code activated a safety gate, it took a long time to shut and they feared that people could gain entry with the intention of harming the residents. The respondents from the villages that advertised that they provided security, but did not expand on what that security was, had a lower expectation of what constituted security than Retirement Village(s) that specified the extent of the security. One respondent had commented on the fact that they (Village Management) said that there were security cameras, but she saw no visible evidence of it. None of the respondents stated that they wanted increased security measure. Generally the respondents expressed the opinion that they felt safer living in a Retirement Village than they would have if they continued to live on their own, in the community.

9.4.2: Service Provision

The analysis of the projected service needs is based on Table 8.5 as well as verbatim quotations.

9.4.2.1: Expectations of Service Provision in the Retirement Village

All respondents were aware of the services that could be obtained from the village they resided in. Some were aware of 'additional services' but were not sure whether it was included in the weekly service fee that they paid. The focus group was of the opinion that if a resident suffered a short-term illness, the village should deliver at least one meal to their unit, preferably the main meal. The felt that this service should be a part of the contractual agreement.

One respondent showed me the handbook she had obtained when she purchased the unit, which outlined various aspects of living in the Retirement Village, including the services that were available. This respondent was well acquainted with all the content of this book. She had purchased her unit while living in another country and had perused information she had obtained from her friend who lived in New Zealand about several Retirement Villages before making her final choice.

All respondents mentioned the fact that they had call buttons in their units. The response to an emergency was different in each village. One had a 24-hour receptionist who would summon an ambulance in an emergency. The respondents said the receptionist did not come to the unit to assess their condition before summoning an ambulance. The other Retirement Villages that provided different levels of nursing care had a nurse on call for 24 hours. The Retirement Village that had a hospital had a nurse on duty for 24 hours each day.

At the Retirement Villages where a nurse was on call, the respondents stated that they felt secure in the knowledge that they *could* call the nurse if they needed assistance. In some instances where there is a Retirement Village and Rest home but no hospital, the nurse on call is not on the premises and would have to travel from

her home in response to a call-out. None of the respondents had tested the availability of the nurse-on-call (in relation to her own case-load) and what the time-lapse would be for a response.

Three respondents at a particular Retirement Village referred to an experience that a resident had of waiting for eight hours for a response when she pressed the emergency button. They said they felt insecure as a result of this incident. One respondent said 'the government should look at defining what is 24 hour care and make it law.' Arguably the eight hour wait was an isolated incidence (so the respondent said) in that particular village, but it is an occurrence that can happen in situations where 24-hour care depends on one nurse who when faced with a high case load of frail disabled people, is not able to 'drop things' and respond to an emergency call as soon as might be required.

The focus group expressed the opinion that the Retirement Village should supply an alarm pendant, to those people who have a physical disability that might hinder them from accessing an alarm button in an emergency, at the time when the unit is purchased. They said it should be a part of the contractual agreement.

Some of the respondents expressed the wish to be transferred to a care facility in the Retirement Village where they lived, if their condition deteriorated due to age or ill-health. Most of them were not sure whether provision was made for this eventuality in their contract. They had not considered the possibility that the Retirement Village might not have vacancies in the care facility at the time they needed care. They were also not sure what the financial implications would be if they needed to be transferred to the village hospital for a short period.

Most of the respondents mentioned village services on a 'user-pay' basis. Those who had their own transport (50%), made use of the services in the community and occasionally used the village restaurant. All participated in the recreational activities. Some did so occasionally, other did so on a regular basis and had their calendars marked with impending events. The provision of informal care provision for each other seemed to have been a natural occurrence between friends and neighbours in

the Retirement Village. Informal care provision by relatives was mainly in the form of transport and socialisation.

One respondent referred to the fact that in her opinion most women of her generation feel disempowered to challenge authority since they had been socialised into not challenging males. She stated that that they were not assertive enough to challenge decisions made by anybody in authority. During the focus group discussion there was agreement that *their* generation had honoured the man as being the head of the house and therefore were inclined not to challenge his authority, but that times had changed and that women of later generations are now much more assertive.

All respondents mentioned the fact that the village had a resident's committee. The respondents said that the role of the Resident Committee had variations but there did not seem to be a defined role. Some of the functions that the respondents referred to were:

- informing their constituency[12] of any emergencies or disaster and assisting with evacuation procedures;
- driving the villagers to social functions or for shopping, using the village transport;
- checking on their constituents 'alive and well' calls every day;
- investigating complaints and if they could not solve the problem, referring the matter to management, and;
- in the case where the resident was dissatisfied with the response from management, the committee member can represent or accompany the complainant if a tribunal was held (statutory supervisor, plus the manager, plus the complainant and a representative that could a the committee member, a lawyer or any person that the complainant so chooses).

[12] Groups of four to five units constituted a constituency. A leader was appointed for each constituency and this person was also the fire warden and guardian of that group

9.4.2.2: Expectations of Service Provision by Providers in the Community

The level of knowledge of services in the community varied. Respondents who had not needed any services because they had not been ill for some time did not mention services spontaneously, but when prompted, had some idea of wellness services such as St Johns and Meals-on-wheels which they said was advertised in the community newspaper. The prevailing attitude was that they did not need additional services, were healthy and had not given the matter of needing care provision in the future much thought. There was a reluctance to talk about the possibility that they might need services later on, in order to help them maintain independence. McClure (1998), refers to Victorian principles of 'self-help' that caused people not to seek assistance even when they were living in relative poverty because at the time Government assistance was deemed to be charitable aid. The respondents contributed more readily to the discussion when asked about services that people, whom they knew, made use of.

Of the sixteen residents who participated in the study, eleven preferred to continue to use the General Practitioner in the community. They stated that they did not want to repeat their health history to different doctors but preferred to have the continuity of their own general practitioner. They all agreed that they were glad that a General Practitioner was available for consultations at set times (and on call) in the village and said there would be a time in the future when their health started failing, when they would make use of this service more frequently. In some instances the General Practitioners made 'home calls' at the Retirement Village. There was general agreement that after hour deliveries by a local pharmacy was a valued service.

Some respondents said they would make use of home-care services provided by non-governmental agencies if they needed assistance with activities of daily living (washing, dressing etc.).

9.4.2.3: By the Government.

Respondents expressed the opinion that an alarm pendant would enable people who have mobility or visual problems to access emergency services such as St John's Ambulance in case of a fall. Conflicting views (based on narrative reports of people who had been to WINZ) were expressed about the availability of government support for the provision of alarm pendants. The predominant view was that if it had been subsidised in the past but the person had cancelled the subsidy of his or her own accord, it could not be reinstated. Word of mouth seemed to be an important means of imparting information. One respondent referred to the fact that some older people have a hearing impediment and it sometimes causes the message they receive to be distorted.

One resident had experienced relative poverty due to expenses related to hospitalisation, as well as travel expenses to and from the clinic when going for a medical check up. He had needed to use additional electricity to heat the house in winter to breath easier (he had a chronic respiratory problem). This was over a period of three years, while being attended to by the same general practitioner. It was only when the doctor told him that he needed to have a telephone in his bedroom (after a triple cardiac by-pass) and he responded that he could not afford to pay for one, that the doctor filled in a form for a disability allowance. In this instance the doctor was acquainted with the available resources but only referred the patient when he was told that the respondent could not afford to pay.

Those respondents who had disabilities and who were welfare recipients had different levels of knowledge about the services or support they were entitled to. One respondent remarked 'If you have a good Doctor, you get everything.' One respondent referred to the fact that he was able to obtain hearing aids through ACC and expressed the opinion that the government should subsidize people who needed hearing aids since lack of it had a deleterious effect on their lives and could lead to social isolation. Opinions about Work and Income New Zealand (WINZ) differed according to the individuals' experience. People with chronic health conditions were

well acquainted with the hospital system as well as to some extent, the social welfare system.

Three people received a Living Alone Allowance. One person said that they became aware of the Living Alone Allowance when the village manager (who had been asked by a resident after unsuccessfully attempting to obtain this information from WINZ) had mentioned it in the village newsletter.

Two people expressed the opinion that people should assume responsibility for their own health and that the input from the government was sufficient. One person expressed the opinion that the government could do more to alleviate the long waiting list. One person said that services should be restructured rather than be added to (this comment was made by a welfare recipient who had positive experiences with WINZ). Five respondents said that they thought a liaison person (four of them said the District Nurse) should periodically come to the village and be available to answer questions relating to their health and welfare service needs. This is in line with the focus group research (Beattie, 1997) where a group of older Irish people suggested that a health visitor focusing on older people could act as a source of advice and assistance.

Three respondents became very emotional when referring to being on a waiting list for surgery. According to the literature a doctor refers a patient with a chronic condition that s/he cannot manage to a specialist who then places the person on a waiting list for diagnostic procedures or surgery. The waiting list is extensive and can be short-listed (by removing people's names from the list). One respondent had been waiting for three years (and was still waiting) for a hip replacement. He said that the hospital informed him that if the doctor does not follow up on the progress of the patient on the hospital waiting list, the hospitals assume that the problem has been resolved and therefore removes the name off the list. When the patient makes inquiries directly to the hospital they may find that they are no longer on a waiting list.

All the respondents had expressed excitement about the lifestyle decision that they had made to live in a Retirement Village and said that they had not thought of the

possibility of selling. Some had approached a lawyer for advice before purchasing their unit but admitted that they had paid little attention to the fine print. They said they had been swayed by the location of the village, availability of amenities, and by the fact that some of them had friends already living there.

In the focus group the respondents said they were aware that in some cases difficulties are experienced when the resident does not want to live in the village anymore. One case was mentioned where the person had to ask 'Fair Go' to intervene to retrieve the money arising from the sale of the unit. One respondent suggested that the government should set standards since 'people do not read the finer print of a contract and people (the realtors) will continue to get away with a lot.' The respondent expressed uncertainty as to whether older people are represented in parliament.

The participants of the focus group were of the opinion that although the Retirement Village Association sets standards of practise for its members, it is the responsibility of the Government to set and monitor standards for *all* Retirement Villages.

According to the literature (discussed in Chapter Four) not all Retirement Villages are subject to or acknowledged by their promoters to be subject to the Securities Act 1978 S 5(1) (b). Villages that adhere to the Act provide prospective buyers with written notice of risks they are running when buying into a Retirement Village. Villages that adhere to the Act, appoint a Statutory Supervisor. Two respondents from the same Retirement Village were well informed about the function of the Statutory Supervisor. One respondent had mentioned that he was aware that the Retirement Villages Bill (now the Retirement Village Act 2003 No 112) had been read in parliament.

9.5: Information dissemination

According to the literature, information about services that the government and others provide is available but is very fragmented and therefore difficult to access. A limiting factor is that some older people find modern technology such as computers

intimidating and do not make use of this means of accessing available information. In this study there was consensus that there is insufficient information about the range of available support and/or services and that it is difficult for an older person to access information. Automated telephonic responses were found particularly intimidating. One respondent expressed the opinion that the government departments should inform them of the availability of all benefits for older people. According to Quinn, Snowling and Denicolo, (2003) a study done in Slough by a Project Working Group with the University of Reading research team (discussed in the introduction) found that there is a need for timely information. They had found that older people wanted information, often at a point of change or crisis in their lives.

This study found that participants had varying views on the role a doctor can play in facilitating service usage from: 'If you have a good doctor you get everything', to 'It is not the doctors duty to give us information'. This study has also found that welfare recipients have more knowledge of benefits and service provision than the other residents do. The level and extent of knowledge about support services among the welfare recipients appears to be influenced by the attitude of the individual that they encounter at WINZ. Some (so the respondents said) were very helpful and others were deemed to obstruct people from obtaining information. This fact has been alluded to in the overview of the Social Security (Work Testing and Community Wage) Amendment Bill (discussed in Chapter One) in which it is stated that WINZ has developed a culture, which discourages applications for assistance. Welfare recipients are a source of information to others. This is in line with research done by Toffaleti (1997), who found that older people in a survey were more likely to turn to their friends and family for advice and information than to professionals. It is also supported by the findings of Tinker et al (1994), who found that word of mouth was cited as the most important source of information about services.

The information residents relate to one another is coloured by their own experience and *their own* interpretation of what they had been told by WINZ and by significant others (doctors, spouse, relatives, friends). This may result in misinformation that does impact on whether some people will go to WINZ or other service provision agencies to establish whether they *are* entitled to benefits. The respondents expressed the need for a person (nurse, community liaison person) to be available at

set monthly intervals so that the residents who have questions relating to service provision could have it clarified.

Retirement Villages do make an effort to make information they have available to the residents. The respondents agreed that the reception desk is a favoured means of obtaining information, as are managers (when they are available). Some referred to the information book that they receive when they sign their contract. Information they would like to have listed in the book is mainly for resources relating to emergencies: transport, hospital, after-hours pharmacies, meals-on-wheels, etcetera. Some said they referred to this book when they needed information but some said they never used it. All of them said that they do read the Village newsletter.

The respondents had given some thought to the role that external agencies can and do play in dissemination of information. Some agencies that were mentioned were: Grey Power, Age Concern New Zealand, Community News Paper, and the Citizens Advice Bureau.

9.6: Conclusion

The research found that there *is* a difference between the availability of government-funded services, knowledge and use of such services, by people who live independently in Retirement Villages. The level of knowledge with regard to government and other service providers varied but most of the respondents were aware of most of the services offered by the Retirement Village that they live in. It also found that there is a link between the expectations that residents have of service provision by the Retirement Villages that they live in. Their expectations are based on the services that were advertised and to some extent are also influenced by word-of-mouth accounts of services received by fellow-residents.

The research found that there is a great deal of information available with regard to service provision for older people but they sometimes find it difficult to access the information due to factors such as fragmentation, inadequacy of information that is available, the attitude of some service providers, and because of automated responses to telephonic enquiries. A degree of misinformation occurs when older people

inform one another about service provision or service availability. Misinformation occurs when the person that transmits the information colours the information with his or her own perceptions and experiences. In some instances people who have a hearing impediment receive only that 'part' of the information that they heard and possibly did not hear a vital part of the information.

There is a higher incidence of old-old people in Retirement Villages than in the community. This is reflected by the correspondingly high projected incidence of disabilities and an increased need for service provision by the Government and others in Retirement Villages. There are more women than men in Retirement Villages especially among those aged 85+. Most of the older people in the sample were financially independent and lead active and busy lives.

The said that the need of older people in New Zealand is to remain in their homes for as long as possible. The current public policy direction (The Positive Ageing Strategy) coincides with their wishes. The respondents appeared to be very happy with life in Retirement Villages. People who choose to live in Retirement Villages do so because it supports a lifestyle change of living independently for as long as possible while being able to enjoy the communal facilities, social activities, security and beautiful gardens without the worry of maintenance. Some of the residents made use of the facilities onsite such as the resident doctor and others made use of personal and care services such as meals and laundry.

The respondents did not perceive themselves to be a community on their own, but continue to participate in, and contribute to the greater society, albeit it is in the form of voluntary work in the Retirement Village or in the community. Although none of the respondents were engaged in formal (paid) work, they knew of a fellow resident who was working full-time and they suggested that the lifestyle would suit an older person who was working. Caring for each other on an informal basis such as fetching the mail of temporarily incapacitated residents, transporting etc. were all aspects of informal work. Most of the respondents do not rely on their family for carer support. This can be viewed positively in terms of the dwindling pool of informal carers because of the fact that people, including women, tend to work longer, and in view of the two-generation older people phenomenon.

The growing number of older people means that their voting power is considerable. Most of the older people were not aware of the -and how to make their concerns known to them. This is a matter for consideration because by inference many of them, and older people in the community, are not aware of the importance of the Retirement Village Act 2003, in protecting them when they consider entering into a contractual agreement with a Retirement Village manager.

In some instances information had been relayed by word-of-mouth and was based on individual experiences or perceptions and did not necessarily reflect the correct procedure to be adopted when in need of services. The sources of information of the respondents were friends, relatives, older people who were welfare recipients, WINZ, and the resources of the Retirement Village. This confirms the survey done by Toffaleti (1997), which found that older people tend to turn to friends and family for information.

The respondents gave valuable insights with regard to their perception of government and other service providers and about the difficulties they sometimes had experienced in accessing services due to factors such as insufficient information or other human factors. Not one respondent mentioned the fact that service-providers may also be experiencing barriers to providing services efficiently.

The participants in the sample had not given much thought to what support services they might need in the future and were not well informed about what services are available and how to access it. The respondents had varying levels of expectation with regard to who should provide services when their condition deteriorated:

- None of the respondents expected the government to provide them with accommodation although some had attempted to apply for the Living Alone Allowance.
- They expected the Government to provide taxi-vouchers if they acquired a chronic condition that required frequent trips to the hospital. Some who wanted to take responsibility for their own health and welfare in the case of

an emergency were paying members of St Johns Ambulance service. Very few relied on relatives for transport.

- None of the respondents' expected additional services to be provided free of charge by the Retirement Villages. Some residents were prepared to purchase services such as healthcare and meals from the Retirement Village they lived in. Some, mainly the respondents who were welfare recipients, relied on the Government to fund care provision such as for activities of daily living and cares that is usually provided by a District Nurse and in the case of cancer, a Palliative Care Nurse.

Generally the respondents did not have any great expectations with regard to the Government providing them with support. Some respondents said that even though they had wondered about welfare entitlements in times of need, they had not been to a welfare office for assistance either due to misinformation from friends, relatives or other residents, or due to their own misconceptions. Most of them stated during the interviews that they wanted to have access to information about support services and were prepared to make use of such services on a user-pay basis. A suggestion that was well supported by the focus group was that formal services should be redistributed or reorganised rather than increased since the belief was expressed that the government was 'doing enough'.

Credibility was sought in this research by forming a focus group of eight from the people who had participated in the individual interviews. Since they had contributed to the information that was given to them to discuss in the focus groups in the form of tables, they could legitimately judge the credibility of the results. The weakness of the sample is that it does not include people who have left the Retirement Villages and who may have expressed different views since there is a probability that some of them may have left because they were not satisfied with life in a Retirement Village or in that particular Retirement Village.

It can be argued that the sample was not representative of the general population since it is not a stratified random sample however maximum variation was sought. In view of the smallness of the sample these results cannot be generalised to the general community or to all older people who live in Retirement Villages. This study could

however be replicated on a much larger scale by choosing a systematic random sample from all Retirement Villages.

In summary:

- Where there is a continuum of care, older people are more inclined to expect to progress from independent living to assisted living to admission to hospital within the same complex where they owned a Retirement unit and that;
- Service provision by Government and other service providers address most of the expressed needs of older people who live in Retirement Villages but that;
- Services are under-utilised because of inadequacy or inaccessibility of information and that;
- Through the involvement of older people appropriate means of information dissemination can be identified and developed to foster a better utilisation of existing resources.
- Based on the literature review, prior research and the opinion of the majority of participants, it would seem that a field officer (community liaison person) is needed to communicate face-to face with older people about service provision for older people.

9.7: Some Issues For Consideration:

- Prior research suggests that the current system of income support for older people has been successful in protecting the great majority of older people from hardship. A minority of the older population is facing some degree of material and economic hardship and are not aware of available resources to alleviate their situation. Some of these older people require support to manage daily tasks which they were once able to attend to unaided, while others, as a result of ill health and/or frailty, will require more complex care. They sometimes elect not to inform the Retirement Village of their physical decline. My own experience leads me to believe that some do not want to transfer to a care facility as they associate a Rest home and hospital with

death. Their suggestion of having a community liaison person available once a month to discuss any of their concerns, might be worth investigating.

- The pool of informal carers is dwindling thus enabling carers to have access to information from professionals on services that are available may encourage them to continue to support their older relatives.
- To meet the varied needs of older people, a broad range of aged care services are available along a continuum of care which includes community services, residential services and acute hospital care, by a multi-disciplinary[13] team of workers with a wide range of qualifications and skills. The available services are under utilised because some older people are not aware of what services are available or how to access it (this is borne out by the research).
- Providers of support services may also be experiencing barriers that hinder service provision.
- Information about the whole range of services and opportunities is a key factor in access to appropriate care (Meredith, 1995).

In conclusion, the problem of inadequate information dissemination about services for older people is not unique to New Zealand, nor is it insurmountable. Involving older people in identifying problems as well as finding solutions may be a factor for consideration.

[13] Some Retirement Villages in New Zealand do use the multi-disciplinary team approach in older care hospitals.

Addendum One: Retirement Villages To Buy in West Auckland

Feature	St Clair Park	Waitakere Gardens	Greenview Park	Hobsonville Villas
Location		Is situated within walking distance of two shopping malls, and close to supermarkets, banks, churches, bowls	Maintenance free, friendly village, architecturally designed A small garden in front of the house.	Around a cul de sac, across the road from RSA and approximately one kilometre to bowling club, shops, doctor, chemist
Tenure	Independent Unit Title	Licence to occupy	License to occupy	Freehold
Service Fee	460 per week GST incl. Includes building insurance, security and emergency call system, lawn mowing, gardening, window cleaning, and exterior maintenance	$77.50 per week includes council/sewerage rates, building/fire/ property insurance, security/emergency call systems, rubbish, lawns, gardening, external windows, exterior maintenance	$78.75 per week. Includes council/ water/ sewerage rates, building/ fire/property insurance, emergency call systems, gardening, window cleaning, exterior maintenance rubbish, lawns,	$41 per week includes lawns, gardens, security pendant alarm service, building insurance, outside maintenance, windows, rubbish
Additional Services	Shuttle bus	Hair salon, podiatrist, visiting doctor, trial apartment before purchase, and 24 hour reception	Van outings	Not mentioned. Reference made to services in the area
Care	In the future, no date specified	Serviced Apartments by 2003. Services such as nursing staff on call, meals, cleaning and laundry services will be available to residents on a user pay basis	Rest home and Hospital	Not mentioned
Communal Amenities	Heated swimming pool, gymnasium, out door bowling green	Restaurant, library, community centre, Games room, Indoor bowls, Heated indoor Swimming pool. All these facilities offer an opportunity for companionship	Lounge, kitchen, dining room, library, hall, gym, card room, billiards, darts, computer room, swimming pool, spa, craft room, men's hobby room, pentaque court, indoor and outdoor bowls	On- site Not mentioned Reference made to facilities in the area.
Security	Security and emergency call system	Personal alarms in every room, smoke alarms and sprinkler systems. Security cameras monitor the grounds and access to carparks, lifts, stairs and buildings are by a secure swipe card system.	Security, building /Fire/ Property insurance	Security pendant alarm service
Maintenance	Exterior maintenance	Exterior maintenance	Exterior maintenance	Outside maintenance

Feature	Metlifecare Crestwood	Metlifecare Pinesong	Ons Dorp	Regents Park
Location	Not mentioned	An unbeatable location. Wonderful views of Manukau Harbour, access to a private beach, acres of bush reserve beautiful gardens. Handy to your favourite shopping malls	Not mentioned	Convenient location
Tenure	License to occupy	License to occupy	License to occupy	License to occupy
Service Fee	$76.50 per week. Includes council water/sewerage rates, emergency call systems, rubbish, lawns, minibus gardening, window cleaning, interior/ exterior maintenance, telephone,	$75 per week. Includes council/water/sewerage rates, building/fire/property insurance, security/ emergency call systems, rubbish, lawns, gardening, window cleaning, exterior maintenance	1-bedroom units: $234.9 per week, 2-bedrommed unit: $249.35 per week 3-bedroomed unit: $261.7 per week includes council/ water/sewerage rates, building/fire/property insurance, security/ emergency call system, rubbish, lawns, gardens, windows, interior/exterior maintenance	$50 (incl. GST) per week until facilities (community centre and hospital) are built
Additional Services	Physiotherapist, podiatry, meals, laundry, cleaning, transport, hair salon, restaurant	Not mentioned	Not mentioned	Not mentioned
Care	Serviced apartments, Rest home	Doctors surgery and hospital planned for the future –no date mentioned	Rest home and hospital	Hospital planned (no date mentioned)
Communal Amenities	Library, communal lounge/recreational area, indoor bowls, Billiard room, bowling green, Heated indoor pool, spa	Gymnasium (latest in fitness equipment), hair salon, library restaurant, community center, heated indoor pool, spa, games room, indoor bowls, bowling green, billiard room	Large communal Lounge /recreational area in rest home, recreation hall in village with library, billiard room, card lounge, indoor bowls area	
Security	Security/Emergency call system, building/ fire/ Property insurance	Security/Emergency call system, building/ fire/Property insurance	Emergency call system, building/ fire/ Property insurance	Insurance (does not specify type)
Maintenance	Interior/Exterior Maintenance	exterior maintenance, window cleaning, rubbish, lawns plus a handyman to do all those little jobs	Interior/ Exterior Maintenance rubbish, lawns	Exterior maintenance, rubbish

ADDENDUM TWO **(Massey University Letterhead)**

A Sample letter to prospective participants

Recipient's address

My name is Virginia Adams. I am completing a Master of Public Policy through Massey University. I am writing to ask if you would be willing to assist with a study that is being undertaken by me under the supervision of Massey University. The study examines the service delivery by the government to people who live in Retirement Villages, and what services they expect (government to provide). Ethics approval for the study has been obtained from the Ethics Committee of Massey University. I am asking you to participate in one or two interviews of approximately one hour each. The duration of the interviews will depend on the information you have to give. The interviews will be taped, but should you request it at any stage during the interview, the tape recorder will be turned off. The interviews will take the form of a conversation, so there are no right or wrong answers, just your experiences of government service delivery as you choose to tell them.

We are keen to get feedback from you in order to make recommendations to government about what could be done to deliver a more efficient service to people who live in Retirement Villages. Any information you are able to offer will be valuable. I will contact you so we can agree on a place, date and time that will suit you. I will ask you to sign a consent form, which gives your permission to be interviewed, and for our conversation to be recorded. I will do the transcripts of the tapes myself.

I want to assure you that anything you say during the interview will be kept confidential. Nothing of what you said will be disclosed to the village manager or to

the resident's committee. A number will be designated to each tape, so that your name will not be used on the tape or any reports that will be written.

You will receive a copy of the transcript of each of your interviews before the next meeting with me. All tapes and transcripts will be destroyed at the end of the research. Should you choose to keep the transcripts and tapes, I will in consultation with you delete any information that may be considered as an invasion of the privacy of a third party.

You may be asked to participate in a focus group discussion that will critically examine a summary of the input of all information received from the interviewees. Anonymity cannot be guaranteed in a focus group discussion but identification will be limited to the group participants.

If you participate in this study, you have the right to:

Ask questions about the study which occur to you during your participation.
Refuse to answer any particular question.
Withdraw from the study at any time, up to two months prior to the completion of the research..
Provide information with the understanding that all information obtained will be regarded as confidential and that it will not be possible to identify you in any of the reports that are prepared from this study.
If you are willing to assist us by being interviewed, please call me before 15th June, 2002.

Thank you again for your assistance,

Virginia Adams
Phone: 09- 8171377
e-mail: saviour@xtra.co.nz

ADDENDUM THREE **(Massey University letterhead]**

Consent Form

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time up to two months prior to the completion of the research and to decline to answer any particular questions.

I voluntarily agree to provide information to the researcher on the understanding that my name will not be used without my permission.

(The information will be used only for this research and publications arising from this research project).

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio-tape to be turned off at any time during the interview.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:

ADDENDUM FOUR **(Massey letterhead)**

Permission To Gain Access

Dear Manager,

REQUEST TO DO RESEARCH

My name is Virginia Adams. I am completing a Master of Public Policy through Massey University. I am a Registered General and Obstetric Nurse with an interest in aged care, however, I am not currently employed by nor am I associated with any facility or business engaged in care of people who live in Retirement Villages. My supervisors are from the Department of Social and Cultural Studies, Albany campus. They are: Dr R. Prasad (ph: 09-443 9700 extension 9050 and Dr. M. Belgrave (09-443 9700 extension 9083).) I may be contacted at home (09) 8171377 or by e-mail: veeberry @ hotmail.com. The purpose of this research is to determine whether there is a difference between the current services delivered by the government and the expectations of the aged who live in retirement villages.

The Waitakere Health Plan towards 2010 states that: 'Professionals and providers working within the system freely acknowledge that they are sometimes confused themselves about how to link with one another's services intelligently, and are developing detailed information aids for themselves.' There is a perception that this confusion is shared by people, especially the aged who live in retirement villages, which has been referred to as a 'community' within the community. It is hoped that the outcome of this study will contribute to improved government service and in this way enhance the quality of life of the aged.

I would like to request permission to interview five people (including one couple) who live independently in your village. In order to ensure that I cannot identify or

contact the participants beforehand, I hereby request permission to address a letter to the residents committee whom I know strives to safeguard the interest of the villagers, to ask them to identify five volunteers to participate in this study. The letter to the resident's committee (copy included) will stress that prospective participants must initiate contact concerning the participation, either through management, the resident's committee or directly with me. This will eliminate the risk of prospective participants feeling coerced into taking part in the study, and also serves to demonstrate a degree of motivation on their part to be included in the research.

In the event that the participant chooses not to be interviewed in his/her own home, I would like to request permission to arrange a suitable alternative, on your premises.

All information will be treated as confidential. No reference will be made of the names of the participants or of your village in the research report. The information will be used solely for the purpose of analysis, documenting the findings and making recommendations that could influence government policy with regard to an improved service delivery to the aged in retirement villages.

A copy of the summary of the findings of the research will be sent to you. You will be asked to sign a consent form, which gives me permission to have access to your premises. A copy of this letter will be sent to the chairperson of the residents committee of the village.

Yours faithfully

_____

Virginia Adams
Ph: 09- 8171377
e-mail: saviour@xtra.co.nz

Cc Residents' Committee

Appendix: Letter to Residents' Committee
Letter to Participants

ADDENDUM FIVE **Retirement Village letterhead**

Permission to gain access

Permission is hereby granted to Virginia Adams to gain entry to... Retirement Village in order to interview the people identified by the residents' committee to obtain their written consent and to interview those who have agreed to participate in a research project.

I have read the information provided and understand the nature and purpose of the research. I give permission for the researcher to use an area identified by me, or my representative for the interviews in the event that the participant does not agree to be interviewed in his/her unit.

Signature.....

Designation.....

Date.....

ADDENDUM SIX **Massey University letterhead**

Assistance to get volunteers

The Chairperson
Residents' Committee
((Retirement Village)).

Dear Sir/Madam,

My name is Virginia Adams. I am completing a Degree: Master of Public Policy through Massey University. I am a Registered General and Obstetric Nurse with an interest in improving the quality of care of people who live independently in Retirement Villages. I am doing research to find out whether there is a difference between the services that are presently being delivered by the government to people who live on their own in retirement villages, and what they expect the government to provide. It is hoped that the outcome of this study will contribute to improved government service and in this way enhance the quality of life of the aged.

I would like to ask you to assist me in finding five volunteers (three individuals including one couple) who live on their own in your village in order to ensure that I cannot identify or contact the participants beforehand. In order to safeguard the interest of those who volunteer to participate, and to eliminate the risk of prospective participants feeling coerced into taking part in the study, I would ask that prospective participants must initiate contact concerning the participation, either through yourself, management, or directly with me. It also serves to demonstrate a degree of motivation on their part to be included in the research. In the event that they prefer to indicate their willingness to participate in the research project to you, I would appreciate it if you would advise me in writing.

All information will be treated as confidential. Nothing that has been said by the participants will 'stay in the room'. No reference will be made of their names or of

your village in the research report. The information will be used solely for the purpose of analysis, documenting the findings and making recommendations that could influence government policy with regard to an improved service delivery to the aged in retirement villages. A copy of the summary of the findings of the research will be sent to the village manager and will be available for any person to read. A copy of this letter will be sent to the Village Manager.

Thank you for your assistance

Yours faithfully

Virginia Adams
Ph: 09-8171377
e-mail: saviour@xtra.co.nz
Cc Village Manager
Appendix: Letter to Participants
Consent Form

ADDENDUM SEVEN **Massey University Letterhead**

INSTRUCTIONS FOR INTERVIEW SCHEDULE

This interview schedule must be used as a guide. The questions are open-ended and defines the topics under discussion but the aim is to provide the interviewer and the interviewee with opportunities to discuss some topics in more detail. If the interviewee has difficulty in answering a question or provides only a brief response, the interviewer can use cues or prompts to encourage the interviewee to consider the question further. The interviewer can also probe the interviewee to elaborate on the original response or to follow a line of inquiry introduced by the interviewee.

Do not take notes or jot down only crucial notes while in the field; listen instead.

- Note taking can be intrusive and make people nervous by continually emphasizing that they are being observed and preserved.
- You learn to listen; you scribble notes and you learn to remember.
- Write the field notes as soon as you return home from the field.

There are typically four phases in the interview:

1. The "nurturing" phase. This is the initial warm-up to the interview. Introduce yourself and talk briefly about neutral topics such as the weather, the view etc. to establish yourself.

2. The "energising" phase. Here the area of discourse, and any existing problems are identified.

3. The "body" of the interview. This is the peak phase of activity.. It is important at this stage for you to remain analytical and neutral. Keep the interview fairly free in structure: the respondent may direct the order of topics, and you should follow them. In order to keep the respondent focused, you may continually probe bringing out the 'ask able prompts'. Otherwise the order of topics is at the your discretion. Before this phase ends, check whether all the topics have indeed been covered.

4. The "closing" phase. Summarise what you have learnt from the interview, and ask the informant whether this is correct. The informant should be asked whether they thought the interview covered all the areas of concern, and whether there were issues that had not been touched upon. It is a good idea to spend a little time on how the informant felt about doing the interview, and whether there was anything that could be improved.

ADDENDUM EIGHT **Massey University Letterhead**

Non- disclosure of information

I ----------

Agree not to disclose the name of, or any information that would lead to the identification of the participants or the Retirement Village in the study being undertaken by Virginia Adams. I will not

retain copies of audiotapes or notes that I may take during the research period. Notes taken during

interviews will be handed to Virginia as soon as the interview is over.

Signed:

Name:

Date:

INTERVIEW SCHEDULE

Research Objective	Interview Question	Prompts/Probes	Notes
To obtain a snapshot of people who live in Retirement Villages	Tell me something about yourself?	• Age • Sex • Marital Status	
To establish why some older people choose to live in a retirement Village rather than in their own homes	How did you come to live in a Retirement Village?	• Health and safety • Security • Social (friends, family) • Home maintenance (repairs, garden) • Lifestyle • Location	

INTERVIEW SCHEDULE

Research Objective	Interview Question	Prompts/Probes	Notes
To establish if respondents are working	Tell me about any work related activities that you do	• Paid/unpaid: formal or informal • Own home • Hobbies • Helping others	
To determine which services older people expect the Government and others to provide	What do you think about service provision for people who live in Retirement Villages?	• Services currently used • Service needs in 5 years • Service needs in 10 years • Services other people in the village use • Who should provide these services?	

INTERVIEW SCHEDULE

Research Objective	Interview Question	Prompts/Probes	Notes
To explore the dissemination of information to older people who live in Retirement Villages	How do you access information about services that are available to older people who live in Retirement Villages	• Receptionist • Notice boards • Newspapers • Newsletters • External agencies such as Aged Concern • Computers	

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