AN ASSESSMENT OF COMMUNITY CARE SERVICE PROVISION FOR OLDER PEOPLE RESIDING IN FEILDING

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ABSTRACT

This study sought to assess whether the community care needs of a purposive sample of nine older people aged between sixty-seven and ninety-six years residing in the semi-rural township of Feilding were being met by current service provision. Qualitative interviews were conducted with nine client participants and thirteen key informants selected from service providers to the older population of Feilding.

Despite the political turmoil of tendering for contracts for specific community care services, providers were delivering a range of services and were aware of the issues concerning quality, access, appropriateness and coordination of services which were enabling these older clients in Feilding to maintain their independence at home. The major incentive for service providers is to keep clients mobile and out of hospital. However, the lack of information to older clients concerning their eligibility for services provided by service providers, may deter potential clients from accessing community care services, thereby decreasing the demand for services.

Providers were constrained by their budget and minimum staffing levels to supply services to meet the potential demand. The older disabled clients of community care in Feilding, faced issues of dependency on formal and informal support services, decreasing mobility, vulnerability and concerns relating to cultural sensitivity, safety in their homes, and the quality of the careworking relationship.

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ABBREVIATIONS

A.C.C.	Accident Rehabilitation, Compensation and Insurance Corporation
ADL	Activities of Daily Living
ATR	Assesment, Treatment and Rehabilitation
CSC	Community Services Card
CHE	Crown Health Enterprises
CRHA	Central Regional Health Authority
DSS	Disability Support Services
G.P.	General Practitioner
HSMS	Home Support Management Service
IADL	Instrumental Activites of Daily Living
NSISS	New Zealand Income Support Service
REACH	Research with Elders and Carers at Home
RHA	Regional Health Authority
SNAF	Support Needs Assessment Form
SNAP	Support Needs Assessment Protocol
WHO	World Health Organisation

Chapter 1

INTRODUCTION

The focus of this thesis is on older people aged 65 years and over who seek to remain in their homes for as long as possible but need the support of community care services to enable them to do so. My interest in the older population stems from my own experience of ageing parents, relatives and their friends, known to me from early childhood. Few have needed to be placed in residential care because of their determination to retain their autonomy and independence at home. I have observed them ageing over the years and I admire their resilience, their positive attitude to life and acceptance of their natural ageing processes.

I now work alongside older people living in the community as a career choice and I feel encouraged by their humour, pride, initiative and fierce independence. I was curious to know what it was like for people to be growing older and as a result of their age-related disabilities, to need to change ways of managing normal daily activities at home and in the community. How does it feel to be older and need to have assistance from community careworkers and health professionals who visit the home and provide support services?

This thesis seeks to assess the provision of community care services for a target population of older people residing at home in the semi-rural township of Feilding. Areas of interest in service provision for older people concern the range, quality, access, appropriateness and coordination of services. The starting point was to examine literature to gain an insight to the health-care and social needs of the older population and current policies and practices which offer viable choices to enable older people to maintain their independence at home.

Previous studies have highlighted the traditional view from health and social welfare agencies that older people are a medical problem and frequent users and consumers of health resources to cope with their deteriorating physical and mental health (Koopman-Boyden, 1988). This view has been supported by statistics that people over the age of 65 years have the highest rate per 1000 population of hospital admission (Health Benefits Review, 1986).

However, estimates also support the fact that reasonable to perfect health is enjoyed by the majority of older people with a low percentage reduced to a dependent life in residential care or to being at home and being cared for by others (Koopman-Boyden, 1988; Opie, 1992). Historically, the provision of institutionalised care became an isolating experience for many elderly by separating the elderly from society, their community and hastening their dependence on others as they conformed to institutionalised routines (Koopman-Boyden, 1988). More recently state policies have been directed to de-institutionalising the elderly, the frail elderly and/or disabled elderly and adopting a community care perspective (Ministry of Health, 1994; Richmond, Baskett, Bonita & Melding, 1995).

The term 'ageing in place' is used to describe the Government's community care perspective in providing services to maintain older people at home (Richmond et al, 1995). The community care services of particular importance for the elderly are home support services which provide assistance with personal care and home management. Such services assist individuals to remain in their homes and out of residential care as long as possible (Richmond et al, 1995; Department of Social Welfare, 1990).

At a local level, in Palmerston North city, valid concerns for the current and future availability of community care services for older people are based on statistical information even though the projections for population ageing within city boundaries are lower than national figures. Currently, Palmerston North figures show that 10.1 per cent of the city population are aged 65 years and over (Statistics New Zealand, 1994b) and predicted to increase to 11.1 percent by the year 2016 (Statistics New Zealand, 1994c). National figures using 1991 census data are higher and show that 11.3 percent of New Zealand population were aged 65 years and over (Statistics New Zealand, 1994b) and predicted to increase to 15 percent of the population in the year 2016 (Statistics New Zealand, 1994c).

However, in the surrounding semi-rural and rural Manawatu-Wanganui region, the population percentage of older people aged 65 years and over, is predicted to increase from the 1991 figure of 11.6 percent to 14.8 percent in 2016 (Statistics New Zealand, 1994a). This increase, based on medium population predictions, closely follows national guidelines. Using these figures, the Strategic Planning Unit, Palmerston North City Council (1994) has forecast that city health-care and social support services, represented by the central headquarters of the area's Crown Health Enterprise (CHE), can anticipate a corresponding upsurge in the demand for community care services from the older population residing in rural and semi-rural areas.

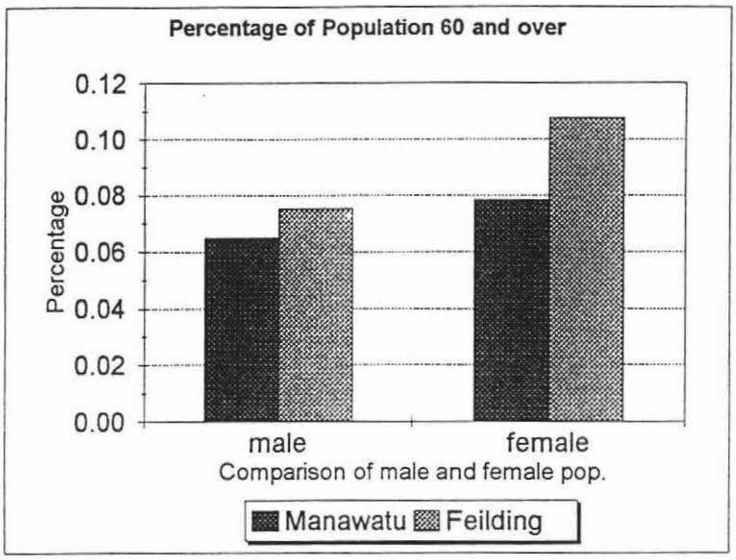
The demand for services for older people may also intensify in response to current government policies which centralise health-care and social services and reduce the availability of community care services in rural and semi-rural areas. Issues surrounding the adequate provision of medical, financial, social and cultural support for older people in the outlying rural and semi-rural communities will need to be addressed by Government policy makers, planners and funders of services for the elderly.

1.1 The Research Objectives

The aim of this thesis is to assess whether the current provision of community care services is meeting the needs of a target population of older residents aged 65 years and over from the semi-rural township of Feilding sited in the Manawatu region. Feilding was selected for study because of the township's semi-rural location and high concentration of older people who choose to retire there. The 1991 census confirmed the high concentration of older people by estimating that 18.3 percent of the total population residing in Feilding were aged 60 years and over (Statistics New Zealand, 1994a).

Comparisons between Manawatu (14.4 percent) and Feilding (18.3 percent) figures reveal the high concentration of older people aged 60 years and over who reside in Feilding (Statistics New Zealand, 1994a) (Figure 1, p.4.). Also significant are the comparative gender differences between Manawatu and Feilding areas. Of the 14.4 percent of those aged 60 years and over residing in Manawatu, 7.8 percent were female and 6.5 percent were male. Of the 18.3 percent of those aged 60 years and over residing in Feilding, 10.7 percent were female and 7.5 percent were male. Feilding figures highlight the gender imbalance in Feilding for this age group (Statistics New Zealand, 1994a) (Figure 1).

Figure 1: Percentage of Population Aged 60 years and over Residing in Feilding and the Manawatu, by Gender



Source: Statistics New Zealand, (1994a)

When seeking to answer a research question based on the needs of a specific population within a community, it is important to understand that a needs assessment requires a clear definition of the need of the group under study (Owen, 1993; Posovac & Carey 1992). In this study the needs of the group are clearly defined by a standardised needs assessment document which identifies individual need for community care support services. Furthermore, the older people themselves were asked to prioritise their needs together with service providers to the elderly who identified the needs of their older client group from their perspective.

The term 'client' will be used at times throughout this thesis when referring to the older people receiving community care services. The use of the generic term of 'client' by service providers replaces the medical terminology of 'patient' previously used by health-care professionals. Also the collective term of 'provider' is used to describe organisations which provide health and disability support services (Ministry of Health, 1994).

This thesis uses a qualitative methodology which follows a semi-structured interview format to give expression to the needs of a purposive sample of nine older people for community care services to enable them to maintain their independence at home. Major supplementary sources of information were obtained from qualitative interviews with thirteen key informants who provided community care services to the purposive sample of older people. Secondary information from public sources, such as quantitative statistical data, previous research studies and reports on community care for the elderly, strengthened the validity of the discussion, analysis and conclusions.

Issues for older people living in rural and semi-rural areas have arisen in terms of their continuing access to community care services to support their stated preference to remain at home for as long as possible. Thesis discussion, analyses and conclusions contribute to the body of knowledge concerning the needs of the older population for community care and the corresponding extent to which current services are meeting those needs.

The sample of nine older people aged 65 years and over from the target population of interest, with the exception of one client, had been previously assessed by a standardised needs assessment. A standardised needs assessment is the first step to accessing community care services funded by either Accident Rehabilitation, Compensation and Insurance Corporation (ACC) services or the Regional Health Authority (RHA). The need for older individuals to be assessed by this process was determined by their identified age-related or accident-related disability and corresponding need to receive some form of community care services to enable them to maintain their independence at home.

The definitions relevant to this thesis and the population of interest are outlined as follows.

1.2 Definition of Terms

Community Care

The definition of community care adopted in this study is,

> "the help and support given to individuals including children, people with disabilities and elderly people in non-institutional settings".
>
> (Walker 1982, p.5.).

Community care in practice therefore consists of formal[1] and informal[2] support in the community.

Needs Assessment

The definition of a needs assessment for people with disabilities is,

> "A process designed to take into account the comprehensive needs of people with disabilities, including age-related disabilities and prioritise their needs so that within available resources, appropriate services can be coordinated to help meet those needs".
>
> (Ministry of Health, 1994).

Disability

Vulnerability to disability increases beyond age 65 years and substantially increases beyond age 80 years (Green, 1993; Hunt, 1988; Koopman-Boyden, 1988). The definition of disability used in this research is based on World Health Organisation (WHO) definitions of Impairment, Disability and Handicap. This definition identifies who is eligible for Government-funded disability support services,

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[1] formal support refers to services provided by health-care and social service agencies.

[2] informal support refers to services provided by kinship networks, friends, neighbours and volunteers.

> "A person with a disability is a person who has been identified as having a physical, psychiatric, intellectual, sensory or age-related disability (or a combination of these) which is likely to continue for a minimum of six months and result in a reduction of independent functioning to the extent that on-going support is required.
>
> Where a person has a disability which is the result of an accident which took place on or after 1 April 1974, their eligibility for entitlements from the Accident Rehabilitation and Compensation Corporation should be determined".
>
> (Ministry of Health 1994).

Activities of Daily Living

Disabling conditions, as outlined in the Ministry of Health (1994) definition, may lead to a reduction of ability to perform daily tasks. Green (1993) discusses that the reduction of ability may be in activities of daily living (ADL) or daily domestic tasks termed instrumental activities of daily living (IADL),

> "ADL include self-care tasks such as bathing, toileting, washing and eating. IADL include tasks such as shopping, cooking, laundry and cleaning".
>
> (Kane & Kane, 1981).

The disabled elderly therefore may experience a reduced or reducing capacity to manage ADL and IADL tasks (Green, 1993).

1.3 Outline of Thesis

The thesis is structured in seven chapters with Chapter One outlining the purpose, aims and definition of terms used in the study. Chapter Two discusses the literature at a local, national and international level concerning community care and the needs of the older population. Recommendations from researchers for social and economic policy changes which enable the elderly to continue to participate in their community and maintain their independence, are reported.

The research methodology is described in Chapter Three and reasons are given for choosing the qualitative methodology as an effective means of assessing the needs of a specific community group. Means of accessing the target population, ethical concerns such as issues of privacy and confidentiality are fully discussed, as are the problems encountered with data reduction, integrating the data using a multi-data source approach and continuity of the findings across the research groups.

Chapters Four and Five discuss the findings from the semi-structured qualitative interviews with clients and providers respectively. Chapter Four reveals the vulnerability of disabled clients wishing to remain in their homes and their dependency on community care services. Chapter Five uncovers the pressures experienced by community care providers to meet the demand for services from the community of older clients and from the environment of political change. Both groups express their fears for the future if fewer choices and services are available for older people living in semi-rural areas and needing community care.

In Chapter Six, the results from the clients' and providers' discussion in Chapters Four and Five respectively are integrated and consolidated. Not only do clients highly value a positive relationship between themselves and their formal careworkers, but their quality of life is also enhanced by the strong personal networks of informal support. Providers however, find themselves striving at times to meet clients' needs in an environment of uncertainty and tension with the advent of the RHA tendering process.

The conclusions in Chapter Seven discuss the limitations of the study and present a summary of the current service provision for older people residing in Feilding. Findings from the purposive sample of older clients residing in Feilding reveal the needs of clients to receive a range of services to maintain their independence at home. The implications for social policy are analysed and suggestions are made for future research in the community care of older people.

Chapter Two

LITERATURE REVIEW

2.0 Introduction

The literature review explores a range of literature in relation to older people, their health and well-being and issues of community care. Older people have stated their preference to remain at home and 'age in place'. In Feilding, local government has conducted their own social research into the needs of their community. Older people, particularly those living alone and on a low income, were highlighted by the survey as requiring services responsive to their need (Manawatu District Council, 1994).

The literature review discusses key issues for older people which encompass older people's health, cultural identity and the variation of need for assistance reported between individuals and their age-related, disabling conditions. Variations in health status between older people has been acknowledged by the state and represented in the design of community care policies which seek to provide services designed to meet individual need (Ministry of Health, 1994).

The need for individuals to be cared for at home may depend on the availability of a carer. Literature on the caring relationship and the future availability of carers to care is discussed, together with the phenomenon of the gender imbalance between older people as women outnumber men in successively older age groups. The gender imbalance is referred to in the literature as the feminisation of old age. However, for both genders, their financial vulnerability is highlighted by research which shows that the majority of older people are solely reliant on National Superannuation for their income (Saville-Smith, 1993).

Financial concerns coupled with issues of health, housing and community care for older people are reported back to the state by national lobby and advocacy groups such as Age Concern. The state is made aware of all issues for older people through regular research, reporting, and the nationwide monitoring of health and community services through feedback from local branches.

At a local level, older Feilding residents benefit from their access to lobby groups who are actively involved on their behalf as well as their local District Council who assists with the provision of community care services.

2.1 Local Government and Community Care

The Feilding community benefits from a motivated local District Council who responded to submissions from local social service groups by supporting a survey designed and collated by the Feilding Social Issues Network Committee (Manawatu District Council, 1994) of the community needs, services and concerns in Feilding. Survey findings concluded that residents were generally happy with the provision of health services in Feilding and preferred the township's smaller size, available services, and the friendly community environment.

However, among the groups of needy identified by the survey and living in the community were the elderly (especially women living alone) alongside individuals and families on lower incomes, those without transport and those with few friends and family in the Manawatu area (Manawatu District Council, 1994). The older population of interest residing in Feilding were highlighted by the survey as being in need of community support services.

Doubts about the capacity of centralised Palmerston North city community support services to cope with the increasing dependency of elderly people have been expressed (Strategic Planning Unit, Palmerston North City Council, 1994). If this is the case, then the rural elderly of the future may be disadvantaged in comparison with their city counterparts. Those seeking to remain in their rural communities amongst long established networks of informal support, may find their choices restricted by the lack of supplementary formal support.

Restricting choices for those familiar with their rural community by withdrawing rural health services may in fact necessitate those requiring community care to leave the familiarity and security of their environment. The potential therefore exists for those elderly forced to move, in order to access community care support services, to experience feelings of isolation and loneliness in an unfamiliar city or institutionalised rest-home environment.

Feelings of isolation, loneliness and the enforced dependency of the elderly isolated from their community and informal support networks were the negative experiences for many elderly in the past and served to hasten the deterioration of their health (Koopman-Boyden 1988). The withdrawal of rural health support services would therefore reduce the choice for rural elderly to remain in their homes and may prematurely return them to the unsatisfactory environment of institutionalised care. The Strategic Planning Unit, (Palmerston North City Council, 1994) has further predicted that access to services for Manawatu elderly may be hampered by competition for community care resources between those of all ages experiencing psychiatric, intellectual and physical disabilities and residing in the community.

In order to gather information to comprehend the implications for older people who may need to compete for resources alongside others seeking to maintain their independence and quality of life at home, previous studies and reports have been sourced concerning older people and their need for community care. The issues for older people when growing older are the diversity of extremes of their health, wealth and education and life expectancy. These are discussed more fully in the following section.

2.2 The Issues When Growing Older

The elderly population are not an homogeneous group but instead represent the most 'poignant extremes' of society (Koopman-Boyden, 1993, p.2.). Extremes of health, wealth, education, past employment and income may contrast with experiences of chronic diseases, low income, limited education, unemployment and poor living conditions. In order to understand the community health-care and social needs of older people, it is valuable to understand some aspects of the ageing process and the view of ageing from the elderly themselves.

A contemporary study which adopted a life history approach by Thompson, Itzin and Abendstern (1990, in Britain), acknowledged that there are many valid ways of growing older. Different aspects of life draw together childhood experiences, education, work, past relationships, hobbies and life experiences to create individual, unique, biographies. The authors concluded that ageing was a process of gradual transition rather than a once and for all event. Although one can be as old or as young as one feels with advancing age, physical and mental abilities do slowly decrease on average with later life.

Another British study by Gilleard and Watt (1983) of adults coping with the changes in their ageing parents suggests that individual awareness of ageing may be something people are more likely to see in others rather than in themselves. The two major features of ageing are biological and psychological ageing. Biological ageing represents a change in the ability of bodily tissues and organs to respond vigorously when infected, damaged, stressed or traumatised (through an accident). Psychologically, the ageing process presents a growing awareness that individuals are not immortal, and that the individual's self is challenged by a variety of physiological and environmental changes.

The challenge to staying healthy is to remain as mentally and physically fit as possible in response to the changes associated with age (Gilleard & Watt, 1983; Picton, 1991, in Australia). The challenges of ageing in New Zealand were examined during a process of community consultation of those aged 60 years and over, culminating in a report (Social Advisory Council, 1984). A summary of the views of those consulted indicates that ageing has its own sequence of stages in the normal process of human development. A future increase in life expectancy would mean that not only could people expect to have a number of extra years of active life but that society would be faced with the challenge of providing for their needs (Social Advisory Council, 1984).

Also utilising a community consultation process, a study by the Department of Social Welfare (1990) for the Minister for Senior Citizens, examined issues affecting the older population of New

Zealand. The process of consultation with senior citizens revealed a tension between needs as expressed by the elderly, and decisions that were being made on their behalf by agencies who ignored their expressed concerns. Older people were vulnerable to losing some control over their lives with decisions being made through policies that limited their choices and hastened premature dependence and lack of autonomy (Department of Social Welfare, 1990). Also highlighted was the need for better information to inform older people of the availability and access to services. Concern was further expressed by older people about the level and provision of services in health and housing, cultural considerations and information needs (Department of Social Welfare, 1990).

A different approach to asking older people their view of the ageing processes was undertaken by Job (1984) in Australia who interviewed 205 people aged 80 years and over, residing in the Brisbane suburb of Toowong. The tape-recorded semi-structured interviews took place in respondents' homes, or in some cases, residential care rooms. Interviewees' responses dispelled ageist myths and misconceptions of images of sickness, loneliness, senility, physical helplessness, financial dependence and powerlessness. Most of those interviewed lived independent lives either alone or with family members. They enjoyed good physical and mental health and coped with problems courageously and creatively (Job, 1984).

The Brisbane study reinforced earlier conclusions from the existing international research on the life-histories of this age-cohort[1]. For example, Thompson et al (1990) had similarly concluded that personality differences may influence health, well-being and longevity for the elderly. Older people have the scope for choice but how they use it depends on personal resources and coping mechanisms built up over their lives. Resilience, variety and adaptability, may be a continuation of a lifetime of behaviour. Personal responses and strategies may build a sense of individual meaning and self-identity essential for survival (Job, 1984; Thompson et al, 1990).

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[1] cohort refers to a group of people who share a common demographic characteristic.

In New Zealand a study which focussed on older people's perception of the quality of their lives, was undertaken by Colmar Brunton (1990) on behalf of Age Concern New Zealand. A total of 1,000 face to face structured interviews were completed with random samples selected from the population of interest, namely, individuals aged 60 years and over. Random sample groups were selected from a range of living environments: three metropolitan centres, ten main urban centres and three secondary/minor urban centres. Results suggested that the majority of New Zealanders aged 60 years and over, are positive about the quality of their lives. However, almost one-third of the representative sample of respondents articulated difficulties associated with old age. This group was defined by the study as those whose quality of life is negatively influenced by factors such as living alone, rental housing, poor health, low income and belonging to an ethnic minority group (Colmar Brunton, 1990).

The Colmar Brunton (1990) study concluded that three factors which increased the quality of life for those aged 60 years and over, were determined by an adequate income, good health and social contact. Life may be good with one or two factors, but without the balanced integration of all three factors, quality of life may, "almost inevitably be poor" (Colmar Brunton, 1990, p.17.).

It would seem that old age appears to encompass a diversity of extremes as reported and observed in health, social and financial status as well as the perception of the elderly themselves to their ageing process. An influencing factor for older people and their perception of their old age is their culture.

2.3 Cultural Diversity

The ageing population in New Zealand reflects cultural diversity with Pakeha/European, Maori, as well as immigrants mainly from the Pacific Islands, China and other Asian countries (Department of Social Welfare, 1990). It is believed that New Zealanders of European descent have adjusted to their social reality as ageing citizens but other ethnic groups have yet to experience this adjustment. Even though the mix of medical conditions and disability may vary throughout cultural groups, all cultural groups have the same needs for access to personal health care and to rehabilitation (Richmond, Baskett, Bonita & Melding, 1995).

The emphasis for service providers of health-care and rehabilitation for all minority ethnic groups is to be sensitive to the cultural needs of older people (Richmond et al, 1995). For indigenous Maori, life expectancy is significantly less than for European New Zealanders. However, the proportion of older Maori (kaumatua) aged 60 years and over is expected to double over the next decade (Department of Social Welfare, 1990; Richmond, et al, 1995).

Traditionally, Maori have regarded their kaumatua with respect and reverence, valuing their wisdom and experience so that the role of the older person expands (Maaka, 1993). There is a trend discussed by Heenan (1993), for kaumatua to move away from city areas on retirement. Heenan (1993) suggests that there are smaller numbers of older Maori residing in city areas because kaumatua, who are predominantly women in older age groups, return (migrate) to rural ancestral land. In response to this trend and need to return to tribal roots, some tribes (iwi) have sought to provide for their kaumatua by developing kaumatua flats on local maraes. Older Maori may then have access to long term care within a culturally and spiritually appropriate environment for them, amongst whanau members (Richmond et al, 1995).

Providing a culturally and spiritually appropriate environment is intrinsically woven with Treaty of Waitangi issues and concern for well-being in its broadest sense with economic, social and cultural dimensions (Durie, 1989). Implications from the Treaty for New Zealand health policy and service provision for older people are that providers must be aware of and sensitive to all culture-specific issues such as religion, food preparation, values, expectations and needs. In addition they must have an understanding of cultural differences to ensure the well-being of all older citizens (Department of Health, 1984; Durie, 1989; Maaka, 1993; Murchie, 1984; Pomare & De Boer, 1988).

Community care policies will need to ensure that services are accessible to and designed for the needs of all cultures requiring community support services (Statistics New Zealand, Ministry of

Health 1993). In order to provide services to match the diverse needs of the older population, it is essential for planners and providers to understand the linkages between good health and happiness for older people.

2.4 Health of Older People

The attainment and possession of good health in old age is the most important element for contentment and happiness (Job, 1984; Picton, 1991). There are strong linkages for older people between an active life and the maintenance of good health. Promoting health rather than focusing on disease is essential to restore and maintain good functioning (Job, 1984; Picton, 1991).

How older people perceive themselves and their health status may have been influenced in the past by society's negative attitudes toward the older population (Buckwalter, Smith & Martin, (1993) in the United States). Buckwalter et al (1993) contend that society's negative attitudes toward older people, known as ageism, may be shared by many health professionals who may lack motivation and incentive to work with the elderly population. Ageism as a negative and prejudicial attitude held by society about the aged, may lead to inadequate delivery of mental and physical health care to the elderly population.

Inadequate delivery of health care services refers to minimal care, treatment and rehabilitation which may prevent older people from returning to their former health and/or achieving optimal function (Buckwalter et al, 1993). Also discussed by Buckwalter et al (1993) is the reported view by some health professionals that older people are unable or unwilling to change and therapy for older people has been considered as unlikely to be effective. It has been argued that this negative attitude by health professionals had Freudian influences. Freud lacked interest in the emotional problems of the elderly believing that their behaviour was not responsive to modification (Freud, 1904).

This view has been challenged by studies that have demonstrated that older adults do respond to cognitive, behavioural and in some cases, psychodynamic interventions (Buckwalter et al, 1993, in the United States; Campbell, 1993, and Koopman-Boyden, 1993, in New Zealand). For example, New Zealand studies have shown that diversion therapy also known as activity or recreation therapy may be offered to the elderly to not only relieve boredom and stimulate thought and memory but also to enhance their quality of life (Cooper, 1994; McDougall & Beaver, 1994; Michel, 1994).

The challenge for health professionals is to firstly, "Confront their own biases and perceptions related to working with this complex group of people" (Buckwalter et al, 1993, p. 57). The issue of increasing disability with age however, cannot be ignored.

2.5 Age-related Disability

The ageing population experiences a rising incidence of disability in successively older age groups beyond age 70 years (Opie, 1992; Qureshi & Walker, 1989). The number and proportion of disabled elderly people in New Zealand is predicted to rise as the elderly population ages (Green, 1993; Hunt, 1988; Opie, 1992; Richmond et al, 1995). The definition of disability used in this thesis (Chapter One), refers to the Ministry of Health (1994) definition and covers a broad range of disability including age-related disability. Using a broad definition but only for physical impairments, a Wellington survey (Jack, Dowland, Dourado & Hyslop, 1981), estimated age-specific disability rates. For example, 27.3 percent of the older population aged 65-69 years, had some form of disability, which increased to 89.7 percent of the old older population aged 85 years and over (Jack et al, 1981, p.16.).

These age-specific rates, when applied to 1986 census figures by Green (1993), crudely estimated that the total number of older disabled people requiring assistance was 60,000. This number of disabled elderly is predicted to increase to 160,000 in 2031 and of those 160,000, the high-dependency group of those aged 85 years and over will grow at a faster rate than the low-dependency group of those aged 65 years and over. It is anticipated by Green (1993) that meeting the extra care needs of older disabled people in the future will require some innovative forms of care that will "consume considerable resources particularly human resources" (Green, 1993, p.155.).

The demands and costs for providers caring for older people in their community could be expected to increase based on Green's (1993) research. These issues concerning community care policy are further discussed in the following section.

2.6 Community Care Policy

Community care was defined in Chapter One of this thesis, based on Walker's (1982) definition. In New Zealand, Opie (1991) found that informal care does not complement formal care but largely depends on the availability and willingness of family members to care. Community services of particular importance for older people are home support services which provide assistance with home help tasks such as housework, cleaning, laundry, shopping, personal care and home maintenance and thus assist individuals to remain in their homes and out of residential care as long as possible (Department of Social Welfare, 1990). Green (1993) lists the main services which need to be provided for older people as home nursing, home help, meals-on-wheels, laundry/help, home physiotherapy, occupational therapy and day-care.

For the state, this increased the desirability of redefining caring as an individual responsibility (Green, 1993; Opie, 1992). However, failure to include family financial contributions with economic policies concerning the costs of care of older dependants, has misrepresented the actual costs of care (Green, 1993; Opie, 1992). It has been suggested that the state needs to be more aware and acknowledge that the elderly are both consumers of health care services and providers, (particularly women), in their caregiving roles (Bonita, 1993; Green, 1993; Opie, 1992).

In the past, community care was funded from several sources which resulted in a fragmented delivery system that was not an integrated, coordinated approach which met clients' individual needs (Green, 1993; Department of Social Welfare, 1990). Since July 1 1993, all funding for disability support, which includes the frail elderly, has been managed by Regional Health Authorities (RHA's).

In order to resolve flaws in the past structure and funding policies for community care, the Government began an extensive review of all Disability[1] Support Services (DSS). The DSS review culminated in a discussion document entitled Support for Independence (Shipley & Upton, 1992). A consultative process followed calling for submissions and holding regional seminars to give expression to people's views and ideas about matters concerning disability and improved service delivery (Shipley & Upton, 1992).

The subsequent product was the New Zealand Framework for Service Delivery, DSS, designed to test individual needs through a national assessment process (Ministry of Health, 1994). The new process has two parts, needs assessment and financial assessment. An accredited assessor[2] assesses clients based on a national assessment protocol[3]. Older clients in consultation, where appropriate, with families, whanau and caregivers, decide on the best mix of services available within their RHA to provide the support they need (Ministry of Health, 1994).

According to the Ministry of Health (1994), the logic and design of the Framework has been formulated to enhance opportunities for the elderly to experience quality of life and lessen opportunities for elder abuse and elder neglect. On-going evaluation of service delivery in health-care to the elderly will need to monitor the quality of services to assess the success of this integrated approach to care.

In response to the Ministry of Health's pledge to monitor and evaluate the integrated approach to care, Age Concern (1995) have challenged the Government to urgently review all services affecting

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[1] all disability, included age-related disability

[2] a specialist assessor holds appropriate qualifications and competencies in their specific field of expertise in line with Standards 5.7 and 5.8 Standards for Needs Assessment for People with Disabilities (Ministry of Health, 1994).

[3] at the time of writing the process of national assessment has a national assessment standard, called a Support Needs Assessment Protocol (SNAP). This national assessment standard is now known as a Support Need Assessment Form (SNAF). The SNAF is a client-centred national tool to assess clients' dependency level.

older people. Age Concern believe that the Government's key objective of an integrated approach to care has not been met. Furthermore the Report (Age Concern, 1995) takes issue with the labelling of older people under Disability Support Services in the Ministry of Health (1994) framework; ageing should not be viewed as a disability but rather as a life stage.

The Report endorsed findings by Opie (1991) that fragmented, poorly organised services are likely to increase the stress of carers and those cared for. The challenge for community care service planners and providers will be to deliver an acceptable quality and range of services that will enable more disabled elderly people to remain at home and provide support and respite care for care-givers (Green, 1993; Opie, 1992). Funding for community support services needs to be increased to cope with the demand for care and to lessen the economic burden, social and emotional cost for carers (Green, 1993; Koopman-Boyden, 1988; Opie, 1992).

Green (1993) believes that if community care is to be maintained, five key factors other than the level of disability are important. They are gender, living status (living alone or with others), type of housing, income and access to informal carers (Green, 1993). Women are affected by gender issues because they are more likely to be caregivers (McPherson, 1992, 1993), they live longer and, as a consequence, are more likely to be needing assistance as the incidence of disability increases at older age groups. Gender differences also relate to domestic skill levels which may differ for men and women so that types of assistance needed will vary between genders. For example, married females in this age group mostly stayed at home and developed home management skills in comparison with males who left the home for paid employment but were responsible for home maintenance tasks. Males would therefore be more likely to need assistance with cooking and home-making tasks and females with home maintenance tasks. Gender differences and issues for carers are further discussed in this Chapter (see 2.7 and 2.8).

However, the changes that occurred in the delivery of community care services for older people residing in the Manawatu region were not directed toward the maintenance of community care as suggested by

Green (1993). The focus of change was on the administration and managing of home support services in the Manawatu, Horowhenua and Wanganui areas. The changes began when RHA's took over New Zealand Income Support Service's (NZISS) funding responsibilities for the Home Support Service and the Central RHA (CRHA) implemented recommendations from the 'Living at Home' document prepared by the National Advisory Committee on Core Health and Disability Support Services (1994).

The Core Services Committee (1994) had recommended that an integrated, coordinated long-term Home Support Management Service (HSMS) using assessment as the tool be contracted to help determine the elderly and young disabled person's total care plan. The HSMS had been tendered as a comprehensive service which extended beyond assistance in the home to include Carer Relief, Day Care, Residential Respite and Intermittent Care services. The purpose of the HSMS was to develop either a Home Support Care Plan or a Carer Relief Plan tailored to match the needs of people with the appropriate services (CRHA Media Release, 1995, June).

Locally, the HSMS contract was awarded by the CRHA from July 1 1995, to a newly-formed Palmerston North-based company. However, the HSMS began business operations in a controversial environment of publicly expressed community and health professional scepticism (Myers, 1995 June, Manawatu Evening Standard). Soon after its inception, the HSMS was severely pressured to respond to an unforseen and therefore unplanned change in government policy regarding entitlement to the subsidised Home Support service. Older clients who held a Community Services Card (CSC) were now eligible for subsidised Home Support services.

As a consequence, numbers of referrals dramatically increased above those anticipated by the new HSMS. The flow-on effects of this policy change to the eligibility criteria, resulted in the HSMS struggling to meet the unprecedented demand. The local company was later taken over by an established HSMS already operating in the CRHA region (Forde, 1995, December, Manawatu Evening Standard). The reduction in service provision for older people during the changeover phase of the HSMS contract, reportedly affected the ability of older disabled people to remain at home (Forde, 1995, December, Manawatu Evening Standard).

Unless older people receive sufficient support services to meet their needs, or have available carers to care, the alternative for those who can no longer be maintained at home is residential care in the community. This alternative form of community care for older people was studied by Ogonowska-Coates (1993, in New Zealand) and the differences between life outside the gate and the separate world within this elderly, mostly female environment, were observed. The large elderly community was secure, outwardly peaceful but solitary, with a "sense of lives going on beneath the surface" (Ogonowska-Coates, 1993, p.3.).

Inevitable losses for residents were associated with leaving the family home and a familiar environment. Other losses were in terms of their abilities to perform daily ADL and IADL tasks. Residents were assisted regardless of their abilities, which hastened their dependence on others. If the services provided by residential care could be equally provided as community care in people's own homes or in a purpose-built unit, then older dependent people need not be separated from their community (Ogonowska-Coates, 1993). The absence of a carer however, may reduce choices for older people to remain at home.

2.7 The Caring Relationship

Caring is a social relationship incorporating physical and emotional elements. The responsibility for physical tending and support coupled with emotional feelings of affection, reciprocity and duty, is primarily assumed by women (Opie, 1992; Qureshi & Walker, 1989). Historically, caring for elderly dependants has been provided by middle-aged women without dependent children and not in the labour force (Koopman-Boyden, 1988; Opie, 1992). There is a strong, cultural, social expectation that daughters and daughters-in-law, not sons will assume care of their dependent relatives (Opie, 1992; Qureshi & Walker, 1989).

In New Zealand, Opie (1991) found however that although women are more likely to be carers at home, the male carers interviewed in her

Research with Elders and Carers at Home (REACH) study reported similar emotions to female carers which ranged from love and respect through to anger and despair. Both genders struggled within the caregiving role and two factors were found to influence carers' coping ability; the quality of the relationship between carer and dependent and how the carer perceives his or her caregiving role (Opie, 1991). These two factors were found to be crucial for carers and a good relationship between carer and dependent helped prevent carers from feeling emotionally destroyed and "victims of uncaring social processes" (Opie, 1991, p.7). Support of the carer therefore, must be central to community care policies.

The dependants of caring relationships were found to be in a dilemma according to a study by Day (1985) in Australia. The study found that frail elderly participants were loathe to ask for help, but would accept help if it were offered. What was most important for the elderly participants was to feel needed and appreciated. Another view from a study of the dilemmas of dependency by Lustbader (1991), in the United States, concluded that the best way for carers to assist participants and help resolve the conflict between participants asking for help and preserving their dignity, was to be unobtrusive in their caring tasks. The helplessness felt by dependants then 'recedes into the background' (Lustbader, 1991, p.124.).

Older people prefer the family as the caring unit because of the emotional ties and the flexibility of families to cope with their needs (Opie, 1992; McPherson, 1992, 1993). However, McPherson (1992 in New Zealand) concluded that the future availability of family members to care is jeopardised by demographic trends, the increase in divorce rate for both elderly and adult children and caregivers, changes in the timing of child bearing and increased female labour force participation. There is a corresponding decrease in the pool of traditional helpers, (spouses and children) for the future care of the elderly. Similarly Green, (1993 in New Zealand) concluded that access for older people to a carer is influenced by living alone, being married and having children.

Older people living alone and needing a high input of care in response to their assessed level of need would be unlikely to remain at home to age in place unless they could afford to pay privately for a live-in carer or there was an available family member to care. In contrast, older people living in relationships with a healthy spouse/partner to care can be successfully maintained at home. Having children provides the potential for older people to access a family member to care. However, as has been previously stated the likelihood of available family members to care is decreasing in response to demographic trends such as the increase in divorce rate for both elderly and adult children and caregivers, changes in the timing of childbirth and increased female labour force participation (McPherson, 1992, 1993).

Implications for the future are that the predicted increase in the demand for care is likely to exceed the supply of available family support (Green, 1993; McPherson, 1992, 1993). In the absence of family members, or the capacity of families to provide significant informal support, community support services are heavily relied on (Koopman-Boyden, 1988). Both formal and informal caregivers play a crucial role in the success of older people living at home (Core Services Committee, 1994; Richmond et al, 1995).

In spite of the crucial role played by formal careworkers providing home support services to older people, their status has been diminished by the view that there have been no formal training requirements for careworkers and the lack of a career structure (Core Services Committee, 1994; Richmond et al, 1995). These formal careworkers are mainly women and beneficiaries, usually working part-time and frequently using their own vehicles with no reimbursement for travel expenses. The invaluable work of careworkers is not currently reflected in the reimbursement of their services (Core Services Committee, 1994; Richmond et al, 1995).

2.8 Gender Imbalance - the Feminisation of Old Age

Women are not only expected by society to fulfil the caring role, but women are more likely to outlive their male counterparts in successively older age groups. The inverse relationship between older age and the shortened life expectancy of men in comparison to women has been well documented (Bonita, 1993; Koopman-Boyden, 1988; Opie, 1992; McPherson 1992, 1993). The imbalance of genders in older groups is referred to as the feminisation of old age. Chapter One summarised comparisons between females (10.7) and males (7.5) of those aged 60 years and over residing in Feilding (Figure 1). Feilding gender percentages were then compared with Manawatu (females, 7.8: males, 6.5) (Figure 1). This figure clearly highlights the feminisation of old age in the Manawatu and particularly significant in Feilding.

It is believed that this current imbalance is not naturally created (Bonita, 1993; Opie, 1992; Koopman-Boyden, 1988). These authors argue that it is neither natural for women to live longer than men, have lower incomes, be more inclined to work part-time nor to give up work at marriage if their men demand it, be the primary care-giver for those in need, the home-maker and keeper of family memory. There is vast potential for possible change in social roles with older women committed to a work calling or older men wishing to be home-makers or carers (Opie, 1992; Thompson et al, 1990).

2.9 Financial Concerns

Another concern for many older people is their financial vulnerability, as previously discussed in 2.6 by Green (1993). Concerns about the vulnerability of the elderly in care to financial discrimination and abuse has been expressed (Colmar Brunton, 1990; Human Rights Commission, 1995; Opie, 1992). The Human Rights Commission (1995) report highlighted cases reported to the Commission where elderly in care have been abused by their relatives by being denied access to health-care services. Relatives may fear losing their inheritances through the current practices of means and asset-testing those elderly people needing long-stay residential and hospital care.

The vast majority of retired older people, have no other source of income other than National Superannuation (Saville-Smith, 1993). Many who have all or some of the financial advantages of a mortgage-free home, retirement schemes inherited from their work place, investment interests from past savings, are rewarded by the increase in their spending power, but are still heavily reliant on the government for financial support (Saville-Smith, 1993). Financial support of the elderly has been a political issue concerning the practice of asset and means testing of elderly in order to assess their eligibility for funding assistance to receive health-care support services. The Human Rights Commission (1995) has warned that asset and means testing the elderly, may lead to families denying their older relatives access to health services and residential care facilities for fear that their inheritance may be diminished.

The Human Rights Commission (1995) believes that the practice of asset and means testing the older population is discriminatory on the basis of age. However, the law governing prohibited grounds of discrimination on the basis of age in Part II of the Human Rights Act 1993, does not come into effect until February 1, 1999. Two powerful political lobby groups in New Zealand, Age Concern[1] and Grey Power, articulate the political concerns and advocate for older people.

2.10 Advocacy for Older People

Age Concern and Grey Power have enabled the elderly to be politically active and to promote awareness of their needs which helps New Zealand society as a whole to change attitudes to the elderly stereotype. Both groups are educated, articulate, astute and powerful and through a collective, political voice are less inclined to be ignored, patronised and marginalised (Levine & Roberts, 1993 in New Zealand; Picton, 1991 in Australia). Both groups represent the elderly vote which, in response to the ageing population in the future, successive governments cannot ignore.

The target for change in advocacy is not the individual, but the policies and practices of the institutions with which individuals regularly interact (Knitzer, 1980; Rees, 1991). Institutions may include education, health and social service agencies, legal practices, state policies, administrative regulations and practices and beliefs of professionals (Knitzer, 1980; Rees, 1991). The major issue for advocates is the central role of rights (Alinsky, 1971; Knitzer, 1980).

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[1] Age Concern is a national body with urban and rural branches throughout New Zealand. The Age Concern philosophy is the promotion of Human Rights and dignity for all older people and carers whatever their age, culture, gender, health status or living situation.

Age Concern (1995) has been vociferous in their condemnation of government policies and the continuing failure of publicly-funded health services to respond appropriately to the identified needs of older people choosing to age in place. Age Concern has called for the Government to establish a Task Force to fully review services for older people and to develop a comprehensive strategy to correct existing anomalies in the funding, provision and delivery of these services.

The strategy was based on United Nations Principles for Older Persons, promotional programmes advocating good health for older people and the integration of policies with the wide range of services such as health, housing, income and support services for older people (Age Concern, 1995). The government has responded to this call for a full review and comprehensive strategy (Prime Ministerial Task Force on Positive Ageing, 1996).

2.11 Summary

The stereotyped perspective of the elderly known as ageism, has historically been compounded by the medical model that viewed the elderly as potentially sick and high consumers of medical resources. The medical model served to segregate the aged in institutions and delivered fragmented social and health-care support services to those remaining in the community.

Attempts to redress the expense and inadequacy of institutional care for the elderly have been made by state policies of de-institutionalisation and community care incorporated into the New Zealand Framework for Service Delivery (1994) for people requiring community care. Ongoing evaluation and monitoring of the needs assessment process, issues of funding, access, and adequacy of available services will reveal the strengths and weaknesses of this integrated approach to community care. Age Concern (1995) and the Human Rights Commission (1995) have already challenged weaknesses in the new system.

Community care depends on the availability of carers and services to enable the frail or disabled elderly to remain in their communities. The caring relationship and the quality of care depends largely on the goodwill and availability of formal and informal carers to care. At a local Manawatu level, doubts have been expressed by the Palmerston North City Council (1994) that the city will cope with the future demand for care. For small semi-rural communities such as Feilding, the availability of carers and services to support the predicted rise in numbers of rural elderly, may be inadequate. These factors may force those elderly needing home support to move away from their familiar environment.

These barriers to community care, particularly in rural areas, may impinge largely on women because of their increased longevity in comparison with men, the increased likelihood of age-related disability requiring community support services and the decreasing pool of available carers. A comprehensive assessment of the health-care needs of the elderly has been viewed as a priority (Department of Social Welfare, 1990; Age Concern, 1995).

A need for health issues to be integrated with housing, relates to the appropriateness of housing situations and issues of access, home help and residential care. Another priority is the need for better information, as many elderly remain unaware of the existence and availability of types of assistance and services designed for them (Department of Social Welfare, 1990; Age Concern, 1995).

These contentious issues for older people were supposedly addressed by the resulting policy document, the New Zealand Framework for Service Delivery (Ministry of Health, 1994), which described the integration of all services for the older and young disabled people under Disability Support Services. By following a standardised process of referral, needs assessment and coordination of services, all disabled people were to have access to the essential services to meet their needs and to maintain their independence in the community. Better information concerning entitlements and services was to be provided within this process as well as improved access to community health-care services (Ministry of Health, 1994).

The motivation for the Central RHA to contract out home support services was to improve access for older people to community care, assist those at home with home management tasks and make available relief for carers of dependent relatives. Time will tell whether the HSMS company is able to deliver these services to the satisfaction of their older clients and the network of community care service providers to older people living at home.

This thesis seeks to discover the successes and failures of the current system of community care in terms of the range, quality, access, appropriateness and coordination of services for older disabled people residing in the semi-rural township of Feilding. The next chapter sets out the methodology employed to do this.

Chapter 3

METHODOLOGY

3.0 Introduction

In order to assess whether the provision of community care services is meeting the needs for older disabled people living at home in Feilding, a qualitative methodology was adopted for this thesis. The advantage of using qualitative interviews for this research was that not only would the richness of the data give expression to client participants' and provider informants' interpretations of their experiences of community care, but would enable quality of life issues for the elderly to be examined. Miles (1983) discusses the advantages of qualitative data in terms of the data's uniqueness, appeal and face validity. However, Miles (1983) not only discusses the advantages but also warns of the problems and pitfalls when collecting and analysing qualitative data.

The process of analysis is labour-intensive and may be prolonged and demanding for researchers in terms of the time and energy taken to code and organise data. Presenting valid conclusions from a wealth of qualitative data is difficult if there are few guide-lines for the researcher to follow (Miles, 1983). Strategies used in this study to reduce the difficulties inherent with qualitative data analysis, will be discussed later in this chapter.

A multi-data source approach was used by interviewing two target groups as the units of analysis using numbered questions as the instrument to guide the semi-structured interviews (see Appendices 2 and 3). Group One consisted of client participants selected from older clients aged 65 years and over who were Feilding residents and receiving community care services. Group Two consisted of provider informants selected from a range of medical and social service providers delivering community care services to their older clients in Feilding. Relevant information concerning current and projected numbers of the older population residing in the Feilding area compared with Palmerston North and New Zealand, was gathered from a public source, Statistics New Zealand.

Gathering data from several sources which study the same phenomenon and maintain common threads and linkages is the process of data triangulation (Jick, 1983). Triangulation improves the quality of the research process in several ways. Multiple data sources means that researchers can be more confident of their results. Deviant dimensions of the phenomenon under study are more likely to be identified and the linkages between competing theories are integrated (Jick, 1983). The starting point in this thesis was to select the target population and generalize to that population as recommended by St. Pierre and Cook, (1984). Although random sampling is stronger in terms of generalizability, selecting a purposive sample of the target population has the intention of making generalizability as strong as possible (St Pierre & Cook, 1984).

3.1 Criteria for the Selection of the Target Population

Older Participants

The criteria for the selection of the target population in this study were that participants needed to be 65 years and over, residing in Feilding, assessed as needing community care support services and receiving some form of community care which enabled them to live as independently as possible in their homes. Although some CHE clients are assessed in hospital prior to discharge, the most preferred option is for clients receiving community care services to be assessed in their home. Similarly, ACC utilise their own standardised need assessment form to assess older clients and provide assistance at home during the client's recovery and rehabilitation from an accident.

In order to gain access to the target population, the first approach to the Feilding community was to place an advertisement in the Feilding Herald outlining the focus of interest of this thesis, namely, the community care of older persons residing in Feilding. The Feilding Herald is widely circulated in the Feilding area on Tuesdays and Thursdays. Both a contact name and telephone number were included with the article and interested individuals who believed that they fitted the criteria were encouraged to phone and volunteer to participate. Only one older person responded to the article.

Another method used was to ask for assistance from a Feilding provider of Social Services to the elderly about ways of locating older clients who may fit the study criteria and be available for an interview. A selection of older clients known to the agency were contacted by a community worker to ask whether they would be willing to participate in this research. This method yielded one participant.

As word of the research study circulated throughout the Feilding network of agencies and groups providing services for the elderly, a request to be a guest speaker at a lunch-time meeting of a community group for older Feilding residents was accepted by me. An informal presentation outlined the purpose for the research and involved the audience by asking them to explain what the key characteristics were that made Feilding a desirable place for older people to retire to. The audience of retired older women, some of whom were disabled and all of whom were living in their homes, were receptive and responded with interest and enthusiasm when asked to contribute their view of the Feilding community. The discussion generated volunteers to participate or who were willing to ask friends and neighbours for assistance with this study.

Overall, the most successful method of gathering sufficient numbers for a purposive sample of the target population was to network with the Feilding community. Building a rapport and trust between myself and with those I made contact with as the interviews progressed, yielded more contacts to be made. The purposive sample of volunteer participants from the population of interest gradually increased to nine clients.

Client participants' ages ranged from 67 to 96 years. Of the nine clients, two participants were male, seven were female; two participants lived with a spouse and seven lived alone. One of the two participants living with a spouse was cared for by a spouse and the spouse in this case, spoke for the client. The other participant cared for a dependent spouse. In each case, participants' daily lives were enhanced by the availability of services to support their stated preference to remain in their homes for as long as possible.

Service Providers

Essential services for older disabled people living at home may include home support, personal care assistance, access to subsidised transport, prepared meals, medical services (including alternative provision for kaumatua), adequate and affordable housing, social support (such as budget advice), Day Care to benefit carers and their elderly dependent relatives, information and advocacy. Key service providers to the elderly selected for this study provided these essential community care services to enable the older people residing in Feilding to maintain their independence at home.

Sourcing service providers was comparatively simple. One valuable source of information used to identify and target key service providers to older persons residing in Feilding and receiving some form of community care and support, was the newly published Feilding Social Services Directory (Manawatu District Council, 1994). The other source was the Palmerston North-based CHE provider. Of the fifteen service providers approached from health professional, social service and voluntary social service agencies, fourteen were willing and available to participate.

One provider who was unavailable for an interview was the HSMS. An initial introductory letter of explanation describing the research and the need to make contact with the Field Officer for Feilding, had been posted. Follow-up messages left with the office receptionist were not responded to, regardless of the time and the date they were sent. Persistence was eventually rewarded by telephone contact with the Field Officer and an appointment was made for an interview. Unfortunately the interview was postponed because of illness and eventually cancelled as the provider failed to respond to further messages.

Of the fourteen providers of services to the elderly who were interviewed, eleven were female. The three male providers interviewed all held authority and supervisory roles, although one had dual responsibility to also work with a client caseload. The female providers were all working at the client/provider interface in a variety of roles alongside their older clients residing at home and receiving community care.

3.2 Contacting Study Participants

A standardised procedure was used when contacting all study participants. The procedure varied slightly between clients and providers. Each client participant had already been contacted by a person they knew, to ask if they would be willing to be interviewed for the study. Willing participants were then contacted by telephone by me and the nature of the research and the length of time the interview would take, was explained. An appointment for an interview was made and client participants were interviewed in their own homes.

In the case of providers, each provider informant was initially posted a covering letter, an information sheet and a consent form for perusal prior to the telephone contact and subsequent interview appointment. Willing providers were interviewed on their work-place site or, in the case of two volunteer providers, in their homes.

Ethical issues were dealt with at the time of the interview. Each participant read through the information sheet (Appendix 1) which outline the principles of informed consent, participants' rights, the identity of the researcher, a contact number, addressed issues of confidentiality and detailed participants' access to the findings. Prior to the commencement of the interview, respondents who agreed to participate, were invited to sign a consent form (Appendix 2).

The confidentiality of respondents was protected by the written guarantee of confidentiality incorporated in the consent form. The guarantee covered the anonymity of research individuals' names and a personal guarantee by myself as researcher to respect the confidentiality and anonymity of individual participants. Respondents were told that their taped interviews would be offered to them on completion of the study, or they could choose to have their tapes destroyed.

All participants were interviewed following a semi-structured question format (Appendices 3 and 4) confined to a single session which lasted up to one hour. The qualitative interviews were audio-taped.

However, research participants could decline the use of the tape recorder if they chose. Two participants declined to have their interviews tape recorded and field notes were taken in these cases. These were later transcribed with care to maintain accuracy. Key verbatim quotes written during these last two interviews were valid contributions and able to be used.

3.3 Participants' Responses to the Interview

Client Participants

As has been previously stated, the interviews were conducted in clients' homes. Individual clients were welcoming and responsive to the interview and appeared to enjoy the one-to-one interaction as the interview progressed. Each respondent was given a copy of the questions to follow with the exception of one client who had reduced sight and hearing. In this case I read the questions out loud, carefully and clearly, to ensure the client could hear and understand.

Job (1984 in Australia) commented about the fact that an interview situation is a contrived and unnatural social interaction for most people. The initial tension is reduced when the interviewer establishes a comfortable rapport with the respondent. Job (1984) found, in her study of residents aged eighty years and over, living in the Brisbane suburb of Toowong, that most interview respondents were initially guarded in their statements and uneasy about the use of the tape recorder. Over a decade later in New Zealand and in a semi-rural rather than urban setting, this unease was replicated in this study with two of the nine participants declining the use of the tape recorder.

An added constraint to the interaction between the interviewer and respondent was found by Job (1984) to be imposed on the interview by the presence of a spouse or other family member. Similarly, in this study, varying degrees of constraint were imposed on the interaction between interviewer and respondents at five of the nine interviews due to the presence of either a family member or a careworker. A degree of constraint was unavoidable with the two married participants.

Of the two married participants, one was unable to speak for himself and his spouse assumed a dual role, speaking on his behalf as well as giving her perspective as full-time carer. The participant's spouse spoke quietly even though the participant was in another room, so that the participant could not hear the interview content. The other married participant had confined the dependent spouse to the bedroom for the purposes of the interview and was relaxed until the spouse made an appearance in the room. The interview resumed once the spouse had retreated back to the bedroom.

Of the remaining three clients who were interviewed in the presence of others, one had specified that a family member be present to assist with the interview where necessary. This interview flowed well with minimal constraint for the client, due to the supportive role assumed by the family member who only intervened when the client asked for clarification. The other two clients had their careworkers present completing household tasks which was unavoidable because of the time of day of the interview. These clients were constrained in the sense that they wished to involve their careworkers in the interview to corroborate certain facts when they were unsure.

The remaining four clients who were interviewed alone, concentrated on giving full accounts in answer to the questions and were well able to respond without assistance. Not one of these four were constrained, the interviews flowed well and the information was clear and concise. This more focussed environment between interviewer and respondent is clearly the most desirable and, as Job (1984) also found, added to the richness of the data. However, in spite of the constraints imposed by the presence of another person at the time of the interviews, respondents seemed to genuinely enjoy the experience, openly reminisced, and went out of their way to be helpful.

Three of the nine clients interviewed shared intimate pieces of their life history interspersed with answers to the semi-structured interview design. At the time of the interview, I experienced the dilemma of feeling tempted to turn off the tape recorder as they chose to share personal information of major significance to them, but was inappropriate for use in the study. My reluctance to record this information was due to my sensitivity and concern for issues of confidentiality and respect for their anonymity.

I was aware of the vulnerability of these older people and the trust they placed in me in the interviewer/respondent relationship. I could only speculate at the time about my role as interviewer and the interviewer effect for older respondents of my being a mature, married female with a family of my own. The interviewer/respondent rapport established between myself and client participants who were relaxed in the comfort of their own homes, seemed to me at the time to encourage intimacy. Even though I was a stranger to respondents, they chose to reveal selected secrets from their past life histories.

As the interviewer, I believed at the time of recording that an arbitrary decision concerning the appropriateness of the data recorded in terms of the research boundaries, needed to be made by me. In three cases, once the final question was answered, the tape recorder was turned off by me when these clients chose to continue. Three participants spoke of instances of loss, bereavement and grief from their past life history and my role changed at that moment, from that of researcher to sympathetic listener. These three clients seemed at the time to be unaware of the tape recorder still recording their biographies. The suggestion was made by me to discontinue the tape recording and the three participants agreed that that was what they wanted.

This practice by me could be regarded as restricting the data collection without a reason consistent with the purpose of the initial research. In my defence, the reason for ensuring that the tape was turned off by me following participants' answers to the final question, was consistent with the purpose of the initial research, namely, an assessment of community care service provision for older people residing in Feilding.

Provider Informants

Similarly, establishing a comfortable rapport with the providers delivering services to older people was facilitated by the providers' commitment and belief in the value of community care. Providers were welcoming, interested in the thesis topic and were given a list of the interview questions to follow which they responded to with care. All providers were punctual when keeping the interview appointment and had set aside up to one hour for the purpose.

Of the fourteen providers interviewed, four were guarded at times during the interview, not wanting to make specific statements on the politics of community care. One provider asked for the tape recorder to be turned off in order to finish the political point being made. The tape was restarted once the point was made. These providers were concerned about being quoted and the potential for some of their comments to be seen to be politically sensitive and a criticism of other disciplines involved in the care of the elderly. Opie, (1995) found similar behaviour when interviewing staff associated with the social work contribution to the care of older people.

Conversely, seven providers were very open about the politics of community care, the political short-comings of the constant changes, restructuring and resourcing of their service and community care services to the elderly in general. The interview was used as a forum by them to air their concerns for the future and frustrations with the focus on cost rather than the provision of service to older people.

3.4 Transcribing the Data

Of the twenty-four interviews recorded, twenty-three were transcribed. The reason for not transcribing one interview with one provider is discussed later in this section. Once the transcripts were completed each study participant was sent a written transcript of their interview for comment. Participants were telephoned two weeks after posting their transcripts to check on their feelings about the accuracy and content of the interview and their willingness for the data to be used for the research. Only two of the client participants requested minor changes. The rest, clients and providers, were satisfied for their transcribed contribution to be used for this study.

As interviewer, this acceptance by respondents of their transcribed information, relieved the anxiety I had experienced (previously discussed in 3.3) at the time of the interviews, with three of the nine client respondents. I also received approval of their transcriptions from four of the fourteen providers who had expressed concern about being quoted when making politically sensitive points.

At the time of data gathering, an extra interview was recorded with a family member of one of the participants who provided a large amount of informal care for their elderly relative who lived alone. The interview was a valuable contribution in terms of reinforcing the high value placed by older people on their informal support networks of family, friends, neighbours and voluntary agencies. However, for the purposes of the study, my focus was on assessing the delivery of community care services. The value of informal networks for clients was an issue, but not the focus. This interview was therefore not included in the body of information used in the study results.

Of the fourteen providers interviewed, one was the provider of a privately-funded community care service. The data from this interview was to be used as a means of comparison. However, as the volume of data grew from the thirteen provider interview transcriptions, the usefulness of this extra contribution diminished. A comparison with a private provider of community care was neither the focus of the research, nor an issue, so the decision was made by me not to transcribe this interview for use in the study. This left thirteen provider interview transcriptions to be used for study purposes.

3.5 Data Reduction

A systematic technique was used with the aid of a computer to reduce the data to establish similarities, differences and uniqueness for cross-referencing purposes. The starting point was the Quality of Life (Colmar Brunton, 1990) study as a useful guide when summarising the transcript data using questions as the categories for structuring the information. Each transcript was reduced to key points given in response to the answers for each question for each participant. Key verbatim quotes which gave strong credence and were relevant to the actual experiences of individual clients and providers were selected.

The key points from the client data were integrated to form a collective summary for each question. The same process was used for the provider data. Maintaining continuity in this way, enabled the information to be ordered in a logical sequence which matched the pattern of the semi-structured interviews and enabled cross-referencing to be made between each question, each group and across both groups. A technique of cross-site analysis as described and displayed by Miles and Huberman (1984), was useful when reducing the data, particularly for the purposive sample of nine client participants. A graphical presentation of relevant data on a site-level display in a matrix format, helped to clarify and condense key points for each heading and for each participant.

3.6 Summary

In summary the qualitative interview process was a lengthy but rewarding experience. It was a privilege to have gained entry into the lives of client participants who willingly shared their stories with me. Their scripts included not only their experience of community care but selected pieces of their diverse and productive histories spontaneously chosen at that time to be shared. Participants' lives had been dramatically altered by old age and disability but individuals were still participating in their community in their own way, assisted by formal and informal community care service providers.

In the case of providers, the interview process gave expression to their view of the community care environment and their responsibility to provide services to older clients needing community care to enable them to maintain their independence at home. Their full contribution and response to the interview questions signified their dedication and belief that they were providing adequate services to meet the needs of the older people residing in Feilding.

The key findings from these two sets of interviews with the small sample of older people and their service providers are now presented in Chapters Four and Five respectively.

Chapter 4

THE OLDER PERSON'S VIEW OF COMMUNITY CARE SERVICES

4.0 Introduction

The focus of the study was to assess whether the current provision of community care services was meeting the needs of older people living at home in Feilding. Specific areas of interest concerned the range, quality, access, appropriateness and coordination of services. Interviews with a purposive sample of nine participants, (at times also referred to as clients), who agreed to contribute to the study, uncovered their unique accounts of their experience of community care. The semi-structured interviews were guided by questions (Appendix 1). Participants' replies to the semi-structured interview were integrated under the following headings to consolidate their accounts and present their individual views as well as a collective summary for each topic.

4.1 Community Care Services Valued by Clients

The most frequent contact with a service provider was between participants and their home helpers and care-workers either working for agencies providing home support or as individuals. Other essential services provided were, the Clevely Health Centre[1], the District Nursing Service[2], General Practitioners (GPs), transport services either utilising the Mobility Voucher[3] scheme or providing transport to attend medical appointments in Palmerston North, social workers, social service agencies, for example, Manchester House[4], community

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[1] The Clevely Health Centre is the focal point for elderly community health-care services. Clevely houses services for the elderly such as District Nursing, Assessment and Rehabilitation services, Maori Health and Meals on Wheels. Clevely also provides thirty beds for short-stay and long stay twenty-four hour hospital care for the elderly. Other providers to the elderly such as the Arthritis Foundation, Foundation for the Blind, Diabetic, Dietician and Podiatry services also use the site.

[2] The District Nursing Service is based at Clevely and deals with medical-physical issues for elderly clients living at home through referrals from hospital and community-based health professionals or self referral.

[3] Mobility Vouchers are funded by the Manawatu Regional Council who subsidise transport costs to a half fare for elderly clients who meet the criteria for disability.

[4] Manchester House is a centrally-sited Feilding Social Services centre based

housing[1], Age Concern, family members, friends, neighbours, church groups and lawn and garden contractors.

Four participants were receiving Central RHA-funded home help through the HSMS, two were receiving ACC-funded Home Help, two paid privately for home help and the spouse of one participant managed the home help tasks independently as well as her full-time caring role. Two participants were unable to manage their showering and dressing without assistance from a careworker.

Of these two, one received personal care assistance from the District Nursing Service and one participant received personal care assistance from her home helper. District Nursing assistance was delivered to another participant three times per week for a medical condition. All participants reported a medical history relating to one or more disabilities.

4.2 Participants' Need for Community Care

Six clients had multiple physical disabilities with two of those participants experiencing mental health problems as well. The range of disabilities experienced by participants included spinal damage, Schizophrenia, heart disease, lung damage, Arthritis, stroke, post-polio syndrome, knee replacement, broken bones (either pelvis, hip or leg), reduced hearing, reduced sight, and Alzheimer's Disease.

Participants' age-related disabilities had led to their dependence on community care services, particularly home support. Most participants were accepting of their need for help in their homes although two admitted to feelings of frustration, anger, resentment and disappointment that they were no longer able to manage some or many ADL's without assistance, "To start with I was very resentful

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on a local initiative originating in 1972 from a concern for giving aid to needy people. Manchester House offers a range of services to the community such as budget and legal advice, information, a transport service to attend outpatient and specialist clinics, Mobility Vouchers, counselling services, a foodbank and an opportunity shop.

[1] Community housing is provided by the Manawatu District Council which provides and maintains two hundred and eight flats for older people who receive National Superannuation and have a housing need.

and frustrated and mainly, I think, disappointed that I couldn't maintain what I had gained".

Seven out of nine participants believed the amount of help they received was adequate for their needs. One participant said that the Home Helper did not have enough time to complete all the household tasks because of the dual role in assisting the participant with daily personal care. Another participant was not eligible to receive subsidised home support services and needed assistance with vigorous home management tasks such as vacuuming and washing inside windows.

One participant with an increasing level of physical disability expressed concern at the rumoured change-over from trained nursing staff to careworker assistance with personal care assistance, "I feel more comfortable because they're trained for that type of thing, where these other people that they might be bringing in - how much training have they had?"

Of the eight clients receiving formal home support services either private or publicly funded, one client felt that receiving help at home also meant retaining independence from family members, "I just feel it's necessary and I'd rather do that than make myself worse than what I am or have to, you know, depend on the family or anything like that you see". Another client felt that receiving home support, "was a case of necessity".

This participant further described what it was like to convalesce in a local Rest Home following an operation. Even though the staff there were considerate and understanding the participant stated, "I didn't want to stay there. I thought I would lose my heart if I stayed there....I didn't want to be sitting around like some of them do staring at the walls." This participant was determined to return home in spite of the GP's encouragement to stay in a Residential Care facility.

Regular contact with Home Helpers was discussed by seven participants who confessed that they enjoyed the company of their Home Helpers who, in four cases, were also considered to be trusted friends. However one of the seven expressed annoyance at the variation of output between Home Helpers. This participant explained that one Helper had completed more tasks in the allotted time in comparison with another.

4.3 Meeting Participants' Needs

Clients had hours of home support allocated to them whether they received assistance from ACC or the HSMS. Only one client believed that she needed more hours of help on a daily basis. The participant explained,

> "She comes in just for an hour, which is insufficient because she showers me - because I can't do it myself and makes my bed and by that time half an hour has gone....And it only gives her half an hour left to do, keep the flat clean...she can't even get time to clean the fridge out and the microwave and things like that".

4.3.1 Home Support and Personal Care Assistance

In spite of this disgruntled client's experience, interviews with the remaining five clients who received home support assistance appeared to support the fact these participants negotiated flexible working times to suit themselves and their Home Helpers. The hours and frequency of home support varied. Three clients received from seven to nine hours of home support per week and three clients received from three to five hours per week. One client had home support for two hours once a fortnight, one client managed without assistance as well as caring full-time for a dependent spouse and one participant received twenty-four hour care from a spouse.

Of the three high-user clients, two needed assistance with their daily personal care such as showering and dressing and the other needed a high level of daily assistance with routine home help tasks such as meal preparation, washing dishes, laundry, house cleaning and tidying. One of the nine clients interviewed was supervised and assisted with personal care by the spouse who was the full-time carer.

Of the two needing daily assistance with personal care, one was assisted by the District Nursing service and the other by a careworker who also provided home support. The client who was assisted by the District Nursing Service felt secure with trained personnel but very insecure with the thought that in the future her Home Helper may also be the one to shower and dress her particularly if the Home Helper had not been trained in the method and techniques of personal care assistance. The participant explained,

> "I mean I'm not happy with any Tom Dick and Harry coming to shower me....I, me, I *(sighs)* I'm not even sure if I want the Home, my caregiver to do it - although I like her very much and I respect her - she's a very nice person, willing to do anything, although she's isn't willing to shower me either because she's not been trained".

This client expressed strong feelings against this possible change in service delivery,

> "Because you see they're talking about changing it round and taking the nurses out of the showering and the home service that they do and put other people in....I'm not too happy with that....I feel more confident with the Nurses and the Nurses do know what to look for".

However a different view was expressed by the other client who had always received personal care assistance from the care-worker who also provided home help. The issue for this client was not the dual role of her care-worker in providing both personal care and home help assistance, but what it was like for her to need assistance with her daily personal care,

> "But the hardest part was being showered because I hadn't been used to undressing in front of other people....And it, well they, they were all right about it - this is the thing I suppose - it's how the person is that's doing it, you know?....So now, I mean I don't take any notice of it now because I just feel well, there's nothing more she needs to know about me *(laughs)*....And I know it's unavoidable

> because I just can't wash myself and I can't dry myself is the worst".

Both participants receiving assistance with daily personal care spoke of their initial extreme embarrassment at undressing in front of a stranger. This discomfort persisted particularly for one client conditioned from childhood to feel uncomfortable about undressing in front of others,

> "I mean I don't want every Tom, Dick and Harry looking at me when I'm undressed....A lot of that is me - but it's the way I was brought up....It's something that you'll never, well I've never got used to".

The participant's confidence and acceptance of this aspect of the home support service was due to the professional skills of the staff providing the service. However, assistance with ADL tasks is only part of daily home management.

4.3.2 Transport and Shopping

Essential activities outside the home are transport and shopping. Participants needed access to affordable transport to enable participation in their community with shopping, visiting the library and banks, socialising and visiting health professionals. There was a wide variation between the physical ability of clients to access both transport and shopping services. Access to transport was a big issue for clients and Mobility Vouchers were widely used. One client reported on the necessity of the help she received when using the local transport service,

> "Oh my shopping I can say that I do that myself....I have a taxi to take me and to take me there and bring me back....I don't **do** the shops....I just go to the, to get my pension and to the New World where I can get everything I need....Other little shops I can't manage because the taxi - I can't keep them waiting at every - and I have a job getting in and out of the - and they're very very considerate those taxi drivers you know."

Clients interviewed were appreciative of the extra help they received from the transport service. Transport providers would pick up and deliver their groceries if necessary. The weather made a difference for clients, "Well yesterday I had to go for a taxi 'cos it wasn't very good weather and you see and the taxi drivers are very good".

However, one client spoke of the inconvenience of having to rely on a transport service,

> "If I want to go anywhere, I've got to go by taxi - and it's just awkward you know...well you don't, you can't get the taxi to more or less wait for you to do what you want, you know....You've got to pay them all and then ring up - ring up from somewhere".

Irrespective of the availability of Mobility Vouchers, five of the nine clients, at the time of the interviews, were physically unable to go shopping and needed assistance with shopping either from a paid Home Helper or from a friend or family member. Four shopped independently with one client using a motorised scooter and two using Mobility Vouchers with taxi transport on a regular basis. Of the nine clients interviewed, only one was mobile enough to walk to the shops.

4.3.3 Prepared Meals

The amount of shopping also depended on whether or not participants were receiving a meal delivery service. Two clients were receiving meal deliveries with differing views on the quality of the meals. The satisfied participant was receiving meals provided privately by a willing neighbour. The ambivalent participant was receiving the hospital-based service which operated five days per week and was co-ordinated from Clevely Health Centre.

For this client the criticism was directed at the food presentation and the design of the meal container rather than the quality of the meal. The meal delivery service was trialling several meal containers at the time of the interview and the client explained that,

> "The present containers are not all that satisfactory....There are no divisions in the base of the container the way there used to be....The meat portions are generous enough but the meal itself isn't as nice because of the mixing through from the other portions."

However, this participant also agreed that the meals were improving,

> "It all depends on who the cook is whether the meals are nice or not....I had a nice meal today - lamb chops, roast potato, pumpkin, peas and beans....That's much better than pasta every day....They seem to have forgotten that now thank goodness".

The frustrations experienced by participants with their decreasing ability to perform ADL tasks such as food preparation were compounded by their decreasing mobility which also affected their ability to garden and mow their lawns. Four participants paid privately for lawn and garden maintenance as often as was deemed necessary by them and only one participant who was a full-time carer still managed the garden and outside maintenance tasks.

4.3.4 Financial Assistance, Safety, Aids and Appliances

Five participants received a Disability Allowance[1]. Clients could choose how they utilised their Disability Allowance, renewable annually. Two of the five participants utilised the Disability Allowance to assist with payment for outside maintenance, one participant for a Day Care programme and two participants for their personal alarm systems. Both participants with personal alarms had used them successfully to summon help in an emergency.

Of these two, one could not wear the neck-pendant alarm which was the desirable alternative because of interference with the participant's pace-maker. The alarm was instead placed in the bedroom, had been

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[1] Disability Allowance application is signed by the client's GP, is Income and Asset tested and administered by NZISS. The Disability Allowance is direct credited to clients' bank accounts on a fortnighly basis and is a cash injection to assist the payment of lawn and garden contractors, or a personal alarm system for security.

tested and was found to be working well. The participant described an incident which tested the effectiveness of the personal alarm, "When we had a black-out not very long ago that thing went "beep, beep, beep, beep", and they answered it, so I know they're on the ball".

The other participant wore the neck-pendant alarm which enabled a prompt response,

> "They are always ringing me up to see how I am....I think I must press a button unintentionally!....I had to ring them up once....I don't know what it was, a heart turn or something....They have a list with three or four names on it....The first name is my niece but she was away at the time, so they rang the next one and she came".

Participants used a variety of security, mobility and personal comfort tools to assist them within their homes. Six participants used a stick for support when necessary and one participant used a walker frame, a device for retrieving objects off the ground, and had purchased a specially designed chair for seated comfort. One client who had been wheelchair-bound at times whilst on the waiting list for an operation, now walked unaided and had fully rehabilitated following the operation. Another client, as was mentioned previously, regularly used a motorised scooter for transport.

Ease of access and physical comfort were major issues for clients faced with physical mobility problems whether they were in a social setting or at home. One of the clients interviewed explained the reason for no longer attending a local social club for older people,

> "I used to go, but I've not given up because I don't like it or anything like that....It's simply because I can't sit in the upright, you know in the chairs that you have there....I like the - if you had ones with arms to them, it helps a lot when you're like I am you know....I find it very hard to get up and down".

Another client described the personal anxiety involved when wondering whether or not to accept an offer of transport to regularly attend church,

> "It does depend whose car you're in, how low the car is. Some of them are harder to get out of than others....So can I still do it?....You know, it's the uncertainty....It does you know, it deals a blow to your confidence....Can you still do these things?....Are you going to get stuck and not able to get out?"

To assist mobility, all participants had handrails fitted in their homes, particularly in the bathroom and toilet areas. Raised toilet seats were common for comfort and four clients had modified bathrooms with wet areas to ease the access and managing of their personal care.

4.3.5 Modified Housing

For participants living in rented Council accommodation, modifications of bathroom areas were willingly organised by the local District Council to meet the changing needs and level of disability of their ageing clients. A suspensory loan for the modifications was provided by NZISS and District Council contractors delivered the service. Participants valued this recognition of their need from the Feilding community for an accessible home environment.

Three of the nine participants were living in rented pensioner accommodation and there seemed to be specific advantages for these participants. The intimate arrangement of the flats within the housing sites encouraged social contact and the provider had willingly adapted rental accommodation to match older clients' changing needs. Most of the rental housing was conveniently sited within walking distance of the central shopping area.

Of the three participants living in rented accommodation, one had been living in a pensioner flat for eighteen years. Two close friends visited regularly and lived close by also in pensioner housing. The participant explained the importance of the social contact with these long standing friends, "We're the only three originals....We also went through the war times together...and we have lots of things to talk about".

Another client in pensioner housing had complained about the ongoing poor quality of the maintenance work to the housing provider. However, the client enjoyed the social contact with the neighbours and when offered the opportunity to move to another housing site, had decided to remain, "Well, I've got plenty of friends here, neighbours which I've got to know....And they did ask me if I wanted to move, but I don't want to move".

For the remaining six clients who owned their own homes, home ownership was seen by them as their security in their old age. One client explained the importance of the security of home ownership,

> "I had made up my mind to have a home of my own - I wasn't going to a Rest Home....It doesn't matter what happens, it takes a bit to put you out of your own home - although nowadays they seem to be able to do anything".

Another client who received a high level of home support was also convinced that home ownership was essential, "Well my home, it's everything....Without this I'd be done....It's very important - it's my life and death you know".

4.3.6 Carer Relief

Subsidised home support services are also available for carers who choose to care at home for a very dependent elderly relative. Such programmes also enable independence and stimulation for dependent clients outside their home environment. One dependent participant's spouse spoke of the conflict between feeling, "Privileged that I can look after him in my own home because I keep good health and am able to do it", and the consistently tiring demands of caring, "It's at night time that I don't handle things so well....I don't get the same rest or sleep that I use to".

The carer explained that sleep was constantly interrupted by the participant needing to be, "up and down to the toilet and...coughs a lot....I only probably get two to three hours sleep each night".

One participant who cared for a dependent spouse at home had been physically disabled prior to an operation. This participant had relied heavily on informal support from the family during this crisis. Short-term personal care assistance had been offered and was available following the operation, but after two visits from the District Nursing Service, the participant declined help in favour of accepting assistance from family members.

The participant believed that as a result of choosing to use a medical insurance policy for surgery in a private hospital after waiting for two years on a public waiting list, access to subsidised community care services had been denied. This participant had not attempted to access any formal support services to assist either with Carer Relief or to provide social and intellectual stimulation for the now heavily dependent spouse.

Another participant's full-time carer described another form of Carer Relief that was available in Feilding for carers providing twenty-four hour care for heavily dependent older relatives. Clevely Hospital provides twenty-four hour hospital care for elderly clients on an intermittent short-term as well as long-term basis. This participant received a planned programme of intermittent care at Clevely Hospital in Feilding.

Intermittent care fulfilled a need for both the client and carer to remain at home for as long as possible. The carer could only praise the quality of care the dependent spouse received from Clevely Hospital staff, "We are fortunate to have them because they listen to people and try to meet both the needs of the care-giver and the person in care". The planned programme was not fully subsidised for the client whose carer (spouse) was required to fund a portion of the care.

During the three week period that the participant was at home, Day Care was also utilised one to two days per week. Day Care consisted of an organised therapeutic programme designed to encourage participants to socialise, reminisce, be stimulated and aware of their environment. The participant was collected and returned home by Day

Care Centre staff in a purpose-built mobility van. The client's carer spoke for the client about the Day Care programme, "the van picks him up at a quarter to ten....He is happy to go but he doesn't remember what he does there".

The suggestion had been made by one of the carers, that Day Care staff document each client's participation in the programme and send this home with the client. The staff had agreed to trial this. Family members had reported back to Day Care staff that the regular note home was working well and encouraged communication between clients and their network of family and friends.

4.3.7 Social Contact

A high value was placed by participants on the support and contact from family, friends, social support agencies and spiritual (church) agencies in Feilding. Where there was an absence of close family members living nearby, friends and neighbours appeared to fill that gap more than adequately for this sample group. The contact from these informal networks ranged from phone contact, shopping, transport, "calling in" and social outings through to providing information, advocacy and financial management.

Social interaction with others continues to be important, regardless of age and age-related disability. However, as a result of decreasing mobility, older participants spent many hours in their homes. They spoke of the necessity for them to be comfortable, feel secure at home and to know who to contact when they needed assistance at home.

4.4 Eligibility and Access to Services

Participants were asked who decided how much help they needed. Of the nine participants, four believed that their General Practitioner (GP) had decided how much help they needed and two of these four thought that the decision was a joint decision between their GP and the District Nurse. Another participant believed the District Nurse was responsible for the decision concerning the amount of assistance needed. Another participant believed that the hospital-based Social

Worker and the Community Worker for Manchester House assisted with the decision for the amount of help this client received at home.

Two of the remaining three participants were ACC clients and were quite clear who made the decisions about how much help they received. Both were regularly assessed and liaised with their individual Case Managers. The remaining participant managed independently of the community care system.

Of the nine participants, two were disgruntled participants. One was receiving a high level of subsidised community care and the other believed that access to Home Support services had been denied because of choosing to utilise a long standing Health Insurance scheme for an operation in a Private Hospital after waiting for two years on a Public Hospital waiting list.

The participant receiving a high level of subsidised community care, experienced a correspondingly high level of disability. This participant's criticism was directed at the allocation of an hour per day to assist both her personal care and home management. The client believed she needed a daily increase of home support hours as well as having a contact number in case of needing assistance for an incident such as,

> "I mean if I needed somebody to do something - I mean if I spill anything which I sometimes do, I have to ring, get in touch with my neighbour and I shouldn't....I should be able to have the help....So it's not very satisfactory."

The disgruntled participant who believed that she had been denied subsidised assistance felt bitter about the user-pays expectation of the health-care system. The unsatisfactory outcome for the participant was intensified by the fact that the participant was caring full-time for a dependent spouse. These events had increased this client's feelings of abandonment by the current community health-care system,

> "I feel that I have been penalised for going privately....I was on a waiting list for two years for my operation and was using a wheelchair at times....The older you get the more you need hospital care....Instead of waiting for hips and knee operations you should be able to go straight in."

Clients' assessed level of need determined their access to services and the amount of services they received was influenced by the following factors. These factors were, whether they were living at home or with others, the nature and extent of their disability and the cause of their disability, either age-related or as a result of an accident. However, clients needed to be referred for assessment and needed to know who to contact to access services. Knowing who to contact is discussed later in this chapter (see 4.7).

Clients accessing ACC-funded services were assessed by their Case Manager. The assessment determined their level of need which was tied to the level of funding they received. Clients liaised solely with their Case Manager who was their key worker. One of the two participants interviewed who was receiving home support services from ACC, praised the ACC Case Manager, "Mr...is in charge of my case so - and he's been really, really helpful".

The criteria for entry to the ACC service for elderly clients was the accident itself. Participants explained that they were assessed at about six weekly intervals. Funding was by a direct credit into their bank account so that clients could directly reimburse a careworker of their choice and/or the provider of their meals.

Overall participants were philosophical about their disability and grateful for the community care they were receiving to enable them to remain in their homes. One participant explained, "I am very satisfied with the help I've been given. They're a wonderful lot of people and I'm grateful and pleased with them."

The fact that of the nine participants, only two had experienced problems in accessing available services seemed to indicate that the support need levels of these participants had mostly been met by the existing community care services whether they were administered by

ACC or health-related agencies. The key to accessing services was the assessment.

4.5 The Assessment Process

For Feilding elderly living at home and referred for assessment, the assessment was mostly conducted in their homes by an Assessor who was either based at the Clevely Health Centre or from Palmerston North Hospital. One client explained that the Assessor had made telephone contact and an appointment was arranged to suit them. Clients could nominate family members to be present at the assessment if they wished and the client received a copy of their assessment.

Two participants found the process and thoroughness of the form-filling and questioning irksome. One stated,

> "I hate forms....I don't like a, question and answer....But I was all right with them...well you see the Nurses have been coming quite a long time and I guess we've kind of become sort of friends".

Another client described her experience of the assessment process,

> "Oh form upon form upon form - they asked me questions and they filled it in....We had a copy of it somewhere haven't we?....Very thorough, very thorough....Yes, that's right and all the needs that I needed you know....They went in and had a look at my - did I need a toilet seat and did I need that - did I need anything?"

One participant was cared for by his spouse and unable to speak for himself. This participant was comprehensively assessed at the hospital by medical staff. The carer described the emotional experience when assisting the participant with the assessment,

> "The doctor asks him questions and he doesn't know who I am when they ask him....They ask him, "Who are you?" and he replies, "I don't know"....I find it really difficult to be there with him during the assessment when they ask him questions and he just doesn't know".

Seven out of the nine participants were living alone so that the outcome of their assessment and their subsequent care plans differed considerably from the remaining two participants who were living with marriage partners. Of the two participants living with marriage partners, one participant was unable to speak for himself; the spouse was the carer and the other participant was rehabilitating from an operation for a debilitating physical disability as well as caring for a dependent spouse.

At the time of the interview, only one of these two couples was accessing community care services to support their caring role as well as to provide their dependent spouse with social contact and stimulation outside the home.

4.6 Knowing Who to Contact

Having a contact person you can trust such as someone popping in regularly whether that person be a Home Helper, neighbour, family member friend or a mix of these support people is very important according to participants. The service may be home help, health-care support, meals, gardening, shopping or just a social visit. The regular reliable contact appears to be vital for an individual's sense of security and well-being aside from the obvious benefits of the home environment being maintained.

Seven of the nine participants gave several choices of who they would contact if they needed help with a problem with their home support services. The most popular choices were neighbours they knew well and family members. Five participants said would contact a neighbour they knew well if they needed help with a problem with community support services and four participants said they would contact a family member.

Three clients said they would contact their home helpers or careworkers and three clients believed that the Clevely Health Centre would assist them. One client mentioned contacting their GP, one client would contact Manchester House and one client believed that Age Concern would assist them. As previously discussed in this chapter, two participants with personal alarm systems had found that they received a rapid response to their call for help, so they trusted that their systems would work in a crisis.

What was significant from the interviews were the gaps in participants' knowledge of the role of the community health professionals who visited them at home, changes in the management of long-term home support services, their entitlement to community health-care services and who had decided the amount and frequency of home support they received. Such issues relate to participants' lack of information and to the coordination of services.

4.7 Coordination of Services

Clients were largely unaware of changes in the coordination of services resulting from the changeover to the HSMS (Chapter 2) and the implications for them. Clients accessing RHA-funded services for the elderly seemed to be confused about the status and function of community health professionals who visited them at home,

> "Well either from Clevely or Palmerston North but you see I get so many nurses come, one then the other, sometimes come to do you, then another one comes to interview you....You see you never know quite where you are *(laughs)*".

Participants were also vague about who the agency was that employed their home helpers and careworkers. Two clients thought that their careworkers were employed by the Clevely Health Centre. One client realised that her home helper's employer had changed but was unsure about the facts, "She worked for hospital but, don't ask me what's happened now because she's not sure herself....You see the Home Helps have been taken over by an agency."

Another client knew that her worker was employed by an agency but did not know the name of the agency, "It's provided through an agency and she gets paid by the agency and I suppose Income Support is paying the agency." Overall, participants were not only also unsure about the agency who employed their careworkers but also their entitlements to community health-care services.

Seven of the nine participants, thought that they were aware of their entitlement to community care services. Of the seven, two were close friends, had both sustained injuries from falls and were able to exchange information about ACC entitlement and how to access the system. Of the remaining two participants, one did not believe that information had been given concerning all of the entitlements, "I don't think I'm fully aware of what I'm entitled to because the Social Welfare certainly doesn't tell you....But I don't think there is any other assistance I do need at the moment".

The other participant had assumed that as a result of choosing surgery in a private hospital after waiting on a public hospital waiting list for two years, access to post-operative home support services had been denied. This client explained,

> "I feel that I have been treated unfairly....Because of the circumstances at the time, I had my operation done privately only to be told that I was not eligible for any Home Help services when I came home....I feel that I have been penalised for going privately".

In spite of the dissatisfaction recorded from two of the nine participants, an assumption could be made based on participants' positive responses, that clients were satisfied with the coordination of community health-care services.

This assumption stems from the fact that the same clients who said that they had no problems in accessing available services also had no problems with the coordination of their community health-care services. Of the two dissatisfied participants, one explained how unsatisfactory the initial contact with the careworker was. This participant explained that the coordination was by phone and not the direct contact in the home that this client would have preferred, between client, careworker and the home support agency,

> "I don't think I had enough consultation with them....I think that they took too much onto their own hands to do these things....And especially when they didn't attempt to know the person, or know me and I think it's all wrong....You need to have coordination and consultations and cooperations in this sort of thing so that's how I feel about it."

The other participant who managed independently from the community health-care system was unable to comment about the coordination of services. Following the question to clients concerning the coordination of services (Appendix 3), participants were asked what was helpful and important now to assist their quality of life.

4.8 Quality of Life Issues for Older Participants

Participants' responses to this question varied and are summarised as follows. The most helpful and important things participants felt they needed now to assist their quality of life were, regular contact with trusted family members, neighbours and friends, closely followed by ready access to shops, health and social support services. Participants spoke of the reassurance they felt from the familiarity of their homes, maintaining their independence within it, and the hope that their health and mobility would improve.

A familiar environment was vital for participants' sense of well-being, with chairs and beds designed for their needs and accessible bathrooms and toilet areas modified for their comfort. A familiar environment appears to assist participants to maintain their independence for as long as possible in their homes. Also important was the regular contact with careworkers and home helpers who could be trusted to work well. Participants also valued their state of health and were hopeful for an improvement in their health and/or disability over time.

Maintaining access to health professionals who monitor the state of their health and ensure their health needs are being met was also valued as was the extra funding provided by the Disability Allowance to assist payment for outside maintenance, personal alarms and day care.

4.9 Summary

At the time of interviewing the participants in this sample group represented not only a range of chronological age but also a range of medical histories of debilitating disabilities. The reality of their experience as recipients of community care services validates their claims and opinions. Participants accessed a range of services to provide their community care. Access was through the assessment process initiated from a referral through health and social work providers. Participants appeared to accept the necessity for assessment. Satisfaction with the help they received and the quality of service was based on the participants' perception of whether their needs were being met.

It would seem from the accounts of these nine participants, that community care providers to these Feilding clients responded promptly, sensitively and appropriately when delivering community care. However, the effective coordination of services was hampered by clients' confusion with the roles of community care professionals delivering services to them at home. These participants were therefore more likely to rely on their informal network of family members, friends and neighbours to contact when they needed assistance ahead of the formal community care providers who delivered the services to them.

The service providers' perspective of the provision of community care services to meet the needs of their older Feilding clients is discussed in Chapter Five.

Chapter Five

KEY PROVIDERS OF COMMUNITY CARE SERVICES TO OLDER CLIENTS

5.0 Introduction

This chapter presents the findings from interviews with thirteen service providers on the range, quality, access, appropriateness and coordination of services available to meet the needs of older clients residing in Feilding. The purpose of community care services is to enable older disabled people to maintain their independence at home. Service providers who contributed to the study believed that the type of services they provided had been determined by the identified need of their elderly clients.

The providers' semi-structured interviews were guided by a series of questions (see Appendix 4). Service providers' accounts are structured under headings which closely resemble the headings used in Chapter Four. Using similar headings has enabled comparisons to be made between each topic as discussed by the two groups, client participants and provider informants.

5.1 Community Care Services

Key Feilding service providers available for older clients were located at both local and central Palmerston North city sites. They included community health-care providers housed in the Clevely Health Centre and long-term home support services provided by the HSMS which were centralised in Palmerston North city. Other local service providers who assist older clients to maintain their independence in the community provide low-rental housing, low-cost transport through the Mobility Voucher system and two well-informed, active agencies advocate and lobby for the health-care and well-being of their older population. Clients needing to access service providers, gained entry to services by referral.

Client referrals were mostly sourced through GPs and the multi-disciplines based at Palmerston North Public Hospital which was also the headquarters of the Manawatu region's CHE. Of the thirteen providers, eight received referrals from GPs, seven received referrals from CHE hospital-based health and social work professionals, six received referrals from community agencies which included Age Concern, Manchester House and Feilding Churches and nine providers accepted self-referrals. Concerned family members were a referral source for five service providers and four providers received referrals from District Nurses. Referrals were based on the identified need for older people to receive some form of community care.

5.2 Identifying Clients' Needs for Community Care

The needs of elderly clients living in the community were identified by service providers as follows. They were, home support and personal care services, transport, assistance with shopping, prepared meals, financial assistance, low rental and modified housing, social contact, information, and Maori-specific needs. These are further discussed under the following sub-headings.

5.2.1 Home Support and Personal Care

The identified need for older clients to receive home support and personal care services was described by an informant,

> "One predominant factor comes through for the elderly, if you can generalise about people which is really quite hard....They need support to be able to cope at home and that can embrace so many different things....The one that's the most predominant of course is the home help - the vacuuming, the dusting, the cleaning, the washing, the ironing - that kind of stuff....But there's a lot that need assistance with personal care".

Another provider explained that there was a distinction between the contracts for home support services. One contract was for short-term home help services and the other contract was for long-term home support for older clients and provided by the HSMS. Short-term home help was provided for older clients in the community who needed extra assistance either following hospital discharge or in the case of an emergency, such as an illness, which temporarily affected the client's ability to perform home management tasks.

Client's assessed as needing long-term home support services would be referred to the HSMS after an arbitrary period of up to six weeks following discharge or recovery from an illness. As well as the necessity for home support, access to transport for medical appointments and shopping was essential.

5.2.2 Transport and Shopping Assistance

Two providers offered a specific transport service for the elderly needing to attend medical specialist and clinic appointments. They believed that the need for transport was crucial for the elderly,

> "One of the main areas with the elderly is transport because they have all these clinics in Palmerston Hospital and they're just asked to be there to get to the clinic....So we do a lot of transporting....And they can't use the public transport often...the bus steps are too high - at the other end...it's a long way to walk - or at this end....I would say that eighty per cent of our transporting would be elderly people who cannot use other services".

Many older people with age-related disabilities do not have their own means of transport. Problems of physical access to services occurred for older persons with limited mobility who not only needed transport but also assistance with transferring into vehicles. The local transport provider explained that the vehicles were not modified to suit all people with disabilities,

> "Sometimes you've got to help....Their legs go on the old people, their knee joints....Often we have to go round and lift their gammy leg in, else, especially if they've had a stroke....It's not a problem".

The provider described further difficulties for older people when shopping. Older clients often needed help when lifting groceries from supermarket trolleys to and from vehicles,

> "Because their arms are gone....You see them out there in their trolleys...most people think, oh well, they got a trolley full, but they forget the lifting....They can't, a lot of them".

The demand for transport was frequently influenced by the weather. Many older people could walk to town on a fine day but on a windy day, problems occurred for those with medical conditions such as heart, chest and asthma and they would request the transport service to assist them. On very hot days older people tired easily and were more likely to access a transport service.

5.2.3 Prepared Meals

Alongside the identified need for transport, was the need for assistance with meal preparation and the provision of nutritious meals. Older disabled clients would frequently experience decreasing mobility which made shopping for food and meal preparation difficult. A meal delivery service in Feilding has been provided for many years to meet this identified need and at a reasonable cost.

5.2.4 Financial Assistance

Providers considered the costs to their clients associated with the payment of medical expenses and transport to services. Providers were very aware of financial problems for many older clients and services responded to this need for assistance with subsidised transport using Mobility Vouchers (Chapter Four), the availability of a Disability Allowance (Chapter Four) and low cost accommodation.

5.2.5 Low Rental and Modified Housing

For older clients with limited mobility and financial assets, low rental accommodation for disabled elderly is provided by a local community accommodation service. The provider explained that clients who meet the criteria for entry have a choice of either living quietly and privately down a right-of-way or to be sited on a busy street where they can observe children and traffic going past.

Providing appropriate housing at a low cost has been a traditional goal supported by the Feilding community. This commitment has ensured that some of the original elderly clients have been in community housing accommodation for twenty years. Some of these clients are now frail, disabled and their needs have become more complex. The willing service provider matched modifications with clients' changing need for access, by providing moveable ramps, widening doorways and establishing wet areas in bathrooms for convenience when showering. The provider explained,

> "It's generally transferring a bathroom into a wet area, shower....We have modified a couple of them for our wheelchair access....with ramps, which are moveable ones which can be taken and used for someone else if, you know, when they're not required at any stage".

Housing modifications are designed in consultation with community Occupational Therapists based at Palmerston North Hospital.

5.2.6 Social Contact

Another essential need identified by providers to the elderly was social contact. An observation was made by a provider that social contact was essential, "Especially when it's pretty crook weather....They just get out of the little flats...they get bored, nothing to do....They've got to see people".

Ten out of thirteen service providers listed social contact as part of their service. The contact between clients and their service may be 'one-to-one' or the provider facilitating social contact through group activities. Social contact was closely linked with providing opportunities for practical support, for example, information to access other services, form filling, budget advice and personal alarms for increased safety in the home.

Social contact was particularly important for carers living at home and caring full-time for a dependent relative. Social contact in the form of an organised Day Care programme provided an opportunity for both the carer and their dependent relative to socialise, obtain relief from the caring role as well as some independence for the dependent elderly person. One provider of a Day Care Programme explained that their clients' needs were, "a little bit different". The provider added that,

> "Mainly they come here to socialise, to feel as they're still worthwhile people and they still actually can enjoy themselves....Because they become very isolated...they can no longer communicate with their old friends or with their families".

5.2.7 Maori-specific Needs

Social contact and community living is intrinsic for Maori who choose to live amongst their traditional whanau-based support systems in the community. Locally, there are few kaumatua residing in Feilding and the surrounding Manawatu District. The provider explained, "There's not too many in Feilding....Off the top of my head, people over seventy - I s'pose I can think of about nine, ten people seventy-plus". In the past, the provider explained, kaumatua have preferred not to access formal health-care and medical services. The needs of kaumatua were identified for those who choose to return to their respective maraes and birth place,

> "In older age you live a lot on memories and you're getting back to your, going back to your roots...to what you remember when you were a child....And you're going back and you're living closer to nature if you're living in a rural area".

To encourage kaumatua to utilise health-care services, providers from this alternative service have Maori ancestry, proféssional expertise in health and social work and understand how to network between Maori, health and social work agencies. The service provides information, advocacy, a network of health support and links Maori people with medical agencies. The provider explained that housing their older people in purpose-built flats on the marae, caters for kaumatua as well as involving them in Marae activity,

> It's the life stream of some of them, our older people....It's just having their grandchildren and never being shut off from anything - they're involved all the time...if only they had been put in a home or something like that, oh they wouldn't last the distance, they'd be dead by now".

5.3 Meeting Clients' Needs

All providers expressed confidence in the way they delivered services in order to meet the needs they had identified for clients. One provider was convinced that an holistic approach was essential when meeting the needs of older people,

> "When you look at an elderly, particularly an elderly person with a disability, you're looking at a lot of things....I mean you look at their social aspect, you look at their safety aspect....Their - even comes down sometimes to nutrition and diet, you know your aids and appliances, your transport, all those sorts of things".

Another provider believed that the core philosophy of their service ensured the quality of their service delivery to older clients. The provider explained,

> 'We take a lot of pride and a lot of integrity about what we do....We are very professional about what we do....I think that it meets the clients' needs well because we are flexible, we are responsive - we network well with other agencies and services".

One provider who delivered prepared meals in the community believed the personal delivery service was valued for not only meeting the nutritional needs of older people but also for the regular social contact. The provider explained that, "Having somebody coming in each day delivering meals, at least it's keeping an eye on people...and if there's a problem they can come back with the problem".

Two providers interviewed praised the work of local community health-care providers to the elderly. One provider believed that older clients were more than adequately catered for by community support services delivered by District Nurses, GPs and other community care agencies, "The District Nurses are absolutely wonderful round here....They are really marvellous". The other provider also endorsed the value to the community of the District Nursing service particularly for older Feilding residents by saying that, "The District Nurses are highly respected and highly valued here".

Providing community care services to older people living at home was thought by government to be cheaper than residential care, (Green, 1993; Opie, 1992). Older people were nonetheless sensitive to criticisms about the costs of care in order to meet their needs and maintain their quality of life. One provider defended the costs of caring,

> "There's an unfortunate attitude that we are costing the country an awful lot of money....Yes we are, but what have we done before and what experience have we had?....We are prepared to go on helping in the community and contribute to it".

Older disabled people who were experiencing hardship as a result of their disability, could apply for financial assistance from NZISS in the form of a Disability Allowance (Chapter Four). The Disability Allowance application was signed by clients' GP and used to help pay for outside maintenance work, personal alarms and Day Care. Subsidised transport was available with the use of Mobility Vouchers (Chapter Four) which entitled the user to a half fare within the town boundary. Mobility Vouchers were promoted by the provider to meet this need. Feilding businesses also supported the transport service by offering a free telephone service for elderly clients needing transport home.

Specific transport needs were met by two Feilding social service providers as part of their service to older people. These providers offered transport for older clients needing to visit Palmerston North for clinic and specialist appointments. Both providers believed they offered a good service for transport because of the extra practical and caring support they gave, "Often the people who take them over will sit with them and chat with them while they're waiting for their thing."

The need for caring social support and contact for older clients who may be feeling lonely and isolated by their disability and who may need reassuring, has been met by two providers working together. The shared service enables clients to have daily contact to meet this identified human need for social contact and support. Another provider meets clients' need through therapeutic Day Care programmes. Such programmes are designed to stimulate clients' communication with others, encourage social interaction and participation in their environment. The provider explained,

> "Mainly they come here to socialise, to feel as, they're still worthwhile people and they can still actually enjoy themselves....they become very isolated because they can no longer communicate with their old friends or with their families and although some of them admit they have problems with their memory, there's a lot that stay in denial".

Meeting the needs of older people with respect and understanding for their culture is the purpose of the alternative community health-care agency. Kaumatua are supported in their need to use indigenous herbal medication known as Rongoa. Historically, Rongoa recipes were not written down but knowledge was learnt from observing family members gathering plant roots, leaves of plants and bark to make the healing potions,

> "I can remember my Mother giving us, making us drink this horrible stuff made from dock roots....She used to boil it up if we got boils...and strain it and put it through the mesh and boil it up again and strain it and put it into bottles....We had to drink it every night...of this horrible yuk stuff....It certainly worked - I never ever had boils again after that".

Blending indigenous with formal health-care support services is more likely to lead to satisfied indigenous clients accessing this alternative service. Client satisfaction is the key to meeting the needs of all older clients receiving community care services.

5.3.1 Measuring Client Satisfaction with Service Provision

The problem with asking older clients if they are satisfied with health-care services was explained by one provider. Older people don't willingly complain when they are unhappy with a health service they have received. The provider gave an example of an older client who was dissatisfied with an aspect of the hospital care service received but was reluctant to explain why on the customer satisfaction survey handed to the client on discharge. The provider encouraged the client to write honest comments and post these to the CHE. The hospital service could then be aware of flaws in their service based on the client's comments and take steps to improve the service.

When providers were asked how they monitored and evaluated client satisfaction with their service, eight of the thirteen providers stated that their service did not have a formal procedure for recording client satisfaction. Of these eight, five relied on "word of mouth" either through the voluntary network of clients, members, or a wide family network. One of these five providers explained that they had not received complaints about their service from the community and believed that some sort of evaluation should be in place. However they often dealt with people in crisis and they believed that asking for an evaluation was difficult when people were under stress.

Two providers responded promptly to clients' requests for service. Of these two, one provider handled client complaints promptly by being visible in the community for clients to communicate with and share concerns. The other provider acknowledged their clients' need for a prompt, accessible and reasonably-priced service. The service meets the need for punctuality by arriving at the client's call within ten minutes. The provider believed that most calls are answered well within this time.

Two service providers acknowledged at the time of the interview that quality measures such as client surveys would soon be in place as a contractual requirement between the CHE and the RHA. One of these providers stated,

> "I wouldn't have over a formal complaint per month over the last two years and we've dealt with something like about, in that time, probably about four and a half thousand clients....We give a very good quality service and

> certainly all the implications tells you, the feedback I receive, that we do achieve high levels of satisfaction".

The five providers who had implemented formal means of measuring client satisfaction used methods which included random sampling, client satisfaction surveys and client evaluation sheets. One provider explained that low levels of client satisfaction had been recorded during a changeover phase from a local supplier to a central city base. Once the new service began, representatives would travel out from the central city base to visit people or they would phone random clients to ask how satisfied they were and suggestions to improve the service.

Three providers had piloted client satisfaction surveys to meet contractual obligations between the RHA and their organisations. Providers had received favourable responses from the randomly selected groups which indicated that their services were meeting client need. Clients' responses were a morale boost for staff because they were positive, offering praise and support for the health-care service they had received. Providers were repeating client satisfaction surveys at regular intervals such as three to six monthly, or annually, to monitor the quality of their service.

One provider had used client evaluation sheets to request feedback on client satisfaction with their services. However the provider stated that client satisfaction with this major community service agency in Feilding was mostly verbal, "A lot of it in this town is word of mouth...because it's so small."

5.4 Eligibility and Access to Services

In order to access the services provided, eligibility criteria for nine providers was based on either an assessment process to determine the clients' physical, psychological, social or age-related need for service, or an interview between the client and the provider so that the client could express their need to the provider. Ease of entry for clients to self-refer and access services was not always publicised widely. For example one provider stated, "It's not a service we publicise because simply the sheer volume of work that could be generated if we ever did that".

The remaining four providers did not specify conditions and eligibility criteria for clients needing to gain access to their services. Nine providers accepted self-referrals but doubts were expressed by one provider about how widely known this simple means of gaining entry to services may be for clients. As one service provider stated, "I would say just simply lack of awareness is probably the biggest problem for elderly in gaining access to our service".

This same provider explained that their 'open door' policy was not widely publicised because, "We certainly don't want to make promises that we can't keep so we're caught betwixt and between". These two quotes reflected the contradiction for older people when accessing services. On the one hand, lack of awareness was a barrier to accessing services, but on the other, if individuals knew they could self-refer, the service may not be able to manage the demand.

There was a variation recorded between service providers who wished to promote their service to the community by advertising, and those who did not. Five service providers advertised their service regularly in the local papers as well as relying on 'word of mouth' to encourage elderly people to access their services. Each of the five providers has their own advertising strategies to promote their service. Of these five, one provider consistently promotes the purpose, availability and accessibility of the service to all older people in need in the community,

> "It's been well advertised in the local papers and and things like that and the churches - it is well advertised in a way and a lot of other community agencies use me too....So people are passed on through different agencies, so yes, it is well advertised in town".

Another provider regularly visits GPs, Rest Homes, churches and any other agencies of interest to the elderly to raise the awareness of the information, education, Day Care and Support Group services they provide. Another provider only advertised in the local and district newspaper when their waiting list had reduced and the supply of their service was greater than the demand.

5.5 Assessment

In order to access long term home support services, clients rely on referrals through their contact with health professionals such as General Practitioners, District Nurses and Hospital Ward staff. Clients are referred for a Support Needs Assessment provided by an Accredited Assessor. The assessment team for Services to the Elderly includes both hospital and community assessors all of whom are very experienced registered nurses and trained specifically in assessment techniques and process.

The assessment process has previously been discussed (Chapter Two). Once a copy of the Support Need Assessment Form is received by Service Coordinators, the client is contacted for an interview either by telephone or, in some cases, a home visit, so that coordinators can assist clients to match their expressed need with appropriate support services. The provider explained,

> "The idea of support services within the home is to keep them out of Rest Homes...and hospital....To support them in their own home so that they can continue to stay there and then they feel...very much more relaxed about it".

Part of the effectiveness of the assessment, treatment and rehabilitation (ATR) process is to establish a rapport and to build a close relationship with the client base. The client/provider relationship is of vital importance in this case as one provider explained, "I think that having a good rapport is very important because it allows you to see subtle changes".

An integral part of meeting clients' needs in the area of ATR is to establish linkages between clients' physical, emotional, familial, practical and medical needs. The assessment information is used as the tool when consulting with clients to match the type of services that will meet clients' assessed needs and their stated needs. Clients are then referred to the appropriate services. One provider believed that for the assessment process to be effective, the assessment needed to be very thorough and that the care and support plan must match the stated and assessed needs of the client,

> "Under this new system it would seem that there is going to be room for more variations and so it may be that people will get a better deal....There'll be more options open to them to choose from and I think that that's good".

Clients could self-refer for an assessment but one provider was aware that this was not widely known by older people living at home.

5.6 Knowing Who to Contact

Seven providers acknowledged the necessity for older people to have information available to them and for providers to ensure that clients can access services they are entitled to. One of the seven providers explained,

> "I think a lot of people don't realise what is available...we had a speaker from the Income Support Services to us and the people there were absolutely amazed at what was available and they didn't realise".

Five providers commented that lack of knowledge for clients about not knowing what services and benefits were available was also compounded by clients not knowing who to contact. Difficulties for clients in knowing who to contact were highlighted by another provider who believed that the recent and on-going changes in community health care systems may mean that some clients are disadvantaged if health professionals lack knowledge of how to access services,

> "There are some health professionals and others who simply, you know don't understand the systems well enough to know what they can do to refer, to hook in to the specialist assessment and support services - they just don't know enough".

One provider suggested that one way of solving the problem of knowing who to contact could be the appointment of a central resource person known to all agencies, who could inform clients of available services and how to access those services. Another provider was aware of the difficulty for clients in knowing who to contact for assistance and gave each client a card with the provider's name and address so that clients knew who to ring if they needed help.

In order to assist clients with information, knowing who to contact and handling clients' complaints, eight providers incorporated an advocacy role for older people as part of their service delivery. One of the eight service providers, a powerful advocate for the rights of older people, explained that their agency no longer labels their clients as elderly but refers to clients as older people. An example of the advocacy role implemented by a major provider of services to the elderly was to ensure that clients were discharged safely from hospital into the community. A safe discharge would mean checking on their health-care needs, home support services and the level of family and social support available so that they could either return home or begin a placement of their choice in residential care.

5.7 Coordination of Services

The effectiveness of service coordination for older Feilding people could be measured, according to service providers, by identifying specific gaps in services. One provider commented that,

> "Overall there's a big gap in Feilding when it comes to the elderly....There's still so much more that we could give them. It's just a matter of working out what's going to work and what's not and starting to fill that gap".

Another provider explained that the previous gap in accessing emergency treatment from local health-care services has now been addressed in Feilding with an answer-phone service linked to the General Practitioner on call. This emergency linkage has been enhanced by the recent employment of a full-time ambulance operator to answer emergencies in Feilding and the surrounding area.

The lack of a modified vehicle for transport was an identified gap in services for disabled Feilding people. At the time of gathering data however, this problem was being addressed by St John's Ambulance Service in liaison with the Regional Council for the provision of a Mobility van with a wheelchair hoist. Another provider believed that gaps in service delivery have appeared as a direct result of contracting out of services. The provider explained how their short-term home help service continued to provide home support for up to three weeks to bridge the gap that had opened up with the inefficiencies of the newly-contracted HSMS. Their service continued so that their clients would not be disadvantaged while waiting to receive long-term home support services.

The major problem for their service now was the loss of flexibility with funding in their budget to provide for emergency services. Concern for their elderly clients, in this case, prevented the obvious loss of continuity and fragmentation between the short and long-term home support contracts. This provider speculated that the potential existed for their public health service to be contracted out to a private firm. There was a feeling that the RHA wished to,

> "Divest as much of what was public health into private enterprise and not back into seasoned health people because it's easier....The changes that the government and the RHA...the government through the RHA want to make will be easier if you bring in fresh blood".

Prior to contracting out, the services were more co-ordinated, more seamless and very well established, "The lines of communication were all there, it was a good web and very few people fell through the net".

Two providers expressed concern about the process of monitoring and evaluating the home support service. One provider believed that, "the monitoring of the new contract has to be very very thorough and they need to go to the clients and check with them....They cannot just do it on paper". The provider could forsee problems arising for elderly clients living at home if the careworkers employed to assist them were not trained to be observant and alert to their needs and changes in the health of their clients.

The other provider spoke of the differing reports from clients concerning individual Home Helpers. Some clients were not happy with the person who provided home support, but others praised their Home Helpers and spoke of the extra tasks that Home Helpers volunteered to do. The provider had observed that an important part of client satisfaction was to ensure that clients were matched with Home Helpers who met their individual standards and their needs,

> "People seem to really appreciate the Home Help but I'd like to see it monitored more closely with a, basically a supervisor that actually checks with the person receiving the Home Help to make sure that everything's fine and that they're happy".

For some older disabled people, social contact with their Home Helpers may be one of few social contacts they have. In order to encourage older people to socialise outside their homes, one provider discovered that providing transport and activities to access social contact for older people does not ensure that people will comply. The provider had responded to a concern expressed from the community. However, when the provider visited, some older people explained that they preferred to stay at home, did not like to be pushed into going out and believed they had the right to choose. Services continued to be offered to clients labelled the 'sit ins' but clients were not pressured to participate.

Another problem when coordinating services for older people, was the decline in the availability of volunteers. Four providers who relied on volunteers to assist them when delivering services to older people, spoke of the volunteer shortage and their struggle at times to maintain current levels of service. However, one of the four providers admitted they were selective when recruiting volunteers. Not all volunteers were suitable for the type of service the agency delivered to older Feilding residents.

A concern for carers isolated at home by the demands of caring for an elderly dependent relative, was expressed by one provider who believed that there was room for a "sitter service" for carers who needed to go out for a few hours. However in the case of disabled elderly with a medical histoy of dementia, care would need to be taken with selecting a sitter. People disabled by dementia require stability in their environment and need to be looked after by someone who is familiar to them.

The effective coordination of services for older clients relies on a seamless service. The seamless service incorporates ATR and service coordination with all the interrelationships and the communications systems established. A major provider of services to older people in the Manawatu region explained that, "Up until the first of July in our area we did operate what we believe, as far as health services are concerned, was a seamless service".

In support of this claim, seven providers believed that services were well coordinated for older Feilding people. However, two of the seven contradicted the claim by adding that there was an overlap of voluntary social support services and that there were lonely elderly in the community that they did not know about and could be targeting.

One provider had found that coordinating services for older people in Feilding was easy to achieve,

> "There seems to be a community of caring for one another generally and an awareness of what's out there....And it's not really too difficult to tap into some service or other if you really need it for clients".

Another provider believed that positive changes had occurred for elderly people in the coordination of community health-care services. The advent of assessment, service coordination and referral for people to access long-term home support services and the availability of the Disability Allowance, had improved the lives of those who accessed the service, "There were a lot that were just struggling at home trying to do everything you know - no-one to help them". However, one provider acknowledged that the difficulties with coordinating their agency's centrally-based but regionally-coordinated service, stemmed from insufficient referrals from Feilding GPs coupled with transport problems for clients to attend medical appointments.

At the time of the interview, two providers were concerned about the fragmentation of services for contracting and costing purposes and that continuity of service would be lost. One of these two believed that on the one hand, the service co-ordination aspect of community care might improve in the future once the HSMS became more established, but on the other hand, this extra point of contact may be confusing for clients,

> "What they've done is they've put another face in the frame so that not only is the service fragmented but the client has to see another face...and I don't think that's helpful for the client".

The other provider believed that continuity of service had been lost through the changeover to the HSMS. Both clients and service providers were unsure about how to access the new system and were finding the different documentation difficult to manage. However the positive change with the new service was that more older clients were eligible for subsidised home support services if they were CSC holders.

Another provider commented that time would tell how well the changes to the management and delivery of home support services would work for clients,

> "If there's going to be a change of caregiver, that may be very upsetting if they've had someone for a long time....If it means they lose - if in an assessment they only need showering and they end up with a caregiver rather than the District Nurse, that will be upsetting".

The provider explained differences in the criteria between the HSMS and ACC when employing a home helper or careworker. The HSMS had a policy of not funding family members to provide home support for their older relatives. However under the ACC scheme, older disabled clients were given the money and could employ family members if they chose. It would appear that the ACC system was more culturally appropriate for Maori who could name a whanau member as a preferred provider.

The alternative health-care provider for kaumatua discussed the fact that service coordination utilised the informal established social networks. These networks which linked families with the service provider, provided knowledge about who to contact and how to go about accessing information and services to assist them with the care of their kaumatua. However, the service must still comply with formal documentation stating their philosophy, standards, procedures and policies, regardless of their alternative practice, to satisfy the funding demands of their RHA contract. Overall, providers believed that the effective coordination of community care services enhanced their older clients' quality of life.

5.8 Quality of Life Issues

Four providers agreed with the Colmar Brunton (1990, p 17) study findings that "good health, adequate finances and social contact" were the key factors to enhance the quality of life for elderly clients. Another provider believed that to improve elderly clients' quality of life they need lots of services, "The whole move is toward community care but if people want to stay in their own homes they've got to provide the services - they've got to be funded."

Another provider said that the ageing process itself does have frailties and reduced capacity in all sorts of areas. However the provider believed that when health professionals make decisions for older people, they can, with the best intentions in the world, undermine their elderly clients' independence. Health professionals working alongside the elderly should, "Try and help them maintain a sense of control and power over their lives."

This view of encouraging the elderly to maintain their dignity and to acknowledge their contribution to life was supported by the provider for kaumatua living in the Feilding area. The provider believed that an essential component of the health and well-being of this group, is to live and socialise alongside their extended family and grandchildren. Older people need to feel connected to their environment,

> "It doesn't matter what they're like physically or mentally, they still have a lot to contribute....And little kids, they love being around their Nanna even though Nanny sometimes says some funny things or is a little bit funny or talks to herself and all that....I mean it's all part of the .human scene isn't it and kids grow up with it".

One provider stated that although quality of life was a complex and an individual matter,

> "Social contact is a major thing for many elderly....They don't want a high level of social contact, they just want some and for a lot there isn't much at all and that's quite sad to see".

5.9 Summary

In summary it would seem from the responses to the interview questions that the community care service providers to older people believed they offered a comprehensive range of services based on the identified needs of their client group. Of the thirteen providers interviewed, eight were either employed by the CHE and/or contracted to the CRHA. These eight providers were aware of the necessity to adhere to the terms of their contract and to demonstrate through specific measures, for example client satisfaction surveys, that they were meeting the needs of their older client group and therefore providing a quality service. However, at the time of the interviews only four of the eight had implemented specific measures.

Other service providers either funded through social service agencies or local community-based funding, were aware of the social and financial needs of their clients for low-cost modified housing, social support, information and social contact. Access to services relied on referrals from social and health-care providers as well as the informal network of family members, friends and the client's themselves. It would appear that problems for clients wishing to access services were alleviated if the following conditions were met. These conditions were that, regular referrals were made from community health-care and social service agencies, the service was advertised and promoted, clients knew who to contact and transport was available and at an affordable cost.

Providers, whilst acknowledging gaps in their service provision, believed that their services were appropriate. For example, an alternative community health-care initiative was sensitive to the needs of kaumatua and provided valuable linkages between the community and health professionals. However, there was room for improvement in the coordination of services. The effective coordination of community care services should ensure that older clients living in the community have access to an integrated service that meets their health, social and cultural needs.

Difficulties in providing a seamless service have arisen due to the increase in numbers of providers participating in community care. Providers reported problems with under-resourcing, such as reduced staffing levels, under-funding and failure at times to consult with older people and share information. However, providers of services to older people residing in Feilding were very aware of clients' needs and were trying hard to meet those needs within a changing and complex community care environment.

Chapter Six combines and summarises client and provider findings on the provision of community care services for older Feilding clients. Meeting clients' needs in terms of the range, quality, access, appropriateness and coordination of services is further discussed. These findings are analysed in relation to the literature reviewed in Chapter Two.

Chapter Six

SYNTHESIS, INTERPRETATION, DISCUSSION OF FINDINGS

6.0 Introduction

This thesis research was designed to assess whether the needs of older people residing in Feilding were being met by community care service provision. The aspects of service provision under scrutiny are the range, quality, access, appropriateness and coordination of community care services. The results from qualitative interviews between a purposive sample of nine older clients (Chapter Four) receiving community care services in Feilding were blended with those from a selection of thirteen service provider informants (Chapter Five) delivering community care services. These results were integrated with previous research findings in the literature review (Chapter Two) in order to highlight similarities and differences concerning older people and their need for community care.

6.1 Community Care Issues

The formal community care services that participants heavily relied on were home support services, which included home help and personal care assistance and other essential services such as transport, prepared meals, adequate housing, and outside maintenance work to maintain their independence at home. Similar findings were found in previous research (Department of Social Welfare, 1990; Green, 1993; Koopman-Boyden 1988). The services provided for older Feilding clients were both centrally and Feilding-based community health and social service agencies, as well as low-cost transport and low-cost modified housing.

In this study, seven of the nine participants were receiving formal home support services. One of the seven, was a disgruntled participant and claimed to need more hours of home support. Two dilemmas had arisen for this client such as, not knowing who to contact to have the Care Plan reviewed in order to ask for more hours and the difference in the output between careworkers.

Providers' recommendations to solve clients' problems with home support, were the regular monitoring of home support services and the introduction of quality measures such as client satisfaction surveys.

Both monitoring of services and quality measures were prescribed by the Ministry of Health's (1994) Framework and linked to service quality as discussed in Chapter Two (2.5). However, once the data results from clients and providers were integrated, it would appear that three factors inhibited clients from either praising the service they had received, or voicing their concerns. These factors were, clients' not knowing who to contact, the reluctance by older clients to complain, and the fact that only five of the thirteen providers interviewed were distributing client satisfaction surveys.

Providers who referred clients to home support services believed, however, that recent changes to home support service provision had disrupted the existing service networks and that more time was needed to establish new linkages between services. This was a logical explanation, but was unhelpful at the time for the disgruntled participant seeking more hours of service and careworker efficiency.

At the time of the interviews, the management of home support changed to the contracted HSMS system. Of the six clients interviewed who were receiving subsidised home support services, only one was aware that there had been a change in the management of home support services, but was unsure of the facts. The reason for this appeared to be that these six clients were already receiving home support services funded by either ACC or the Central RHA. Their services were simply 'rolled-over' because they were already in the community care system; their hours were not disrupted and their careworkers continued to deliver services regardless of the change in management.

However, this lack of awareness contrasted with providers' heightened awareness as they found the changes (from July 1, 1995) both uncertain and confusing. The lack of information from the RHA to community health-care services about the changing lines of responsibility, meant that existing providers were unsure about their service boundaries. One provider whose service was directly affected as a result of the change, continued to provide a short-term home support service beyond the level of their funding after the July 1, 1995 changeover to the HSMS as previously discussed (Chapter 5.7). The provider chose to extend their short-term home help service regardless of the cost, rather than observe disabled elderly clients struggle to manage on their own.

This provider acknowledged the tension between the need for accountability and a reduced level of funding from the RHA. Incidences such as these tested the compassionate and caring culture of a community care service for Feilding clients regardless of the conflict between the RHA contract and the funding resource to provide the service. It would seem that the divestment of the long-term home support service to a separate agency had eliminated the flexibility and funding provision inherent with the original service to the older community. However, in this case, the goodwill and professionalism of a long established community care service remained.

Another concern raised by one heavily dependent client participant and two providers, was the possible change from experienced District Nursing Service providers to careworkers for assistance with clients' personal care needs. A change from a trusted and highly respected provider to an unfamiliar provider agency responsible for employing careworkers to assist with personal care assistance was an unpopular change. For clients who had built up trust and a rapport with their existing personal care helpers, a change of provider posed a threat to their confidence. The necessity for careworker training was shared by both clients and providers and also strongly supported by Government-funded reports (Core Services Committee, 1994; Richmond et al, 1995).

Nevertheless, there could be a reassuring message for the apprehensive client. Overall, clients clearly valued a careworker who demonstrated a helpful, flexible, considerate attitude and someone they could trust and rely on to be punctual and complete tasks in the allotted time. Trained providers who met these desired standards, would be capable of delivering a service that met the clients needs for care, regardless of the agency who employed them. Care-workers' training will be essential to ensure the safety and well-being of older clients living at home (Core Services Committee, 1994; Richmond et al, 1995).

Two participants described how it felt to need assistance with personal care. They spoke of feeling vulnerable when receiving assistance with private and personal tasks. However providers, whilst identifying the need for clients to have assistance with personal care, did not elaborate on their understanding of clients' feelings about what it was like to need to be assisted with showering and dressing. The routine, practical nature of these tasks may mean that health professionals forget how self-conscious their clients are when needing assistance with them.

The value of building a rapport and trust between clients and providers in these formal support relationships, was voiced by client participants in this study. Apart from one provider who discussed the importance of rapport building with their clients (Chapter Five), providers made no mention throughout the interviews of being aware of how important this was for clients. Clients, randomly selected to respond to client satisfaction surveys from RHA-contracted providers as a quality measure have an opportunity to voice these feelings. Comments from clients feeding back to providers should increase providers' awareness of the need for clients to trust their providers.

The need for all services contracted to the RHA to meet their contractual requirements was indeed pressuring providers to ensure client satisfaction with their services through documented measures. However, feelings of confusion, frustration and uncertainty were reported from these providers who believed that decisions were being made without consultation and that the integrity of their services was being eroded by cost-driven, rather than quality-driven, decisions by the RHA.

Considerations for cost and quality were key issues for the local provider for pensioner housing in Feilding who stated their commitment to provide and modify housing to meet the changing health and mobility needs of their older disabled clients. This commitment from the local provider to the older Feilding residents, enabled older people to be well provided for in terms of their housing needs and in comparison with their national counterparts. At a national level, the government had been severely criticised in the Age Concern Report (1995) for failing to implement a housing policy that would enable older people to move easily into better-designed and better-sited accommodation. Recommendations from an earlier Department of Social Welfare (1990) Report, had identified a need for social policy to integrate health with housing issues for the elderly.

In Feilding, the housing provider has not failed to implement a housing policy to suit the needs of their older disabled clients. Existing accommodation is being modified to suit the clients' changing needs and the housing is sited close to services. It would seem that the local provider is adapting housing to meet clients' needs and in this sense is integrating health with housing issues as recommended by the Department of Social Welfare Report (1990).

6.2 Clients' Needs Matched with Providers' Services

Participants' not only spoke of their frustration and disappointment at the loss of mobility but also the corresponding limitations and changes to their daily lives. Similar feelings were expressed by participants in two British studies (Gilleard & Watt, 1983; Thompson et al, 1990) who reported their awareness of the process of gradual transition as they grew older. Experiences varied between these individuals, depending on their health status and personality. Variations were also recorded in this thesis between the health and mobility expectations of ACC-funded clients and RHA-funded clients receiving home support and personal care services.

Differences related to the fact that the two ACC clients interviewed expected their mobility to improve over time as their injuries healed. One of these two expected the level of home support through ACC to decrease in response to an improvement in physical mobility. In contrast, RHA-funded clients did not expect an improvement in their health status: their needs were long-term needs.

Clients' long-term needs for assistance with mobility at home were helped by the use of aids and appliances. This assistance was crucial for the comfort and mobility of the participants interviewed, as discussed in Chapter Four. Such tools were essential for all client participants with only one of the nine able to walk unaided for any distance and this was only after lengthy rehabilitation following an operation. Aids for older people are discussed by Richmond et al (1995) levelling criticism at GP's, the usual contact for the elderly, who failed to inform their clients of the technology available and information about who to contact to access these services. Referrals by doctors to Occupational Therapists and Physiotherapists are essential for the elderly disabled, so that their independence is optimised and their safety improved (Richmond et al, 1995).

Older clients need practical assistance, as one provider explained, to encourage their independence and safety. Older clients frequently needed help with lifting heavy objects, such as shopping bags from shopping trolleys into cars and once home, from the car to their house. Similarly, a need for assistance with lifting heavy objects was shared by almost half of the older people who participated in the Age Concern Quality of Life study (Colmar Brunton, 1990).

The need for assistance because of physical limitations and the physical discomfort experienced with access problems, discouraged two of the thesis participants from attending community activities. However, of the thirteen providers interviewed, only two acknowledged these barriers faced by older disabled clients as a result of their decreasing physical abilities. Providers spoke of their clients' need for social contact, but they did not comment on the physical and psychological difficulties experienced by client's when leaving the comfort and familiarity of their homes in order to participate in social activities.

The need to feel secure and safe at home is an issue for older people, particularly for those living alone (Colmar Brunton, 1990). Decreasing mobility increases the need for security and safety for clients. The Feilding Social Issues Network Committee (1994) survey found that most of the 3.1% of respondents who reported that they felt either unsafe or very unsafe, lived alone and/or were elderly (Manawatu District Council, 1994).

This thesis also found that security and safety were issues for older disabled clients. Two client participants had personal alarm systems installed to increase their feelings of security and to reassure their families concerned for the safety of their older relatives at home. Funding assistance for personal alarm systems was available through the Disability Allowance (Chapters Four and Five). Funding assistance was essential for those on lower incomes to cover the costs of extra health expenses and payments to contractors to maintain gardens and lawns.

Eight of the nine participants were frequently house-bound by their physical restrictions and having their home environment maintained was a boost to their sense of well-being. Providers, in turn, were sensitive and aware of older clients' need to feel secure and to maintain their environment to enhance their well-being. Consulting clients about their needs is essential to ensure that services are appropriate for clients seeking to maintain their independence at home.

The need for consultation was a major issue articulated by older people in the Department of Social Welfare (1990) report. The Report found that older people preferred to have some control over their lives and wished to be consulted concerning decisions that were being made on their behalf. It would appear from thesis research findings, that Feilding-based providers are regularly consulting their clients. However, as one provider explained, it was difficult to consult with older people who lacked family members, were not known by local community care agencies and the provider was unaware that they needed assistance.

These concerns were also voiced through results from the Feilding Social Issues Network Committee survey (1994) which were outlined in Chapter Two and concluded that there were groups of needy individuals living in the community. Needy groups included the unemployed (of all ages), the elderly (especially women living alone), individuals and families on lower incomes and those without families and friends in the area (Manawatu District Council, 1994).

The issue of lonely elderly either living in the community or in long-term residential care, has been addressed by a service provider who has initiated a visitors service staffed by trained volunteers. This service reaches out to older people who agree to participate and are known to have limited informal contact with family members and friends. Another community care initiative provided for clients either living at home alone or dependent on full-time caregiving by a spouse or family member, is subsidised Day Care programmes. As discussed in Chapter Two, older people do respond to therapeutic programmes which include recreation and activity therapy. Such programmes relieve boredom, stimulate thought and memory and enable clients to participate in their environment (Buckwalter et al, 1993; Campbell, 1993; Cooper, 1994; McDougall & Beaver, 1994; Michel, 1994).

Sharing the care with others, as explained by one participant's spouse and one provider of Day Care, has the dual benefit of enabling carers to have a break from their caring role and the opportunity for socialising independently outside the home for both the carer and the dependent older relative. Previous research has highlighted the emotional and psychological struggle carers may have with the full-time caregiving role (Opie, 1991; Qureshi & Walker, 1989).

The availability of a full-time carer was a determinant of whether an older disabled person could remain at home (Core Services Committee, 1994; Richmond et al, 1995). Of the two client participants living with spouses, one cared for and the other was cared by a spouse. Community care policies whilst providing some formal support for those living alone, still depend on families being available to care and to provide informal support (Opie, 1991; Richmond et al, 1995). Both dependants would have needed long-term residential care had they lived alone.

Both carers in this study, were women. Chapter Two discussed gender issues inherent with the caring role such as the predicted unavailability of female carers to care in the future given demographic trends. Demographic trends included the increase in the rate of divorce for both elderly and adult children and caregivers, changes in the timing of childbirth and increased female labour force participation (Green, 1993; McPherson 1992, 1993). In the absence of family members, Koopman-Boyden (1988) found that formal support services are heavily relied on. Given that future predictions point to the unavailability of female carers to care (McPherson, 1992), the demand for residential care placements may increase for those who live alone without an available spouse or family member to care.

Another gender issue discussed in Chapter Two, was the feminisation of old age and the likelihood of women outliving men in successively older age groups (Bonita, 1993; Koopman-Boyden, 1988; Opie, 1992). Of the nine participants in the purposive sample used for this study, seven were female and two were male. Even though the gender ratio of females to males (7:2) in the small sample used for this study was coincidental and included a broad range of ages across both gender's (age 67 to 96 years), this ratio compares with the percentage of females (10.7) to males (7.5) aged 60 vears and over residing in Feilding (Statistics New Zealand 1994a), as discussed in Chapter's One (Figure 1) and Two.

However, the significance of gender differences, whilst pertinent to the body of research on understanding the community care needs of the elderly and strategic planning for the future, was not an issue for this thesis. Participants' interviews endorsed previous findings which have concluded that the full-time caring role is a stressful occupation, even for the most devoted couples (Opie, 1991; Richmond et al, 1995; Qureshi, & Walker, 1989). The relevant issue for those caring for dependent spouses, was their need for respite from the caring role.

One participant who cared for a dependent spouse at home, described their social isolation as a couple, but said that she was still able to go out without her spouse to socialise for short periods. Another participant needed twenty-four hour care and the spouse spoke of the importance for respite care to be available to give both of them a rest from the demands of their caring relationship. In support of their claims, one provider interviewed understood the needs of dependent older people to be included in social, recreational and intellectual activities and to have fun. Carers of dependent relatives needed respite Day Care, intermittent care in some cases, encouragement and information about their older relative's disability.

Eight of the thirteen providers interviewed spoke of the need for older people to be given information concerning their entitlement to practical and financial support, whether they lived alone, were in a caring role, or being cared for at home. The need for providers to assume an advocacy role in support of older people was also regarded by these eight providers as important. Previous research on the elderly has substantiated this information need as well as the important role of advocacy (Age Concern, 1995; Department of Social Welfare, 1990; Levine & Roberts, 1993; Picton, 1991; Richmond et al, 1995).

In contrast with providers' opinion about the importance of information to clients, the need for more information was not included by the nine client participants in their list of perceived needs. It would seem to be an impossible task to reach out to every older person in the community to ensure that they are receiving the services they are entitled to. However, if information is being withheld because of fear that the service can not cope with either the sheer volume of work that would be created, or the cost of the increased uptake rate of entitlements, then clearly the policies underpinning publicly-funded services to the elderly, are flawed. If the demand for services is not matched to the supply of staff to process referrals, then the elderly disabled community will be forced to queue while waiting for services to support them at home.

A community care initiative that has responded to community demand, is an alternative service for Maori, as discussed in Chapter Five. In Feilding, few kaumatua reside in the area and the purposive sample of nine older clients receiving community care services, failed to include a kaumatua for this cultural perspective to be included in the study. However, the alternative provider had an intimate relationship with kaumatua, understood their needs which included the importance to kaumatua of indigenous herbal medicine (Rongoa), was a qualified Maori health professional and delivered the alternative service to kaumatua, with cultural sensitivity.

Similar community initiatives based on traditional Maori values, have evolved nationally for health-care and health education as discussed in Chapter Two. Such initiatives promote healthy lifestyles in a culturally sensitive and appropriate environment (Department of Health, 1984; Durie, 1989; Murchie, 1984; Pomare and De Boer 1988). Strategic health initiatives will hopefully meet the demand for culturally appropriate services to match Statistics New Zealand and the Ministry of Health's (1993) projected increase in numbers of older Maori aged 65 years and over.

Even though few kaumatua were found to reside in the Feilding area at this time, this may change in the future as numbers increase for those choosing to migrate from city areas to rural ancestral land, as predicted by Heenan (1993). An increase in the kaumatua population in rural and semi-rural areas will increase the demand for housing and community care in those areas. Community care initiatives for Maori must continue to respond to need. An increased uptake rate by kaumatua and their whanau in response to community care initiatives may be the measure of client satisfaction with the alternative health-care and referral service for Maori.

Overall, the key to client satisfaction with the services provided is for clients to believe that their needs are being met by the services delivered to them. Chapter Four described clients' perceived needs and the services they valued to meet their needs. Chapter Five discussed how providers were meeting client need, and included discussion of ways of monitoring and evaluating client satisfaction and identifying gaps in service provision. Providers' claims that they were providing services in response to clients' needs were supported by seven of the nine clients interviewed who were content with the level and quality of home support services they were receiving.

Of the remaining two participants who were dissatisfied with the level of service they received, it would seem that the reason for their dissatisfaction stemmed from their lack of knowledge and understanding of how the community care system worked and knowing who to contact. In Feilding, results from the Social Issues Network Committee survey, had served as a quality measure to identify gaps in community needs, services and concerns (Manawatu

District Council, 1994). Those who participated in the Feilding Social Issues Network Committee survey, were asked if they were satisfied with local health services. The District Nursing Service scored very highly (Manawatu District Council, 1994).

Results from the Feilding Social Issues Network Committee survey also supported findings from thesis participants and provider informants about the value of the District Nursing Service (Chapters Four and Five) Findings from thesis client participants also revealed that a common problem for those interviewed was confusion about knowing who to contact to access information on services. This was a replication of similar findings from the Feilding Social Issues Network Committee survey (Manawatu District Council, 1994). Knowing who to contact is discussed later in this chapter (6.5) and is linked to problems for older people with accessing services.

6.3 Access to Services

Of the nine participants, only two reflected back their concern with either failure to access services they were entitled to, or lack of information. Another participant had assumed that their ineligibility for subsidised home support services was related to income and the choice this participant had made, to access private health insurance funding for essential surgery. It would seem that this client's failure to access home support services during recovery and rehabilitation, was not, as the participant had assumed, due solely to income. The client had been allocated subsidised assistance for personal care from the District Nursing Service following surgery in a private hospital, but had declined such assistance soon after discharge home. The participant had opted to use informal help from a family member for showering and dressing.

It would appear that this client's decision to decline the available short-term home support services following hospital discharge, had curtailed the procedure of assessment for long-term home support or Carer Relief. Subsidised Carer Relief services may have been particularly appropriate for this client caring at home for a dependent spouse. The participant appeared to be unaware of the entitlement in this case. However, this case was one of many, according to a later media reports, which stated that older disabled clients had missed out on essential information and community care services following the change in the home support contract from July 1, 1995 (Forde, 1995 December, Manawatu Evening Standard).

The seven participants who were satisfied with their level of knowledge and information about services, discussed the importance to them of the help they received through informal networks of friends and family. Their informal networks frequently sought information on participants' behalf and encouraged participants to seek assistance from health professionals and social support agencies. These findings supported similar conclusions from the Feilding Social Issues Network Committee Survey (Manawatu District Council, June 1994) and the Colmar Brunton (1990) research for Age Concern.

However, the remaining two clients had a clear understanding of how to access information when they needed it and were accessing services successfully through their own ability to communicate with service providers. It would seem that in Feilding, services were being provided to older clients which enabled their independence and autonomy to be maintained thereby matching a recommendation from the Department of Social Welfare (1990) report as discussed in Chapter Two. The key to accessing home support services was the clients' assessment, as discussed in Chapters Two, Four and Five.

6.4 The Assessment Process

Clients referred by a community health professional or self-referred, had to agree to the assessment if they wished to access home support services. The assessment was viewed by clients as more of a formality to be tolerated in order to gain entry and access to subsidised services. The assessment was a compulsory condition and the only means for both RHA and ACC-funded clients of gaining entry to formal community care.

The assessment document which clarified the clients' needs was valued by providers as the tangible evidence of need. The resultant score in either points for ACC-funded clients or Support Need Level for RHA-funded clients determined funding and/or the level of support services required. For the assessment outcome to be effective, the Core Services Committee (1994) believed that the clients' needs must be viewed as a whole picture, together with the needs of the family with whom they may be living. Services should be based on need rather than on the severity of the disability (Core Services Committee, 1994).

Furthermore, support services based on need should promote the health and well-being of older people as discussed in Chapter Two. Strong linkages were found between promoting health and restoring good health and functioning for older people (Age Concern, 1995; Buckwalter et al, 1993; Colmar Brunton, 1990; Koopman-Boyden, 1988; Picton, 1991). Even though Government-funded reports such as the Core Services Committee (1994) Report, promote and recommend community care for older people to enhance their well-being and health status, there is room for improvement to the existing mode of service provision in community care for older people. The subsequent Age Concern (1995) Report was highly critical of the failure by Government to provide an integrated, coordinated community care service that was meeting the needs of older people.

Providers who relied on government-funding for services to the elderly, reported their reluctance to advertise and promote their services, fearing that the demand from the older community would exceed the supply of staff to meet needs for community care. The solution for older clients living in the community who needed access to home support assistance, was to know who to contact for the necessary information.

6.5 Knowing Who to Contact

A solution to bridge the information gap for both clients and providers was suggested by one provider interviewed for this thesis, who believed in the benefit of a central contact person or agency. This solution was also one of the conclusions drawn from the earlier Feilding Social Issues Network Committee Survey (Manawatu District Council, 1994). The survey concluded that Feilding residents would benefit from the establishment of a centralised, efficiently run, well advertised information centre (Manawatu City Council, 1994).

However, with the complexity of change in community care services to the elderly, providing information about who to contact would need to be regularly updated for the service to be effective for older Feilding residents.

The major gap identified in this thesis by providers and supported by clients' comments about service quality was, quite simply, knowing who to contact. This was not a problem for two clients receiving ACC services who knew to contact their key worker, their Case Manager.

For those participants not receiving ACC-funded services, their informal support networks of family, friends, and neighbours, were heavily relied on. Informal networks helped to motivate clients, gather relevant information and provide practical support, for example with transport, shopping and home maintenance. Previous findings support the importance for the elderly of their informal networks (Colmar Brunton, 1990; Opie, 1991). Similar conclusions were reached by the Feilding Survey (Manawatu District Council, 1994).

The Feilding Social Issues Network Committee survey, for example, speculated that the reasons for the reliance on informal networks may reflect residents' lack of knowledge of social services and the lack of an organised information centre. The hidden side of this speculation was the vulnerability and isolation for residents who had no close friends, neighbours and family to turn to (Manawatu District Council, 1994). This did not appear to be the case for the nine participants interviewed in this thesis who had regular social contact with friends, neighbours and family members. However, they seemed confused about the roles of the various community care professionals who contacted them at home.

6.6 Coordination of Services

It could be argued that if the multi-disciplinary team of community health professionals and care-workers visited clients at home at various times, an elderly person could potentially be seen by a Registered Nurse Assessor, Occupational Therapist, Physiotherapist, District Nurse, Social Worker and/or Service Coordinator, an HSMS Field Officer and a careworker. Once services had been put in place to meet their needs, careworkers became the most frequent contact for formal support.

The purpose of Service Coordination was to ensure a client focus, reduce duplication, clarify responsibility and ensure accountability (Ministry of Health, 1994). Service Coordination was designed to identify the package of services required to meet a person's needs, develop service plans with individuals on the basis of their assessed need and negotiate access to services. According to one health-care provider interviewed, duplication had not been reduced but rather introduced since the advent of the HSMS contract. Part of the Service Coordination function overlapped with the function of the HSMS Field Officers in terms of developing service plans with clients on the basis of their assessed need.

The replication of roles between Service Coordination provided by the CHE and the HSMS contract was a cause for confusion between roles and responsibilities at this time. Confusion between the roles and responsibilities seemed to have blurred the lines of responsibility between each contract. Rather than creating the desired seamless service as discussed by providers in Chapter Five, the number of health professionals involved with older clients added to the confusion and the feeling that services were fragmented.

In contrast, coordinating services for ACC-funded clients appeared to be relatively straight forward as two clients explained. The two clients interviewed who were recipients of ACC assistance, were given autonomy through direct funding, to employ helpers they knew and trusted who could be family members if they wished. Unlike the ACC system, the HSMS took responsibility, as one provider explained, for organising a provider and the HSMS policy did not include the employment of a client's close family members, although clients could name a preferred provider.

It may be that this aspect of the HSMS business policy is not appropriate for all clients when acknowledging the needs and cultural differences of older New Zealanders. As was discussed in Chapters Two and Five, kaumatua prefer to be cared for by their whanau network. Cultural preference, in this case, may prevail if the HSMS policy is challenged in the future by kaumatua and their whanau members.

Other concerns were raised by the Age Concern (1995) Report which documented objections to older people being classified under Disability Support Services when old age was a natural process and not a disability. This supports previous findings that society's negative and prejudicial ageist attitudes to the elderly may lead to a lack of motivation and incentive by health professionals to provide better health and social services (Buckwalter et al, 1993). The Report recommended that more resources be available for older people to address health prevention, promotion and early intervention. The Age Concern (1995) report discussed the need for an integrated and coordinated approach to services provision to enable older people to continue to participate in society.

The Report called for a Task-force to urgently review services for older people and to develop a comprehensive strategy encompassing funding, provision and delivery of services. The Report's conclusions pointed to the fact that the New Zealand Framework for Service Delivery (Ministry of Health, 1994) designed to integrate and coordinate services for older people based on their assessed need, was not seen to be delivering.

However, at a local level, findings from the participants interviewed for this thesis did not support the anomalies in service provision as outlined by the Age Concern Report (1995). As has previously been discussed, these participants were "roll-over" clients, and the services they received were not disrupted by change at the time of the interviews. In fact, these participants, together with older Feilding residents, would seem to be advantaged by the commitment from the Feilding community to meet their needs for subsidised transport, modified housing at a low cost, health-care services, meal delivery, advocacy and social services.

The provision of these local services coordinated by local agencies complemented the centralised community care services based in Palmerston North and coordinated for Feilding residents. Services, aids and appliances and extra funding which enabled older people to remain in their homes were viewed by participants as contributing to their quality of life. However, the social contact with trusted family members, friends and neighbours was very important.

6.7 Quality of Life Issues

Participants valued regular contact with people they knew and trusted. Other quality of life issues included maintaining their independence, the hope that their health may improve and their need for a familiar, accessible environment which assisted participants to feel safe and secure. Safety at home was monitored by regular contact with trusted careworkers and home helpers. A positive relationship with health professionals was valued as was the extra funding provided by the Disability Allowance.

Providers believed that key factors which enhanced their older clients quality of life matched findings from the Colmar Brunton (1990) study, namely, good health, adequate finances and social contact. Another provider believed that the provision of more services would improve clients' quality of life. This view was strongly endorsed by the Age Concern (1995) Report which advocated that more services be provided now to match the increase in the older population, particularly for older, old people aged 80 years and over. In this sense, current planning and service provision is inadequate for the changing needs of the older population (Age Concern, 1995).

Another view from two providers interviewed in this thesis supported findings from the Department of Social Welfare (1990) briefing paper for the Minister for Senior Citizens. Providers should enable older people to maintain a sense of control over their lives rather than make decisions on their behalf.

6.8 Summary

In summary, the combined data raised issues for clients of the struggle for them to accept that they were no longer physically independent. Accepting assistance for home support services meant that their privacy was invaded to enable them to remain at home. The issue was raised by clients of the necessity for trained careworkers to provide personal care assistance to ensure clients' safety and the quality of the service they provided. If home support providers were trusted and worked well for their clients, participants appreciated the help they received and in some cases, regarded their helpers as friends.

The challenge for providers is to remember that their older clients are vulnerable. Providers were making decisions that contributed to older people's quality of life. In order for providers to meet the diversity of needs of older clients, all clients needed to be treated appropriately, with respect for their individuality and their collective well-being. Respect for older people's health and well-being should ensure that health-care and rehabilitation takes place in a culturally aware environment. Alternative health initiatives, such as those promoted by Maori community health workers, are enabling kaumatua to accept community health-care services alongside their indigenous herbal medicine and whanau support systems.

It would seem that overall, clients' needs were being met by the range of available services but providers were simply under-resourced. Factors which seemed to discourage clients from complaining about gaps in their services were, their reluctance to complain, not knowing who to contact and the lack of an avenue for complaint. However, those participants who communicated well, knew who to contact or had a network of people who would advocate on their behalf, managed to access their entitlements to home support assistance without too much difficulty.

An assumption could be made, based on comments from provider informants in this thesis and from respondents in the Feilding Social Issues Network Committee survey (Manawatu District Council, 1994) that clients (particularly women), receiving a low income and living alone without family members for informal support, were struggling and not receiving the subsidised services they were entitled to. These assumptions support Green's (1993) view that factors other than the level of disability, such as gender, living alone, type of housing, income and access to informal carers influence clients' ability to manage at home.

However, the purposive sample of nine clients interviewed in the study were affected by only some, not all of these factors. These clients were assessed as having some form of age-related or accident-related disability, seven of the nine were female, seven of the nine participants were living alone, three of the seven female participants were in rental housing and therefore on a low income, but all had family members and, or friends providing informal support. The presence of family members and friends providing informal support was the key factor that ensured that these participants' accessed community care services.

The final chapter will consider these findings in relation to the aims of this thesis, the literature on the broad range of community care for older people and the methodological limitations of the study. Recommendations will be made for government policy, practice and further research.

Chapter Seven

CONCLUSIONS

7.0 Introduction

The broad aim of this thesis has been to assess whether the community care needs of a small sample of the older disabled population residing in Feilding are being met by current service provision. The questions used in the semi-structured interviews with participants and provider informants, were designed to address issues concerning the range, quality, access, appropriateness and coordination of services. This chapter discusses the limitations of the study, summarises the current service provision for older people residing in Feilding, clarifies the implications for social policy, suggests further research in this area of interest and makes recommendations for change.

As has been previously discussed throughout this thesis, the essential community care services needed by older people to assist them to maintain their independence at home includes home support services, personal care assistance (for those with a higher level of disability), access to aids and appliances, medical services (with alternative provision for kaumatua), meal deliveries, pensioner housing, transport services, lawn and garden maintenance and social support. Service providers contracted to deliver essential community care services to older residents, whilst aware of the needs of their clients, were faced with the dual dilemma of under-resourcing and a competitive market place for community care services created by contracts with the RHA.

Locally, concern for older people living in rural and semi-rural areas has been expressed by the Palmerston North City Council (1994), in regard to the ability of community care service providers being able to respond to the future needs of the elderly. Numbers of older people choosing to reside beyond city boundaries are predicted to rise more rapidly in comparison with their Palmerston North city counterparts. Pressure will therefore be placed on existing rural and semi-rural as well as centrally-based community care providers of services to the elderly to meet the projected need.

Most community care agencies, other than ACC services, in the Manawatu region which provide care for older disabled people living at home, have separate contracts negotiated with the Central RHA for services designed to meet the assessed need. More recently in 1995, the CRHA asked for tenders from community care agencies to be submitted for the HSMS contract. The frustration for existing and proven providers who tendered for the contract, was well documented at the time when the CRHA awarded the contract to a previously unknown company (Myers, 1995, June, Manawatu Evening Standard).

The subsequent demise of the newly contracted company within four months of being awarded the HSMS contract, has highlighted serious flaws in the CRHA tendering system. With the benefit of hindsight, it would seem to have been irresponsible for the CRHA to have allocated publicly-funded health dollars to an unproven company to provide a complex home support service for vulnerable, needy older people living at home. Media reports at the time highlighted the loss in credibility of the CRHA and the loss in confidence from the community concerning this issue. Accountability for this mistake must rest solely with CRHA decision-makers.

The turmoil which ensued was a major issue for providers of community care services. In contrast however, the small sample of client participants interviewed for this study, were mostly unaware of and largely unaffected by the change in the contract for long-term support services. They were existing clients of either RHA or ACC-funded community care services and their services were "rolled over". What was crucial for them, was the quality of the relationship between themselves and their careworkers.

Even though client participants reported some confusion with the roles and responsibilities between the different community care professionals, participants valued the trust and rapport they established with individual providers regardless of who the agency was delivering the service. The highest level of formal contact was between themselves and their paid careworkers. The value of the relationship between careworker and client should not be underestimated.

7.1 Summary of the Service Provision for Older People Residing in Feilding.

Comments from local providers supported some of the concerns expressed by the Age Concern's (1995) report on existing services for the elderly being unable to respond appropriately to the health-care needs of older people choosing to live at home for as long as possible. Local provider concerns were based on the under-resourcing of services and the reliance of social support services on a diminishing pool of available volunteers. However, in this study, findings revealed that in general, the small sample of older clients in this research were satisfied with the provision of community care services. Services were responsive to their need. What then were the desirable characteristics of service provision at this local level that led to client satisfaction?

As has been discussed in Chapters Two, Four and Five, Feilding is a caring, community-minded semi-rural township with local government committed to supporting their older citizens with the provision of housing and social services to enhance their quality of life. The range of community care services offered to the elderly both locally and centrally administered, ensured that older disabled people were not disadvantaged by distance from Palmerston North city.

In Feilding, clients appear to be provided for by a dedicated team of health professionals and social service agencies who respond with proven integrity and understanding to the needs of their client group. Similarly, the local District Council Social Issues Network Committee has assumed responsibility for understanding their township's social issues. Initiatives such as the Feilding Social Issues Network Committee survey (Manawatu District Council, 1994) and the subsequent design and distribution of the Feilding Social Service Directory, were promoted by the Council to benefit the community and to link the community with the community network of providers.

In Feilding, client satisfaction hinged on the ease with which clients were able to access services, the pleasant, professional attitude of the service providers and the quality of the work that their careworkers provided at home. Providers practising implementation of quality measures through their policies, procedures and client satisfaction surveys will strengthen their bid when renewing contracts with the CRHA. Similarly, ACC Case Managers must be accountable through similar measures for the service they provide to their older clients.

Access to services for clients relied on referrals from health and social service professionals for clients' assessment. At the time of the interviews, the sample of older people had accessed their community care and had been receiving community care services for some time. They relied heavily on their informal networks of family and friends to provide information concerning further entitlements to services.

Continuing to meet the older clients' needs is a valid measure of the appropriateness of current community care services. Current services received by the sample of Feilding client participants who were already in the community care system, were meeting their needs to remain at home for as long as possible. The range of services for older people also included an alternative community care service for kaumatua and two local lobby groups available to actively advocate, provide information and identify gaps in services which contribute to the health and well-being of older Feilding residents.

Gaps in service delivery were acknowledged by clients such as the confusion with knowing who to contact for help with home support services, understanding the roles of health professionals working in the community, the difference in output between care-workers, concern for provider changes to personal care assistance, the changing quality of a meal delivery service and the lack of comfort to manage their disability when accessing social events. Gaps in service delivery acknowledged by providers were the lack of information which prevented some older people from accessing services, problems with service coordination which included the fragmentation of services and the overlap in lines of responsibility, the monitoring of home support services, a decreasing pool of volunteers and the need for continuing support for carers of dependent relatives living at home.

For client participants, the major concern was the future provision of services and the fear of losing highly valued services. An example used in this study was the possible change from trained District Nursing providers who currently assist clients with their personal care needs, to the employment of careworkers for this physically intimate task. The issues here for clients needing home support services which included assistance with personal care, were their vulnerability, safety in their homes, trust and confidence between themselves and their careworkers.

7.2 Limitations of the Study

Interviews with key informants pin-pointed the issues of need and concern for older people in Feilding seeking to 'age in place'. However, the methodological limitations of the study were that the results are not generalizable because of the small sample size, the presence of others affected the interview and requests by respondents to turn off the tape recorder diluted the findings (Chapter Three).

Further limitations are that the purposive sample of nine clients were "roll-over" clients, already integrated into the community care system and receiving formal support services. These clients were motivated people with established networks of informal support such as family, friends and neighbours which, together with the use of qualitative methodology, means that the results are not necessarily representative of the older disabled population of Feilding; they lack generalizability.

At the time of data gathering, seven of the nine client respondents who volunteered to participate, were female. The gender difference (7:2) occurred because female participants were easier to access in Feilding through their own informal networks. Volunteer participants, disabled by age-related circumstances, knew of someone else in similar circumstances and receiving community care services. The relative ease in obtaining older female participants could also be due to the higher percentage of older females to males in Feilding, synonymous with the gender imbalance recorded in successively older age groups, as discussed in Chapters One (Figure 1), Two and Six.

Another discrepancy in the purposive sample, was the lack of an interview with kaumatua living in the Feilding area. Only a few kaumatua reside in and around Feilding. The conclusions reached from a bicultural perspective, have relied on primary data gathered from the experience and knowledge of a provider of alternative health-care and a referral service available in the community for Maori. Secondary sources (Core Services Committee, 1994; Department of Health, 1984; Durie, 1989; Maaka, 1993; Murchie, 1984; Pomare & De Boer, 1988) have reinforced the bicultural view.

The only ethical dilemma arising from the methodology and discussed in Chapter Three, was my concern, as interviewer, when gathering qualitative data from the interviews. Three of the nine clients interviewed chose to confide intimate pieces of their life history in addition to their responses to the semi-structured interview questions regarding community care service provision. An arbitrary decision was made by me to turn off the tape recorder once the body of the interview was completed, to reduce the risk of recording clients' confidential information that transcended the thesis boundaries. In each case, clients appeared to have forgotten that the tape recorder was still recording their contribution and they agreed with my intervention.

As a researcher, I was also constrained by the concern expressed by four of the thirteen providers whose interviews were used in this study. Their concerns were discussed in Chapter Three and related to politically sensitive information they were reluctant to share for fear of being quoted. However, these providers approved their transcripts and gave consent for me to use their contribution.

The results gathered from willing participants already receiving services to enable their needs to be met and remain at home, reflected their networks of formal and informal support and their positive attitude to life in general. It would appear that members of this purposive sample are responding to the challenge to stay healthy as discussed by Gilleard and Watt, (1983) and Picton (1991). Their positive attitude would seem to be reflected in their psychological health and their acceptance of biological and environmental changes associated with natural ageing processes as suggested by Thompson et al, (1990). The richness of the qualitative data gathered from the interviews with this purposive sample group represents members' individual experiences and in this sense, means the interviews constitute valid and unique encounters.

Client participants were confined to their home environment by their natural ageing processes and their age-related disabilities. Their independence at home was maintained by their dependence on community care services as predicted by the Social Advisory Council (1984). The quality of participants' lives was enhanced by health services and home support services responsive to need, access to appropriate housing and social contact. Conclusions from previous research in New Zealand (Colmar Brunton, 1990; Koopman-Boyden, 1988; Department of Social Welfare, 1990) support similar quality of life findings.

The validity of the data collected from clients was matched by recurring themes throughout the data gathered from the wide range of local and centrally-sited providers interviewed for this study. However, as identified throughout this thesis, the most important services for older people living at home are home support services. The lack of an interview with the newly-contracted HSMS provider of home support services, as previously discussed, is a missing link. However, data gathered from community health providers working alongside the HSMS has enabled a comprehensive understanding of the needs of older people residing in Feilding for home support services. The providers' perspective in this sense both reinforced and expanded on participants' experiences.

7.3 Implications for Social Policy

Key issues for older people and their provision of community care services, were to be resolved by the effective coordination of services as outlined in the New Zealand Framework for Service Delivery (Ministry of Health, 1994). Service coordination (also referred to as case management), was to ensure a focus on the client, reduce duplication, clarify responsibility and ensure accountability. However the blurring of the boundaries between the CRHA contracts for example, short-term and long-term services, Service Coordination and the HSMS, has resulted in reported uncertainty from service providers, confusion from clients and some duplication of roles between service providers to older people living at home. Open communication between providers to ensure that services were client-focused and effectively coordinated is therefore essential.

It would seem that effective service coordination was thwarted by the fragmentation which occurred following the awarding of the HSMS contract to a privately-owned company. Clearly, the unavailability of a representative from the newly-contracted HSMS company for an interview at the time of data gathering, signalled a community care agency under stress when compared with the availability of other service providers. The HSMS company's subsequent failure to provide quality community-based services, exposed flaws in the CRHA system of awarding contracts.

Questions about whether the CRHA had sufficiently checked the tenders for the HSMS contract to ascertain the ability of individual companies to provide the necessary home support services have been highlighted. Hopefully, lessons for the future will have been learnt by the CRHA's documented mistake in awarding the HSMS contract to a company which had no proven work history and did not meet the desirable characteristics[1] as outlined in the Ministry of Health's (1994) policy document.

In order to meet their contractual obligations to either RHA's or social service community groups specialising in the elderly, the major incentive for community care providers is to keep clients mobile and out of hospital. All service providers to older people have a responsibility to ensure their clients are treated equitably by increasing the community's awareness of their services and to offer choices for older people. The collective goal of community care service

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[1] Desirable characteristics of the purchaser of Disability Support Services were that purchasers would possess knowledge and understanding of disability, a commitment to the empowerment of clients and the ability to provide quality community-based services (Ministry of Health, 1994).

providers is to support the clients of elderly services to remain at home for as long as possible.

The Government sought to support older clients needing community care services by implementing a sudden change in the eligibility criteria for subsidised home support services for older people in July 1995. Eligibility for access to home support services was extended to all older people who were holders of a CSC and assessed as having a need. Providers were clearly supportive of this sudden but positive policy change for their elderly clients. However, the policy change created a large gap between the demand for services from older people now eligible for home support, and the supply of providers to process the assessments and coordinate services in response to the demand.

It could be argued that this sudden change in eligibility for subsidised services may have been a reaction to quell the dissension that arose from the Age Concern (May, 1995) report. Age Concern (1995) had attacked the Government for the identified gaps between current health policy and the actual provision of health-care services to meet the needs of this age group. Age Concern (1995) believed that problems have occurred for older people as a result of changes in government policy and that in fact the Government has transferred responsibilities for the care of older persons to families, communities and voluntary agencies. The burden of care has been placed on the unpaid carers of older people. This supports findings by Opie (1991, 1992).

At a local level, this thesis recorded differences between the hours of home support services given to clients living alone and to clients with an available spouse to care. It would seem that the allocation of home support hours was heavily dependent on the availability of a spouse or family member to provide care at home. The subsequent cost saving by the government at the expense of families has been highlighted in the Age Concern (1995) report and the work of Opie (1991, 1992). If the Government is as committed to a policy of community care as ministers state they are, the work of carers must be valued and reimbursed.

Cost saving at the expense of families, is discriminatory and must be addressed by future social and economic community care policy. Discrimination against older people in New Zealand and the potential for the financial abuse of the elderly, has also been under scrutiny by the Human Rights Commission (1995). Concerns are directed toward families who may be denying their older relatives access to health-care and residential facilities because of the cost of care and the subsequent drain on the older person's financial assets. Families may wish to ensure that they can claim their inheritance at the expense of their frail, older relative (Human Rights Commission, 1995).

Community care policies must acknowledge cultural preferences and choices for older people to name preferred providers as carers. Providing choices for kaumatua to be cared for by members of their whanau, is appropriate when enabling clients to maintain their independence for as long as possible in their own homes. However, careworker training is an issue and is discussed later in this Chapter. If a kaumatua (or older person who is eligible for subsidised home support services) chooses a family member as their careworker for long-term care, the prerequisite for reimbursement for the careworker should be training, to maximise the quality of the care for older people.

At the time of writing, issues for the care of older people are being addressed by a Prime Ministerial Task Force on Positive Ageing (1996), established in response to the Age Concern (1995) Report. The Task Force is currently developing the range of options gathered from nationwide public forums to make recommendations to Government for the future health and well-being of older New Zealanders. The public consultation process between Task Force representatives, older people and interest groups, is meeting recommendations from previous reports (Age Concern, 1995; Department of Social Welfare, 1990; Social Advisory Council, 1984) coupled with the essential requirement of a partnership approach and a consultation process through Treaty of Waitangi issues (Department of Health, 1984; Durie, 1989; Maaka, 1993; Murchie, 1984; Pomare & De Boer, 1988).

The impetus for the formation of the Task Force was the positive outcome of the Age Concern (1995) Report. The effectiveness of Task Force recommendations will be measured in the future by the changes to social policies and service provision for the care of older people in New Zealand.

7.4 Recommendations for Changes in Policy and Practice Arising From this Study

To ensure that the older people in Feilding may 'age in place' with adequate services provided to meet their needs, issues concerning the range, quality, access, appropriateness and coordination of services were of interest to this thesis. This thesis recommends that if the needs of older people living in Feilding are to be met, the following measures must in place.

Careworker Training

Care-workers providing services to the elderly must be trained and their service delivery monitored at regular intervals, for example three monthly. Specialised training with personal care assistance must acknowledge the physical frailty, vulnerability and need for privacy for older clients. At present, monitoring service delivery and reviewing the hours of home support and the work performance of careworkers, is the responsibility of HSMS Care Managers. Checking with clients if they are satisfied with the work performance of their careworkers is an essential part of the review process.

However, there are conflicts of interest with the provider of the service having the responsibility for managing the service, monitoring the performance of the careworkers and checking with clients to ensure client satisfaction. Maintaining neutrality, in these cases, could be difficult. The role of monitoring not only the HSMS, but all services to the elderly contracted to the RHA, should be the role of an independent auditor.

Independent audits would seek to ensure that older clients are satisfied with the services provided by their careworkers and careworkers feel comfortable with the working relationship between themselves and their clients. This information would be fed back to the agency responsible for managing community care home support services. One measure of quality required by RHA community care contracts and currently enforced, is the use of client satisfaction surveys which assure anonymity and highlight client concerns and satisfaction. Regular client satisfaction surveys may serve as an incentive for providers to strive to improve their service delivery.

Communication and Information between Clients and Providers

Channels of communication must be kept open between clients and providers so that clients know who to contact to access information about their service provision. The difficulty for both clients and providers is to understand the lines of responsibility between the increasing number of providers contracted to deliver specific components of community care services. Clients have reported their confusion with the roles played by the community health professionals who visit them.

For example, clients interviewed who were receiving ACC-funded services knew to contact their Case Manager if they needed assistance with any aspect of their service. However, clients receiving RHA-funded services were more likely to contact a member of their informal support network or the Clevely Health Centre in Feilding for advice. Solutions from provider informants to alleviate the confusion for clients included creating new initiatives such as a central contact agency or an independent advocacy service specialising in information about services for the elderly. However, there are enough existing community care providers already competing for funding and service contracts. Existing providers must assume responsibility for marketing their own services and include contact names and numbers for their clients as well as for other providers.

The need for clients and providers to have information on how to access services was acknowledged by providers, (Chapter's Five and Six), but this need may present a problem for providers concerned about staffing levels and budget restrictions. Underfunding and low staffing levels mean that older people seeking to gain entry may have to queue for services. If better information leads to an increased demand for services and service providers are only contracted to provide for specific numbers of older clients, then clients will need to be prioritised on waiting lists.

Age Concern (1995) have already demonstrated their political clout from the storm of publicity surrounding their Report on the gaps in services to the elderly as discussed in Chapters Two and Six. The subsequent government action in responding to this Report by appointing a Task Force to widely consult and formulate policy recommendations for older people, is an example of the power of the older lobby groups to raise awareness of their needs. Similarly, the Human Rights Commission (1995) Report received media attention on issues of discrimination for older people. Powerful interest groups such as these must continue to advocate for change and positive action from the state to meet the community care needs of older people.

Assessment

The need for assessment has been highlighted throughout this thesis and is the key to accessing long-term community care at home for older disabled people. Access to an assessment is by referral. The most frequent point of contact with a community health professional for older clients is likely to be with General Practitioners, the primary health-care providers. Although GPs no longer assess clients over the age of sixty-five, they do have a responsibility to ensure their older clients are referred to accredited assessors for assessment based on the older person's need for services. GPs must be reminded of their responsibility to refer by the community agencies promoting services for older people.

The assessment process involves a chain of referrals beginning with a health professional, to the assessment team. The assessor, through the assessment, may generate contact with a Medical specialist, Services Coordinator, Social Worker, Occupational Therapist, Physiotherapist, District Nurse and a HSMS Care Manager, all with their specific area of expertise to assist the older person living at home. Accredited assessors are trained to be sensitive to older clients' needs.

Findings from this thesis reveal the importance for assessors to be reminded of the intrusive nature of the assessment process for older clients and to use their professional expertise and communication skills to capture their clients confidence. Other providers in the referral chain, also need to be reminded that older clients may understandably become confused by the individual roles and responsibilities of community care professionals contacting clients at home as a result of the assessment.

Unfortunately, older people who decline a referral for assistance from formal services because they rely heavily on their informal networks, may not only miss out on accessing their entitlements to long-term support services, but also become a burden and dependent on their families for care. Government-funded home support services are coordinated for older people to maintain, not lose their independence at home. A task for service providers must be to encourage the elderly to access their state-funded entitlements to share the care between the state and family members.

However, if service providers to the elderly continue to be under-resourced, the inevitable outcome will be that some older people will fail to access the services they are entitled to. Older people in need of home support services, who do not have a support person such as a family member or friend they can contact for information, may be the casualties of under-resourcing.

Aids and Appliances

Older clients living at home are heavily dependent on aids and appliances to ease their mobility and promote their safety at home. Mobility is a major issue for the elderly and they need the support particularly from General Practitioners to refer them promptly to Occupational Therapists, Physiotherapists and specialist agencies, for example, the Arthritis Foundation. Fortunately, all assessed clients are referred through the assessment process to appropriate agencies to meet their specific needs.

An area of frustration cited by older participants, is their decreasing ability to maintain their outside environment, gardens and lawns. The availability of the Disability Allowance administered by the NZISS assists with the payment for contractors to be employed to complete these tasks. The Disability Allowance may also be utilised to cover the costs of a personal safety alarm, particularly for older disabled people living alone at home. Service providers to the elderly whilst aware that the Disability Allowance is Income and Asset tested, should be encouraging their clients to apply.

Modified Housing

Decreasing mobility and the need for modified, affordable housing, enable older people to maintain their comfort and independence at home. The current trend is for local authorities to move away from housing provision for the elderly (Palmerston North City Council, 1994). In contrast to this trend, the Feilding community housing provider has made a commitment to continue supplying pensioner housing for their older citizens in need. Findings from this thesis support the need for the Feilding housing provider to continue this commitment.

Transport

For older people with decreasing abilities, affordable and accessible transport services are a necessity. RHAs must acknowledge the need for older clients residing in rural and semi-rural areas to have access to subsidised transport to central city health services. Otherwise, older people who choose to 'age in place' in rural and semi-rural areas are discriminated by distance from centralised services.

Social Contact

Previous research findings show that regular social contact with family members, friends and neighbours is an essential component contributing to the daily health and well-being of older people (Colmar Brunton, 1990; Koopman-Boyden, 1988). Social contact is important for all age groups, however findings from this thesis show that in Feilding, older people rely heavily on social contact from their formal and informal support systems to provide services, information, advocate on their behalf or to just be available for friendship.

In the past, befriending services offering social contact with home visits and transport to activities outside the home, were available from the work of volunteers. Feilding providers who have traditionally relied on volunteers, have identified the struggle to maintain their services with declining numbers of volunteers available to assist. The unpaid work of volunteers, the majority of whom were women, has been taken for granted in the past and has been undervalued by society (Green, 1993; Opie, 1991; Palmerston North City Council, 1994).

Today however, women are more likely to return to the paid workforce following child rearing and decreasing numbers are available for volunteer work (Palmerston North City Council, 1994). Planning for the future community care of the elderly will need to be realistic in terms of fewer volunteers being available in the community in the years ahead. If the Government is to remain committed to 'ageing in place', the actual costs of providing a comprehensive community care service for older people will need to be met by the state.

The need for social contact may be frustrated for older people through their reduction in mobility and a corresponding loss in self-confidence. Local groups specifically targeting older people to encourage their participation in social and recreational activity, need to be made aware that older disabled people may choose to stay at home, not because they are unsociable, but because of the physical discomfort they may experience at the venue. Findings from this thesis revealed that access and comfort are major issues for older people confined to their homes through age-related disabilities. All community service providers seeking to encourage older people to utilise their facilities, must provide access and a comfortable environment.

Relief and Reimbursement for Carers

Creative initiatives could be developed if more funding was available for community care services, for example, a 'sitter service' to enable a carer to seek some respite from their caring role. Carer Relief and Day Care programmes were available for older people in Feilding. Day Care programmes and sitter service initiatives must continue to be available in smaller communities such as Feilding to enable older people to 'age in place' for as long as possible.

A healthy older spouse choosing to care full-time for a dependent spouse or relative, provides unpaid care that the government would otherwise subsidise if the dependent relative was living alone. The availability of a carer may determine whether the older person can in fact choose to 'age in place' or enter residential care. The need for government policy makers to examine this area of discrimination will increase as the population continues to age.

Maori-Specific Needs

Reimbursement for carers is an issue for whanau members caring for their kaumatua. Service providers to kaumatua must be acceptable to Maori and deliver services in a culturally sensitive way (Core Services Committee, 1994; Richmond et al, 1994). For example, kaumatua may wish for their whanau members to provide home support services. Community care agencies must be flexible to enable kaumatua to have their preferred providers. However, service quality is an issue and the acceptance of regular monitoring of the client/careworker relationship must be negotiated between agencies and whanau members to ensure that kaumatua are receiving the quality of service they are entitled to from their whanau members.

7.5 Suggestions for Further Research

Time will tell if the Prime Ministerial Task Force on Positive Ageing (1996) findings and conclusions are significant enough to change Government policies for community care and the way services to the elderly are delivered. At least the documented information gathered from the nationwide consultation process will alert Government policy makers to the gaps in services to the elderly and suggest positive changes for the future.

An area ripe for further research is to gather information about the actual costs of community care. If the Government is reneging on their responsibility to provide community care by placing the burden of care onto families, then the actual costs of care need to be known. Achieving a balance between the responsibility of the state to subsidise care for the elderly and families to care will be an ongoing debate between the Government and interest groups for example, Age Concern New Zealand, Alzheimer's Society New Zealand and the New Zealand Association of Gerontology.

Another issue needing further research is the cost of transport to centralised health-care services. Currently in Feilding, older people are well catered for in terms of the availability of transport for those in need to attend clinic appointments and hospital stays. However, if rural and semi-rural areas and their increasing older population are to be disadvantaged by distance as more services are centralised, the costs of transport needs to be known and subsidies made available. Issues of equity are at stake for older clients choosing to 'age in place' in semi-rural areas and who therefore contribute to their local economy. RHA's must be prepared to reimburse elderly clients living in semi-rural and rural areas for transport costs to meet their health-care needs to balance this current inequity.

In the case of community care providers contracted to the RHA, more use could be made of customer satisfaction survey results within their service. Individual client complaints could be prioritised, fully discussed at team meetings and targets set by providers to eliminate problems with their service delivery. Providers' targets could be regularly checked against the comments from on-going client satisfaction surveys to measure whether their service to clients is improving. The on-going self-auditing process is an essential part of the quality initiatives from the Ministry of Health (1994) Framework for Service delivery. This thesis has shown that some providers have been slow to implement quality measures.

Hopefully older people living in rural and semi-rural areas may be guaranteed that they will be supported by community care services covering a range of services with attention to quality, access, appropriateness and service coordination to meet their assessed needs. This study which has assessed the provision of community care services in meeting the needs of a small sample of older disabled Feilding residents finds that, at the time of writing, their needs are being met. However, any reduction in the future provision of community care, will be detrimental to the health, well-being and quality of life for older Feilding residents choosing to 'age in place'.

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APPENDIX ONE

INFORMATION SHEET

My name is **Robyn Scott** and I am a student at **Massey University**.My research is about the current community health-care services for the Feilding elderly living at home and needing home support services to assist them in their daily lives. This research is being done for a Masters Degree in Social Work. **Messages** for **Robyn** may be left, ph: **355.2090.** Robyn's research supervisor at Massey is **Mervyl McPherson,** ph: **350.4361** or **350.5222.**

I would very much appreciate an interview with you, using a tape recorder, to find out your opinion of the community health-care services provided in the Feilding area for the elderly at home, needing home support. The interview itself may take up to one hour of your time. If you choose to take part in the study, you have the right to -

*agree/not agree to your interview being taped.

*request that the audio tape be turned off at any time.

*refuse to answer any particular question.

*ask any questions about the study at any time.

*withdraw from the study at any time.

*know that your contribution to the study is confidential.

*know that the information you give will be anonymous. It will not be possible to identify you either in the written study or in the taped information.

*be given a copy of a summary of the findings from the study when it is completed.

APPENDIX TWO

CONSENT FORM

'Are Current Community Health-Care Services Meeting the Needs of the Elderly in the Feilding area, Manawatu?'

I have read the Information Sheet for this study and have had the details of the study explained to me. I am satisfied that my questions about the study have been answered. I understand that I may continue to ask questions at any time.

I have the right to request that that the audio tape be turned off at any time. I am free to withdraw from the study at any time, or to say that I do not wish to answer any particular questions in the study. I agree to provide information to the researchers on the understanding that this information is completely confidential.

I am willing to participate in this study under the conditions set out on the Information Sheet.

I agree/not agree to my interview being taped

Signed: ____________________________

Name: ____________________________

Date: ____________________________

APPENDIX THREE

OLDER CLIENT RECEIVING HOME SUPPORT SERVICES

1: What help do you have, for example shopping, housework, gardening, to assist you with your daily life?

2: Who provides this help, for example, a paid worker, an agency, a volunteer, a neighbour or family member?

3: How do you feel about having/needing this help?

4: What extra help do you feel that you need?

5: What is the main reason for you needing help in the home?

6: What home support services, for example, shopping, housework, nursing assistance, are you aware of that you are entitled to? Who provides these services?

7: Who decides how much help you need?

8: What problems, if any, do you have in accessing services that are available for you?

9: Who you can contact if you need help either for a specific or a general problem with home support services?

10 Do you feel that the help or services you receive could be better coordinated. If so, how?

11: What are the most helpful and important things that you feel you need now to assist the quality of your life?

APPENDIX FOUR

SERVICE PROVIDER

1: Who refers clients to your service?

2: What are the conditions and eligibility criteria for clients needing to gain access to your services? Are there any problems for the elderly in gaining access to your service?

3: What are the needs of the elderly clients receiving your services?

4: How well does your service meet client's needs with respect to,
    a) what you offer?
    b) overall?

5: Are there any 'gaps' in the service you provide? If so, what are they?

6: What are the priorities for you as a service provider to the elderly?

7: How do you monitor and evaluate client satisfaction with your service?

8: How well do you think services are co-ordinated at present?

9: What changes, if any, would you like to see in the way Home Support Services are provided for the elderly?

10: What do you think your elderly clients need to improve their quality of life?