SUPPORTED INDEPENDENT ACCOMMODATION
FOR OLDER NEW ZEALANDERS:

A Review of Current Policy and
Innovative Practice

By

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ABSTRACT

Supported Independent Accommodation (SIA) for Older New Zealanders:
A Review of Current Policy and Innovative Practice

Existing research establishes a clear link between poor housing and poor health. There is also growing evidence that the physical, mental and social wellbeing of individuals and households can be improved by ensuring their access to suitable accommodation. Despite the growing body of research documenting the benefits of supported independent accommodation (SIA) as a means of maintaining the independence and wellbeing particularly of older people, there is little research evaluating the place of such accommodation within the New Zealand context. This thesis aims to address that gap. It reviews the existing body of literature surrounding this topic – exploring population and accommodation demographics, and analysing government policy in relation to both housing and health. It considers six New Zealand examples of SIA – each selected on the basis of their distinctiveness and innovation – documents these, and compares them using a case study approach. Adopting a general inductive methodology, each case study is then analysed against themes identified in the literature review, identifying any further trends, and the implications of these for ongoing policy and service development. Intersectoral collaboration is identified as having had particular bearing upon the development of SIA within the New Zealand context.

This thesis concludes that SIA will play an increasingly important role in the continuum of accommodation and care for older people. It offers an alternative to more institutionalised models of care for older people, maintaining their independence and social integration within their own community. As demographic and economic factors drive up the cost of more traditional models of residential care, SIA offers government an equally important alternative. However, ongoing development in this area is not without it challenges. To this end, a number of policy implications are also identified and discussed.

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1. Introduction

New Zealand research already establishes a clear link between poor housing and poor health (Howden-Chapman, 1999). There is also growing evidence that the health outcomes and wellbeing of individuals and households – particularly those categorised as socio-economically disadvantaged – can be improved by ensuring their access to suitable accommodation. Overseas research notes the value of what, in this thesis, is referred to as supported independent accommodation (SIA), in maintaining older people's physical, mental and social wellbeing. Likewise, there are strong and convincing arguments in favour of both 'positive ageing' and 'ageing in place'. Yet it is vital to ensure that the appropriate structures, resources and support required enabling older people to remain independent in their own homes and their own communities are readily available and accessible.

The range of options for older people in New Zealand in this regard is, however, comparatively limited, and often beyond the financial means of many who would potentially benefit from SIA. For example, the most common model of SIA in New Zealand is that offered by retirement villages, where occupants purchase a 'licence to occupy' and pay an additional (and ongoing) maintenance or facility charge.

Research commissioned by Age Concern New Zealand (Robinson, 1994) suggests that a significant proportion of older people – particularly older women currently living on their own – would not only choose the retirement village option, but would benefit from it. Not only would living in such an environment contribute to their personal sense of 'positive ageing', it would also likely lead to improved health outcomes, in turn delaying their need to receive the higher levels of support provided by way of residential care. Yet, Robinson suggests, because of the high entry costs and ongoing financial contribution required, the very category of older people who would most likely benefit from such a model of supported independent accommodation are the least likely to have the income or capital resources to do so.

Similarly, while more older people than the national average own their own home, the proportion that do so is slowly decreasing – though not yet at the rate of national home ownership trends in general. Other older people are reluctant to sell – even in the face of high maintenance costs, reduced income, or their home's inappropriateness to their changing needs (Austin, 1998).

The Ministry of Social Policy's 2001 Positive Ageing Strategy emphasised affordable and appropriate housing options for older people and proposed intersectoral partnerships "to increase the supply of universal design and energy-efficient low-rental housing, including supported pensioner housing complexes" (MSP, 2001, p.20). The Ministry of Social Development's subsequent Status Report (published six months after the release of the Positive Ageing Strategy) concluded,

> "A 'whole of government' approach to housing assistance, incorporating health services and the state housing sector, will improve the ability of people to age in place. Housing interventions focusing on a closer relationship between the physical aspects of housing and support services can result in significant savings in health-related costs, by delaying or preventing older people's entry into residential care." (MSD, 2001, p. 49)

The New Zealand Housing Strategy (2006) has also been guided by the notions of 'ageing in place' and 'positive ageing', and a report of the Housing New Zealand Corporation's Older Persons Working Party (HNZC, 2002) noted the linkages between health and housing. The same report emphasised the importance of maintaining a level of social connectedness for older people – many of whom have to move from their present location either because their accommodation is itself unsuitable, or because they are unable to readily access the support services they require. The Working Party envisaged the development of housing that would allow older people to move to 'purpose-built' accommodation more suitable to their needs, and yet remain settled within their usual neighbourhood.

Between 2002 and 2004 the researcher was employed as General Manager of the Wellington-based Te Hopai Trust Group, then operating a 100 bed aged residential care facility in the Wellington South suburb of Newtown, providing rest home, hospital and dementia level care. Established in 1886, the Trust's charitable purpose was defined as 'relief of the aged needy'. A key priority in terms of the researcher's role as General Manager was to review what 'relief of the aged needy' meant in the current environment – particularly in terms of the Trust's present and future strategic direction. For example, while the notion of 'aged' was fairly well defined, what did the terms 'relief' and 'need' mean in the current health and social climate?

Approaching the task from a background in social services and community development, the researcher began by examining current trends in aged care service delivery, and meeting with various stakeholder groups to determine and discuss what they perceived to be gaps in services for older people.

Initial meetings were held with representatives from a variety of organisations and agencies, including:

- Capital & Coast District Health Board
- City Housing (Wellington City Council's rental housing division)
- Age Concern Wellington
- Ministry of Health
- Housing New Zealand Corporation
- Presbyterian Support Central
- Wesley Community Action
- Abbeyfield Inc.
- Housing and Health Research Programme (Otago University, Wellington School of Medicine and Health Science)
- New Zealand Housing Association
- New Zealand Council of Christian Social Services
- New Zealand Institute for Research on Ageing

Even from this initial research and preliminary discussions, a number of consistent factors began to emerge:

1. The clear link between poverty, poor housing and poor health noted earlier.
2. The value of SIA as a means of maintaining the physical, mental and social wellbeing of older people. This is consistent with the Ministry of Health's commitment to the notion of 'ageing in place' – outlined in the government's New Zealand Positive Ageing Strategy, and reiterated in the Ministry's subsequent Health of Older Persons Strategy.
3. The relatively limited range of SIA options available in New Zealand, and the suggestion that what was available was often beyond the financial means of many of those older people who would most benefit from it.

Yet, while a growing body of research continues to document the benefits of SIA within the so-called 'continuum of care' for older people, there had at that time been little research undertaken to evaluate or compare the relative merits of the various examples currently available – whether from an economic, social or operational point of view.

This thesis takes a step in that direction. Firstly, it reviews the existing body of national and international literature surrounding this topic – exploring population and accommodation demographics, and analysing government policy in relation to both health and housing. Secondly, six New Zealand examples of SIA – selected on the basis of their distinctiveness and innovation – are documented and compared, using a case study approach. Each example is then analysed according to a number of themes identified in the literature review, in order to identify any further emerging trends, and any implications for ongoing policy and service development.

2. Background

2.1 Definitions – What's in a Name?

Ageing in Place. Supported Housing. Retirement Village. Assisted Living. Housing with Care. The multiplicity of concepts, and consequent attempts at defining such concepts in a logical (if not consistent) way, continues to add a level of confusion to any discussion around the range of supported yet independent accommodation options that are the focus of this thesis. The title of this chapter, *What's in a name?*, borrows from a similar chapter in the UK-based Joseph Rowntree Foundation's (JRF) review of supported housing research (Croucher, Hicks & Jackson, 2006). The JRF review will later provide a framework and key themes for subsequent discussion of policy and practice within the New Zealand context (see section 3.3). As JRF review observes, "…the ambiguity surrounding a universal definition of assisted living creates both flexibility and confusion for providers and consumers" (Croucher et al, p.48). The growing range of definitions itself reflects an evolutionary process within this part of the housing sector, with new providers – be they public or private, commercial or not-for-profit – each attempting to respond to the changing social and physical needs and expectations within the housing sector. More recently, those involved in the social and health care sectors have taken more of an interest in what the JRF review terms 'housing with care' (Croucher et al, 2006) – particularly given the potential capacity of such models to reduce demand upon traditional residential models of care for older people (i.e. what are, within the New Zealand context, categorised as rest home and continuing or hospital level care).

> "The once sharp divide between 'housing' and 'care' has recently been breached. There are now emerging…models of provision which conform neither to pure sheltered housing nor pure residential care. The blurring is coming from two directions. Residential care is becoming more 'homely' and sheltered housing more institutional" (Heywood, Oldman & Means, 2002, p.128).

In reality, different providers tend to 'label' their accommodation according to whichever aspects of that accommodation they wish to emphasise – as the JRF review suggests,

> "…depending on whether they were trying to promote their schemes as alternatives to residential care, remodeling existing provision, or setting out to promote something they felt was conceptually different from what had gone before" (Croucher et al, 2006, p9).

In general, however, it is suggested that any differences in definition or description across the various models of 'housing with care' for older people tend to relate to differences in (a) the nature of the accommodation itself, or (b) the level of support offered. Conversely, this latter distinction can be viewed in terms of the level of independence such support affords its occupant.

Croucher et al (2006) note that, within the UK context alone, an extensive range of labels for such 'housing with care' exist, including:

- 'sheltered housing'
- 'very sheltered housing'
- 'enhanced sheltered housing'
- 'supported housing'
- 'integrated care'
- 'extra care'
- 'close care'
- 'flexi-care'
- 'assisted living'
- 'co-housing'
- 'retirement village'

Each is used to refer to the notion of grouped housing for older people. Add to this the notions of 'independent living units' and 'self care units' commonly used in

Australia, 'supportive living' from the Canadian context, notions of 'congregate housing' and 'continuing care retirement communities' adopted from the United States, and one begins to understand how a certain level of confusion can arise!

Within the New Zealand context, such confusion assumes a further dimension, with even government departments appearing at times unclear as to where the boundaries between the various models and definitions – in particular, specific housing categories – lie. For example, there would appear to be some discrepancy in the classification of retirement villages (especially those incorporating rest home and hospital level care as an adjunct to their independent units) as either private or non-private dwellings. While such variation may, in itself, reflect evolving understandings of what does or does not constitute SIA, it can potentially give rise to some confusion when comparing some of the statistical data.

Statistics New Zealand (in its consideration of housing options available to older people), defines non-private dwellings as "those where a number of generally unrelated people live" (Statistics NZ, 1998, p.46) and as being "open to the public". While this category also includes boarding houses, motels and public hospitals, the majority of older people encompassed by this category reside in residential aged care facilities – i.e. rest homes and 'continuing care' hospitals. Yet elsewhere, Statistics New Zealand equates non-private dwellings with "institutional" accommodation. For example, their 2004 publication, 'New Zealanders – 65 and Beyond', refers to an expected increase in the number of people "living in non-private dwellings (institutions)" (Statistics NZ, 2004, p.7). Though there appears no intention to include those residing in Retirement Villages within this definition – and certainly those purchasing such units would seem unlikely to think of themselves as residing in an 'institutional' setting – other definitions would appear to extend the notion of 'institution' or 'non-private dwelling' to include retirement villages along with other forms of residential aged care:

"Institutional accommodation is … provided by private life-care organisations (mostly oriented towards the upper end of the market, where the use of equity becomes crucial), private rest homes, charity and religious-based rest homes and sheltered housing in pensioner-only settings." (Thorns, 1993, p.97)

"In 2001, a small proportion … of the older population was living in non-private dwellings. Of these, 81% were *living in a retirement village or residential care facility…*" (Ministry of Social Development, 2003, p.12, italics added).

That one of the New Zealand Census categories cites 'home for the elderly, retirement home' as an option, only serves to further compound such confusion.

For the purposes of this thesis – though, admittedly, at the risk of further confounding an already complicated lexical landscape – a further term is introduced: *Supported Independent Accommodation (SIA)*. It is suggested that such a term is particularly useful because it not only encompasses the broadening range of accommodation options available for older people in New Zealand, but also enables models within that range to be examined according to three distinct aspects:

(a) the nature or extent of *support* offered,

(b) the nature or extent of *independence* afforded the older resident, and

(c) the nature of the *accommodation* itself (whether that be in terms of tenure, design, or some other aspect).

Using such a concept, it is then possible to locate particular models (or, for that matter, specific examples) of SIA along a continuum – i.e. from those offering lower levels of support (and therefore higher independence), to those offering significantly higher levels of support (where residents are, by virtue of their health or social needs, more dependent). In the subsequent Case Study section of this thesis, such a threefold typology proves particularly useful.

2.2 Demographics

2.2.1 Introduction

In considering the demographic material underpinning this thesis, a primary source of for such material has been, predictably, publications produced by the Statistics New Zealand – focusing largely upon data progressively available from the 2006 New Zealand Census, though, in some cases only material from the earlier 2001 Census has been accessible. Other demographic material has also been drawn upon, including that contained in various reports and/or strategies produced by other Government agencies (e.g. Ministry of Health, Ministry of Housing, Housing New Zealand Corporation, and Ministry of Social Development). While again, much of this is based upon Statistics New Zealand information, in many instances these data have been supplemented with such agencies' own demographic research, analysis and interpretation. Some international comparison has also been possible.

It is important to consider such demographic material because it sets the context within which policy and practice take their place, and because demographic change is such a critical driver in terms of New Zealand's older population – in relation to both population and accommodation change. For this reason, discussion of the demographic material is presented in two sections, exploring firstly population and secondly accommodation demographics.

2.2.2 Population Demographics

The 2006 Census indicated that, of New Zealand's population of just over four million, some 495,600 (12.3%) were aged 65 and over. In effect, the number of people aged 65 and over has virtually doubled – both numerically, and as a proportion of the population, since the early 1970s (Statistics NZ, 2007). In comparison, the population as a whole increased by 44 percent over this period (Statistics NZ, 2006). This trend is projected to continue, with the number of older people expected to increase by 100,000 over the next decade, to comprise 20 percent of the population within 20 years, and to double as a proportion of the population within the next 30 years (Statistics NZ, 2007).

Figure 1:
Change in Population Aged 65+
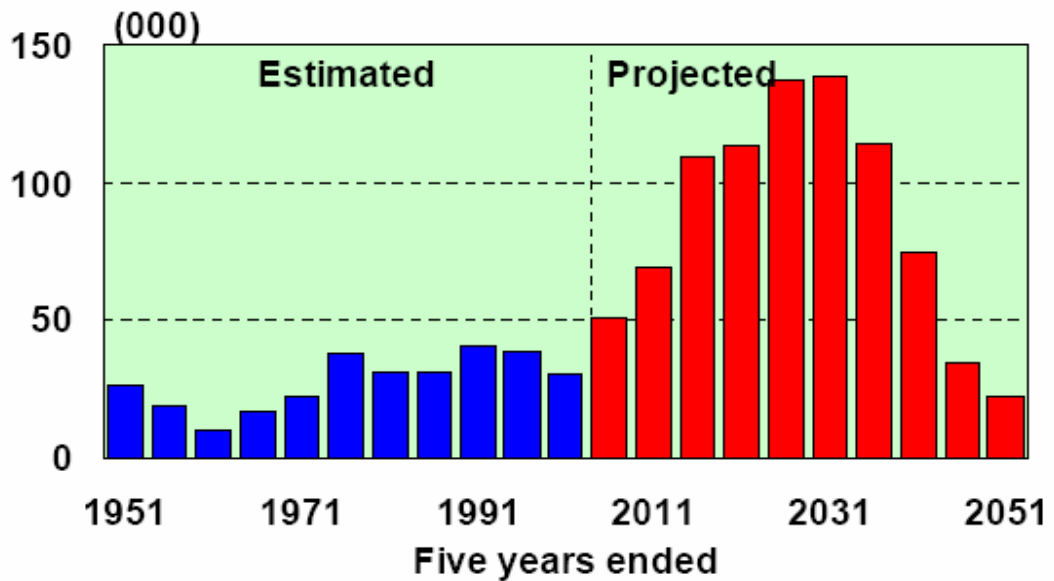
(Source: Statistics NZ, 2006)

Figure 2:
Growth in 65+ Population
By 10-yearly intervals, 1951–2051
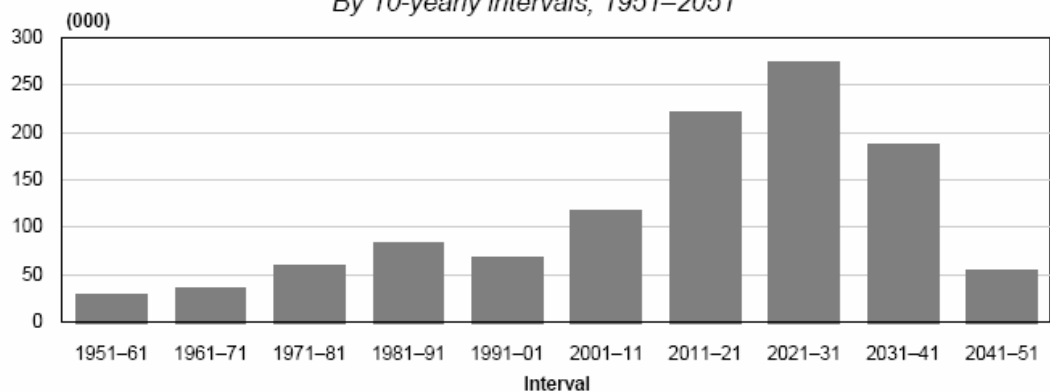
(Source: Statistics NZ, 2007)

Given such dramatic demographic change on the horizon, it is somewhat surprising to note, in their 2003 Briefing to the incoming Minister for Senior Citizens, the comment from the Ministry of Social Development's Senior Citizens Unit that, while this ageing trend will accelerate around 2010, when the first of the baby boomers

reach 65, "it does not have any immediate implications for the Senior Citizens portfolio" (Ministry of Social Development, 2003, p.2). In fact, it does.

According to analysis of the 2006 Census data, over half (54%) of older New Zealanders fall into the 65-74 age range, a little over a third (35%) are aged 75-84, and 11% are aged 85 and over. Those aged 85+ represent the fasting growing sub-group both within 65+ category, and the population as a whole. As a sector of the population, those aged 85 and older have trebled in number between 1978 and 2006 (Statistics NZ, 2007), and are currently increasing in number at the rate of 5% per annum. Statistics NZ projections suggest that the number of New Zealanders aged 85 and over will more than quadruple by 2051 (Statistics NZ, 2007) – by which point they are likely to make up 22 percent of all New Zealanders aged 65+ (Statistics NZ, 2004). It is therefore not surprising that one government report suggests that this 85+ group "poses the greatest challenge in terms of enhancing independence among older people" (Ministry of Social Development, 2001, p.2).

Such statistics, though dramatic, are nevertheless largely in line with international trends. As Statistics NZ (2006) note, population ageing is not unique to New Zealand or even to 'developed' nations. The transition to lower fertility and mortality rates has occurred, or is occurring, in other countries, often at a much faster rate than is being experienced in New Zealand. Both in New Zealand and internationally, such increases are also driven by the ageing of the sizeable post World War II baby boom generation – those born between 1946 and 1965.

Research suggests that life expectancy is consistently greater for females than males. Accordingly, women outnumber men by a significant margin amongst New Zealand's older population – a gap that widens as age increases (Davey, de Joux, Nana & Arcus, 2004).

The probability of living alone increases with age. In New Zealand, 24% of those aged 65-74 live alone, 41% of those aged 75-84, and 56% of those aged 85+. While

the living arrangements of men and women are similar until around age 65, because women have greater life expectancies than men, and generally marry men older than themselves, they are likely to live longer and to outlive their husbands (Statistics NZ, 1998; Peace & Holland, 2001). Consequently, a greater proportion of those older New Zealanders living alone are women.

Figure 3:
Projected 65+ Population in One-Person Households
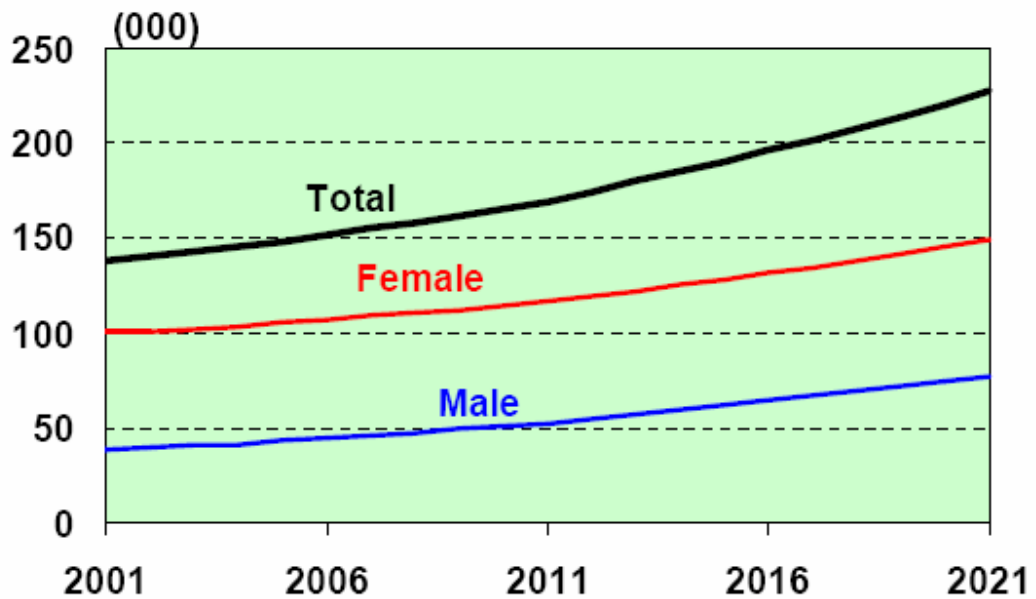
(Source: Statistics NZ, 2006)

One consequence of differences in mortality between men and women is that by the time New Zealanders reach their late 80s, half the men are not partnered, and almost 9 in every 10 women do not have partners (Statistics NZ, 2004). While, in the future it is likely that a higher proportion of older people will be married, this trend may be offset by an increase in the proportion of separated or divorced older people, as cohorts which have experienced higher rates of marriage breakdown reach old age (Davey & Gee, 2002).

2.2.3 Accommodation Demographics

Any analysis of New Zealand housing demographics needs to take into account apparent variations in definition relating to private and non-private dwellings – in particular, the classification of retirement villages (especially those incorporating rest home and hospital care as an adjunct to their independent units). While such variation may simply reflect evolving understandings of what does or does not constitute SIA, it can nevertheless lead to some confusion when comparing some of the statistical material.

For example, Statistics NZ (in a discussion of housing options available to older people) defines non-private dwellings as "those where a number of generally unrelated people live" (Statistics NZ, 1998, p.46). This description also includes boarding houses, motels and public hospitals, and the majority of the people included resided in aged residential care facilities – i.e. rest homes or continuing care hospitals. Elsewhere, their definition is more precise – for example, in the Category Definitions noted on their website, the overarching notion of non-private dwelling is broken down into a further 21 sub-definitions. Yet their 2004 publication, 'New Zealanders – 65 and Beyond' refers to an expected increase "…in the number of people living in non-private dwellings (institutions)" (Statistics NZ, 2004, p.7). While there appears no intention to include those residing in retirement villages within this definition – and certainly those purchasing such units would seem unlikely to think of themselves as residing in an 'institutional' setting – other definitions or interpretations appear to extend the notion of 'institution' or 'non-private dwelling' to include retirement villages along with other forms of residential aged care. For example:

> "In 2001, a small proportion … of the older population was living in non-private dwellings. Of these, 81% were *living in a retirement village or residential care facility…*" (Ministry of Social Development, 2003, p.12, italics added)

Latest Census figures suggest that, of the nearly 495,600 New Zealanders aged 65 and over in 2006, approximately 90% lived in private dwellings (including both

permanent and temporary dwellings), and the remaining 10% in non-private dwellings. Of these, the majority (85%) lived in residential care facilities for older people (Statistics NZ, 2007).

Davey et al (2004) note that while the proportion of older people living in non-private dwellings (including residential aged care) increases with age, it does not however exceed 5% until past the age of 80 – when, as a proportion of the overall population, those in non-private dwellings begins to increase more rapidly. To put it another way, of the 28,000 older New Zealanders living in institutional care of one form or another, over 20,000 (70%) are aged 80 and over. As would be expected, the proportion of those older New Zealanders living in residential care increases with age – to include 8% of those aged 80-84, 18% of those aged 85-89, and 38% of those aged 90 and over.

Again women are disproportionately represented, comprising three in every four of those aged 65+ living in residential care (Statistics NZ, 2007). 2006 Census figures suggest that, in the 85 plus age group, 15% of men and 28% of women were in residential care. Further, not only is the average age of those in residential aged care increasing, those entering residential care are doing so with greater levels of disability and more complex health care needs (Davey et al, 2004).

As alluded to earlier, the ageing of the population – especially, in the shorter term, those aged 85 and over – is expected to give rise to a significant increase in the number of people living in non-private dwellings (projected to increase to 100,000 by 2021). 40% of these are expected to be over the age of 80. This immediately raises questions as to whether current residential aged care provision will be able to cope with such an increase. 'Ageing in place' initiatives are seen as an alternative to simply increasing the number of aged residential care beds to the level required to accommodate such growing demographic demand. With an increasing range of community-based health and support services available – designed to enable the equivalent of rest home (and, in some instances, hospital) level care to be provided to

an older person in their own home – it is anticipated that the *proportion* of older people able to 'age in place' can be expected to progressively increase. However, this has to be interpreted with some caution, given the increasing *number* of older people in the population – particularly those aged 85 plus. It is this group who are the predominant users of higher hospital and psycho-geriatric levels of residential care. Furthermore, it is difficult to foresee such high-level care being managed within the community-based packages of care to the extent that less complex levels of care are able to be delivered in that setting. Accordingly, it seems likely that, despite an increasing array of ageing in place initiatives, the actual number of aged residential care beds required may need to remain at current levels, if not increase.

Alongside this is the growth that is already occurring in the so-called 'retirement village' market. While national statistics on retirement village occupancy are difficult to source, it is estimated that some 21,000 New Zealanders aged 65 and over (or a further 4-5% of the 65+ age group) were living in retirement village settings as at 2003 (Ministry of Social Development, 2003). Retirement Village operators themselves, however, suggest that the growth in the retirement village is sector is due largely to an increasing aged population rather than because the proportion of older people choosing the retirement village lifestyle is itself necessarily increasing (Greenwood, 2005). Nevertheless, growth in the sector is likely to continue to increase, with Ryman Healthcare, for example, anticipating building a further 250 retirement villages units per year, and holding an existing 'land-bank' sufficient to accommodate some 1200 units (Greenwood, 2005).

Despite the confusion around definitions noted above, it can reasonably be assumed that those who reside in retirement villages are included in the 90% of older New Zealanders (407,000) who, as at 2001, resided in what are classified as private dwellings – over three quarters of whom lived in owner-occupied housing (Davey et al 2004) – a higher percentage than the population as a whole. Home ownership amongst older New Zealanders is higher than the population as a whole, with three-quarters of older people owning or part-owning their own home (Ministry of Social

Development, 2003). In part this reflects past government policies designed to encourage home ownership through low-interest loans and the ability to capitalise family benefit (Ministry of Social Development, 2003).

While home ownership amongst older New Zealanders peaks at ages 65-74 years, more than half of the over 85 population owned or part-owned their own home in 2001. While overall rates of home ownership for older New Zealanders have remained relatively stable, latest statistics indicate an increase in home ownership amongst the 'older old'. This is suggested to reflect the increase in services that encourage older people to live in their own community with appropriate support (Ministry of Social Development, 2007).

As well as having higher levels of home ownership, older people are more likely to own their own home without a mortgage than those aged 16-64 years, with less than 5% of people aged 65 and over still paying off mortgages (Davey & Gee, 2002, p.7).

Of the 43,000 older New Zealanders who rent accommodation, over a third rent from private landlords, just under a third from Housing New Zealand or other central government agencies, and the balance primarily through territorial local authorities (e.g. local council housing) or trusts.

Figure 4:
Category of Landlord for Renters Aged 65 Plus by Age and Gender

	Age group	Private person or business %	HNZ or other public sector %	TLA %	Private Trust %	Not specified %	Total %
Total	65-74	38	29	18	6	9	100
	75-84	27	29	26	8	10	100
	85 plus	24	22	29	11	14	100
Male	65-74	41	24	20	6	9	100
	75-84	30	25	26	9	10	100
	85 plus	27	20	25	12	16	100
Female	65-74	36	32	16	6	10	100
	75-84	25	31	26	8	10	100
	85 plus	22	22	30	11	15	100

(Source: From Birth to Death Database, cited in Davey, et al, 2004, p.48)

Low-asset, low-income older people traditionally make up the bulk of social housing tenants in New Zealand (Thorns, 2000).

Government research suggests that reductions in government housing stock, coupled with lowering home ownership rates and an ageing population will lead to a greater reliance by older people on private rental housing (Ministry of Social Development, 2003). Peace and Holland (2001) note that older people with low socioeconomic status who have lived in rented accommodation and who are not able to live with family, are more likely to move into institutional settings than those who have owned their own homes. If affordable and suitable rental housing is not available, this will in turn impact upon the ability of older people to remain living independently in their community. Davey (2006) notes that those who rent (of whatever age) are overrepresented in a range of measures of social and economic deprivation. On the other hand, those who own their own homes enjoy greater housing security, lower housing costs, and the benefits of capital appreciation. Jera (2005) cites a range of research suggesting that home owners have better self-reported physical and emotional health, and report a greater sense of security than those who rent. The

significance of these distinctions forms the basis for further discussion later in this thesis.

Despite an increasingly ageing population, with both the number and proportion of those aged over 85 steadily increasing, it would seem that the proportion of older people who have remained living independently in the community has remained largely unchanged over the past decade (Ministry of Social Development, 2001). A contributing factor to this has been the increasing availability of (funded) community-based support services – i.e. those services designed to enable older people to 'age in place'. Similarly, overseas research indicates that the proportion of people aged 85 and over living in non-institutional settings is steadily rising, suggesting that old age and widowhood are now less likely to result in the need to move from one's own home than may have previously been the case (American Association of Retired Persons, 2004). As will be explored further in the next section, a variety of factors contribute to this – including greater expectations of independence and choice on the part of older people, the perceived cost-effectiveness of community-based as opposed to residential aged care and, in line with this, the greater range and availability of community-based care.

Latest Census data suggests that a quarter of New Zealanders aged 85 and older currently reside in institutional settings (Statistics NZ, 2007). Analysis of earlier Census material suggests that of those who remain living in the community – i.e. in other than residential or institutional settings – a half do so independent of any support services (Ministry of Health 2002, cited in Davey et al, 2004).

3. Literature Review

3.1 Introduction

> *"Population ageing is one of the most significant issues facing New Zealand. Its implications are crucial for government and will affect individuals, households, communities, government, business and voluntary organisations. An in-depth knowledge of factors that promote wellbeing in later life is fundamental to successful social and economic adjustment as the age composition of the population changes. The availability of suitable accommodation to meet the needs of an ageing population is part of this challenge, recognising the important part which housing can play in the quality of life of older people." (Davey et al, 2004, p.16)*

The above quotation from *Accommodation Options for Older People in Aotearoa/New Zealand* (a report prepared jointly by the New Zealand Institute for Research on Ageing, and Business and Economic Research Limited, for Housing New Zealand's Centre for Housing Research), highlights both the significance and the breadth of the issue this thesis seeks to address. While significantly informed by the NZiRA/BERL report – recognising that this report provides the most recent and comprehensive review of demographic and research data currently available – this literature review surveys a range of other documented research and theory, from New Zealand and overseas.

As New Zealand's older population grows and changes – both in number, and as a proportion of the overall population – so too does the significance of accommodation options for older people. While the links between housing and wellbeing are well-documented, to date little research has specifically focused on this linkage in terms of older people (Gardner, Browning & Kendig, 2005). Nevertheless, governments in New Zealand and overseas are endeavouring to respond to this linkage in their development of both health and housing policy.

Accordingly, in the first section of this literature review, the relationship between health and housing – in particular, the correlation between poor health and poor housing, and its implications – will be explored.

In an earlier section of this thesis, the notion of SIA was introduced – a useful term, in that it enables various models of accommodation and care for older people to be examined according to the distinctive nature of the support, independence and/or accommodation they exemplify. In the second section of the literature review, an extensive UK review of various SIA schemes will be considered – with the key themes identified within that review adopted as a framework for analysing other relevant literature. For the purposes of continuity and consistency, these same themes will be used in a subsequent section of this thesis, in order to provide an equivalent framework for the analysis of a series of six case studies.

3.2 Health and Housing

"Care packages count for nothing without good housing,
and the best housing is of no value without appropriate care" (Bransbury, 2002, p.11)

Jera (2005) notes that, while housing is a determinant of health, the unequal distribution of adequate housing throughout a society has the potential for creating equivalent health and social inequalities. A number of factors influence the way in which adequate housing promotes health and wellbeing, including "having a house that is of good quality; is affordable; is stable and secure; is in a safe neighbourhood; is able to provide opportunities for social networking; and is able to impart a sense of pride and empowerment to its occupants" (Jera, 2005, p.16). If some or all of these elements are lacking, then the occupants may be at risk of suffering detrimental effects to their health and/or wellbeing. Given the well-established correlation between poor housing and poor health, it should also be of concern that those in poor housing circumstances, yet who – including many older people – spend a disproportionate amount of their day-to-day lives 'at home' (Bond et al, 1993), are potentially at greater risk of negative health outcomes. This includes many older people, along with the very young and those living with disabilities. Such a concern is reflected in the United Nation's International Plan of Action on Ageing (2000), which

acknowledges the importance of suitable housing for older people given that, for many, their homes are the centre of virtually all of their activities. It has been estimated that older people spend between 70-90% of their time in their home (Windle, Burholt & Edwards, 2006).

Peace & Holland (2001) take this argument further, suggesting that the division between those who are able to fully participate in the life of a society and those who are hindered by either material or cultural deprivation harms that society as a whole. "Older people – particularly the very old – are among those groups which, by virtue of their relative economic disadvantage and increased propensity for long-term limiting conditions and disabilities, are most at risk from social exclusion and its consequences" (Peace & Holland, 2001, p.1f). Indeed, as Gibson & Griew (2002) note, many of the more vulnerable older people in society are in large part vulnerable because of their poor housing status, and that those of lower socio-economic status may be disproportionately at risk. Howden-Chapman et al. refine this argument further:

> "As housing is the biggest item of household expenditure for low-income older people, older people who are mainly on fixed incomes are particularly affected by the level at which rents are set. Housing costs are the main determinant of how much food is on the table and, when it is cold, whether the heater will be turned on. Some choices can be fatal." (Howden-Chapman, Signal & Crane, 1999, p.25)"

While Peace & Holland (2001) rightly note that housing in itself may not substitute for other deficiencies – in terms of health, social or mental wellbeing, for example – appropriate housing can provide important support in situations where other such deficiencies exist, and certainly inadequate housing can serve to compound such deficiencies. For example, various support services may be offered to enable an older person to 'age in place', yet that person's wellbeing may still be ultimately compromised by sub-standard or inappropriate housing. For example, if an older

person's accommodation presents issues relating to access or mobility, the provision of home-based services may result in that person becoming, effectively, 'institutionalised' in their own home. Likewise it is well-recognised that adequate heating in the home is imperative for older people who are, as a cohort, far more susceptible to the effects of the cold (Windle et al, 2006). It could be argued that many of the difficulties experienced by older people are related more to their health and functional status than to the state of their home. On the other hand, Windle et al (2006) note, if such functional limitations are exacerbated by inappropriate housing conditions, then some older people will inevitably face increased risk in relation to their health. Increasing social isolation can leave older people in the community, but not necessarily a part of it (Heywood et al., 2002). Further, with increasing delivery of higher levels of care into people's own homes, the value of 'home' itself may be eroded as independence and privacy are threatened (Davey et al., p.170).

3.3 Supported Independent Accommodation – Key Themes

While demographic trends and government policy set general parameters in terms of the nature and extent of health and housing provision for older people, various other factors influence the choices older people will themselves make as they seek to (or are forced to) respond to their individual health and housing circumstances and aspirations. Despite the growing recognition of the importance of the link between housing and health for the overall wellbeing of older people (Howden-Chapman et al, 1999), there has been little research around the world on the subject (Faulkner, 2001; Howe, 2003). There is, however, a dawning recognition of the inter-relatedness of various factors influencing the health and housing needs and preferences of older people, and of the need to take such diversity into account when planning policy in both areas.

Recognising the growing interest and investment in this area – particularly in housing options that enable older people with relatively high care needs to remain living independently – the UK-based Joseph Rowntree Foundation (JRF) commissioned, in 1994, an extensive review of recent literature on the subject (published in Croucher et

al, 2006). While an increasing array of supported independent accommodation options for older people are being developed internationally – and, alongside this, a growing body of literature researching and evaluating such models – the JRF initiative represents, to date, the most extensive and comprehensive analysis of the literature currently available. As noted earlier, one of the difficulties associated with this area of research relates to the variety of terms used to describe or define supported accommodation options for older people. For the purposes of their review, the JRF project adopted the term 'housing with care for later life' – referring to models of housing for older people that, regardless of tenure, allow private living space for the occupants, and provide a range of care designed to forestall or preclude entry into residential care. Their definition encompasses models of supported accommodation commonly referred to as 'ageing in place' – many examples of which are, at least in the UK, promoted as 'homes for life'.

Searching multiple electronic databases, the JRF review excluded both individual (i.e. 'stand-alone') housing and 'traditional' models of residential or nursing home care, together with material produced for primarily marketing purposes or that produced prior to 1985. From 4,000 references originally identified, 145 studies were used to construct the review – including a sample of literature on models of housing with care in Europe, USA, Canada and Australia. Despite such an extensive survey of the available literature, and the comprehensiveness of the research base upon which they have drawn, the authors still express a certain caution regarding their findings:

> "Collectively these studies present a heterogeneous body of work. They can be seen as pieces of a mosaic of evidence which when placed together show various emerging themes. The rather patchy nature of the evidence informs the debate around housing with care rather than providing answers to some of the key questions; indeed some of the research raises more questions than it answers." (Croucher et al, 2006, p.55)

Nevertheless, the JRF review provides a much more substantial and detailed meta-analysis of supported housing models for older people than is currently available in New Zealand. As such, it offers a critical point of reference for this thesis – against which both current policy and Case Study examples of innovative practice in New Zealand will be evaluated.

Reflecting upon the extensive material considered in the JRF review, Croucher et al (2006) identified 7 emergent themes:

    i. Promoting independence
    ii. Health, wellbeing and quality of life
    iii. Social integration
    iv. Home for life
    v. Alternative to residential care
    vi. Cost effectiveness
    vii. Affordability

These themes are confirmed by an earlier review of research undertaken by Bransbury (2002), which arrived at similar criteria – with older people seeking housing which promotes independence, security, a sense of community, social and economic participation, and quality.

In the next section of section of this Literature Review, each of the seven themes identified by the JRF review is examined, and discussed in relation to other relevant literature identified. Later in this thesis, the same themes provide a useful framework for considering three relevant government policy documents – namely, the Positive Ageing Strategy (PAS), the Health of Older People Strategy (HOPS) and the New Zealand Housing Strategy (NZHS) – and (as noted above) in a subsequent chapter, for analysing a series of case studies, each of which provides an example of innovation in terms of New Zealand's approach to SIA.

3.3.1 Promoting independence

"There are a number of factors that influence an older person's capacity to maintain independence. These include personal health, income adequacy, safety and security, access to community-based support or social services, and mobility. For many older people the key to maintaining independence is remaining in their own home." (Ministry of Social Development, 2003, ch. 4, p.2)

Independence also carries different meanings for different people. For some older people, their independence is maintained through the support of family and friends – thereby enabling them to remain independent of state support. For others, such state support is the very thing that defines their independence – so that they need not feel they are burden upon their family and friends.

While the combination of independence and security is clearly valued by older people, accommodation providers and their older residents do not always have a shared understanding of what is *meant* by independence (Croucher et al, 2006). For some older people, for example, independence relates to their ability and/or freedom to undertake everyday household tasks for themselves; for others, assistance with such tasks does not compromise their sense of independence, as their understanding of independence has more to do with privacy and autonomy.

Accordingly, in drawing the comparison with residential care, Croucher et al (2006) note that one of the significant advantages of 'housing with care' models are their potential to afford residents greater independence and autonomy. They encountered a considerable body of evidence demonstrating that one of the most valued aspects of supported independent accommodation was often, in fact, independence itself – more particularly, the combination of independence and security.

In a subsequent report, Croucher (2006) acknowledges that the concepts of independence and security are, however, complex. Independence, she suggests, is closely related to privacy – in particular, being able to maintain a degree of control

over who comes into your private domain, and maintaining a level of choice regarding participation in social and communal activities. Similarly, one's sense of security has to do with more than an assurance that help is close at hand day and night – e.g. the security of knowing that care staff are available around the clock in a residential setting. It has as much to do, Croucher suggests, with knowing that help is available across a range of domains, including benefits and financial advice, home maintenance, living in an environment that is comfortable and barrier-free, having a sense of 'belonging', even one's sense of trust in an accommodation provider or in the nature of accommodation tenure.

Peace & Holland (2001) agree that one of the main concerns of older people relates to security – they cite the way in which the incidence (or more often the perception) of crime in their area, leaves many older people feeling as if they are prisoners in their own homes. Likewise, the New Zealand Disability Strategy observes that, for older disabled people, "one of the biggest problems can be being denied the opportunity to remain in their familiar surroundings and 'age in place'. Even in their own homes, some can feel isolated and insecure if they have limited contact with families, friends and their community" (NZ Disability Strategy, 2001, p.8). Earlier research published by the Joseph Rowntree Foundation (1995) goes so far as to suggest that dwellings that would otherwise be highly satisfactory in terms of meeting an older person's housing needs, may be deemed less so where that older person perceives their safety or security to be threatened.

The desire to retain autonomy and choice are key influences in older people's housing decisions. Hanson (2003) suggests that most housing decisions in later life boil down to choosing whether to risk continuing to live in an ordinary house within their own established community, or to move to more specialised housing as part of some form of aged or retirement living community. "Neither is perfect. Both options have drawbacks… A move from one to the other signals an assumed shift in the balance from independence to care" (Hanson, 2003, p.7).

In considering the importance of independence and autonomy, it is also important to recognise, however, that this can relate as much to a resident's choice *not* to move as to move – or, if they do decide to move, the extent to which they subsequently participate or not within the range of communal activities that are invariably offered within supported independent settings. Indeed, as Heywood et al (2002) note, a polarised view of independence and dependency may not contribute to the overall wellbeing of older people at all – rather, it may only serve to reinforce the idea that dependency is an abyss into which we must all, one day, fall.

> "While independence is an appropriate and laudable goal for older people, it needs to be recognised that not all older people will have the capacity to be fully independent…On an individual level, being or not being independent is not the measure of a person's worth" (Ministry of Social Development, 2003, Advice to incoming Minister, ch. 4, p.2)

For many older people, staying put in their existing accommodation is simply not an option. Others choose to move while they are still able to make such a choice. In an Australian study cited in the JRF review, factors associated with housing tenure and socio-economic circumstances also served to influence the degree of choice surrounding an older person's decision to move or otherwise:

> "For those residents who moved as home owners, concerns were closely linked to the likely changes in health and neighbourhoods. For those who were not home owners, affordability of the living situation was the main concern" (Croucher et al, 2006, p.34).

Those providing supported accommodation for older people need to be sensitive to the fact that the expectations of support and assistance may differ between residents. Provision of meals to residents provides a useful example. Some providers do not offer meals as part of the accommodation 'package' as this might be seen to compromise residents' independence. Other providers may offer residents the option

of meals – either in an adjacent dining room, or delivered to their accommodation – not as an intrusion on their independence as much as a means of supporting residents' nutritional needs. Given the established links between poor nutrition and premature entry into residential care, the latter approach may reflect a more useful balance between support and independence.

Croucher et al (2006) also note the importance of self-contained accommodation – enabling not only privacy and autonomy in terms of both activities and possessions, but also the way in which having 'one's own front door' has the potential to change the dynamics between resident and care staff. Such independence serves to create "the sense of being 'at home' rather than 'in a home'" (p.56).

While the Ministry of Social Development affirms that "adequate, affordable, and suitable housing is essential to positive ageing" (Ministry of Social Development, 2001, p. 43), the fact remains, that

> "Most housing has not been designed with older age and impairment in mind, and the arrangements of the home environment often inhibit older people's ability to manage their daily lives…Less than adequate housing conditions might ultimately threaten wellbeing and health and lead to premature entry into residential care" (Davey, 2006, p.1)

Physical design aspects may be critical in their own right. Many older people move to alternative accommodation due to the inappropriateness of their existing housing. Issues of mobility, increased maintenance or heating costs, and access to transport feature regularly in the reasons older people give for moving – reflecting either frustration with, or a fear of, ongoing deterioration. Importantly, however, Croucher et al (2006) note growing evidence that a move to more accessible, warm, comfortable purpose-designed environments not only has the potential to promote and maintain independence, but in some instances to enable a return to levels of activity and independence that had previously been lost. They also note the role that

the *philosophy of care* has to play in maintaining independence – citing research that suggests that care which focuses on what residents can do rather than what they can't, improves self-confidence and can lead to further gains in independence and wellbeing. Similarly, the *security* derived from knowing help and care were at hand was also a highly valued aspect across the schemes evaluated in the JRF review (Croucher et al, 2006).

In research cited by Appleton (2002), the importance of a balance between dependence and independence for older people is reiterated – as is the importance the research participants placed upon choice and autonomy. Those interviewed:

> "…wanted to be able to plan and organise their days, and enjoy a normal pattern of life. They wanted to maintain their own standards of cleanliness and tidiness in their own homes, to feel securely connected to the world, and to avoid boredom and isolation. They wanted to be able to have and deploy resources to achieve these outcomes, including having access to the maximum levels of benefit to which they were entitled, having sufficient information about services and entitlements to make choices, and being able to choose whether or not, and when, to draw on family assistance…" (Qureshi & Henwood, 2000; cited in Appleton, 2002, p.4)

Choice and control become key factors. Whilst the majority of older people want to live independently in the community for as long as possible, older people who want to move but who cannot find appropriate housing feel less independent and less able to cope (Ministry of Social Development, 2001).

> "…In a society which equates 'bigger' with 'better' and owning as somehow superior to renting, the moves many older people make (larger to smaller; owning to renting) are likely to be seen as a 'downward step' when all previous moves have been seen as 'upward'." (Heywood et al, 2002, p.85)

Awareness of the choices available is also a factor. While there is little doubt that remaining in their own home is the choice the majority of older people would make when asked, this can often reflect either an absence of attractive alternatives, or a lack of information about the alternatives that might be available (Appleton, 2003).

3.3.2 Health, wellbeing and quality of life

The key issue is not whether housing and social policies contribute to independence but whether they improve quality of life" (Heywood et al, 2002, p.158)

In an extensive study recently undertaken in Australia, Gardner et al (2005) sought to determine whether living in supported independent accommodation – in this case, a retirement village setting – enhanced quality of life (or at least did not diminish it), by examining the impact on quality of life of moving into such a setting. Two retirement village populations were surveyed – one from a facility operated by a not-for-profit provider; the other privately owned. The critical distinction between the two was seen, however, not in terms of their management or operational structure, but rather as in the residents' contrasting levels of resources prior to moving. Entry into the not-for-profit facility was restricted to people with low income that did not have the assets to purchase alternative accommodation; whereas the resident-funded village participants had all been homeowners before their move into the facility. Both facilities were located in Melbourne's south-eastern suburbs, and were roughly comparable in terms of size, quality, and range of facilities. A third population surveyed comprised a group of older people who had considered moving into supported independent accommodation, but had decided to remain in the community.

Two interviews were conducted with respondents from each group. Initial interviews with those in the retirement village setting took place soon after they had moved in. Initial quality of life measures were similar at this point across all three groups. When subsequently interviewed again, however, more of those who had moved into supported independent accommodation reported an improved quality of life, than was

reported by those who had remained in the community. In fact, a significant proportion of those who had remained in the community reported a decline in their quality of life. The survey explored further the reasons why those retirement village respondents who had reported an improvement in their quality of life felt this was so. Respondents from both the not-for-profit and resident-funded samples cited the social life and activities within their village as significant, together with a more manageable dwelling and garden, and the health support available. In addition, those in the not-for-profit village said that life had improved due to more secure and affordable housing. A number of the not-for-profit participants also noted that they had experienced a considerable improvement in the quality of their housing, security of tenure and housing costs compared with their situation prior to their move.

Such research reinforces the complexity of factors underpinning the notion of quality of life for older people – with some factors more tangible than others. Health status is a key determining factor. Many older people suffer from multiple minor impairments which do not reach the disability statistics, but collectively can pose real challenges to living an independent and fulfilling life. Satisfaction with one's quality of life is also influenced by residents' prior circumstances – as the Gardner et al (2005) research above highlights. Croucher et al (2006) note similar research that suggests that residents are more satisfied if they feel they have moved while they were still 'in control' (or, even if they considered the move inevitable but, as a result of their move, nevertheless felt they were getting on well).

Clearly, in order to meet such a diversity of experience and expectation, an equivalent diversity of options is essential if older people are to exercise choice and avoid the dilemma of having accommodation that is either too demanding or overly supportive (Office for an Ageing Australia, 2002). The effect of gender differences should also be noted, as these can further compound the variety of influences already identified. As already observed, women have a longer life expectancy than men. They have also tended to marry men older than themselves, and thus it is more likely that they will become widows and, with increasing age, live alone (Peace & Holland, 2001). For

this reason, and given that older women are also more likely than men to suffer from chronic illnesses in later life, it is not surprising to find that the majority of those living in residential aged care are women.

When considering the meaning of health, quality of life and wellbeing for older people, one key determinant is the fit between the older person and their environment (Gardner et al, 2005) – an important aspect of which is, as noted above, the balance between security and autonomy. This involves, they suggest, a balance between an older person's increased needs for physical, social and emotional security on the one hand, and their need for challenge, growth and a variety of experience on the other. Research cited by Croucher et al (2006) notes, along similar lines, that the main reasons for older people planning for their future care needs related to security and coping. "People mainly made plans which could be adapted if they needed help…making flexible plans was seen to be a way of coping with contradictions between the wish to control life and the difficulty of an unknown future" (Croucher et al, 2006, p.32). Yet Heywood et al (2002) quite rightly observe that ill health and immobility have the potential to institutionalise older people wherever they are living – and that the processes of institutionalisation can be as pervasive 'at home' as 'in a home'. Croucher et al (2006) also note the difficulty of trying to measure the impact of supported housing schemes on older people's individual health status. One's quality of life and wellbeing are determined by a complex mix of factors – and certainly related to more than just health and functional status. "Social relationships and roles, activities, health, home and neighbourhood, psychological wellbeing, financial circumstances and social and political issues all frame quality of life for older people" (Croucher et al, 2006, p.65). Nevertheless, their research found that underlying health issues were frequently a predominant factor influencing an older person's decision to move into a supported environment. In one study considered in their report, the proportion of residents who reported suffering from a limiting and long-standing illness was significantly higher within the 'housing with care' setting than was the case in similar samples from the wider community. In another study cited, although many of the residents interviewed had moved to a particular retirement community due to their poor health, they subsequently self-reported better

health status than an equivalent sample drawn from the local community. Retirement village residents, it seems, had "developed a shared culture and identity that emphasised the positive effects on health of living in the village" (Croucher et al, 2006, p.62). Other studies considered in their report noted the positive impact of moving to a warmer, safer, more accessible environment than where residents had lived before, a reduction in social isolation due to increased social contact and companionship, and, perhaps most significantly, care staff recognising and being able to attend, within that setting, to previously unrecognised health and care needs. In fact, a number of studies identified by Croucher et al (2006) show an increase in care needs following a move into a more supported environment. Almost without exception, however, this is attributed to better needs assessment and the identification of formerly unrecognised needs, rather than from a deterioration in health status.

3.3.3 Social integration

> *"…older people are malleable and will go to great lengths to sustain a coherent sense of self and find ways to stay in touch with their community" (Grant, 2006, p.3)*

The sense of social connectedness that a person feels is critical to their overall wellbeing and identity. Various writers have observed that our sense of connectedness to the community within which we live is not only central to our identity and sense of wellbeing but can take on greater significance and become increasingly critical in our later years (Grant, 2006; Howden-Chapman et al, 1999; Keeling, 1999; Peace & Holland, 2001). Similarly, Croucher et al (2006) note an extensive body of research that has demonstrated that increased social integration has the potential to lead to more positive outcomes in later life.

The rise in what has come to be collectively referred to as 'age-segregated communal living' has developed as something of an antidote to the perceived risk of increasing social isolation seen to face many older people in the wider community. By gathering older people together with others of similar age, it has been assumed that a greater

level of social interaction will be able to be sustained than if those same older individuals were left dispersed throughout the wider community. Croucher et al (2006), however, suggest that there is conflicting evidence as to the benefits of such an approach. One piece of research cited indicates that, for residents moving into a particular retirement village, their attitudes to their ageing improved measurably, suggesting that such an environment is conducive to 'positive ageing'. Other research cited, though, suggests that – particularly for those moving into such communities earlier in their old age - being confronted with other more frail and inactive older residents in fact served as an unwelcome reminder of some of the more negative aspects of ageing.

While many older people move into supported independent accommodation in an attempt to suppress the loneliness they experience living in the community (Greenwood, 2005), the reality is that former friendships tend to cease – or at least prove significantly harder to maintain – once one friend moves into an age-segregated environment, while the other remains in the wider community. And the further apart those friends live, it is suggested, the more difficult it will be for them to provide support for each other.

> "Friendships rarely extend to places of institutionalisation, such as nursing homes and other places seen as accommodation for dependent people. As such, older adults are even for their 'good friends', socially dead" (Buys, 2001, cited in Greenwood, 2005, p.56).

Follett (2006), himself manager of a large aged care complex in the United States, goes further – though in similar vein – suggesting that virtually no one would choose to live in a nursing home; rather most residents feel that they've been 'sentenced' to this by their physical condition and their children. Even retirement villages are seen by many older people as but one step up from a rest home (Greenwood, 2005).

Various factors have been identified as contributing either positively or negatively to older people's experience of social integration. Research undertaken by Victor et al (2003) suggests, however, that even in terms of the language we use in exploring this subject, some caution needs to be exercised. They note that while, for example, there is a tendency to use such terms as 'loneliness', 'social isolation' and 'living alone' somewhat interchangeably, they represent three quite distinct (albeit linked) concepts. 'Living alone', they suggest, is the most straightforward to define and measure. 'Social isolation' – also objectively measured, and relating to the integration of individuals into their wider social environment – is usually determined by the size and scope of an individual's social network. 'Loneliness', on the other hand (according to their definition) is less objective, and relates to how individuals evaluate their level and quality of social contact and engagement. Following on from these definitions, Victor et al (2003) are able to develop a fourfold 'typology' according to which they have been able to further analyse the interaction between these concepts. They suggest that, in categorising older people as either lonely, isolated, lonely and isolated, or neither, it is then possible to explore more accurately the factors that influence their experience of loneliness and social isolation.

Their research noted that there were factors that increased 'vulnerability' to loneliness and others that had a 'protective' effect:

> "Greater vulnerability to loneliness was associated independently with six
> characteristics: not being married (with the widowed most vulnerable),
> increased time spent alone, increased perception of loneliness…, poor health
> rating, health worse in old age than expected and impaired mental health…
> Two factors were independently associated with decreased likelihood of
> experiencing loneliness. These were advanced age and the possession of
> educational qualifications." (Victor, Scrambler, Bowling & Bond, 2003, p.29)

The research goes on to caution, however, that while the identification of such 'protective' factors is innovative, and that their analysis usefully highlights those most

vulnerable to the experience of loneliness (and those who seem to be less 'at risk'), their research does not directly suggest interventions to combat loneliness and isolation. However,

> "Older people themselves when asked directly to identify interventions they felt could combat loneliness and isolation, suggested enhancing social networks, promoting a sense of neighbourliness/community, developing a portfolio of 'appropriate' activities and attending to structural barriers to social participation such as transport and financial provision for later life." (Victor et al, 2003, p.30)

Similarly, Croucher et al (2006) cite the availability of social opportunities as one of the key reasons older people move into supported independent accommodation – particularly where residents in such environments are able to retain both the companionship of others and their 'own front door'. The latter factor, they suggest, was important for older people as it "allowed privacy and the choice of whom you entertained in your own private space" (Croucher et al, 2006, p.66). Nevertheless, they also recognised that some older people found it hard to adjust to communal living – precisely because of the enforced communal component. They cited a number of studies that had evidenced the development of cliques of residents – and the way in which this in turn led to tensions between residents and sometimes even open hostility.

To this end, Percival (1997) establishes a useful link between privacy, autonomy and social integration. He notes that, where an older person's living environment undermines their autonomy (e.g. through constraints placed upon their use of space – or as, in the concern noted above, through a level of 'forced socialisation') effective social integration is likely to be compromised. "In any social setting, a mark of the individual's wellbeing is likely to be how privacy is sustained alongside sociability" (Percival, 1997, p.4). While it is true that "without social relationships it is possible for people to become so isolated that independence alone cannot sustain wellbeing" (Peace & Holland, 2001, p.246), it must also be acknowledged that there

is a limit to which loneliness can be 'engineered' out of the lives of older people (Appleton, 2002). For which reason, it is suggested, the distinction that Victor et al (2003) draw between 'loneliness' and 'social isolation' – the former a more subjective notion – is important. In various studies considered by Croucher et al (2006), residents in supported independent accommodation noted that life could still be lonely. Further, many within such schemes who were identified as most marginalised and socially isolated also had sensory, physical and cognitive impairments, which could well limit their ability to 'join in'. "It is difficult to know whether these people are any more or less isolated than they would be elsewhere" (Croucher et al, 2006, p.67). Likewise, for some, both loneliness and isolation are a continuation of previous life experiences, whereas for others loneliness and isolation are a new experience as a result of negative life changes such as bereavement (Victor et al, 2003). They conclude:

"Loneliness and isolation are associated with a variety of factors, including demographic characteristics, and a range of different sets of resources including health, material and social. However many of these individual variables are linked. Vulnerability to loneliness is associated with poor mental health, low ratings for current health and expected health in later life, changes in perceived loneliness in the previous decade and time spent alone." (Victor et al, 2003, p. 31)

With such growing recognition of both the positive and negative influences on social integration, there is evidence to suggest that supported independent accommodation providers are intentionally taking a more flexible approach to the social integration of residents – acknowledging the need to attend to issues of social integration, but recognising that residents needs and expectations in this regard will differ. In a number of the retirement facilities considered in research cited by Croucher et al (2006), for example, it was not unusual for the age range from the youngest resident to the oldest to span up to 40 years. And the larger the facility, the wider the range of resident expectations. Some residents, Croucher et al (2006) note, will be happy to be 'corralled' into organized activities. Others will see this as an intrusion on their

autonomy. Similarly, residents differ in their opinions about living in 'age-segregated' environments. Some miss the presence of younger people and children; others express feelings of greater security than they experienced in the wider community (Croucher et al, 2006).

Multiple factors – reducing levels of social contact, isolation and loneliness – are each consistently associated with reduced quality in older people's lives. As a consequence, the more we are able to understand these factors, the better we are able to respond – for those older people who continue to remain living independently in the community, for those who transition through supported models of accommodation and care, and indeed for those who may ultimately find themselves residing in more institutional care settings.

> "…understanding the extent of isolation and loneliness among older people, the trajectories underpinning these experiences, and the factors associated with these states, is important in both theoretical and policy terms, for developing our understanding of quality of life. From this we may then be able to develop interventions and strategies that reflect the complexity of these experiences and enhance the quality of life of older people and contribute towards the major policy objective of 'adding life to years'." (Victor et al, 2003, p.32)

Croucher et al (2006), in surveying a wide range of available research literature, acknowledge that 'housing with care' serves a number of functions, including "the promotion of independence, the reduction of social isolation and the provision of an alternative to institutional models of care, allowing ageing in place" (Croucher et al, 2006, p.50).

The following two sections explore two related themes – in some ways, two sides of the same coin. For some older people, decisions around their housing and care are influenced by their desire to remain in their own home – the focus of the next section; for others, their consideration of various models of supported independent

accommodation is framed more around a desire to avoid unnecessary or premature entry into residential care – the focus of the following section. To what extent do the emerging models of supported independent accommodation (as seen through the lens of the existing body of research and literature) reflect or respond to each of these considerations?

3.3.4 Home for life

> *"This is the true nature of home – it is the place of Peace;*
> *the shelter, not only from all injury,*
> *but from all terror, doubt and division."*
>
> *(John Ruskin, 1865)*

Croucher et al (2006) note that, while the notion of 'home for life' has a certain logical appeal – implying that rather than older people having to move from setting to setting as their care needs change, they may be able to remain in their own home with the care provided to them *in situ* changing as their needs change – research suggests that in practice the concept is more muddled and difficult to define.

> "[It] appears to offer older people the reassurance that the upheaval and distress of further moves, or moves to institutional settings, will be avoided. For providers there is an underlying assumption that institutional models of care, which may be more costly, can be replaced." (p.70)

A growing range of support services are now available to older people in the community – including older people living in their own homes, and those in SIA environments. Nevertheless, it is clear from both anecdotal evidence in New Zealand, and from the research findings considered by Croucher et al (2006) that there remain limits to which such support services are able to safely and satisfactorily meet some of the more complex care needs of many older people. Dementia-type illnesses, for example, were frequently highlighted in the research considered by Croucher et al (2006) as being beyond the ability of existing models of SIA to address, as were older

people with other high or complex health needs requiring significant levels of medical or nursing intervention. Most older people enter SIA while still largely independent. Indeed, many facilities have strict entry criteria to ensure this. However, if a resident's care needs subsequently change – to a point where either their continuing safety or security is compromised (in the case of dementia, for example), or they need significant health intervention – then, regardless of their initial expectations, either they or the facility may deem either the risk or the cost of their remaining in that facility too great, necessitating a move into more appropriate care.

In many instances, this risk is mitigated – for both the older resident and the provider – by the provision of SIA and aged residential care (e.g. rest home, hospital and/or dementia care) as part of an integrated complex. Croucher et al (2006) cite various research findings that suggest that older people choose such complexes because of the reassurance that the availability of higher levels of care 'on site' provides, should they or their partner subsequently need such care. This is particularly the case for older couples in these 'integrated' environments – where, even if one partner needs to go into a higher level of care (e.g. rest home or hospital), the other partner is still able to remain 'at home' in their more independent accommodation.

It is clear, then, that – regardless of whether an older person is living fully independently in the community, or in a more supported accommodation environment – the notion of 'home' carries significant psychological value, and therefore represents a critical consideration. Home is the locus of hospitality, reciprocity and social interaction (Davey et al., 2004, p.170). Reduced mobility, reduced social opportunities (as a result of reduced incomes and the death of friends) results in a strong attachment to home. The significance of this increases with age as social roles are relinquished and identity becomes increasingly tied to space and place (Grant, 2006). Home confers a set of memories. Home is familiar; it is the "locus of control" (Heywood, et al., 2002, p.30f). Home can also be a symbol of self. Resistance to moving into smaller accommodation, for example, is often grounded in a desire not to relinquish the majority of a lifetime's possessions, or to move into

accommodation where friends or family members may no longer be able to come and stay (Appleton, 2002). Similarly, if an older person's existing house symbolises a valued identity, they will be less likely to choose to move – moving only at the point where their existing home no longer supports the maintenance of that identity (Heywood et al, 2002).

Even for those living in rented accommodation, home may be a key focus for their hopes, dreams, achievements and memories – connecting them into a network of neighbours, relatives and friends. While research indicates that older people who rent their houses are more likely to be dissatisfied with their accommodation than those who own their own home, that dissatisfaction can be shown to relate more to the presence of deficiencies and defects within their accommodation, rather than to the fact that it is rented (Joseph Rowntree Foundation, 1995). For both those older people who rent, and for those who own their own home, adequate and appropriate housing – that is, housing that fulfils the social and psychological expectations and aspirations of older people, as well as their physical and environmental needs – represents a critical determinant of wellbeing. "It is this that many older people value most and are most fearful of losing" (Hanson, in Peace and Holland, 2001, p.37).

Similarly, it is clear that moving home in later life involves far more than just one's choice of house. The issues involved extend beyond the physical design of a house to what Appelton (2002) refers to as the whole context of social relationships – including shopping, transport and social facilities – all that the older person needs to maintain an independent and fulfilled life.

The reality is that, as they age, older people spend significantly more time in their homes – due either to increased frailty or, conversely, the availability of more leisure time. As a consequence, their immediate surroundings and environments play a vital role in how an older person adapts and copes with advancing age (Woodbridge, 2003). Home, for many older people, comes to be seen as the last bulwark of independence (Day, 1985, cited in Woodbridge, 2003).

"If the house is a symbol of achievement, failure to care for it may (as a corollary) be seen as a sign of failure, and this is what makes the issue of housework, decorating and maintenance services so important." (Heywood et al., 2002, p.58)

As people become, with age, both less fit and less well off – and so less able to manage independently – the fear of becoming dependent or 'a burden' grows (Heywood, 2002). Research has shown that what older people more often want is not 'care' but 'help' – "just enough (and of the right sort) to enable them to retain their precious independence" (Heywood et al., 2002, p.57).

The boundary between housing and support is a complex one. Most older people would prefer to remain in their own home, receiving the necessary long-term care services in that setting (Forrest et al, cited in Appleton, 2002; Barrett et al, and Parsons et al, cited in (Ministry of Health, 2007). However, some researchers have identified that simply moving care into the home and community can itself be problematic – regardless of the fact that the home may be the preferred locus of care from the older person's perspective:

"The experience is often complex for the older people who are the focus of care and for the informal and formal providers of care (Wiles, 2005). For example, there can be a blurring of public and private spaces within the homes of people providing the care, which Milligan refers to as "an institutionalisation … of private space" (Milligan, 2004). Home care can also be related to social isolation as the nature and use of the home changes (Wiles, 2005)." (Ministry of Health, 2007, p. 4)

3.3.5   Alternative to residential care

Another key theme in relation to models of 'housing with care' identified from the research considered by Croucher et al (2006), is its aim to provide an alternative to existing residential models of care. While some schemes do indeed seem to provide equivalent levels of care, by and large the research they examined suggests that

'housing with care' models are emerging as an alternative rather than as a replacement for residential care. This, however, can be significantly at odds with the expectations older people have in considering the option of 'housing with care' (or supported independent accommodation) as opposed to entering – or as a means of forestalling entry into – residential care. Croucher et al (2006) make the point that providers need to be far more explicit in their promotional material about what is available and not available in their facilities. This is important not only in terms of the levels of support available to residents (and the associated cost of such support), but also in terms of defining when a resident may need to move from the facility in order to access necessary care. And who makes that decision? Croucher et al (2006) cite the example of residents in a number of facilities being advised by management that they would need to:

> "…move on if their care needs became too great, although the specific circumstances under which they would be asked to move were not clear to residents or to the organisations. This resulted in residents wondering how long they could stay, concealing their frailties or health problems, and created a sense of stress, anxiety and displacement…" (Croucher et al, 2006, p.48)

For example, the financial model underpinning the licence-to-occupy (LTO) model of tenure (now almost universal amongst retirement village operators in New Zealand), – whereby the key returns to the operator are generated by the regular sale and resale of the licences – could be seen to create a subtle pressure on such operators to move residents out of independent living into other levels of care sooner than may be necessary, thus enabling a further resale of the licence. This is discussed further in a later section of this thesis.

There is equally a growing body of evidence suggesting that a significant proportion of older people are inappropriately placed into residential care settings. For example, while the United States records a similar proportion to New Zealand of older people in aged residential care (5%) some research has suggested that up to 40% of residents

in such facilities do not actually need that level of care (Division of Aging and Seniors, 2002, p.10).

Inevitably then, comparisons are made (at both a policy and service delivery level) between the relative advantages of community-based care versus residential or institutional models. There is, it would seem – even in the Ministry of Health's own apparent determination to pursue so-called 'ageing in place' initiatives at the expense (quite literally, in some instances) of residential aged care – the gradual emergence of what might be termed an 'institutional care – bad; community-based care – good' polarisation. Yet historically, only a relatively small proportion of the population – of whatever age – have lived in any form of institution (Bond, Coleman & Peace, 1993).

While, increasingly, alternative options to institutional care for older people are being sought and developed, it seems unlikely that the growing range of community-based accommodation and support options will ever completely obviate the need for some degree of residential aged care. What is, apparent, however, is that such institutional care will increasingly cater for only those older people with the highest and most complex health care needs – those for whom, by virtue of their acute medical condition and/or for reasons of personal safety and security, community-based care (no matter how comprehensive) is simply not an option. It has been suggested that, as the rate of population ageing increases over the coming years, aged residential care will become more of a palliative care service than an alternative to home (Schultz, 2004), and already we are seeing, within the context of aged residential care in New Zealand, early signs of a shift in the balance away from rest home level care, towards an increasing proportion of hospital and dementia level care.

Nevertheless, significant research and effort continues to be invested in minimising some of the more negative characteristics associated with institutional care. Models of care such as 'social role valorisation' or, more recently, the PILS (Promoting Independence in Living Study) project developed by Auckland University are cases in point.

Yet Higgins (1989, cited in Ministry of Health, 2001) argues that the real distinction is not between the institution and the community but between the institution and home. In fact, a very real danger of home-based care is that the care-workers providing such a service become, in the minds of those receiving care, 'intruders' (Hale, 2003). Hale goes on to note that certain aspects of care (particularly some of the more intrusive activities, such as bathing and dressing, etc.) when offered in a residential care setting are tolerable. They are seen to be part and parcel of the nature of institutionalised care. Yet when those same services are offered (imposed?) in one's own home – where we are accustomed to privacy and to being in charge – they are, somewhat ironically, far less acceptable. Furthermore, with increasing amounts of care and support that would normally have been provided in an institutional setting now being provided to older people in their own homes, a good deal of caution – and an even greater deal of training – needs to be reflected to ensure that, through the community-based models of care currently favoured, we do not unwittingly end up doing little more than institutionalising older people in their own homes. For it is not only the location and design of aged residential care facilities that imbue life in such settings with negative institutional characteristics, but also, as Bond et al (1993) note, often the institutional attitudes of staff and residents alike.

> "…the building of modern residential homes with exclusive provision of single rooms has not changed the fundamental nature of residential care for elderly people. Changes in physical design may be a necessary but not sufficient condition for independent living. Without changes in social attitudes towards elderly people, their living arrangements are unlikely to meet their needs or their desires." (Bond et al, 1993, p.225)

Nor are such 'resource' issues confined to those *employed* to provide care for older people in their own homes. International trends indicate that, significantly, over the half the informal care received by older people is provided by other older people – predominantly spouses – and that the availability or otherwise of such informal care is a key determinant in delaying entry into more institutionalised forms of care,

particularly among those aged over 80 (Gibson & Griew, 2002). In one piece of research considered by Croucher et al (2006), up to 70% of residents in retirement village settings reported their families being the most important source of help – although the ability for family members to be involved in this was seen by some to be one of the key advantages of supported independent accommodation over more institutionalised models of residential care.

Yet, as earlier noted, while the instititutionalisation of older people is underpinned by and perpetuates a negative view of ageing (Schultz, 2004), we cannot afford to lose sight of the fact that many aspects of such institutionalisation may also be experienced by older people living in the community.

> "In supporting the principle that older people have a right to stay put, we must not ignore the fact that the price of this decision for many of them is:
>
> - Increasing social isolation and exclusion;
> - A deteriorating physical environment; and
> - Only being offered or able to consider an alternative at the stage when residential or nursing care is the only realistic option" (Bransbury, 2002, p.3)

There is an increasing awareness that for older people, simply remaining at home does not alone guarantee that they remain part of the broader community (Schultz, 2004).

3.3.6 Cost-effectiveness

> *"When very sheltered housing is claimed to be cheaper than other forms of care, the question must be asked:* cheaper to whom?*" (Twigg, in Heywood et al, 2002, p.131)*

As with the preceding two sections ('Home for life' and 'Alternative to residential care'), this section and the next ('Affordability') can be seen to be interlinked – again,

each two sides of the same coin. This section considers the value models of SIA represent to the sector – in particular, to government and providers. A great deal is being invested in the development of such initiatives – but are they economically sustainable in the long-term? In the next section, the perspective shifts to that of the older occupant themselves: to what extent are such models of care and accommodation affordable from their perspective?

In an economic evaluation of the Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) project – described as "a meta-analysis of three initiatives designed to promote independence and continued living in the community for elderly people" (Ministry of Health, 2006, p.1), the the Ministry of Health presented the results of a cost effectiveness analysis of each of three ageing in place initiatives – in each case assessing their cost effectiveness relative to conventional health care services (usual care). In each case, costs:

> "… are measured in terms of the health care resources used by the elderly participants involved in the assessment over the two-year study period, and include community costs incurred by either the DHB or elderly person, and the residential costs associated with permanent entry into either a rest home or hospital." (ibid, p.1)

The report suggests that, while all three initiatives cost slightly more per person (ranging from $20 to $340 per person per annum) relative to 'usual care', "all had the result of increasing the time spent in the community over a 12 month period by decreasing time in residential care…" (Ministry of Health, 2006, p.4).

The report notes a number of caveats concerning the interpretation of their findings – primarily relating to small sample size and statistical comparability between the three initiatives. Nevertheless, such research supports the observation that *in general terms*, the provision of care and accommodation in an institutional setting tends to be less

costly than providing the equivalent level of care within an older person's own home environment. Such a statement, however, is itself subject to a number of caveats.

Firstly, as demonstrated by the ASPIRE project, while the *direct* cost of the ageing in place initiatives may have been higher than equivalent care provided in an institutional setting, the report suggests that additional direct cost is offset by *indirect* savings 'elsewhere in the system' – the reduction in demand for residential care bed days, or acute hospital admissions, for example.

Secondly, the extent of any 'savings' is significantly influenced by the health status and care needs of the older person. For those with low-medium needs, it may well be as cost-effective to provide care in a less institutional setting. For those with higher and more complex care needs, however, such cost savings may be progressively diminished. The report alludes to this when they note:

> "…the sample for the Hamilton Community FIRST initiative had much higher levels of mean physical and cognitive disability at entry into the ASPIRE trials than the sample for the Christchurch COSE initiative, with the Lower Hutt PIP initiative having a mean level of disability between the two other initiatives. These differences, which were not adjusted for in the cost effectiveness analysis, may influence the final results, as Community FIRST may appear much more expensive for the outcome it achieves, but this is because it faced greater challenges with its sample participants." (Ministry of Health, 2006, p.5)

Similarly, Gibson & Griew (2002) note that not only do community-based (as opposed to residential) care services suffer the risk of substantial cost diseconomies with high needs clients, but that, with the move away from residential care as a preferred option (both for health funders and older people themselves), the number of older people with high needs being cared for in the community is itself increasing. They ask the question: 'How far can community care go?' and suggest that, perhaps, part of the problem lies with competing pressures:

"There is a values-based pressure toward increasing home-based service delivery. There is also a cost-based pressure in this direction, sometimes but not always accompanied by a recognition that the process of cost reduction involves a proportion of costs being shifted from the public sector to the informal care sector, and that there is a dependency level beyond which community care is less efficient." (Gibson & Griew, 2002, p.8)

They conclude that not only is community-based care more costly to provide for those with high and complex care needs, but that for many older people community and residential aged care simply do not constitute equally viable alternatives. Howe (2003) takes this argument still further, suggesting that not only are the costs of providing services to older people in their own homes (including supported accommodation environments) considerable, in some instances those services may not even be warranted – particularly where these are provided on a 'user pays' basis. "There is evidence to suggest that retirement villages are over-providing services that are not wanted or used by large proportions of residents" (Howe, 2003, p.17).

In similar vein, while Croucher et al (2006) note some emerging evidence that indicates that models of SIA may in fact reduce demand on health services, they also suggest that this may reflect as much a redirection as a reduction, with one source of health spending/staffing effectively substituting for another.

A final caution relates to the need to 'compare apples with apples' – not necessarily an easy task when comparing across sectors that are funded in quite distinct ways. And as Croucher et al (2006) observe, simply transferring costs to other budgets – i.e. from one 'budget-holding' agency to another – does not equate to cost savings overall. Their analysis of various attempts to compare the costs of different levels and models of care and accommodation highlights "the difficulties in arriving at an overview of cost-effectiveness, due in part to the lack of a suitable cost model, and also the many differences in the ways the costs are calculated" (Croucher et al, 2006, p.83). Further,

Oldman (2000, cited in Croucher et al, 2006) reiterates the importance of informal care, and argues that the costs associated with its provision should also be taken into account when calculating the overall cost-effectiveness of models of housing with care.

In New Zealand, caution needs to be exercised when comparing, for example, aged residential care with other community-based models, as the total 'cost' of aged residential care includes the provision of both care and accommodation – a cost borne in varying proportion by the resident and/or the state, depending on each resident's income and assets. In comparison, for an older person residing in the community and receiving the community-based equivalent of rest home level care, while the cost of that home-based care will likely be government-funded, for most (other than those on low incomes and receiving government-funded accommodation assistance) the cost of their accommodation is one that they will have to bear themselves.

Yet, as the following chart indicates – comparing relative costs to a DHB of the various levels of aged care provision – the true distribution of those costs can easily become distorted. In this case, the chart would seem to suggest that the cost per person of providing rest home and hospital level care is significantly higher than the cost per person of providing home-based support.

Figure 5:
Average Annual Cost of Care per Aged Person 05/06
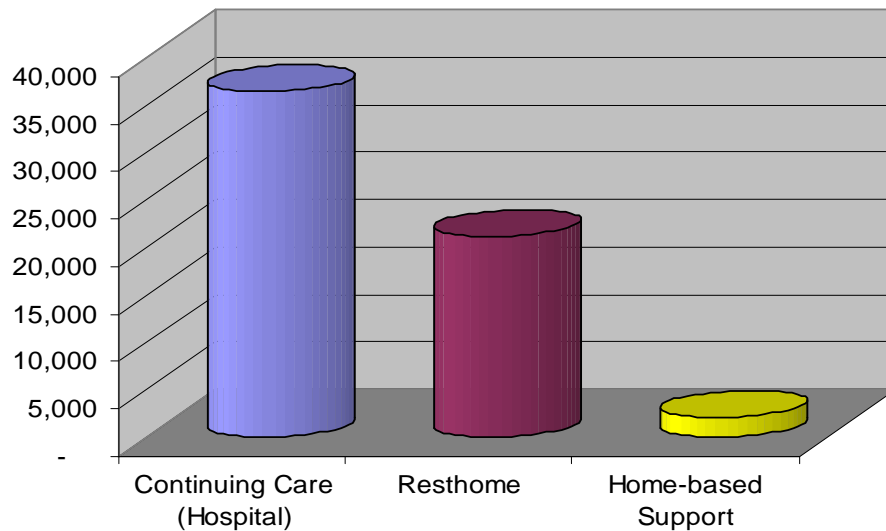
(Source: Canterbury DHB, used with permission)

What the chart does not clearly indicate, is that the comparison being made is only in terms of the cost to the DHB – a cost that, in terms of rest home and hospital level care carries an accommodation component as well as care provision, but only relates to the cost of care in terms of the amount shown for home-based services.

This serves to sharpen Twigg's question: "When very sheltered housing is claimed to be cheaper than other forms of care, the question must be asked: *cheaper to whom?*" (Twigg, in Heywood et al, 2002, p.131).

3.3.7 Affordability

"The main reason for not moving was the perception that they could not afford to do so."
(Oldman, 1991, quoted in Heywood et al, 2002, p.82)

Bransbury (2002) notes that many older people with the financial capacity to do so are opting to move into retirement flats and villages built privately for owner occupation when such housing offers the right facilities and environment. However, Bransbury raises the question, 'Would other older people make the same choice if they had the means?' It is an important question.

> "The option of a home large enough to maintain a reasonable social life and appropriate relationships should not be seen as a luxury and should be possible for everyone as they get older, not just those who have enough capital to buy larger and better facilities" (Bransbury, 2002, p.5)

As the quote from Oldman (1991) above suggests, affordability is a key factor for older people in determining where they reside, if and when they move, and the levels of care and support – beyond any that may be government-subsidised – that they may be able to afford. Some older people are more vulnerable in this regard than others:

> "Older people who have not attained homeownership by old age are a particularly vulnerable group. This group is subject to a considerable amount of environmental pressure at a stage in their life when lifespan transitions impact on their physical capabilities and social networks" (Gardner et al, 2005, p.193).

Yet Croucher et al (2006), while identifying affordability as one of the key themes of their comparative analysis also noted that few studies asked residents about value for money or affordability. Yet, where people were asked, "…it seemed that affordability was an issue, particularly for those who were self-funding" (Croucher et al, 2006, p.84). Despite the observation made above – that there is some evidence to suggest that retirement villages, for example, 'over-provide' services (Howe, 2003), One of

the ways in which older people – particularly those for whom their accommodation and care is self-funded – maintain the affordability of their accommodation is by declining those services they perceive as unnecessary (Croucher et al, 2006). The tables below highlight the fact that older people – regardless of the nature of their accommodation – resort to a range of economising strategies:

Figure 6:

Economising Behaviours of Couples Aged 65 Years and Over
2000
Economising behaviour

Economising behaviour	Percent
Cancelled insurance	14
Postponed dentist visit	12
Put off buying new clothes	31
Bought second-hand clothes	16
Bought cheaper cuts of meat	36
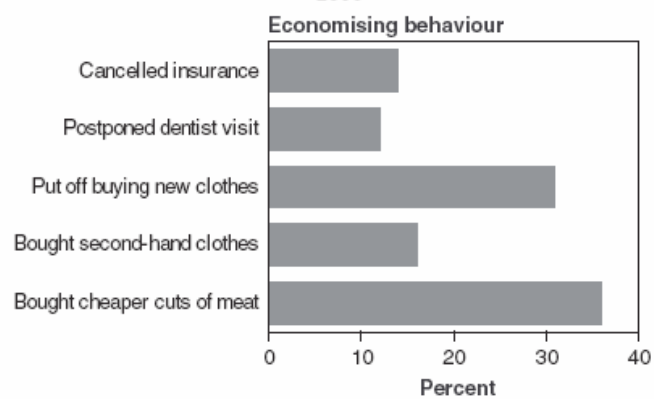
Source: Statistics New Zealand, Survey of Older People, 2000

Figure 7:

Economising Behaviours of Non-partnered Individuals Aged 65 Years and Over
2000
Economising behaviour

Economising behaviour	Percent
Cut down visits to shops	11
Cancelled insurance	12
Stayed in bed for warmth	11
Put up with cold	11
Put off buying new clothes	31
Continued wearing old clothes	13
Bought second-hand clothes	18
Bought cheaper cuts of meat	35

Source: Statistics New Zealand, Survey of Older People, 2000

While most older people wish to remain in their own homes, this can become problematic even for home-owners – particularly if their home is difficult to maintain or, if increasing rate bills are unaffordable for an older person on a low or fixed income. Yet home maintenance may prove difficult for an older person for a number of reasons – including not only cost, but access to support and their own personal frailty (Peace & Holland, 2001). Failure to address maintenance issues, however, risks putting an older person at even greater risk, through home accidents, or other health problems associated with inadequate housing (e.g. the correlation between poor heating or insulation and cardiovascular problems).

Nor is buying a newer home with lower maintenance costs always a viable option, particularly if the cost of the more modern home is more than the amount able to realised from the sale of an older person's existing home. So the fact remains: many of our older population may remain, to a large degree, 'trapped' in houses that have not been built with their later accessibility and health needs in mind – they may be too big, too inconvenient, too expensive to run, or simply in the wrong place (Peace & Holland, 2001) and with little opportunity or scope for upgrading.

While reliable figures relating to the cost for an older person in terms of home upkeep and maintenance are difficult to source, it is suggested that some 4-5% of older New Zealanders experience financial distress due to major home maintenance costs (Ministry of Social Policy, 2001). It is also recognised that, along with heating and (perhaps more disturbingly, food), home maintenance is one of the areas where older people who are struggling financially will choose to economise. Anecdotal evidence suggests that this is particularly so if an older person is uncertain of their future length of tenure – e.g. if there is the likelihood of entry into residential care in the future (Dwyer, Gray & Renwick, 1999; Ministry of Social Policy, 2001). Further, there is at least strong overseas evidence to suggest that older people, as a demographic cohort, are more likely than others to live in older housing, which is likely to be in poorer condition, lacking in amenities and with sub-standard heating (Bond et al, 1993).

Citing Australian research, Thorns (1993) suggests that, from the 1950s to 1970s, each successive cohort entering retirement had a higher percentage of home ownership – reflecting, amongst other things, the prosperity of their income-earning years. In the 1980s, 90% of those entering retirement owned their own home, and of those a further 90% owned their home mortgage free (Thorns, 1993, p.99f). However, in New Zealand as in Australia, Thorns suggests, economic prosperity has not continued, and younger earning households in the 1980s have found economic life significantly harder. Housing has become progressively less affordable, increasingly requiring two incomes to accumulate a deposit and service a mortgage, and, as a consequence, levels of home ownership have declined. Those coming into retirement in the 1990s are therefore more likely to be asset-rich than asset-poor. "The likely result will be a continuing, if not growing need for state assistance for the elderly to meet their housing requirements" (Thorns, 1993, p.118). Thorns concludes:

> "Issues of inequality among the elderly are not simple, nor are they confined to the present level of superannuation payments. Rather they reflect lifetime experiences in the job and property markets. This suggests that housing-based distinctions formed during working life are often perpetuated in retirement, rather than radically altered by the withdrawal from the job market." (Thorns, 1993, p.109)

Bond (1993) also notes the way in which the living arrangements of older people are strongly influenced by their structural position in society at earlier stages of the life cycle.

> "Owner-occupiers tend to remain owner-occupiers, council tenants tend to remain council tenants, and private tenants tend to remain private tenants, but some transitions in tenure do occur as a result of bereavement or the onset of frailty." (Bond, 1993, p.223)

Bond concludes, "our lives in later life are strongly marked out by our access to resources and social goods throughout our lives" (Bond, 1993, p.223). Advantage and disadvantage translate into older age (Austin, 1998).

Similarly, while there is a common assumption that people who are homeowners will want to continue as homeowners through later life, evidence suggests, however, that this is not necessarily the case.

> "Some older homeowners are eager to become leaseholders or tenants, as the costs and responsibilities of homeownership in later life are perceived to outweigh any advantages. Others are looking to release the equity in their homes so as to be able to afford a better standard of living generally. Some older homeowners simply can no longer afford to be homeowners, or the relatively low value of their property … does not afford them many choices in the housing market" (Croucher et al, 2006, p.6).

Others, however – by virtue of their home ownership – have a wider range of options available to them. A growing number are choosing the option of retirement village living. In fact, at latest estimate, some 4-5% of the older population currently live in retirement villages – an equivalent proportion of the older population to that in residential care (see Demographics chapter, above). Yet the retirement village option – with growth in this sector clearly reflecting its popularity – remains largely limited to those existing home-owners who can afford it.

> "The cost of moving into one of New Zealand's retirement villages is quite significant and most older people would have to have led fairly lucrative working lives if they are to afford retirement village living in later life." (Greenbrook, 2005, p.99)

Greenbrook (2005) also observes that most of the residents interviewed as part of her research "were fairly well educated people who appeared to have a relatively large

amount of discretionary income" (p.100), and that while the retirement village sector may be growing, this should be seen to be more as a result of growth in both population and supply rather than simply because the proportion of older people choosing the retirement village lifestyle is increasing.

A number of writers have cautioned that, as most involve both significant capital contribution and ongoing monthly service or facility fees, retirement villages (or equivalent LTO accommodation models) may not be as affordable as they might first appear. This is particularly the case for those older people facing considerable and ongoing maintenance costs in relation to their own current dwelling, and who may be considering the retirement village option as a means of avoiding the cost of such maintenance.

Gardner et al (2005), researching a sample of community-dwelling older people who had chosen not to move into a retirement village, note that most

> "…said they did not move because of the tenure and financial arrangements for purchasing a unit in the village – they were concerned that their money might be 'tied up' after their death – and that the weekly service fee would rise in the future" (Gardner et al, 2005, p.193).

Nevertheless, for some, the benefits of living in a safe and secure environment, free of maintenance worries, outweighed the increased costs. Similarly Croucher (2006), while acknowledging that many perceive the retirement village option as only accessible to the relatively affluent, points out that – of all the models considered – it is the retirement village model that represents least cost to the public purse. As noted in the section above, however, cost-shifting is not the same as cost-saving – and any saving to the public purse is largely due to the fact that the equivalent cost is likely being borne by retirement village residents themselves.

While the retirement village sector in New Zealand has come to be associated with some of the more high profile companies now listed on the Stock Exchange and regularly reporting multi-million dollar profits, only two thirds of villages aim to make a profit (Dagarin, 2007, p.17).

> "While many retirement villages are 'lifestyle villages' and cater primarily for the young old who can afford to enter, other villages [e.g. Selwyn Village, Auckland] exist to provide residents with support rather than a lifestyle, thus meaning that those on the waiting list who are considered to be the most vulnerable will be given the first priority." (Greenbrook, 2005, p.60)

As with the previous section (on cost-effectiveness) it is difficult to draw clear-cut, objective conclusions regarding the affordability of supported independent accommodation options – particularly the LTO retirement village model – given the inherent subjectivity associated with determining both affordability and 'value-for-money', and the increasing range of SIA options. How does one determine the value to be placed upon quality of life, sense of security, and maintenance of independence – in such a way that these can be factored into a costing equation that makes sense to funders, providers and residents themselves? Although there is growing evidence to suggest that providing support in an older person's own home environment – including emerging SIA models – is more expensive overall than residential care, Croucher et al (2006) conclude that the evidence on both cost-effectiveness and affordability of such models is scant, and therefore remains contradictory. This in turn raises questions as to who pays (where the cost of accommodation and care is greater), and who benefits (when possible savings accrue)?

4. Health and Housing Policy in New Zealand

4.1 Introduction

While the health of the older population influences both the number of older people needing care and the nature of such care and support, healthier old age and longevity do not uniformly reduce demand for aged care services. Given that those older people who enter residential aged care now tend to do so only in the last two years of their life, improving the health status of older people may only serve to delay the demand for such residential aged care (Myer Foundation, 2002, p.15). Indeed, the majority of health expenditure on older people is spent within two to three years of death. As Gibson & Griew (2002) note, it is distance from death not birth that is the key factor in predicting health resource use.

Policy changes in both the health and housing sectors have been largely driven by a move away from the notion of a welfare state. The key turning point in policy thinking is dated, overseas, around the early to mid-1970s, largely influenced by rising oil and commodity prices and a breakdown in the international monetary system (Barnett & Barnett, p.221).

The decades prior to this had seen significant government investment in health and housing, and – in part as a result of financial incentives to invest in the sector – a burgeoning growth in residential aged care facilities. Entry into such facilities was driven as much by housing need as by health need:

> "…many older people found themselves in [aged care] homes because their housing was inappropriate rather than the level of their care needs. For example, a review of research on reasons for admission to nursing homes found the ability impairment of residents was not detrimental to a degree that required the total care and support provided by residential homes." (Faulkner, 2001, p1)

Indeed, going back to the 1950s, the primary role of the residential aged care sector was to provide appropriately for the housing rather than the health care needs of older people. In Australia, for example, "over time the needs of disabled and ill older people, combined with shifting policy and some perverse financial incentives for providers, led to the virtual disappearance of the original 'housing' based intent" (Gibson & Griew, 2002, p.7). A similar shift was reflected in New Zealand in the 1960s, with significant government financial incentives (e.g. suspensory loans schemes) leading to significant expansion in the residential aged care sector – particularly amongst not-for-profit social service agencies.

Complicating this dynamic is the reality that in New Zealand, as in many other countries, certain policies relating to the health and wellbeing of older people may have themselves 'passed their use-by date'. A good example is the introduction of the so-called 'old age pension' for older people over the age of 65 – a form of welfare support introduced at a time when far fewer older people lived many years beyond this age. Similarly the long-standing 'housing intent' of aged residential care noted above. Such policy directions can take many years to influence or adapt to societal changes.

For example, the photograph shown here commemorates the opening in 1980 of a new wing in a Christchurch Rest Home. Although today rest home level care would unquestionably be seen as an aspect of health provision, it is interesting to note that only a generation ago such a wing was officially opened by the Minister of *Housing*.

(Source: Researcher's own photograph)

Driven by both fiscal and social concerns, by the 1990s the concept of 'ageing in place' – if not yet named as such – was at least in principle beginning to emerge.

Policy, particularly in relation to older people, was beginning to be shaped as much by social considerations as health considerations –with perceived cost savings also a major driver. This was reflected internationally in an intentional move away from the institutionalised models of care and housing for older people, to more community-based approaches.

In 1994, a critical agreement was reached between OECD member countries on the overall objective of care for the frail elderly, which stated, in part:

> "elderly people, including those in need of care and support should, wherever possible, be enabled to continue living in their own homes, and where this is not possible, they should be enabled to live in a sheltered and supportive environment which is as close to their community as possible, in both the social and geographic sense." (OECD, 1994, p.7)

In a subsequent OECD report, it was noted that "the ageing process should no longer be viewed as an inevitable economic and social isolation from the rest of the community" (OECD 2003, p.11).

In what amounts to a useful definition of 'ageing in place', Davey et al suggest that such an emphasis "implies that older people will remain in the community, either in their family homes, in homes to which they have moved in mid or later life, or in supported accommodation of some type, rather than moving into residential care" (Davey et al, 2004, p.20).

4.2 Health Policy

In April 2001, the Ministry of Social Policy launched the New Zealand Positive Ageing Strategy (PAS). The strategy reflected, in part, the government's response to the direction encouraged by the OECD report. It also built upon an extensive consultation undertaken in 1997, initiated by a Prime Ministerial Task Force, and

resulting in the report *Facing the Future*, and was further influenced by research undertaken in 2000 by the then Ministry of Social Policy's Senior Citizens Unit (in conjunction with the 1999 International Year of Older Persons). The purpose of the PAS was to "reposition ageing in the public and political arena so it becomes more noticeable, and find ways to dismantle the perception that old age is mostly about dependency and decline" (Grant, 2006, p.2). It recognises that, previously, funding for services for older people gave priority to those with high levels of assessed need, and contributed to an increase in admissions for long-term care. "This approach limits opportunities for positive ageing and 'ageing in place', thus increasing dependence and costs in the longer term" (National Advisory Committee on Health and Disability, 2000, p.12). A more positive approach was needed, recognising that "positive images of ageing, availability of appropriate housing, health care and support in the community and promotion of healthier lifestyles impact on older people's health and independence" (National Advisory Committee on Health and Disability, 2000, p.13), and thereby improving opportunities for older people to participate in the community in ways that they choose. The success of the strategy will be measured by improvements in the status of older people.

The strategy provides a set of ten principles to be used as a framework to enable greater integration of government sector policies and programmes in relation to older people. These principles affirm that effective positive ageing policies will:

1. Empower older people to make choices that enable them to live a satisfying life and lead a healthy lifestyle;
2. Provide opportunities for older people to participate in, and contribute to, family, whanau and the community;
3. Reflect positive attitudes to older people;
4. Recognise the diversity of older people and ageing as a normal part of the lifecycle;
5. Affirm the values and strengthen the capabilities of older Maori and their whanau;

6. Recognise the diversity and strengthen the capabilities of older Pacific people;

7. Appreciate the diversity of cultural identity of older people living in New Zealand;

8. Recognise the different issues facing men and women;

9. Ensure older people, in both rural and urban areas, live with confidence in a secure environment and receive the services they need to do so; and

10. Enable older people to take responsibility for their personal growth and development through changing circumstances.

(Source: NZ Positive Ageing Strategy, MSD, 2001)

The PAS recognises that while age-specific disease and disability rates for older people may continue to fall, overall demand for publicly-funded health and disability support services by older people is likely to continue to rise, and that a re-focusing of funding arrangements to give greater priority to 'ageing in place' is necessary.

Internationally, the concept of 'ageing in place' has become a policy priority. It recognises the desire of older people to remain in familiar environments and is seen as a way of achieving their optimum wellbeing and healthy ageing (Faulkner, 2001).

Such a shift in thinking was to be reflected not only in the 2001 Positive Ageing Strategy, but subsequently in the Ministry of Health's Health of Older People Strategy (HOPS), released a year later in April 2002. Outlining the notion of 'ageing in place' in more detail, the HOPS represented a key response by the Ministry of Health to the PAS, and adopts 'ageing in place' as a guideline standard for the development and delivery of services for older people in New Zealand. Within the HOPS 'ageing in place' is defined as the "ability to make choices in later life about where to live and to receive the support needed to do so" (Ministry of Health, 2002, p.78). Central to this is held to be the development

of services that support older people to continue to live safely in the community. The strategy also arises from the Ministry of Health's recognition of the lack of strategic policy development and planning for health and disability support services for older people (Ministry of Health, 2002).

The primary aim of the HOPS was to develop "an integrated continuum of health and disability support services that is responsive to older person's changing needs" (Ministry of Health, 2002, p.2). In doing so, the Ministry acknowledged that the previous approach to funding and coordinating support services for older people was complex and fragmented, and as such inevitably worked against more collaborative approaches. As part of their response, the Ministry (from 1 October 2003) separated off funding for services for older people from the wider Disability Support Services funding stream, devolving all funding for older persons' services to District Health Boards.

The so-called 'continuum of care' approach has not been without its critics, however. It is based on a 'conveyor belt' ideal (Heywood, et al., 2002). It assumes that older people will live at home until a certain level of dependency is reached, before moving on to the next stages – some form of supported living, followed (as their dependency increases) by residential care, and finally death in a long-term or acute hospital setting. Popular in the United Kingdom in the early 1990s, some considerable investment was made in ensuring resources were appropriately allocated to ensure that the model would work. "Of course, it never did and studies continually found that there were older people living in ordinary housing who were very much more dependent than those in sheltered housing or there were people living in residential care who were less dependent than people living in the community" (Heywood et al., 2002, p.35). Other international research suggests that a lack of adequate housing can be blamed for the unnecessary admission of frail elderly people into residential care – particularly those who are impaired, handicapped or disabled (Bond, 1993). A number of pilot projects designed to offer greater choice to older people who, while qualifying for

entry into residential aged care may, in fact prefer to receive equivalent care in their own homes, are currently being funded and researched by the Ministry of Health. There is also growing criticism of what some refer to as 'the myth of the one-way continuum of care' – the assumption that old age represents both an inevitable and indeed an irreversible decline towards death.

Greater emphasis is now being placed upon services that promote 'positive ageing' and 'ageing in place', in order to "change people's expectations of the degree to which ageing is unavoidably associated with ill-health and disability" (National Advisory Committee on Health and Disability, 2000, p.7). "Promoting independence is perhaps the key principle underpinning policy and practice relating to older people" – the central objective of which "is to maintain 'independent living' as long as possible" (Heywood et al., 2002, p.35).

Objective 8 of the HOPS picks up this focus, and notes further that the development of a comprehensive range of service options and accommodation is needed to "enable older people with long-term health and support needs to age in place for as long as this is a feasible option" (Ministry of Health, 2002, p.57). A commitment is made to fund a range of health and disability support services to enable ageing in place, acknowledging again the need for a range of alternative care options, with social and personal care delivered in a variety of settings. As the following diagram indicates, only "at the highest levels of dependency, where there is a need for continuous nursing care, is there little opportunity to substitute other (community-based) care options for residential care" (Ministry of Health, 2002, p.58).

Figure 8:
Range of Support Options for Different Levels of Need
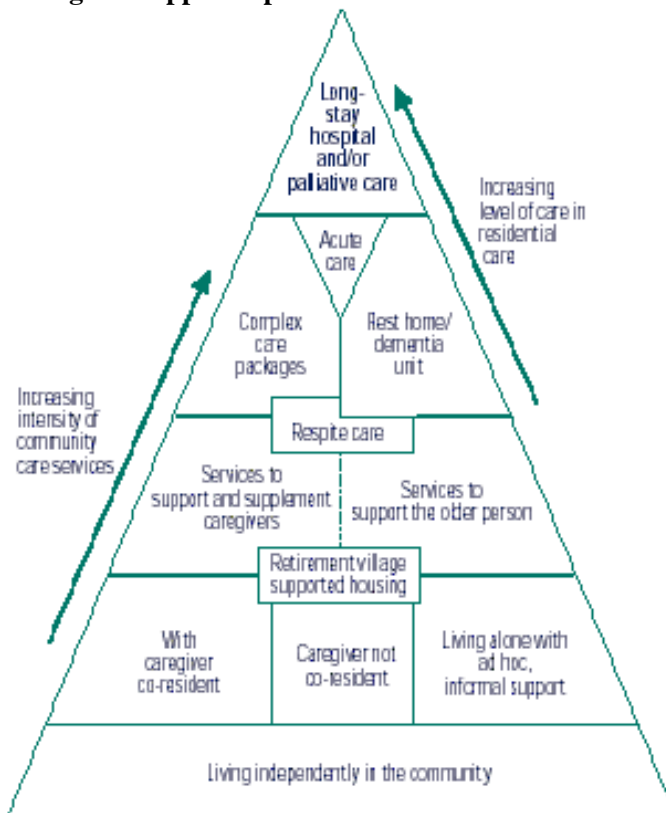
(Source: Health of Older People Strategy, Ministry of Health, 2002)

It should also be noted that any policy shift away from the state (or formal) provision of care will, of necessity, imply an increased provision of informal care and support – including, where necessary, accommodation support. Yet, as was clearly revealed at the time when government attempted the introduction of a Code of Family and Social Responsibility in the mid-1990s, it is difficult if not impossible, as McPherson (1993) notes, "to impose a collective ideology of family responsibility onto a generation valuing individualism and self-fulfilment rather than self-sacrifice" (McPherson, 1993, cited in Greenbrook, 2005 p.20). Further, such a shift may run counter to some aspects of demographic change. The ability to provide increased levels of informal, community-based support will likely be restricted by such demographic factors as higher dependency ratios, increasing numbers of women in the paid workforce, the mobility of families, and a general decline in volunteering (Schultz, 2004). Failure to

take account of such ideological and demographic shifts is like to result in failed policy outcomes (McPherson, 1993 cited in Greenbrook, 2005).

4.3 Housing Policy

Such a shift in health policy focus (away from residential care towards the concept of 'ageing in place') has clear implications for housing policy and planning also – especially in terms of the way accommodation and services fit together to best support frail older people and their carers (Faulkner, 2001). Older people draw on a significant range of services, and housing can potentially operate as a significant mediator in the demand for assistance and success (or otherwise) of service delivery. Consequently, the potential for effective home-based care may be "very significantly compromised for those whose housing does not offer an adequate physical or social environment in which care can be provided" (Howe, 2003, p.16).

No longer can we afford to treat policies in relation to health and housing as separate domains. Housing is more than shelter, particularly for those populations with particular health needs (McNelis and Herbert, 2003).

> "The combination of the right type of housing with the appropriate care and support is essential to the government's role of enhancing the whole of people's lives. Inadequate housing can diminish a good support package while a poor support package can have a detrimental effect on independence despite the availability of adequate housing. Both scenarios are likely to adversely impact on an individual's quality of life." (Faulkner, 2001, p.10)

Inevitably, the decisions and lifestyle of people during their working years influence the circumstances in which they spend their later years. The housing situation of older people is the culmination of a lifetime of opportunities and obstacles (Faulkner, 2001). Yet it is also true that "the social and physical environment in which older people live has, to a significant degree, been constructed by others: architects, builders, planners,

politicians, welfare workers and so on … [and] depend at least in part on political decisions and legislation as well as on social assumptions, norms and expectations" (Drake, 1998, p.254).

Thorns (1993) suggests that, in the past, the assumption of policy-makers has been "that the market will provide sufficient units of accommodation at the right price, dictated by supply and demand" (Thorns, 1993, p.117). However, overseas evidence suggests that reliance upon market processes only serves the needs of the more affluent elderly. "Those with restricted funds tend to have fewer opportunities, in part as they become caught in poverty traps – for example, those not poor enough to attract a state subsidy but not wealthy enough to have choice within the private market" (Thorns, 1993, p.117). Thorns concludes that the outlook for older people who are not asset rich is not promising, particularly when growth in the aged care housing sector has focussed predominantly on those in the middle to upper income groups. Public housing policy has tended to concentrate on older people who rent – those most 'at risk' – yet they represent the minority in terms of housing status (Robinson, 1994). Little by way of policy has been developed in relation to the majority of older people who are home owners. However, as Robinson notes, it is those home owners with moderate cash assets who are perhaps in the most difficult situation.

> "Their asset levels are too high to qualify for the Rates Rebate scheme or assistance from Income Support, however they do not have sufficient assets to either pay the cost of maintenance or rates themselves, or obtain a commercial loan….Many home owners are effectively 'trapped' in homes which need repair, renovation and are unsuited to their needs. They can neither afford to maintain or adapt them, or to move to more appropriate accommodation." (Robinson, 1994, p.13)

In their preliminary discussion document, *Building the Future: Towards a New Zealand Housing Strategy*, the Housing NZ Corporation acknowledged this dilemma.

"Many older people are asset rich and income poor, with their house representing their most significant or only form of investment saving. In retirement, older people generally have low incomes and can find the cost of rates, insurance and maintenance difficult. About 5% of older New Zealanders appear to experience quite marked material hardship, and a further five to ten percent have some difficulties… Older private renters are likely to be concerned about the security of their tenure in the private rental market." (Housing NZ Corporation, 2004, p.61f)

Both health services and housing services for older people – and, until fairly recently, the respective policies underpinning each – reflect a high degree of fragmentation, complexity and inflexibility. In the early 1990s Thorns called for a more co-ordinated housing policy for the elderly than that which was in place at that time, when, as earlier noted, policy was "effectively left to the vagaries of the market-place" (Thorns, 1993, p.119).

In their report on factors affecting the ability of older people to live independently (commissioned by the Ministry of Social Policy to mark the International Year of the Older Person) Dwyer et al (1999) note that one of the biggest policy challenges in New Zealand is to find ways to ensure older people – particularly those with limited means – can access a wider range of housing (and I would suggest, health) choices. In particular, the report notes, older people need "more choices that provide for degrees of supported or assisted living than currently exist at an affordable price for them" (Dwyer et al, 1999, p.69). Even the Ministry of Social Development's subsequent 2001 Positive Ageing Status Report notes the need for a 'whole of government' approach to housing assistance – focusing on a closer relationship between the physical aspects of housing and support services – as a means to reducing health expenditure, improving the ability of older people to age in place, and thereby delaying or preventing older people's entry into residential care (Ministry of Social Development, 2001).

Despite such an imperative, there remains a clear need for a more co-ordinated approach, both within and across the respective government departments responsible for developing and implementing health and housing policy. A study by Bransbury (2002) concluded that the housing dimension of community care is frequently the 'junior partner' in terms of policy development and resource allocation, when compared with health planning and funding. As their report challenges, "better co-ordination between all local services and across tenures is required if we are to provide more appropriate and cost effective solutions to older people's needs for adequate housing and support in the future" (Bransbury, 2002, p.11)

As Davey et al. (2004) note:

> "The role of government (with the dual aims of minimising net fiscal costs and improving overall wellbeing) is to ensure that there is a co-ordinated approach between housing providers (Housing New Zealand Corporation, local authorities, voluntary organisations, private sector) and providers of health services, care and support (DHBs, private and voluntary sector). This co-ordination necessarily requires cross-sector strategies as well as leadership, with a reduction in the 'silo' approach to funding and continuing emphasis on the 'whole of government' approach to policy and the associated determination of funding." (Davey et al., 2004, p.180)

In light of this discussion, it is interesting to note that, in the state of South Australia, the State equivalent of New Zealand's Ministry of Health and Housing NZ Corporation have been combined into a single Department of Human Services, responsible for policy and funding across both areas of health and housing. While this has inevitably resulted in a sizeable bureaucratic entity, it has ensured that policy and funding issues relating to housing are not developed in isolation from the related health issues, and vice versa.

If we are serious about any commitment to enhancing older people's lives and wellbeing, then it is essential that the ever-changing needs and requirements of the older population are continually assessed and reassessed (Faulkner, 2001) – particularly in terms of public policy. This applies to both health and housing needs. 'Ageing in place' can only be sustained if housing and support services are integrated and operate well together (Davey et al., 2004).

Heywood et al (2002) conclude:

> "A broader, richer understanding of housing, home and later life is called for so that there might be less dissonance between what governments provide and what senior citizens want" (Heywood et al., 2002, p.38).

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5. Methodology

As outlined in the introduction, a key purpose of this research study has been to identify emerging themes from the existing body of literature on the general topic of older persons' health and housing, and compare these against findings from the analysis of a limited number of case studies; effectively, to 'listen for echoes' between the two. Each case study represents an example of innovation in supported independent accommodation for older people.

Initially it was intended to incorporate a meta-analysis of any existing evaluations of New Zealand Supported Independent Accommodation options – to source such material and extend the case study analysis by including this material also. At the time at which the thesis proposal was being developed, it was acknowledged that the inclusion of a meta-analysis would be dependent upon the availability of (and access to) independent evaluative material. As it has turned out, there has proven to be a paucity of such material. What limited material was able to be sourced lacked the objectivity required for inclusion. Invariably, such material had been prepared either in support of a funding proposal prior to the establishment of an initiative, or as part of subsequent reporting process back to a funder (and therefore heavily influenced by that funder's specific reporting requirements).

Accordingly, the methodology used in this thesis has, to a certain extent, 'evolved'. It reflects aspects of what Patton (2002) refers to as 'emergent design' – an "openness to adapting inquiry as understanding deepens and/or situations change" (Patton, 2002, p.40). This enables the researcher to avoid more rigid design methodologies, and to more responsively explore emerging research pathways. Such a methodology draws upon a number of approaches. It reflects aspects of grounded theory – a range of research techniques, often differentiated according to whether they take a deductive or inductive approach to data analysis (Rice & Ezzy, 1999). Given the breadth of material considered, it also continues to incorporate aspects of meta-analysis. Although strictly speaking meta-analyses are categorised as a quantitative research technique, variations of this form of analysis are increasingly proving useful as a

means of comparing both quantitative and qualitative data pooled from a variety of different studies – as is the case in this thesis. Because the data is not pooled uncritically, each study drawn upon is able to be treated as a component of the larger meta-analysis.

While there is no one correct or uniform way to conduct qualitative research (Mantzoukas, 2004, cited in Jera 2005), methodologically this thesis best sits within what Thomas (2003) describes as a general inductive approach. Such a general inductive approach is increasingly used in health and social science research. Its primary purpose, as such, "is to allow research findings to emerge from the frequent, dominant or significant themes inherent in raw data, without the restraints imposed by structured methodologies" (Thomas, 2003, p.2). Emerging themes or categories are developed by studying the text data repeatedly, considering possible meanings and how these fit with the emerging themes/categories. In this way, it provides a systematic means of analysing qualitative material where that analysis is still able to be guided by specific objectives.

As its name suggests, the general inductive approach allows key themes/categories to 'emerge' from close reading of the text data being compared. However, within this methodology, these *emerging* categories are also able to be 'cross-checked' against *existing* categories. The key strength of such an approach is that it allows for qualitative comparison between the themes inherent in existing data and any additional themes emerging from close analysis of the case studies themselves. In doing so, such a range of research and evaluative material – each valuable in its own right – is given 'added value' by providing the basis for further comparative analysis. Within this general inductive approach, the context for data analysis is able to be determined both *deductively* (guided by the research objectives for example) and *inductively* (through multiple readings and interpretations of the data) (Thomas, 2003).

During the course of this research project, the JRF published a substantial and comprehensive summary of UK literature regarding models of supported independent accommodation for older people (Croucher et al, 2006). It identified a number of key themes emerging from this literature.

While this material was neither available nor envisaged at the time the research proposal for this thesis was being developed (and so a further expression of Patton's notion of 'emergent design'), use of the themes arising from the JRF material has nonetheless proved consistent with the general inductive methodology chosen. The themes identified in the JRF project provide a useful lens through which to analyse the case study material – addressing the question, 'To what extent do these NZ examples of SIL reflect the findings of similar overseas research?' Such thematic analysis also reflects the *deductive* component outlined in Thomas' general inductive approach. Any further themes that emerge – beyond those identified within the JRF material – in turn represent the *inductive* component that in part distinguishes the general inductive approach from other content analysis methodologies.

The case study approach was chosen because it afforded the opportunity to explore the extent to which findings from local and overseas research – in particular, the JRF material subsequently published – were being demonstrated as emerging examples of supported independent accommodation within the New Zealand context. Six aged residential care facilities were initially identified as potential case studies. Each was identified on the basis of innovation – that is, that the model of SIA that each represented reflected a degree of innovation, whether that be in terms of building design, for example, or the nature of tenure, or the organisation's financial or management structure. Three of the case studies identified were already known to the researcher through his own work in the health sector. A further two were recommended as examples of innovation by the then Chief Executive Officer of the Retirement Villages Association. A further facility originally identified declined to participate. However a sixth facility was able to be included, arising from the researcher's attendance at a seminar on supported housing options for older people,

initiated by the New Zealand Council for Christian Social Services. As noted, in selecting these particular case studies, the intention was to explore a range of innovation. Reflecting what Patton (2002) refers to as a 'mixed purposeful sampling' approach, the case studies chosen reflect not only a diversity of design, tenure and management structure, but also provide examples from both the private and not-for-profit sector, and offer some insight into the various models of intersectoral collaboration that are emerging in the aged care and housing sectors. Ethics approval for the research project was sought from and granted by the Human Ethics Committee of Victoria University, Wellington.

Those responsible for the management of each facility were contacted – initially by telephone – to determine their willingness and availability to participate in the research interviews. As noted, one potential research participant declined at this point – in part because the facility had participated in a number of research projects already, and was seeking to limit further involvement. Once verbal consent to participate in the research had been obtained, an outline of the research project was sent to participants (Appendix 1), along with a consent form (Appendix 2). Interviews were conducted between September 2005 and June 2006, and followed a semi-structured format (as outlined in the following chapter). Interviews were audio recorded and later transcribed for subsequent analysis and reporting.

In terms of research validity, Thomas (2003) suggests that the 'trustworthiness' of the findings from such an approach may be assessed by a number of means including independent replication of the research, comparisons with findings from previous research, triangulation, or feedback from research participants. In the case of this research project, while use of the JRF material provides a level of comparison with previous studies, the key means of assessing trustworthiness (and thereby determining validity) has been to provide the six case study interviewees with the opportunity to read and correct the reporting and analysis of their interviews.

6. Case Studies

6.1 Introduction

As part of the original thesis design – and, as noted in the preceding chapter – the researcher proposed interviewing a small number of managers from a range of aged residential care facilities. The facilities were identified on the basis of innovation. As also noted in the previous Methodology section, the six facilities finally included were selected on the basis of the researcher's own experience in the health sector, and upon advice from others involved in the aged residential care and retirement village sectors. Each facility offered some form of Supported Independent Accommodation. Further, each, in its own way, was considered to be taking an innovative approach (be that in terms of the support offered, or the independence afforded residents, or of the accommodation itself).

Of the six facilities initially identified, five of the managers indicated a willingness to participate – however in one instance the invitation to participate was declined. As noted, a further facility was subsequently identified, to ensure a sufficient number and diversity of case studies for the purposes of later comparison.

The six facilities participating in the research reflect a range of 'not-for-profit' (social service) and 'for-profit' (private sector) models, in both rural and urban settings, and represent both a variety and combination of levels of care – from largely independent care, through to rest home, hospital and dementia-level care.

In order to recognise and respect any potential commercial sensitivities, the managers participating in the interviews were assured that the identity of their respective facilities would not be disclosed. Accordingly, in the following case studies, each facility is identified by number only.

As noted in the preceding Methodology chapter, each case study interview followed a semi-structured format, with discussion guided by the following questions:

i. Why was this particular model of SIA chosen?

ii. What do you see as its distinctiveness?

iii. What have been the key learnings from adopting such an approach?

iv. What do you see as the strengths and weakness of this particular approach?

v. If you were to undertake such a development again what, if anything, would you change?

In reading through the following case studies, it may be noted that some appear to give greater weight to the accommodation dimension of the facility, for example, while other case studies explore in more detail the nature of the care that is offered residents. This reflects the varying emphases across the case studies chosen. As noted above, some provide examples of innovative approaches to accommodation design, while others demonstrate innovation in terms of the nature of support offered or the independence of residents – or, indeed, how these two factors interact. While the term 'supported independent accommodation' was coined prior to the case study interviews being undertaken, it has proved useful in delineating such variation in emphasis – that is, between the support, independence or accommodation offered.

6.2 Case Study 1

Background

The facility visited in Case Study 1 is a substantial retirement village located on the outskirts of a North Island city. Established in the mid-1990s, the retirement village currently provides a range of two and three bedroom villas, one and two bedroom townhouses, and one bedroom apartments – currently over 100 units in total, though further planned expansion will see the village grow to more than 200 individual residences.

Adjacent to the village is a private (aged care) hospital – a separate complex, operated as a distinct legal entity, though established, marketed and managed in conjunction with the retirement village. The private hospital, recently expanded to 90 beds, offers

a range of aged residential care including continuing (hospital level) care, dementia and psychogeriatric care, together with a recently opened private medical and detoxification unit.

The Managing Director of the private hospital was interviewed on site for the purposes of this case study.

Distinctiveness of the Model

At a time when many aged residential care facilities are endeavouring to offer services that span the so-called continuum of care – that is, independent living, together with contracted rest home, hospital and dementia care – this model is somewhat unusual in that it has effectively 'skipped' the provision of rest home level care, at least in the traditional sense of providing rest home level beds, on either a private-paying basis or under contract to the local DHB.

Normally – that is, according to the usual continuum of care – those living in the adjacent retirement village would, if assessed as requiring such care, be able to make the transition from their independent environment through to rest home level care and onto hospital level care. That this facility has elected not to provide rest home level care could be seen as both unusual, and also potentially disadvantageous to an older person seeking such continuity of care; particularly for those who have entered the adjacent retirement village, expecting that they would be able to access such a continuum. The facility has deliberately sought to address this 'gap' through the development of a hospital facility that has been designed, built and is resourced in such a way that a range of health care services – virtually to the equivalent level as rest home care – can be provided to retirement village residents without the need for them to become 'resident' in the hospital/dementia complex.

The hospital complex – in its design and staffing – has intentionally included services and resources well beyond those required to meet its contractual obligations in terms of hospital and dementia level care. It offers extensive physiotherapy facilities

(including a hydro-therapy pool) and a number of clinic rooms for nursing staff and the facility's contracted General Practitioners (GPs). On days when the GPs visit the hospital/dementia complex, they are also able to offer clinic services to residents of the retirement village. This essentially provides a medical practice adjacent to the village – and therefore more accessible for residents than having to travel into the city to visit a GP.

In addition to this – and in return for a nominal fee (at the time of interview, $1.00 per day) – retirement village residents are also able to access the hospital's nursing resource in the same way as they might a practice nursing service in the city. At the on-site clinics the hospital's nursing staff are able to undertake blood tests, wound care, diabetes and blood pressure checks, flu vaccinations, etc. – again avoiding the necessity for travel into the city.

The provision of this range and level of health services to the retirement village residents is intended to obviate the need for them to enter rest home level care. In other words, they can access a level of health care that will enable them to remain resident in the retirement village until such time as they need significantly higher and more complex levels of care – i.e. hospital level care, involving the provision of 24 hour nursing oversight, or dementia level care in a secure environment.

Strengths and Weaknesses of the Model

The integrated model of care presented in this case study stemmed originally from a desire to offer a higher standard and more extensive range of services to aged care hospital residents than the limitations of the former facility and existing levels of state funding would permit. By developing and operating the hospital/dementia complex (with residents' care funded through the state system) in conjunction with a privately owned retirement village (operated along purely commercial lines), it was anticipated that economies of scale would be achieved. It was not intended that profits from the retirement village would cross-subsidise the aged residential care complex. Nevertheless, it was accepted that the latter would operate at a significantly lower

level of financial return – given the financial investment required to establish and maintain a complex offering higher staffing ratios, and more extensive services and facilities than those required under the standard aged residential care contract. It was also recognised that such services and facilities could only be economically sustainable if they were also to be made available to the residents of the adjacent retirement village residents on, effectively, a 'user-pays' basis.

According to the Managing Director the model has, in large part, proved to be an effective one. Some anomalies were, however, identified – primarily relating to the absence of contracted rest home level beds in the aged residential care facility.

Increasingly, residents were moving into the retirement village with higher and more complex health needs – sometimes on the verge of requiring rest home level care. This is a common trend nationally and internationally – particularly when a couple move into a retirement village, the move prompted by a deterioration in the health status of one but not necessarily both partners.

Where a resident had been in the retirement village for some time – and therefore feeling settled and secure in that environment – they were more likely to draw upon the range of health services available through the hospital complex. In comparison, where a resident had more recently arrived in the retirement village – and especially if their health needs were already at a higher level – there was a tendency for such residents to 'move on' into rest home level care at another facility. A corollary of this has been a higher than anticipated proportion of the hospital and dementia residents admitted from other facilities in the city, as compared with the number admitted from the retirement village – suggesting that the model has not been as effective in offering a continuum of care as had initially been envisaged.

A further anomaly noted related to the funding of a resident's 'rest home level' care. Whereas – subject to income and asset testing thresholds – an individual entering a rest home may qualify for a level of state-funded care, those resident in this

retirement village (and receiving an equivalent level of care through the complex's hospital staff and facilities) must meet the full cost of such care themselves. This has been identified by some as a disincentive to entering or remaining in the retirement village.

In response to these factors, the facility's management were investigating the possibility of offering rest home level care from the aged residential care complex – following completion of an already-planned extension to the existing hospital facility.

6.3 Case Study 2

Background

The facility visited in case study 2 is one of an extensive number of retirement villages owned by one of New Zealand's larger national retirement village operators. It is also one of a number operated by this company in this particular North Island city.

The facility offers two levels of accommodation – 233 Independent Living and 15 Serviced Apartments – determined according to the level of care offered to residents by each. As its name suggests, the Independent Living units offer a greater level of independence, with residents able to be as involved in the life of the village community as they choose, yet with the security of both a 24 hour emergency call system. The Serviced Apartments, on the other hand, offer a higher level of care, designed for residents who require extra assistance in their day to day life while still maintaining their independence in the privacy of their own unit. Apartment residents can receive a range of services including regular household cleaning, laundry, meals, personal care and medical care.

Unlike some of the other case studies explored – and, indeed, unlike many other retirement villages (both nationally and within this particular company) – no DHB contract is held for the provision of aged residential care at either Rest Home or Hospital level.

The interview was conducted off-site with the Clinical Team leader from the facility.

Distinctiveness of the Model

As noted above, one of the distinctive aspects of this facility – in comparison with most others within the company and across the Retirement Village industry nationally – is that, by not holding contracts for either Rest Home or Hospital level aged residential care, it offers a more narrowly defined range of Supported Independent Accommodation than many of its competitors. Whereas other providers have endeavoured to span the so-called continuum of care (from independent through to higher levels of support), this facility has elected to offer accommodation only at the more independent end of that spectrum. They have, however, endeavoured to mitigate this narrower range by piloting – in partnership with their local District Health Board (DHB) – a 'site specific' home support contract, enabling them to offer a level of DHB-funded care that would normally only be contracted to an external Home Based Support provider.

In the more usual approach to the provision of care and support within the Retirement Village sector, residents either purchase a level of such care and support from the facility (on a private paying basis) or, if they are assessed by the DHB's Needs Assessment and Service Coordination (NASC) agency as requiring such care, may receive it on a funded basis, with care delivered by an external provider contracted by the DHB to provide such a service.

Traditionally, two levels of Home Based Support have been funded – personal care (providing assistance with bathing, dressing, skin care, hydration, oversight of medication-taking, etc), and household management (providing assistance with more basic household tasks such as cleaning, meal preparation, laundry, etc). Household management is means tested – i.e. only normally available on a government-funded basis to older people holding a Community Services Card. For this reason, many retirement village residents – where a significant level of capital investment and

ongoing income is required to enter and sustain residence in such an environment – will not qualify for the household management component of Home Based Support services. In such cases, these residents – should they require such support – would normally purchase these directly from the facility. The personal care component of Home Based Support, however, is not means tested, and residents requiring such care – as determined by the NASC – would normally receive such care fully funded through a DHB-contracted provider.

A number of retirement villages (including this one) have noted the difficulties associated with such a complex arrangement. In most urban settings, DHBs will contract a number of Home Based Support providers – with older people thereby guaranteed a level of choice as to which provider they wish to receive support from. As a consequence, a retirement village may find that a range of Home Based Support providers are delivering care to their residents – over and above what they may provide. In fact, given the means testing of those receiving the household management component of Home Based Support, it is not unusual for a retirement village resident to be receiving DHB-funded personal care through an external provider, and assistance with household tasks from the retirement village's own staff on a private paying basis.

The retirement village in this case study had identified this problem. They noted, for example, that their own support staff – as a result of their direct contact with residents – may identify situations where the external support being provided was either (in their view) inappropriate to the needs of the resident, or apparently not being delivered to the standard or level that they believed the resident's allocation of care indicated. In many instances, this was due solely to the amount of care allocated to a client – e.g. 7 hours per week – needing to accommodate travel time as well as actual care delivery time. Further, when the daily task may only take half an hour, a greater allocation of time allocated may not be utilised to the benefit of the client.

In response to these concerns, the facility approached their local DHB with a proposal to pilot what amounted to a 'site specific' Home Based Support contract. The facility suggested to the DHB that residents were not receiving their full or the appropriate allocation of care, and also that the DHB was not getting the best value for money for its investment in such care (as not all of the hours allocated to a provider for a particular client necessarily translated into actual hours of care delivery). In the view of the facility, such a contract that would enable them to provide funded care to their own residents assessed as qualifying for such care, thereby overcoming many of the aforementioned complexities and inequities.

The DHB agreed to a pilot of this initiative – in part on the understanding that residents in the retirement village could choose to receive their care either from the retirement village itself, or from an external Home Based Support provider, thus retaining their freedom of choice.

Strengths and Weaknesses of the Model

At the time at which the case study interview was conducted, this 'site specific' initiative was still in its pilot phase – and the only one of its kind in the country. The facility had, however, recently been successfully audited against the relevant Health and Disability Sector Standards for the provision of Home Based Support, and informal feedback from residents, facility staff and the DHB (both Planning and Funding, and NASC staff) was reported in the interview as being entirely positive about the pilot contract.

In particular, the ability to provide care by staff 'on site' (as opposed to an externally-contracted Support Worker travelling to the facility) has enabled care provision to be individualised to a resident's needs to a far greater extent. Staff turnover in the facility has been relatively low (in comparison with the Home Based Support sector), meaning greater continuity of care for residents. Most importantly, care has been able to be 'packaged' in smaller time allocations than an external provider – needing to balance direct care provision against travel time – would be able to manage. For

example, where an external provider may only be able to justify a Support Worker visiting a client for an hour or two daily, the facility – with staff visiting a number of clients – has been able to deliver the same quantum of care in smaller increments, and on a more regular basis (e.g. visiting a resident up to four or five times a day, but for shorter periods of time). As a result, residents' needs have been addressed in a more flexible way, and more closely monitored. Similarly, because care is not provided by way of a geographic 'run' – i.e. where an external Support Worker will visit a number of clients in a particular area of town in sequence – residents who may, for example, prefer an earlier shower to a later one have been able to have such preferences accommodated. Nor has the provision of such DHB-funded care precluded residents from continuing to purchase additional care (on a private-paying basis) over and above that funded by the DHB – e.g. medication supervision (as the DHB contract only allows for prompting of medication-taking).

The service itself is provided by a team of trained care workers, working under the supervision of a Registered Nurse. The role of the Registered Nurse was seen as significant – providing the ability to closely monitor resident care, and enabling a 'case management' approach to the coordination of that care. The Registered Nurse also acts in a liaison role with the DHB, maintaining a strong level of direct communication with the NASC.

Not only has this service resulted in high levels of satisfaction (over 96% according to a recent resident satisfaction survey), but there are clear indications that it has, in a number of instances, forestalled premature entry into aged residential care.

In terms of weaknesses, the facility manager considered both the DHB's current funding model and their referral model as unnecessarily cumbersome. It was suggested, for example, that if such a service were able to be bulk-funded (as opposed to the current 'fee-for-service' model, where providers are paid according to the hours of care per client delivered), then care could be provided in an even more flexible manner. Similarly, it was suggested that if the facility were funded simply to provide

the service – i.e. there was no need for residents to be individually assessed – then care could be provided in a timelier manner. The current needs assessment process can take up to three weeks from the time the facility makes a referral to the NASC, to when the facility is approved to provide funded care to a resident. Nevertheless, it was noted that the facility had maintained a good working relationship with the NASC, and that, over time, assessment and reassessment processes had become more flexible and responsive.

While not a weakness of the model as such, it was noted that, in the absence of the availability of either Rest Home or Hospital level care on site, residents at the facility do not have the option of moving to those levels of care within the village – i.e. when they do need such care, they must move from the facility to another provider. Conversely, however, the pilot contract has enabled the facility to provide a more comprehensive model of care to its residents, arguably precluding in many cases (or at least forestalling) the need to move.

Finally, despite the success of the pilot, and the parent company's hope that similar contracts may be negotiated for their facilities in other DHBs, this seems unlikely in the current contracting environment. While, as noted above, DHBs endeavour to contract a sufficient range of Home Based Support providers to ensure a level of client choice, it seems unlikely that they would enter into site specific contracts with any one retirement village operator, given the precedent this would set, and potentially the plethora of such contracts DHBs could then be faced with managing.

6.4 Case Study 3

Background

Case study 3 is a rural initiative that represents a partnership between a large not-for-profit social service provider, and the District Council in the area where the aged care facility is located. Additional financial support was provided through Housing New

Zealand's Housing Innovation Fund. The Regional Operations Manager for the service provider was interviewed for the purposes of this case study.

A unique solution to combining housing and care needs for older people in a North Island rural community, the complex itself originally comprised 16 pensioner cottages owned by the District Council. A further 4 units have subsequently been built (along with a recreation/dining/kitchen facility for use by the residents) funded by the Housing Innovation Fund, together with local fundraising.

While the social service organisation that spearheaded the development already had an extensive involvement in the aged residential care sector in the North Island, the nature of this development represented a significant departure in terms of both its development and the nature of the concept.

The organisation's initial involvement came at the request of a local community trust that had been endeavouring (unsuccessfully) for a number of years to secure rest home level care in their small rural community. Through local fundraising, some funds were held towards such a development. However, in the absence of support from the local DHB towards the project in its initial form, no further progress had been made.

Having reached a stalemate in their negotiations with the DHB, the community trust approached the social service organisation – given that organisation's existing involvement with service provision in the area – to see if they could assist in any way. Initially, they also saw merit in the idea of developing in-patient beds for older people in conjunction with the medical centre. Again, however, the necessary DHB support for such a venture was not forthcoming.

The organisation was also aware that the local District Council operated a block of 16 pensioner cottages. These were of somewhat dated design, reasonably run-down, and significantly under-tenanted. At least half were unoccupied, with older people

viewing a move to rest home care (even if in another community) as a more attractive option. Likewise, given their low occupancy, the District Council could neither justify nor afford to bring them up to a higher standard.

By this time, the organisation had found itself playing a facilitative role in the process. Through its involvement as a service provider in the community, and through its discussions with the community trust, DHB and District Council, it began to identify an emerging 'synergy'. The issue of social isolation for older people in the community was well-recognised – as was the reality that, in the absence of any appropriate model of supported independent accommodation and care at a local level, a move into rest home level care further afield became, for many, the only option. The community itself, while host to an under-utilised medical centre and an equally under-utilised pensioner housing complex, nevertheless had a strong sense of community identity and spirit – evidenced by their own efforts in fundraising.

So, despite (at this point) a lack of support from the local DHB on the Medical Centre proposal, the focus shifted to better use of the existing pensioner cottages – refurbishing these, and 'wrapping around' them a level of support to the older tenants in their own units. In order to facilitate this, the District Council granted the social service organisation an 80 year lease on the pensioner cottages, with no rental payable in the first five years. The social service organisation, has in turn, taken responsibility for the management and maintenance of the cottages, and the employment of a part-time support worker (five hours per day, five days per week). As noted earlier, a recreation/dining/ kitchen facility has subsequently been built, and the complex has been extended by a further four units, again with support from the Housing Innovation Fund.

Distinctiveness of the Model
This initiative is notable not only for its innovative nature, but also for the manner in which that concept evolved. It represents a very good example of a local response to local need. It is also an example of the importance of intersectoral collaboration – in

this case, between a not-for-profit social service provider, Housing New Zealand, the local District Council, and a local community trust. Each has made a significant contribution to the development and ultimate success of this model. It arose in the first place from the community's inability to negotiate collaborative support from their local DHB. In other words, an intersectoral initiative arose despite the DHB, rather than – at least in the initial stages of its development – as a result of its support.

It has also taken particular account of the local context. Firstly, the community itself had identified the issue of 'social dislocation'. In the absence of a rest home, older people had no option but to move out of their community in order to access residential care.   This situation was further compounded by the community's relatively poor socio-economic situation. As a result, many families didn't have the necessary resources (e.g. money, transport) to travel out-of-town to visit their older relative should they be placed in residential care.

Finally, in terms of process, the community trust's focus on establishing an in-patient Medical Centre had effectively stalled in its own efforts to negotiate a community response to this issue of social dislocation. In hindsight, it was the initial refusal on the part of the DHB that lead the community trust and others to explore other more innovative options. In the words of the Operations Manager:

> "We were the missionaries. We went in there and sold them the idea – that we would build on the capacity in the community – and then let it go, let the community carry on with what it needs to do."

Ironically, as soon as the community sensed that something new and innovative might be possible, demand for the existing District Council pensioner cottages began to increase – even before the project itself was realised.

The result is a small rural community that, while it still doesn't have the rest home it had once envisaged, nevertheless has a viable alternative. Instead of coming off the farm or from their own home and having to head out of town into a rest home, this

community's older people now have the option of low-cost rental pensioner units with access to a support worker five days a week, and to a communal centre – resources many other pensioner housing complexes do not provide. It is also interesting to note that, despite the age of the initial pensioner cottage housing stock – built in the late 1950s to early 1960s – little was done by way of physical modification. In other words, the appeal of the units was increased not by way of the physical upgrade of the units as such, but rather by the services and support 'wrapped around' the complex and its residents.

Strengths and Weaknesses of the Model

In the case study interview, the manager responsible for the initiative identified the financial structure adopted in relation to the project as both a strength and a weakness. He noted the important distinction between cost-effectiveness and longer term financial sustainability. From a cost-effectiveness perspective, the project made good use of existing housing stock, with little additional investment. Similarly, the intersectoral nature of the initiative ensured that costs were shared across a number of organisations, rather than falling disproportionately on any one.

Nevertheless, some level of investment was required, and therefore some level of return on that investment also needed to be evident in order to secure the longer term sustainability of the project. It is interesting to note that, two years after this case study interview was conducted, the organisation involved in the establishment of this particular initiative has withdrawn from any ongoing involvement – largely due to reasons of financial sustainability. It has, however, undertaken a further initiative – along very similar lines – in partnership with another District Council. In this new initiative the District Council is leasing the older persons' units to the social services organisation, which in turn charges a sufficient rental to cover the cost of maintaining those units. This has been seen to reflect a more equitable sharing of costs involved than that of the original case study.

Another strength and weakness of this model has been its determination to remain a 'low-cost rental' alternative to the more common 'licence to occupy' approach taken by many retirement village operators. In the latter, financial sustainability is ensured by the regular turnover and re-sale of units. In the case of this case study's low-cost rental approach, however, no commercial return is sought. It has been established – quite intentionally – as a social service. This approach has challenged the long-term financial viability of this model. On the other hand it has made affordable a model of care that would otherwise have been out of reach for older people in this rural community. While it may not have provided a long-term alternative to residential care, it has certainly provided a means of forestalling earlier entry into residential care than would otherwise have been the case, thereby enabling a group of older people to remain socially connected to their rural community – 'ageing in place'. This, in the view of the manager interviewed for this case study, has been its critical strength – and the key reason why the organisation has continued to seek to roll out and refine the model elsewhere in their region.

6.5 Case Study 4

Background

Case study 4 reflects a communal concept of supported independent accommodation whereby a group of older people live together in a purpose-built home, with the support of a live-in housekeeper. Developed and managed by a not-for-profit trust, this particular facility consists of a large stand-alone house, located on the outskirts of a North Island city, and accommodating up to ten residents and a housekeeper. With accommodation provided on a rental basis, each resident has their own bedroom and access to communal areas. Rental was, at the time of interview, set at $245.00 per week, which includes accommodation, food, power, and a share of the housekeeper's wages. It was felt that this rate compares favourably with the outgoings an older person would face were they renting from Housing New Zealand or a City Council. A key principle for those involved in the establishment of the complex was that it be affordable to older people whose only income was from National Superannuation.

One of eleven such facilities now established throughout New Zealand – each operated by its own incorporated society, and together providing accommodation for some 90 residents – this particular facility was officially opened in 2005, after five years of voluntary planning and fundraising. Funds to purchase the land were provided through a local benevolent trust, and construction of the facility itself was significantly assisted by Housing New Zealand's Housing Innovation Fund.

Adopted from a similar model in the United Kingdom, the philosophy underpinning this approach to supported independent accommodation is that older people should have access to locally based, affordable, family-styled housing – with volunteer support actively assisting them to enjoy a secure and happy life within the companionship of a small household.

The case study interview was conducted with one of the steering group members involved in the initial planning and establishment of the local society, and subsequently the facility itself.

Distinctiveness of the Model

Unlike other facilities documented in these case studies, this complex is fully 'stand-alone'. Residents are expected to care for themselves, and, apart from the provision of a housekeeper (who provides residents with two meals a day, and cleans the facility's communal areas) no other support is provided. Further, the local society is not involved in the provision of rest home or hospital level care. In fact, new residents are required to provide a medical certificate demonstrating that they can live independently without the need for such support. If, subsequently, a resident's health deteriorates or they become less independent, then they would be able to access DHB funded home support as if they were living in their own home.

The initial impetus for the development of the facility came from a suggestion from a local Age Concern staff member that such an accommodation option was needed in

the city concerned. A coordinated approach to social service delivery by various agencies had already been established, and a number of agencies were already operating from shared facilities on a large site on the outskirts of the city – the land having been purchased from an existing religious and welfare sector agency. The suggestion from Age Concern was consistent with the social service agencies' own demographic research, and, with adjacent land available for purchase, it was decided to proceed with the development of older persons' accommodation. Specifically, the group involved in the initial planning stages wished to address the accommodation gap between 'own home' and 'rest home' – and felt that this concept best suited that intention.

At the same time as work was being undertaken to establish a local society, discussions were being held between the organisation's national coordinating body and Housing New Zealand, exploring the potential for financial support, utilising the recently launched Housing Innovation Fund. While, at that stage, these discussions were at a more general level – i.e. not specifically focused on this particular project – this case study subsequently became the first expression of a partnership between Housing New Zealand and a local not-for-profit society to build housing for older people. In return for their financial support, Housing New Zealand secured allocation rights to 50% of the facility – i.e. the ability to nominate half of the home's residents according to their own selection criteria.

An approach for financial support was also made to the local City Council, with the suggestion that the Council secure mortgage-funding for the project (at, presumably, a more competitive rate than the local society could itself negotiate). While the Council was unable to provide such support, in a further expression of intersectoral collaboration, they provided the society with an annual grant, equivalent to the differential between the mortgage rate that they – the Council – could have negotiated, and that secured by the society.

Strengths and Weaknesses of the Model

Through the course of the case study interview a number of strengths and weaknesses emerged. Clearly, on the continuum from full independence in one's own home, through to nursing care in a residential facility, the concept holds a somewhat unique position. It has been described – not entirely facetiously, nor with any implied criticism – as a group of older people flatting together. Where the concept is not unique – particularly when considered alongside some of the other case studies – is in terms of the significant role intersectoral collaboration has played in its development and implementation. Representatives from a number of existing social service agencies identified an accommodation gap, and responded to this by establishing a local society – itself linked to the structure and resources of a national parent organisation. From there, the necessary financial support to purchase the land and undertake development came from various sectors – including charitable organisations and both local and central government (namely the local City Council and the Housing New Zealand Corporation).

The model has not, however, been without its obstacles and challenges. During the three years prior to the opening of the facility, a list had been compiled of older people who had indicated interest in residing there – having either heard of the concept, or read of the facility being established. At the time the facility opened, however most of those on this initial list had either found alternative accommodation – including, for many, entry into aged residential care – or for other reasons chose not to move in. Given Housing New Zealand's allocation rights to half of the rooms, the society only needed to find five initial residents, and had fully expected that all ten rooms would be allocated by the time the facility opened. Yet, at the time of interview – some three months after the facility had opened – there were still a number of vacancies, with Housing New Zealand also unable to fill their five room allocation. One factor was the location of the facility, some distance from the centre of the city, and on the same campus as a large multi-agency social service complex. Around the same time as the facility was opening, this social services complex was the centre of some local controversy, as the trust owning the property offered to make

land on the campus available to the Ministry of Justice for the establishment of a residential youth facility (Ministry of Justice, 2006).

Further, it was noted in the interview that initial projections as to the size of the target population may have been overestimated. It seems that, while the facility fills an important gap in the continuum of accommodation for older people, it does represent something of a niche market – particularly considering the range of criteria (income level, health status, level of independence sought, etc) that underpin this model of SIA. In an effort to raise both awareness of and demand for the facility, the society has begun marketing the concept to local aged residential care providers and retirement villages, as they may be able to refer potential residents for whom, by virtue of either their health or economic status, this particular model is more appropriate. It is perhaps also worth noting that, while the demand for this model of SIA may be small, nevertheless the fact that eleven such facilities have been established throughout New Zealand attests to the place this model holds within the wider continuum of accommodation and care.

6.6 Case Study 5

Background

Case study 5 relates to a 'religious and welfare' provider within the not-for-profit sector, offering both rest home and hospital level care, and a number of Licence-to-Occupy (LTO) units. A number of other facilities are operated by the organisation throughout the North Island. The organisation's Chief Executive Officer was interviewed for the purposes of this case study. The interview was undertaken on the writer's behalf by another researcher, as a supplement to associated research being undertaken for another organisation.

A long-standing provider of aged residential care in this particular community, the organisation, in the early 1980s identified a need for LTO units which were lower-

priced than others available in the market – yet that could offer residents a similar security of tenure. As a result, 18 two bedroom chalets were built.

The organisation has subsequently identified a further gap in the supported accommodation continuum – between the fully independent units, and rest home level care. In response to this perceived need, a further 13 one bedroom apartments have recently been built, within the rest home complex.

Distinctiveness of the Model

Often – as outlined in the other case studies – there is a relatively clear line drawn between the provision of independent accommodation and rest home or hospital level care. Indeed District Health Boards, in contracting for the provision of rest home care, have to date been justifiably wary of the risk of providers 'double-dipping' by receiving the full aged residential care subsidy (which includes an accommodation component) while at the same time charging separately for accommodation (by way of rent, or a licence-to-occupy).

In negotiation with their DHB, however, this organisation reached an agreement whereby the risk of 'double-dipping' was effectively nullified. It was anticipated that residents would purchase their LTO apartment while they still maintained a high level of independence. If they were subsequently assessed as qualifying for Home Based Support services, these would be provided to them by a contracted community provider in the usual way. However, if that same resident was subsequently assessed as requiring rest home level care, at that point their licence-to-occupy for their apartment would be terminated, and the usual agreement for the provision of rest home level care (including a contribution towards the cost of accommodation) would be initiated.

The 13 new apartments have been purpose-built to facilitate this arrangement. They are physically attached to the rest home complex to enable the smooth and safe delivery of rest home level care. Yet they also offer the residents fully separate and

independent access to their apartments – i.e. without the need to go through the rest home complex itself. Significant consultation took place between the provider, the Ministry of Health and the DHB to ensure that the design of the apartments would meet client expectations, yet also meet the standards required for the provision of rest home level care – for example, the provision of wet area showers.

Strengths and Weaknesses of the Model

In the course of the interview, the Chief Executive Office described the organisation – in terms of this project – as something of a 'guinea-pig'. In developing this model, the organisation was entering uncharted territory. In fact, at the time of the interview, while the DHB had indicated their support for the model, no formal agreement had been entered into between the two organisations. Nevertheless, the project reflects a significant level of collaboration and trust between the provider and the DHB, in terms of both its development and now its delivery. Certainly existing aged residential care service specifications and contracting mechanisms – designed for DHBs on a national basis – make no provision for such an approach. To this end, a degree of risk exists for both the provider and the DHB in implementing this model – even in pilot form – in the absence of such contractual guidelines.

A further risk relates to the mix of services and accommodation provided. An increasing number of aged residential care providers are effectively underwriting the less well-performing aspects of their operation – invariably rest home and hospital level care – through the provision of more independent forms of accommodation, provided via more reliable (and indeed more lucrative) models such as LTO units. The challenge, then, is finding the appropriate balance between the provision of subsidised aged residential care and the potentially more lucrative LTO options. That balance has proved critical for this provider. For, while they offer both LTO units and subsidised residential care options, their range of care and accommodation also includes their 13 new units, which effectively straddle both options. Further, as a not-for-profit provider (with a commitment to providing affordable models of accommodation and care), the organisation also hopes to be able to offer some of

their new apartments on a low-cost rental basis. If too many of the residents in the apartment units relinquish their LTO contracts in favour of subsidised rest home level care, or too many apartments are committed to the lower cost rental option, the financial sustainability of the organisation's operations could be significantly compromised.

In some respects, this case study simply represents – for those residents receiving rest home level care delivered into their apartment – an enhancement of the rest home model as opposed to an example of supported independent accommodation. Residents will receive the same level of care as they would were they in the rest home itself – albeit in a less institutionalised environment. Yet, in an aged care sector where the 'integrated continuum of care' has become something of a catch-phrase, this model also seems to be offering an additional dimension to that continuum. Whereas many older people in independent or semi-independent accommodation are – at the point at which they are assessed as requiring rest home level care – faced with the prospect of moving into a more institutional setting, for those in this facility's apartments at least one further move is prevented.

6.7 Case Study 6

Background

The facility visited for case study 6 is operated by a religious-based charitable trust, and is located in one of the North Island's larger cities. The case study interview was conducted on site with the facility's Nurse Manager.

Established in the late 1800s, the facility reflects, more than any other considered in this thesis, the changing face of residential care in New Zealand – particularly amongst so-called 'religious and welfare' providers. Originally, in response to demand at the time, the facility offered care for single mothers and then later for orphans. In the early 1950s rest home level care was added to the suite of residential services offered from the site, with a further 21 low cost rental villas added soon after.

These units tended to be occupied by 'younger older people' – primarily unmarried women, who did not have the resources to purchase their own home or to rent on the open market. While the low rental reflected the charitable philosophy of the trust, it also meant that the income that derived from the villas was insufficient, in the longer term, to adequately provide for their ongoing maintenance. By the early 1990s, the villas were in such a state of disrepair that the trust was forced to review their viability. While it was clear that the villas would require major refurbishment – and therefore a level of investment that their below market rental could not recuperate – the trust remained reluctant to move away from their original vision of providing accommodation to those who could not afford other options in the market. As a result, the original 21 'bed-sit' villas were fully redesigned, with the result being a mix of 14 one and two bedroom villas now occupied on a licence-to-occupy basis.

Of some significance to the philosophy behind this approach has been its timing. The comprehensive review of the future of the villas took place at the same time as the government released and promoted first the Ministry of Social Policy's PAS, and subsequently the Ministry of Health's HOPS. In the course of the case study interview, the Nurse Manager identified each as key influences for the trust.

The trust also offers a range of aged residential care from the site – including rest home, hospital and dementia level care – under contract to the DHB.

Distinctiveness of the Model
In making the transition from low cost rental to a LTO approach, the trust was not, primarily, looking to follow the trend amongst other providers – where returns from the LTO component of a facility are used to offset significantly lower returns from other aged residential care components. In fact, whereas the usual approach within the retirement village market is to seek to attract residents who are as fully independent as possible, this facility deliberately sought to target its LTO villas to the 'older old'. In that sense, where the usual retirement village model effectively offers residents an alternative to living in their own home (with facilities and programmes

designed for older people seeking to maintain a more active lifestyle), the villas are intentionally offered as an alternative to residential care, for those with significantly higher care needs. It is indicative of this distinction that the majority of the villa residents – at the time of the interview – were in their late 80s or older.

As with other independent accommodation for older people, where a Needs Assessment and Service Coordination (NASC) agency, upon referral from a health professional, determines that a resident qualifies for home-based support services, such services would normally be provided to residents by one of a number of Home Support providers, contracted by the DHB and selected by the resident. This had originally been the case for villa residents.

However, the facility was situated in a part of the city where it was notoriously difficult for home-based support service providers to recruit care staff and therefore deliver services. In response to the facility's concerns about the unreliability of Home Support service provision, the Nurse Manager approached the DHB with a proposal for a 'site specific' Home Support contract (similar to that outlined in case study 2). While the DHB was reluctant to concede to such a proposal – in part because its estimated demand for Home Support had already been fully contracted to existing community-based providers – they did suggest, as an alternative, that the facility could 'sub-contract' the provision of Home Support through an existing community-based provider.

The model made sense, and represented a win-win situation for the Home Support provider, the facility, and for residents. The Home Support provider was – in using the facility's care staff – able to provide services to clients (the villa residents) in an area of the city where they normally had difficulty resourcing such care. The facility in turn was able to maximise utilisation of its own staff, and to develop relationships between staff and villa residents – many of whom would, over time, transfer into other areas of care within the facility. For the residents, the arrangement provided on-

site care, continuity of care, and a more responsive, flexible form of care than services provided externally could have been expected to afford.

While the intention behind the sub-contracting agreement was that facility would provide DHB-funded Home Support to villa residents, in practice a significant level of care (equivalent to 'household management' in the DHB's home-based support contract) was already being provided to those residents as part of the service fee they paid in conjunction with their LTO. All villa residents, for example, receive a visit each morning from a caregiver to see that they are 'up and about', and to assist where necessary with their medications or showering. Linen for residents is supplied and laundered by the facility, and staff assist with domestic cleaning for villa residents. Similarly, if a nursing visit is required – or even an overnight stay in the rest home (for observation, after a fall, for example) – both the cost and provision of such care is currently met internally, rather than charged to the Home Support provider as part of the sub-contracting arrangement.

Strengths and Weaknesses of the Model

In offering such support – what the trust refers to as 'independent care' – it is endeavouring to distinguish itself in an increasingly populous retirement village market. The villa complex has opted not to incorporate a swimming pool or petanque court, for example – not only to position itself in terms of affordability, but also to intentionally target older people with significantly lower levels of independence than might be attracted to other retirement village options. As a result, the villas have come to be seen as an alternative to rest home level care, as opposed to an alternative to remaining in one's own home. This differentiation represents a key strength of this model, and indeed part of its distinctiveness.

However, despite the clear merits of the sub-contracting agreement for all parties concerned, it was acknowledged that little use of this arrangement has been made by the facility to date. Instead, the level of care that might have been provided to villa residents under this arrangement – i.e. those residents assessed by a NASC agency as

requiring funded Home Support – continues to be provided to all villa residents, with the cost of such care deemed to be covered by the service fee. While this reflects something of the historical philosophy of the trust – to meet as many of the needs of residents for as little cost as possible – it does appear to represent something of an anomaly. New residents coming into the facility are now encouraged to contact their General Practitioner to arrange for a needs assessment prior to their entry, to ensure that firstly, the level of support provided is appropriate to their needs, and secondly, that any government-funded support they might be entitled to (e.g. Home Support) is put in place.

As with a number of the other case studies, this facility struggles with the tension between providing services that they recognise will be of benefit to residents, and the risk of providing services that they are not funded to provide – either within their contract, or paid for directly by residents. For example, no funding is received to meet the cost of a night-time caregiver for the villa residents – yet this is identified as a potential gap that, if filled, would enhance both the level of care and the sense of security for residents.

Similarly, as with other case studies, this model provides a further example of ways in which providers are endeavouring to establish a more integrated continuum of care – minimising the need for disruptive moves for residents from one level of care to another, and allowing providers to use independent accommodation and care serving as a 'feeder' to other levels of care available on site. However, it was suggested that the cost to the facility of providing care from on-site was probably not dissimilar to the cost of providing an equivalent level of care into a person's own home in the wider community.

A further weakness of this model was in terms of its physical design. The current 14 villas reflect the redevelopment of an original villa complex. While on the same site as the facility's rest home, hospital and dementia units, the villas are physically distinct – with a driveway and car parking areas separating the villas from the rest of

the complex. Were the independent care component of the facility's overall operation to be redesigned – to better reflect the mix of independence and care currently offered – the villa complex would likely incorporate its own dining and lounge area, together with office space for the staff that provide care to the villa residents.

7. Analysis and Discussion

7.1 Analysis of Case Studies against Key and Emerging Themes

As noted earlier, the literature review commissioned by the Joseph Rowntree Foundation (Croucher et al, 2006) provides a substantial meta-analysis of supported housing models for older people, primarily in the United Kingdom. While the authors of the review note the limitations of their work, it provides a far more comprehensive analysis of such housing models than is currently available in New Zealand. The authors describe their work as representing "pieces of a mosaic of evidence which when placed together show various emerging themes" (Croucher et al, 2006, p.55). As such, these themes provide a useful lens through which to compare and contrast the preceding six case studies – and to determine to what extent the findings of the JRF research are mirrored in the New Zealand context.

Croucher et al (2006) identified seven themes as emerging from the literature they had reviewed:

1. Promoting independence
2. Health, wellbeing and quality of life
3. Social integration
4. Home for life
5. Alternative to residential care
6. Cost effectiveness
7. Affordability.

In the first part of this chapter, the case studies (each summarised below[1]) will be analysed according to each theme to determine the extent to which the New Zealand examples reflect the UK experience. Any additional themes identified will be discussed subsequently.

7.1.1 Promoting independence

Much of the literature considered in this study – including the JRF review itself – identified that a sense of independence was important for older people. Various factors contribute to this, a number of which are able to be identified in the case studies considered.

Croucher et al (2006) note a number of factors that either contribute to or potentially diminish an older person's sense of independence. These include the philosophy of care (for example, do the services provided focus upon residents' abilities or subtly emphasise what they may no longer be able to do?), maintaining residents' autonomy, and the appropriateness or otherwise of the accommodation itself (given each resident's particular needs).

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[1] Case Study 1: Hospital operated in conjunction with retirement village. Privately owned. Hospital-based health services available to retirement village residents on a user-pays basis.

Case Study 2: Retirement village – part of national chain – holding a site-specific Home Support contract as part of a pilot initiative with their DHB.

Case Study 3: Rural initiative – a partnership between social service provider and District Council. Providing low-level management and support for existing council flats

Case Study 4: Rental housing option, with 9-10 older people residing together, supported by live-in housekeeper. Established by local trust, with financial support from HNZC in return for allocation rights.

Case Study 5: LTO apartments operated by not-for-profit provider in conjunction with adjacent rest home and hospital. Rest home level care able to be delivered to apartment residents, with accommodation component deducted from residential care subsidy – a pilot arrangement with local DHB

Case Study 6: LTO villas operated by not-for-profit provider in conjunction with adjacent rest home and hospital. Home Support available to residents utilizing rest home staff – the result of a sub-contracting arrangement with local Home Support contract-holder.

When considered together, the six case studies can be seen to fall along a continuum – from some offering very low levels of support (case studies 3 and 4), to those offering higher levels of support and health intervention (case studies 1 and 5).

The diagram below locates each of the six case studies along a continuum, according to the levels of support and intervention each facility offers its residents.

Figure 9:
Supported Independent Accommodation – Independence Continuum
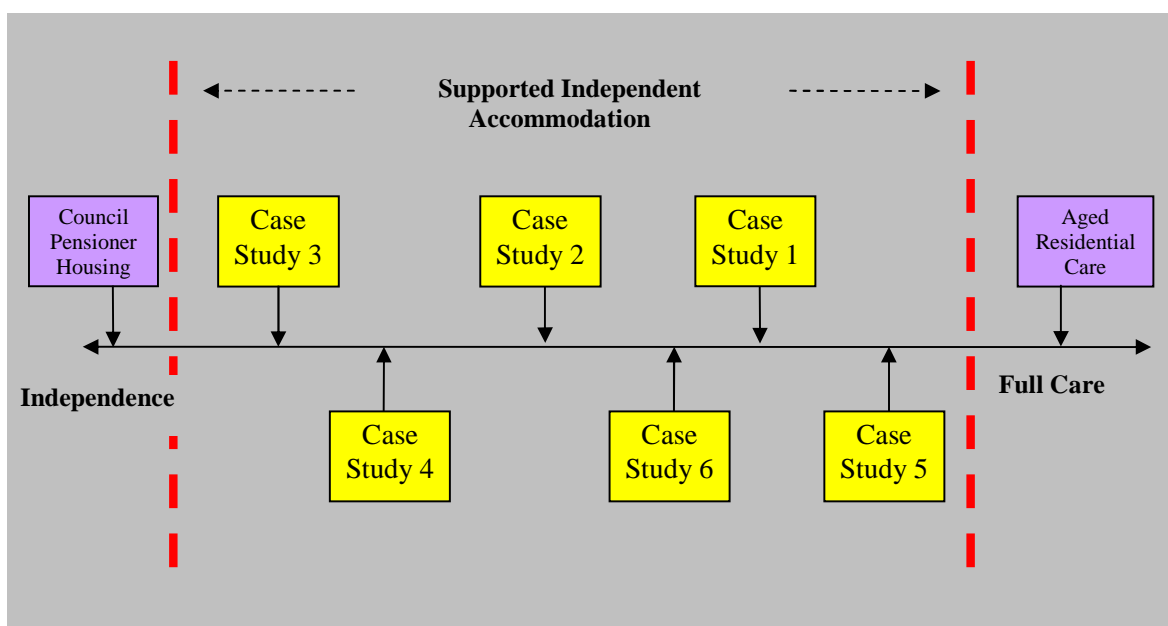
Those to the left of the continuum offer lower levels of support and intervention, and therefore afford residents a higher level of independence and autonomy. Those to right offer higher levels of support – in terms of case study 6, to the point of rest home level care – and consequently offer residents less in the way of independence and autonomy. The diagram also indicates models of accommodation and care that, for the purposes of this thesis, fall outside the definition of supported independent accommodation. These include Council pensioner flats, where no support services are offered and, at the other end of the continuum, aged residential care facilities providing contracted and funded aged care in a more institutional setting (e.g. rest home, hospital and dementia level residential care).

In case study 3, the organisation managing a group of pensioner cottages provides additional communal space and employed a part-time support worker to visit residents on a regular basis. No other services or support are provided. In case study 4, on the other hand, the facility employs a full-time live-in housekeeper, who purchases food for the (up to) ten residents, cooks the residents' two meals a day, and cleans the communal areas in the house the residents share. Residents are, however, responsible for cleaning their own rooms, able to cook their own meals if they wish, and are assessed prior to entry into the facility to ensure a sufficient level of independence. While residents could receive DHB funded home support while continuing to remain in the house, if a higher level of support or intervention is assessed, they are required to move into alternative accommodation – usually an aged residential care facility.

Sitting further along the independence continuum, case studies 2, 6 and 1 are variations of the standard retirement village model. In each case, residents are able to purchase a range of low-level support services from the facility as required, either as part of their fee or on a 'user pays' basis. Yet in each case, residents are also able to access significantly more comprehensive care than would normally be available in a retirement village setting – thereby enabling them to remain independent for longer, and potentially forestalling their entry into residential care. Indeed, the facility detailed in case study 6 specifically caters for residents who might otherwise have been admitted to rest home if not hospital level care – intentionally providing a level of care and accommodation appropriate for those with significantly higher levels of dependence. In this sense, it positions itself as an alternative to aged residential care, rather than as an alternative to living in the community.

Case study 5 is a little more difficult to place on the above continuum – and has been located closer to the boundary between supported independent accommodation and aged residential care. In many respects, it too represents the standard approach to retirement village living, with residents able to access a range of low level support services on a user pays basis. Where this example differs, however, is that funded services normally only available within a rest home setting are able to be delivered

into a resident's independent apartment. As with case study 2, it represents an innovative partnership between a provider and their local DHB. In case study 5, the provider has been given exemption to deliver funded rest home level care to residents living in their licence-to-occupy apartments – subject to those residents being assessed as requiring such care. The reason for placing this case study on the boundary of the supported independent accommodation continuum is that it could just as accurately be categorised as an example of aged residential care as of supported independent accommodation – given the extent of care provided, and (more importantly) that such care is provided within an aged residential care contract and funding arrangement. Nevertheless, it does reflect a level of innovation designed to enable apartment residents to remain in a more independent environment, despite having been assessed as needing a higher level of care.

Consideration of the case studies in terms of the way and extent to which each enables independence, also highlights the importance for older people of a sense of security, and their desire – for as long as they are able – to retain a sense of autonomy and an ability to make choices for themselves. There are, however, limits to each of these dimensions – and these will often mark the transition not only from independence to greater dependence, but also from supported independent accommodation options into aged residential care. This is discussed more fully below in section 5 – Alternative to Residential Care.

7.1.2 Health, wellbeing and quality of life

It is difficult to measure the impact of specific models of supported independent accommodation on the health status of older individuals. Health, wellbeing and quality of life are determined by a complex mix of factors – including not only health and functional status, but social relationships, psychological factors and financial circumstances. Nevertheless, Croucher et al (2006) did determine that underlying health issues were frequently a predominant factor influencing older people's decisions to move into supported housing.

As noted in the earlier discussion of this theme, ill health and immobility have the potential to institutionalise older people wherever they are living – and older people may become as readily institutionalised 'at home' as 'in a home'. An ever-growing variety of 'ageing in place' initiatives are being developed and trialled. A number of these appear to do little more than relocate rest home level care into the home environment. The resultant risk of institutionalising an older person in that home environment must be carefully considered and avoided.

Each case study examined differs in the way in which each provider has sought to respond to and accommodate the varying (and often fluctuating) levels of health need residents experience. Croucher et al (2006) note that often, following entry into a SIA environment, increased levels of health care and intervention may be needed. They note that while in some instances this may reflect actual deterioration in the health status of residents, it can also result from the closer monitoring of an older person's health status that is possible in a supported environment. There is growing evidence that when such changes are able be identified and responded to at an earlier stage, overall health, wellbeing and quality of life may be better sustained.

The case studies considered varied in their response to this. In some instances, monitoring of health status was an explicit part of the support provided. In all six case studies considered, residents were able to access increasing levels of health care – either provided by the facility, or from community-based. In at least one case new residents needed to demonstrate their independence from such support before admission to the facility. At the other end of the spectrum, in case study 6, it was *expected* that new residents would enter the facility with existing high levels of health need, and that further assistance – provided by the facility itself – would most likely be needed in order to maintain residents in their independent accommodation.

While each case study implicitly acknowledged the likelihood of residents' health deterioration, what also differed between them was how each facility saw its

responsibility to respond to changing health needs (compared to that of the wider health system). Again, something of a continuum could be identified – from those who sourced any health provision externally, to others who contracted with the DHB to provide such care, to those who provided health care on a purely user-pays basis.

7.1.3 Social integration

As with the notions of 'quality of life' and 'wellbeing', 'social integration' can be notoriously difficult to define and measure. Again, many factors influence the extent to which older people feel socially 'connected'. Many assumptions as to what contributes to social integration have been made; some correctly, others quite falsely. Croucher et al (2006) give extensive consideration to the growing trend towards what has come to be known as 'age-segregated congregate housing' – in other words, older people living with other older people. Most models of supported independent accommodation – including all six of the case studies – are predicated, philosophically and physically, on the basis of this notion.

It is not, however, without it flaws. The preference for many older people would be to remain connected to their own *geographical* community – the suburb or rural town in which they have lived for many years – regardless of the age composition of that community. Moving an older person – any person for that matter – from an isolated rural community, for example, into a more urban environment can exacerbate rather than alleviate that individual's sense of isolation and social disconnectedness. Moving away from friends and family – again, of whatever age – can have a similarly negative effect. Simply locating older people with other older people does not, of itself build community – nor automatically foster social integration.

For example, although retirement villages are sometimes (disparagingly) referred to as being somewhat exclusive, they do offer an environment that provides ongoing support as well as encouraging residents to express their independence and dignity (Hansen 2001, cited in Grant, 2006). However, others question what older people

gain by voluntarily putting themselves into what is, in effect, an age-segregated ghetto, away from the rest of society – a 'warehousing' of older people that contributes to negative stereotypes of ageing (Grant, 2006).

Contrasting with these concerns are a growing number of studies suggesting that moving to a retirement village setting may have positive impacts for an older person – particularly in terms of independence, perceived health and social relationships, and levels of social integration (Gardner et al, 2005). This may be because retirement village residents perceive themselves "to be part of a community which, rather than focusing on illness and degeneration, focuses on ability, mutual interdependence and wellbeing" (Kearns & Andrews, 2005; quoted in Greenwood, 2005, p.67)

To what extent then, and in what ways, have the six case studies taken older people's need for social integration into account? Case study 4 is perhaps the most innovative. In effect, it represents a group of older people 'flatting together'. Central to the success of this model, however, has been that any decision regarding the admission of new residents is made corporately by the residents themselves. A guest room is available in each house, and potential new residents are able to stay there for an extended period of time to not only determine whether they feel comfortable living in such an environment but, as importantly, whether other residents feel that they 'fit' with the already established community.

Case study 3, on the other hand, was a deliberate attempt to maintain existing social connections for residents in what was perceived to be an already socially isolated rural community. By putting in place a relatively minimal level of support and coordination, this model has enabled a number of older people – who might otherwise have had to move to a larger centre to access care – to remain within their own community.

The other distinguishing factor between these two case studies and the other four – and an important one in terms of social integration – is their nature of tenure.

Differences in tenure, in turn reflect differences in the socio-economic levels of the residents accommodated. The remaining four case studies (case studies 1, 2, 5 and 6) each represent – in one way or another – variations on the conventional LTO retirement village model. By comparison, case studies 3 and 4 are tenanted on an intentionally low-cost rental basis, As such, they are specifically targeted at older people for whom market rental rates – let alone the purchase of a licence-to-occupy – is beyond their financial resources. The effect of this – whether intentionally or otherwise – has been to effectively establish communities of older people of similar socio-economic standing.

Croucher et al (2006) suggest that the degree of choice that people are afforded regarding participation in social activities will influence an older people's sense of social integration, particularly in congregate settings. While many older people deliberately choose the retirement village option because of the range of social activities (and therefore potential for social integration) offered, having the choice as to whether or not to participate in such activities is equally important; as is having a sense of private space to withdraw to should one so choose. Again, the facilities examined in the six case studies varied in terms of both the range of social activities provided – from few if any, through to quite an extensive array – and in the manner in which residents' need for 'private space' was catered for.

7.1.4 Home for life

The concept of a 'home for life' is an attractive one. For older people, as Croucher et al (2006) note, the opportunity to remain in their own homes with whatever care required being provided *in situ*, changing as care needs change, has great appeal. Likewise obviating the need for successive moves as an older person's dependency increases, or simply avoiding entry into more institutionalised levels of care. The success of such a concept, however – whether from the perspective of older people or from the funder/provider view – remains a matter of some contention.

Croucher et al (2006) caution that there remain valid limits beyond which models of SIA cannot satisfactorily or safely meet the care requirements of many older people. This is particularly the case for older people with more complex health needs – those who might currently be admitted to hospital or dementia level aged residential care facilities. A growing number of 'housing with care' providers – including four of those included in the case studies – have sought to mitigate such limitations by including higher levels of care on the same campus as their supported independent accommodation. This reduces risk for both resident and provider. For residents, it gives the assurance that, should their needs change to the point where they do in fact require a higher level of care than is able to be provided to them *in situ*, then at least they are able to access such care elsewhere within the same complex, rather than having to move to a different facility with different staff and management. This can be particularly reassuring where a couple have moved into supported independent accommodation. The knowledge that one's partner, regardless of their changing health needs, will be no further away than an adjacent hospital or dementia unit, is preferable to the prospect of their having to move to another facility elsewhere. From the provider perspective, the ability to offer a continuum of care represents the opportunity to maintain continuity of income. While such assurances are reasonable in principle, in practice the continuum of care may not be as clear-cut. It depends, for example, on a bed being available in an integrated dementia or hospital facility at the precise time that a resident in supported independent accommodation is assessed as requiring such care. Otherwise that resident may still need to consider moving to an alternative facility or they may have to remain in their existing accommodation, managed at a level below their assessed need, until an 'on site' bed becomes available.

Case studies 1, 2, 5 and 6 offer funded aged residential care in addition to supported independent accommodation. Residents enter these facilities knowing that, should their care needs change, and at least the likelihood of a move into residential care 'on site' will be possible. What differs between the case studies is the point at which such a move would be triggered.

In case study 1, where hospital and dementia level care are available but rest home level care has effectively been 'leap-frogged', the expectation is that retirement village residents who may require the equivalent of rest home level care will access support on a user-pays basis from the hospital facility's nursing, medical and allied health staff.

In case studies 2 and 5, on the other hand, rest home level care (or its equivalent) is provided to residents in their independent accommodation through contracts with DHBs. Following the success of case study 2's initial pilot of a site-specific home support contract, the DHB extended the contract, and granted a similar contract for another of their facilities in the same city. In case study 6, residents are accepted into SIA with higher needs than would normally be the case, and consequently receive higher than average levels of care from day one.

Case studies 3 and 4 do not purport to offer a 'home for life'. Neither facility offers more than basic housekeeping assistance. Residents enter these facilities in the knowledge that, should their care needs extend beyond the level of care able to be provided by way of DHB-funded home support, then they would need to move to other facilities.

Hanson (in Peace and Holland, 2001) draws the distinction between *medical disability* and *architectural disability*. Medical disability relates to an individual's inability to do things because of health impairment. Architectural disability, on the other hand, refers to the ways in which the physical design, layout and construction of buildings and environments render an environment uncomfortable or unsafe for a person to use. Hanson cites as an example of architectural disability the imposition of levels of personal or medical care to the extent that the older person receiving such care finds distressing, intrusive, or even traumatic. With this in mind, a word of caution needs to sounded about the trend towards providing increasingly comprehensive care in older people's home environments – whether mainstream housing or supported independent accommodation – simply in order to maintain an

older person in that environment. The end result may well be a 'home for life' – but an architecturally disabling, and ultimately unsatisfactory one (Hale, 2003).

7.1.5 Alternative to residential care

Many models of 'housing with care' have been developed in an attempt to offer an alternative to residential care. Croucher et al (2006) acknowledge that a need for residential care for older people requiring higher and more complex levels of health intervention, or accommodation in a more secure environment, will continue. Thus, 'housing with care' or supported independent accommodation should be seen as an alternative rather than a replacement for aged residential care. Residents entering such accommodation need to be aware of this – particularly given the aspirations many may have for a 'home for life'. Croucher et al (2006) caution that providers in turn need to be quite explicit about what their models offer residents, and what they don't. While, as earlier noted, there is evidence suggesting that many older people may have been prematurely and inappropriately placed into residential care, it may be equally inappropriate for them to move into SIA when what they have sought from that environment (in terms of security, support, social connectedness or 'home for life') is at odds with what that environment could actually provide. The Introduction of the Retirement Villages Act (2003) in New Zealand has in part been an attempt to ensure that adequate, transparent and reliable information is provided to older people before they commit to that particular model of accommodation.

The risk of institutionalising older people in their own homes has already been touched on. Institutionalisation of aged care is not solely the result of architectural design, but also relates to the attitudes of staff, relatives and sometimes even older people themselves. Similarly many other aspects generally associated with residential care may also be experienced by older people living in supported independent accommodation environments. The move into supportive environments can represent a lessening of independence, privacy and dignity, and the provision of support can readily become routinised. An increasing array of care and support is provided to an

older person *in* their *own* home, the difference between being 'at home' or 'in a home' can become less and less. Twigg (in Heywood et al, 2002) refers to this as 'institutional drift'.

Case studies 3 and 4 do not purport to offer alternatives to residential care. Their intent is rather to provide a means for older people to remain living in – and therefore connected to – their own community, and, for as long as possible, to forestall entry into residential care. The low level of support offered, however, limits the extent to which this can happen. While externally provided services may extend a resident's tenure, when they are assessed as requiring rest home level care a move becomes inevitable. Case study 2 is not dissimilar, in that while the facility's contract with the DHB enables it to provide home support to retirement village residents, they too would need to move from the facility when assessed as needing higher level care.

Case studies 1 and 6, on the other hand, do promote themselves as an alternative to residential care – though each does so by providing a range of services that serve to forestall entry into residential care.

While at first glance case study 5 also appears to offer an alternative to residential care, it could equally be argued that this model is offering nothing other than residential care. Given the facility's contractual arrangement with the DHB – whereby they are able to offer DHB-funded rest home level care to residents in their licence-to-occupy apartments – all that has really changed is the locus of that care.

None of the case studies considered – nor, to the researcher's knowledge, any other providers in New Zealand – are yet in a position to offer either hospital or dementia level care in an SIA environment in the wider community.

7.1.6 Cost effectiveness

As noted in the introduction to this theme, cost effectiveness and affordability are interlinked. Cost effectiveness considers the value that models of supported independent accommodation represent to the aged care sector – in particular, to government and providers. The following section considers the extent to which models of care and accommodation represent an affordable option from the older residents' perspective.

Cost effectiveness in the health and housing sectors is notoriously difficult to measure, especially in comparative terms. While it may be possible to compare the cost effectiveness of different models of supported independent accommodation, comparing the cost effectiveness of supported independent accommodation against residential aged care is much more complex. Nor, it is suggested, should cost effectiveness ever be the sole determinant of 'value' when making such comparisons.

Much of the analysis around cost effectiveness undertaken in New Zealand to date has focussed upon home-based ageing-in-place initiatives (e.g. the economic evaluation of the Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) project, published by the Ministry of Health, 2006) as opposed to the models of supported independent accommodation discussed in this thesis. Nevertheless, such research provides a useful starting point. What has been learnt to date – reflected both in the Ministry of Health's 2006 report and other overseas findings – is that the cost of providing care to older people in their home environment in comparison with providing the same level of care in residential aged care is not only greater but, it could be said, is 'greater for longer'. In other words, not only is it more expensive to deliver the same care in a community setting as opposed to an institutional setting, but, in the latter the cost of providing care extends for a longer period, because older people tend to remain alive longer there.

This comparison, however, only considers the cost of health care and not that of accommodation – an important distinction when considering models of supported

independent accommodation. Comparing the cost-effectiveness of supported independent accommodation against residential care has to take into account the accommodation component of the subsidy received by an increasing number of older people in? aged residential care facilities. This subsidy meets some (if not all) of their accommodation cost, whereas, in the community setting, most older people must meet the full cost of their accommodation. This skews any comparison of cost effectiveness and may make the residential care option appear more attractive (at least from a cost perspective) from the individual's point of view. This will be discussed further in the next section. For the government, it is clearly more cost-effective – at least in terms of accommodation costs – for an older person to remain living either in their own home or in an environment where they meet the full cost of their accommodation (i.e. without the need for government subsidy).

Further, insofar as the health sector is concerned, the health status and care needs of older people inevitably vary from person to person and this must be taken into account when determining the cost effectiveness of different models of care. As has been noted earlier, for older people requiring relatively low levels of health intervention, it can prove just as cost effective for them to receive such care in community settings (including supported independent accommodation) as in residential settings. As health care needs increase or become more complex, however, the cost effectiveness of community-based care as against residential care diminishes.

In considering the case studies – given the complexities and confounding factors noted above – it is difficult to make any detailed comparison of the relative cost effectiveness of each model of supported independent accommodation. In terms of government funding, the models outlined in case studies 1 and 3 represent no ongoing cost to the state. Similarly with case study 4, although it did receive support towards its initial establishment from HNZC's Housing Innovation Fund. The facility in case study 6 would potentially receive state funding through their sub-contract arrangement with another DHB-funded home support provider. While this arrangement has not yet been drawn upon, it could be argued that, in absorbing the

cost of delivering the equivalent of DHB-funded home support to the residents in its independent apartments, this facility is in effect saving the DHB money!

By and large, comparison of the six case studies tends to support the contention of Croucher et al (2006) that the retirement village model, while perceived by many to be the most expensive (and the preserve only of the most affluent), often represents the least cost to the public purse.

Relative cost-effectiveness from a provider perspective is again both difficult to measure and beyond the scope of this thesis. Different facilities have different approaches to cost management – even though the overall financial impact may be difficult to compare. Case study 1 has elected to pass on to residents any costs associated with their care – some of which are covered in the facility's management fee and others are charged on a user-pays basis. Conversely, in case studies 2 and 5, such costs are effectively recovered by the provider by way of DHB contracts. Case study 6 – a not-for-profit provider – has elected to absorb the majority of the cost of care associated with maintaining residents in a supported but independent environment. Finally case studies 3 and 4 have minimised the cost of care by minimising the levels of care and support provided. As noted earlier, cost-shifting should not be confused with cost effectiveness – and any saving to the State may simply be due to the fact that the cost of care is effectively being borne by either the provider or by residents themselves.

7.1.7 Affordability

Affordability from an older person's perspective is more readily assessed. Various researchers have noted that both 'push' and 'pull' factors determine whether or not older people move from their own homes into supported independent accommodation. These include the availability of suitable accommodation within their own community – and within the range of what they can afford – and the costs associated

with maintaining their own home versus accommodation that is often newer, warmer, and with maintenance provided as part of the package.

The factors affecting affordability are relatively clear, and it is possible to compare, with a reasonable degree of accuracy, the overall costs associated with the various options available.

The socio-economic circumstances of the older population vary widely, as in any other demographic cohort. It is therefore not surprising that choices made by older people regarding SIA options likewise vary according to their socio-economic circumstances. For example, some older people would find the retirement village option neither affordable nor for that matter appropriate to their social needs and expectations. Others, by virtue of their financial means, would not meet the means testing criteria for entry into a low-cost rental facility.

Greenwood (2005) notes that retirement villages in New Zealand "tend to be home to middle class white people" (p.64), and elsewhere that most of the residents interviewed in her research were fairly well-educated people who appeared to have a relatively large amount of discretionary income. While she does not make the point directly, Greenwood's comments elsewhere in her thesis support the argument that older people not only surround themselves with people they are comfortable with but also, where possible, with people of similar socio-economic, cultural and educational background. As do we all, given the opportunity.

In terms of the six case studies, yet a further continuum emerges – though a somewhat more complex one. In the case of affordability, it reflects a number of inter-related factors:

        a.   the cost of the accommodation component itself

        b.   the extent to which residents are expected to meet some or all of the costs of the care and support provided to them, and

<blockquote>
c. any government subsidy available to them – towards either the cost of their accommodation, or the cost of their care.
</blockquote>

At one end of this continuum are the facilities detailed in case studies 3 and 4. In each case, accommodation is provided on a low-cost rental basis. Case study 3 is an expression of council-funded social housing, with residents means tested prior to entry into the units. While residents in case study 4 are not means tested, the cost of the accommodation component is benchmarked to Housing New Zealand and council social housing rentals, and the overall cost to residents is based upon what would be affordable with National Superannuation as the only form of income.

The other four case studies each provide accommodation on the basis of a licence-to-occupy arrangement, whereby residents make an initial capital investment and, in addition to this, to pay a management or service fee. Both vary, on the basis of the geographical location of the facility, the value of the property, the range of services available, and whether the facility is operated on a 'for profit' or 'not for profit' basis. In case study 6, the fee covers administration costs and the provision of all services (including all care and support). In the remaining case studies, the fee covers administration and some basic care and support services – though more comprehensive care and support is either charged for on a user pays basis (case studies 1 and 2) or covered by a combination of residential care subsidy and DHB funding (case study 5).

The other factor influencing where each case study sits on the continuum is what, if any, accommodation subsidy is available to residents. A means and asset tested accommodation subsidy may be available to some residents in the low-cost rental facilities outlined in case studies 3 and 4. For residents in case study 5 who receive rest home level care in their apartments, the notional value of the accommodation component of any residential care subsidy that they might be entitled to is taken into account in the funding arrangement that the facility has negotiated with the DHB.

It remains of some concern that four out of the six facilities considered in these case studies – and the only facilities that offer sufficiently high levels of care and support to forestall entry into residential care – provide supported independent accommodation on a licence-to-occupy basis. Earlier, Greenwood (2006) notes that the cost of moving into such retirement village living is significant, often requiring high levels of initial and ongoing investment. For all the potential advantages it offers, the LTO retirement village model will inevitably be beyond the financial reach of many (some would argue a growing number of) older people. This issue is discussed in more detail in the following section.

7.1.8 Intersectoral Collaboration – a further emerging theme

The general inductive methodology proposed by Thomas (2003) encourages analysis according to *emerging* themes. It acknowledges that, while we bring to any analysis certain predetermined themes and expectations of what we may find, we should always be prepared to be surprised!

Analysis of the six case studies against the themes identified by Croucher et al (2006) has established significant congruence between models of 'housing with care' in the UK and six examples of supported independent accommodation in New Zealand. However, consistent with the general inductive approach, a further theme can be identified – one not explicitly identified by Croucher et al (2006). It relates to the importance of intersectoral collaboration in the development of innovative models of supported independent accommodation.

The Ministry of Social Policy's (2001) New Zealand Positive Ageing Strategy (PAS), while not referring explicitly to intersectoral collaboration, nevertheless recognises the importance of government departments working together to facilitate positive ageing, and of the role that non-governmental agencies and organisations have to play. According to PAS, each government department is required to report on their achievements against the goals of the strategy on an annual basis. However, although

this inter-departmental action plan is described as the most important part of PAS, the document subsequently notes:

> "Creating a society in which people can age positively requires more than government action. Achieving this vision depends upon the involvement of central and local government, business, non-government and community sectors." (MSD, 2001, p.24)

As noted in the earlier policy discussion chapter, the HOPS (Ministry of Health, 2002) was in part developed in response to the requirements of the PAS. Similarly the New Zealand Housing Strategy (HCNZ, 2005) cites PAS as influential in shaping its recommendations concerning the social housing needs of older people. Both the HOPS and the New Zealand Housing Strategy specifically emphasise the importance of intersectoral collaboration. However, this commitment has (ironically) found greater expression in partnerships and collaboration between government and non-government agencies than between government departments themselves. This observation will be discussed in more detail in the following section.

Such intersectoral collaboration has played a significant role in each of the case studies. Indeed, it was the absence of such collaboration in the developmental stages of one case study that effectively stymied the initial direction one provider had sought to follow. In that instance (case study 3) the not-for-profit provider had sought a three-way collaboration between themselves, the local District Council, and the local District Health Board. While the unwillingness of the DHB to fund any further health services in this particular rural community did not, in the end, prevent the development of a supported independent housing initiative, it did significantly curtail the level of health services that were subsequently provided through that initiative.

Intersectoral collaboration played a more positive role in the other case studies. In two of the initiatives (case studies 2 and 5) innovative partnerships between the provider and their local District Health Board were central to their establishment. In

both cases the initial approach was made by the provider to their DHB, and in both cases the initiative required a significant variation to the normal form of either contracting or funding on the part of the DHB. Interestingly, the provider in case study 6 had approached their own DHB with a proposal very similar to that adopted in case study 2 – essentially a site-specific home support contract – but their suggestion was declined by the DHB. Instead, the DHB concerned suggested that the facility in case study 6 approach an existing home support provider, with a view to negotiating a sub-contracting arrangement. This they did and, the resulting intersectoral collaboration now enables that facility – at least in principle – to deliver funded home support services to their own SIA residents, albeit through an alternative collaboration to the one initially intended.

In case study 1, the level of intersectoral collaboration is less significant, but has proved nonetheless important to the success of the SIA initiative. Collaboration exists at a number of levels: between the retirement village and the hospital (each separate legal entities, through the role that various health professionals – contracted by the hospital, but serving the retirement village residents – play, and through the financial underwriting contributed to the hospital by the various sub-contracts it holds (e.g. also providing the laundry service for the local prison and hospice).

The nature of intersectoral collaboration reflected in case study 4, on the other hand, is more significant and more straightforward. Not only were a number of local not-for-profit organisations involved in the establishment of this SIA initiative, but its key intersectoral component is the funding partnership between those involved in establishing the facility and the Housing New Zealand Corporation. Further, in return for funding support from their Housing Innovation Fund – a key qualifying factor for such funding being demonstrated intersectoral collaboration – the corporation has retained allocation rights to a share of the rooms in the facility.

No doubt significant examples of intersectoral collaboration exist amongst the wide range of facilities researched by Croucher et al (2006). Such collaboration was not,

however, highlighted as an independent theme. Yet clearly it is emerging as a common and important theme in the development of innovative SIA models within the New Zealand context.

7.2 Discussion

The term 'Supported Independent Accommodation' (SIA) adopted for this thesis has proved a useful framework for highlighting three key determinants of good health and good housing for older people – namely the nature of the *support* older people receive, the nature of their *accommodation*, and the level of *independence* that their support and accommodation affords them. Since first being coined in the initial proposal for this thesis, the notion of SIA has already gained wider currency (e.g. NZ Council of Christian Social Services, 2006).

In reflecting upon the analysis of the various case studies considered in this thesis, along with the themes identified within the JRF report (Croucher et al, 2006), and the additional emergent theme of intersectoral collaboration, a number of conclusions and recommendations regarding SIA in the New Zealand context are able to be offered. Each reflects a challenge to the ongoing development of innovative approaches to SIA for older people. Each also highlights, to a greater or lesser extent, inadequacies or inconsistencies in 'the system' – and, as such, inadequacies or inconsistencies that may best be addressed by way of policy response.

7.2.1 Ageing in Place

Many of the recent developments in older persons' health, as in other policy areas such as housing and social development, have arisen in direct or less direct response to the New Zealand Positive Ageing Strategy (2001). Following international trends, the strategy had, as a key point of focus, the notion of 'ageing in place' – establishing as a central (if unstated) goal, a preference for older people to remain living in their own community, preferably in their own home (or a close approximation), with an appropriate level of support to enable them to remain safe and independent. In

essence, the intent of ageing in place is to avoid the unnecessary or premature institutionalisation of older people. It is a philosophy that has gained strong support, although it has not been without its critics. Some researchers have argued that institutionalisation is endemic in the lives of frail older people receiving care and support – regardless of whether they live *at* home or *in* a home (Tinker, in Peace and Holland, 2001). In *both* settings, the recipient of care can have little influence over the nature of that care, little control, little real independence. Or, as has been expressed earlier in this thesis, is not a risk of 'ageing in place' initiatives – where all that changes is the *locus* of care, rather than the nature/intent of that care – that older people simply end up being institutionalised in their own homes?

Further, as Greenbrook (2005) suggests, a fundamental challenge to theories of ageing in place relates to the question, 'Which place?'

> "It may make sense for the policy makers to provide home care for people in their own homes to prevent them from entering residential care, but many older people require company more than any type of home help… Living independently does not equate with living alone." (p.23f)

Regardless of their merits, such philosophical arguments in support of ageing in place represent only one of a range of drivers underpinning the concept. As has been demonstrated in this thesis, both demographic and economic drivers are also playing an increasingly important supporting role, as reflected in the chart below.

It is well-documented that our older population is increasing, both numerically and as a proportion of the total population. As noted in the earlier discussion on population demographics, of that older population, the 85+ cohort is increasing at the fastest rate – currently around 5% per annum. This 85+ cohort is the major contributor to New Zealand's aged residential care population – particularly in respect of hospital level care. The growth of this cohort, then, will continue to place increasing pressure on the availability of aged residential care beds, particularly at that higher level of care. For,

while innovative models of home-based care (that effectively offer a community-based equivalent to rest home level care) are now being developed and implemented, the development of an economically viable model of home-based *hospital* level aged care has proved singularly elusive. Assuming that the Ministry of Health will be reluctant to fund the required increase in hospital level aged residential care beds to meet this demographic growth – and given that some growth projections have suggested that, within ten years the equivalent of every existing aged residential care bed (both rest home and hospital level) will be required to accommodate demand for hospital level aged care alone – the challenge is a pressing one.

Figure 10:
Changing Demographic and Accommodation Trends in Aged Care
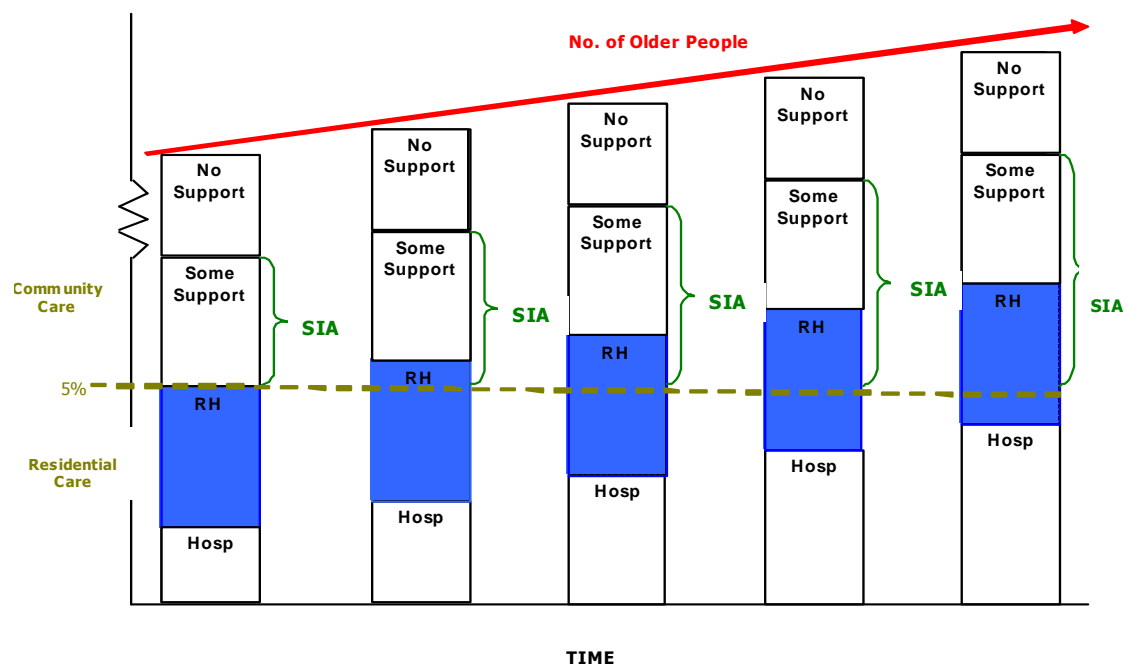
As indicated in the above chart, the proportion of the older population currently in residential care sits at approximately 5%. It is likely that this will decrease over time – but perhaps only slightly, given wider demographic changes in older population. Given the increasing number of older people aged 85+ – and therefore the subsequent

increasing demand for hospital level aged residential care – the *number* of hospital level beds required to accommodate such growth will continue to rise. This growth in demand for hospital level care is clearly one of the key factors influencing the development of new models of support whereby the equivalent of rest home level aged care is effectively relocated into an older person's own home. As such, this reflects an emerging *demographic* driver for such 'ageing in place' initiatives.

As also indicated in the chart above, current models of supported independent accommodation comprise those existing examples of community-based accommodation where only limited support is offered. However, over time, as there is a growing need for higher levels of care and support to be delivered in the community setting (up to and including the equivalent of rest home level care), both the range and extent of supported independent accommodation will inevitably increase. As will its importance in terms of both health and housing provision.

7.2.2 The Subsidisation Tension

It is suggested that one of the barriers or limitations in relation to innovation has been the current models of subsidisation for older people's care and accommodation. With the accommodation supplement and residential care subsidy each being means tested, asset tested or both, a number of innovative options that might otherwise be both appropriate and available to some older people are not – because either their assets or income are above the threshold that would otherwise enable them to access such options. Similarly, though – as has already been noted – a number of innovative housing and care options are only available to those older people with significantly higher assets and income, and therefore beyond the means of many. This tension is one that both health and housing policy development needs to address.

The current aged residential care subsidy, for example, contributes towards the cost of both accommodation and care. The challenge that the provider in case study 5 faced was to effectively 'extract' from that subsidy an agreed accommodation

component – otherwise the provider would have been open to the charge of 'double-dipping'. Similarly with case study 6, the provider has no need to pass onto their DHB the cost of the home support that is effectively (if informally) being provided to residents in their LTO units, because the cost of such care is deemed to be met by way of residents' service fees. Yet, were those same residents in any other LTO environment, such low level domestic assistance (subject to needs assessment) would be DHB-funded.

Various reports (e.g. Bransbury, 2002; New Zealand Council of Christian Social Services, 2005) propose models whereby older people are charged individually for accommodation, living costs, care and support, with residents having some choice over both the range and extent of services they receive. While the NZCCSS report acknowledges a need for there to be strong links built between health service delivery and housing and accommodation needs, it also suggests that "uncoupling the care services provided to older people from the accommodation choice they wish to make is a key component of a future vision for flexible services focused on the older person at the centre" (New Zealand Council of Christian Social Services, 2005, p.12).

7.2.3 The 'Licence to Occupy' Financial Model – a Perverse Incentive?

As noted earlier Australian research (Gardner, 2005) suggests that older people who move into a retirement village environment experience better quality of life than those older people who choose to remain in their own homes in the community. This is true regardless of whether the retirement village is run on a licence to occupy (LTO) basis, or on a low cost rental basis. Each, Gardner suggests, represents a model of communal living, and therefore offers a level of socialisation and security over and above what an older person might experience remaining in their own home in the wider community. Retirement villages are seen by residents as 'places to live' rather than as 'care settings' (Croucher, 2006).

Nevertheless, the fact remains that access to the LTO retirement village model is in effect limited to those with both the capital means required to purchase the licence itself, and the financial income to meet the ongoing cost of facility management fees (over and above the LTO itself). They have been described as "a form of privileged retreatism" (Blaikie 2005, cited in Grant, 2006, p.4). A recent article (Dagarin, 2007) cited a 2006 survey by the New Zealand Retirement Commission that indicated purchase prices ranging from $55,000 to $2 million, with a median price of $200,000. Management fees ranged from $60-$1,200 per month, with a median monthly fee of $300. Over half of the 52 villages surveyed did not return any capital gain to residents on or after their departure. In the words of the Bransbury (2002) quoted earlier, 'Would other older people make the same choice if they had the means?'

As significantly, the standard LTO model represents something of a perverse incentive when considered in context of the government's 'ageing in place' policy direction. As the primary return to a retirement village operator under this model is made when a licence is on-sold – i.e. when a resident leaves the village, their licence is sold back to the operator (usually at a pre-determined value) and then on-sold to the next resident – the incentive to providers is to maintain regular turnover of LTO units, rather than encouraging residents to remain in their unit for as long as possible.

This could be argued as creating a subtle pressure on some LTO providers. In particular, where providers also offer higher levels of care – e.g. rest home or hospital level care – such providers may be tempted to encourage residents in their LTO units to consider a move into that facility's rest home or hospital facility sooner than might otherwise be warranted. In that way, they may gain an earlier turnover of the licence for that resident's unit than might otherwise have been the case. However, it should also be noted that a number of the case studies considered in this thesis suggest a changing approach in this area – with some facilities offering services that effectively enable residents to remain in their LTO unit longer. Given the usual financial structure underpinning the LTO model, this represents a potential financial risk to

such providers – and yet each, in different ways, has developed strategies to mitigate such risk (see case studies 2, 5 and 6).

There is a similar challenge to DHB's to also think differently. In case study 6, for example, it could be argued that this LTO facility was in fact saving the DHB money by providing to residents services that, if that older person were in their own home, would be funded directly the DHB. The question must be asked as to why the facility is not funded to provide such services when the only difference is the physical location of the older resident. In Australia, retirement village operators are able to contract to deliver government-funded Home and Community Care packages – the equivalent of New Zealand's home support. This is seen to offer the potential for greater efficiencies in terms of service delivery, and to enable greater access to these services for residents. Some villages have the capacity and expertise to offer quite comprehensive packages of care to older residents with complex needs and who require significant management of their care. Such arrangements are seen to allow a combination of services from public and private providers, and increase competition in service delivery (Gardner et al, 2005). Case study 2 in this thesis likewise serves to demonstrate that such site specific provision of Home Support can be not only cost effective, but also offer the opportunity for individualised care that is both more flexible and less intrusive.

7.2.4 Intersectoral Collaboration

As noted in the preceding chapter, the confluence between health and housing factors in determining a person's health and wellbeing is not only widely recognised but acknowledged within both the health and housing sectors. The NZ Housing Strategy (2005) for example notes the importance of taking into account issues of health and wellbeing – particularly in relation to older people. Local councils are also increasingly incorporating such an emphasis into their own strategies. Similarly, the health sector has played a lead role in researching and consequently emphasising the

important correlation between a person's home environment and subsequent health outcomes.

Despite increasing recognition of this key relationship, however, there appears to have little intentional discussion or joint policy development across the two sectors to date – i.e. between the two government departments holding primary responsibility for health and housing. This is unfortunate. It is also, as noted earlier, somewhat ironic – given the government's explicit encouragement of intersectoral collaboration, and growing evidence of the value of such collaboration in terms of innovative service development and delivery. The Housing New Zealand Corporation's Housing Innovation Fund, for example, cites evidence of intersectoral collaboration as one of the criteria against which any application to the fund – whether by a non-government organisation (NGO) or a territorial local authority (TLA) – will be assessed. The various case studies considered in this thesis highlight the importance of such intersectoral collaboration. Yet in each case, any such collaboration is between the relevant government agency and an NGO, or between respective NGOs and TLAs themselves. There remains little evidence to date of the Ministry of Health and Housing New Zealand Corporation themselves taking a similarly collaborative approach at the level of policy development and implementation.

8. Conclusion

New Zealand stands at the edge of a massive shift in its age demographics, where those aged 65 and over are not only increasing in number, but also represent a growing proportion of the population. We also face a significant paradigm shift, as those responsible for the provision of aged care come to terms with the government's policy emphasis upon the notion of 'ageing in place'. As a result, proportionally fewer older people are being assessed as requiring residential care, and those who do enter residential care facilities are doing so with higher and more complex health needs.

There is growing evidence that accommodation plays a significant role in improving the wellbeing of individuals and households – and, in particular, that 'supported independent accommodation' can help to maintain the physical, mental and social wellbeing of older people. Indeed, the notion of supported independent accommodation (SIA) – coined in the developmental stages of this thesis – has now gained some wider currency. It has also provided a helpful framework for exploring three key determinants of health and wellbeng for older people – the nature of their *accommodation*, the nature of the *support* they receive, and the level of *independence* that their accommodation and support affords them.

Yet in New Zealand the options for older people in this regard remain somewhat limited, and often beyond the financial means of many who would potentially benefit. Nor, to date, has there been much research undertaken to evaluate or compare the models currently available in New Zealand – whether from an economic, social or operational point of view.

This thesis has taken a step in that direction. It has reviewed the existing body of literature surrounding the topic of SIA, including both population and accommodation demographics, together with relevant government health and housing policy.

During the completion of this thesis, a major UK study of supported independent accommodation for older people was published. Funded by the Joseph Rowntree Foundation (JRF), this was a comprehensive review of existing models of what the report termed 'housing with care'. It identified seven themes emerging from the 145 studies they considered:

These themes have been used as a lens through which six examples of innovation in the area of SIA in New Zealand have been examined. A general inductive methodology was used to analyse the case studies – firstly 'listening for echoes' of the JRF themes, but also allowing for any further themes to emerge. This methodology enabled an additional theme to be identified in the New Zealand SIA context , over and above the JRF themes. This emergent theme related to the importance of intersectoral collaboration in developing and implementing models of SIA in New Zealand.

Subsequent analysis of the case studies, along with the JRF themes and the additional theme of intersectoral collaboration, has lead to a number of conclusions and recommendations regarding SIA in New Zealand:

Firstly, the notion of 'ageing in place' has been a key influence in terms of government policy, reflected in the (then) Ministry of Social Policy's Positive Ageing Strategy (2001) and the Ministry of Health's subsequent Health of Older People Strategy (2002). While it is clear that most older people, given the choice (and the resources), would seek to remain living independently in their own homes and communities, it would be disingenuous to suggest that this has been the sole – or even the primary – driver of 'ageing in place' as a strategic policy level. Demographic and economic drivers also play a significant part – with growth in the 85+ population projected to place increasing demand on aged residential care – particularly at hospital level. Alternative (and more economically sustainable) models of community-based care for older people – as an alternative to residential care – need to be developed.

Secondly, this thesis has identified something of a tension within the current regime of government subsidies for care and accommodation in the aged care sector. The accommodation supplement and residential care subsidy are each means tested, asset tested or both. As a result some older people are missing out on innovative options that might otherwise be available to and appropriate for them. Conversely, other equally innovative housing and care options – particularly in the LTO retirement village sector – are only available to older people with sufficient assets and income to access them. In light of this, some organisations are suggesting effectively 'uncoupling' the current subsidisation link – that is, that the subsidy component for accommodation and the equivalent subsidy component for care should be more clearly delineated.

A third question raised by this thesis relates to the popular 'licence to occupy' model – specifically, whether this model represents something of a perverse incentive in the context of the government's 'ageing in place' philosophy. The financial sustainability of the LTO model depends upon older people moving from their retirement village unit – thus enabling the on-sale of their licence at, inevitably, a higher price than they will receive. Does this represent an incentive for LTO providers to move older people on into higher levels of care? This suggests a transition which is at odds with the notion of ageing in place, where older people are encouraged to remain longer in an independent or semi-independent accommodation environment.

Finally, this thesis reiterates the fundamental importance of intersectoral collaboration for facilitating and sustaining innovation in the SIA environment. This represented a key strength in each of the case studies considered. Nevertheless, it must also be noted that, while the recognition and practice of intersectoral collaboration continues to grow between government agencies (both central and local) and non-government agencies, collaboration between the two government departments responsible for older persons' health and housing – namely the Ministry of Health and Housing New Zealand Corporation – has been slower to evolve. There

has been little in the way of collaborative policy development between these two governmental players – and even less in terms of practical, conjoint strategic initiatives. The challenge to each, it is suggested, is to model between themselves the intersectoral collaboration they encourage of others.

In line with international trends, New Zealand's older population will continue to grow – numerically, and as a proportion of the overall population. Increasing demand for aged residential care will ensure that models of SIA will take on greater significance, providing a necessary alternative to residential care. Yet SIA represents a significant model of aged care in its own right. The research undertaken by Croucher et al (2006) highlights the contribution that SIA has to play in providing innovative and alternative solutions to the growing demand for more traditional models of aged residential care. In addition to the demographic and economic drivers noted, the promotion of independence, health and wellbeing, together with maintaining older people's sense of social integration, further reinforce the importance of identifying and developing innovative models of SIA in the New Zealand context.

Six such examples of innovation have been considered in this thesis. Each reflects, to varying degrees, the themes identified by Croucher et al (2006). They also highlight the diversity of models emerging – that span the not-for-profit and private sectors, and offer varying degrees of support for their residents. Some offer very little in the way of health intervention or support, with residents effectively as independent as they might have been in their previous home environment. Others offer such high levels of support that they become, in fact, difficult to distinguish from the models of aged residential care they seek to differentiate themselves from.

As such models continue to evolve – and, as demand for SIA continues to increase – some of the issues noted above will need to be addressed by government at a policy and funding level. For example, financial sustainability represented a challenge for some of the models considered in this thesis. In each case, such risk was seen as part

and parcel of innovative development. However, if such development is to continue –
in response to increasing demand – then the longer-term financial sustainability of
SIA for providers will need to be assured.

As new models are developed and implemented, SIA will continue to find its place
along the 'integrated continuum of care'. For older people it will represent an
alternative to residential care, enabling them to remain independent within their own
community. For government, it will likewise provide an increasingly important
alternative to aged residential care, as demand for such care (and therefore its cost)
inevitably increases. Models of SIA will continue to be refined. New examples of
intersectoral collaboration will continue to be forged. And hopefully those charged
with responsibility for the care of older New Zealanders at a policy level will work
cooperatively to create an environment within which such growth, development and
innovation can thrive – to the benefit of our elders, and therefore to the benefit of us
all.

VICTORIA UNIVERSITY OF WELLINGTON

**Participant Information Sheet for a Study on Supported Independent
Accommodation Options for Older New Zealanders**

Researcher: Max Reid, Faculty of Humanities and Social Sciences, Victoria University of
Wellington

I am a Masters student currently undertaking an MA in Social Policy through Victoria University of
Wellington. As part of this degree I am undertaking a research project leading to a thesis. The
research project aims to examine the existing theoretical basis for supported independent
accommodation as a valid model of care/housing for older people. It will compare up to six
examples of innovative approaches to such accommodation for older people currently operating in
New Zealand – in particular, identifying the perceived strengths and weaknesses of each. From
this analysis and comparison, it is hoped to identify any particular gaps or issues in relation to our
understanding of this model of care/housing which may then be able to be prioritised for
subsequent research.

Examples of supported independent accommodation have been selected on the basis of difference
and innovation. Each will be documented and compared, using a case study approach and semi-
structured interview technique. The characteristics of each model, and its distinctiveness, will be
analysed according to a range of key categories/typologies – e.g.

- Tenure,
- Design,
- Type and mix of accommodation available (e.g. apartments, villas, bed-sits, etc.),
- Range of services available (i.e. the nature and extent of 'support' offered),
- How such additional support – i.e. over and above the provision of accommodation –
  is funded,
- The extent to which the facility is open/closed to the wider community.

The categories/typologies chosen will reflect – and, to some extent, emerge from – earlier analysis
of the literature surrounding and underpinning the concept of supported independent
accommodation.

As the University requires that ethics approval be obtained for research involving human
participants, should you choose to participate, your written consent to such participation in the
project is required. Once your consent has been obtained, I would arrange to visit your facility (at a
mutually convenient time), in order to discuss with you the nature and distinctiveness of your
particular facility. In particular, I would appreciate your comment on the following questions:

- Why was this particular model of supported independent accommodation chosen by
  your organisation?
- What do you see as its distinctiveness?
- What have been the key learnings from adopting such an approach to SIA?
- What do you see as the strengths/weaknesses of this particular approach to SIA?

- If you were to undertake such a development again, what if anything would you change?

The interview will be tape recorded, transcribed, and the transcript subsequently analysed for common themes. Any written material arising from the interview and incorporated into the thesis itself will be made available to you for comment and/or amendment prior to submission of the thesis if you wish. It is anticipated that each case study will contain extensive detail and analysis concerning the nature and structure of each model considered. All information collected will remain confidential, and no other person besides my academic supervisor, Dr Judith Davey, and myself will have access to it. However, given the small size of the sample, and that the participant facilities are to be chosen, amongst other things, on the basis of their distinctiveness, ensuring anonymity of participants and/or the facilities they represent in any subsequently published material will not be possible. Both the semi-structured nature of the interview format and the form of subsequent reporting will allow participants to choose which information they are comfortable to share with a wider audience, and which they may wish to subsequently withhold – either for personal reasons, or for reasons of commercial sensitivity. You will be able to check your transcript and make whatever amendments/deletions you wish to, indicating which information you would not like to have linked to you or your facility. Further, should you for any reason feel the need to withdraw from the project, you may do so at any time before the data is analysed. Should you wish to do so, please let me know as soon as possible.

The thesis will be submitted for marking to the Faculty of Humanities and Social Sciences and deposited in the University Library. It is intended that one or more articles, based upon the research project, will be submitted for publication in scholarly journals. Again, your prior approval would be sought before any such articles were submitted for publication. Audio tapes and transcripts from any visit(s) to your facility will be destroyed two years after the end of the project.

If you have any questions or would like to receive further information about the project, please contact me at:

41 Colwyn Street, Bryndwr, Christchurch
Telephone (03) 351 5677

or my supervisor,

Dr Judith Davey
NZ Institute for Research on Ageing, Victoria University
PO Box 600, Wellington,
Telephone (04) 463 5233

Yours sincerely

Max Reid

Appendix 2 – Consent Form

VICTORIA UNIVERSITY OF WELLINGTON
CONSENT TO PARTICIPATION IN RESEARCH

Title of project: 'Emerging Trends in Supported Independent Accommodation for Older New Zealanders'

I have been given and have understood an explanation of this research project. I have had an opportunity to ask questions and have them answered to my satisfaction. I understand that I may choose to withdraw myself (or any information I have provided) from this project (before data collection and analysis is complete) without having to give reasons..

- I understand that any information I provide will be kept confidential to the researcher and his academic supervisor.
- I understand that my decision to participate in the interview does not obligate me to answer any or all questions should I so choose.
- I understand that I will have an opportunity to check written material arising from any interview(s) with me prior to publication.
- I would like to receive a copy of the transcript of my taped interview
  (Please tick)   Yes   No
- I understand that while, given the size and nature of the research sample, anonymity will not be possible, that, before the publication of any findings and/or reports arising from the research, I will be given the opportunity to exclude any information provided from such findings/reports.
- I understand that the tape recording of interviews will be electronically wiped at the end of the project unless I indicate that I would like them returned to me.
- I understand that the data I provide will not be used for any other purpose or released to others without my written consent.

- I agree to take part in this research.

signed:

name of participant:
(please print clearly)   Date:

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