The New Zealand Health of Older People Strategy

An evaluation of District Health Board implementation and service alignment

A report commissioned by
The HOPE Foundation for
Research on Ageing

Lisa Stewart PGDipHSc, BA, RN

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

PO Box 87-343, Meadowbank Auckland 1742
www.hopefoundation.org.nz
Chair: Professor David Richmond
MD FRACP FRCP (Lond)
Executive Officer: Miss Jan Bowman MNZM
Mobile: 021 455 466
Email: janbowman@xtra.co.nz

The HOPE Foundation for Research on Ageing is an independent organisation without ties to any government funding. It is committed to disseminating research-based information in order to improve the quality of policy making as NZ communities grapple with the implications of rapid ageing. We do not confine our research only to the area of health, but to any discipline that can demonstrate that research in its field is of relevance to the ageing population.

In 2002 the New Zealand Government released *The New Zealand Health of Older People Strategy* which set out policy for the future direction of health and disability support services for older New Zealanders from 2002 -2010.

Preliminary enquiries by The Foundation revealed apparent divergences in the preparedness of District Health Boards around the country to meet the objectives of the Health of Older People Strategy.

One of The Foundation's objectives is to influence decision-makers in order to improve the quality of life for ageing New Zealanders. We therefore commissioned this special Report to evaluate the implementation of the Strategy by the various District Health Boards throughout New Zealand. We are indebted to Lisa Stewart of the Faculty of Medical and Health Sciences of The University of Auckland for undertaking the research. In preparation of this Report, Lisa contacted all 21 District Health Boards and their local Age Concern branches, each of whom was invited to participate.

There is opportunity for much more research in this area. It is encouraging that DHBs are making reasonable progress towards implementation of the Strategy even though the level of consumer or community satisfaction is not clear. What is disconcerting is the lack of documentary evidence to support DHB management contention that the Strategy is being satisfactorily rolled out.

It is of interest that recent weeks have seen concern expressed about the quality of care in some rest homes. At least four of the eight Objectives of The Health of Older People Strategy (Numbers 1, 6, 7 and 8) have some bearing on this issue. The responses of District Health Boards ought therefore to be congruent with the expectations of the Health of Older People's Strategy. Although this particular issue was not specifically addressed in our research it is an example of the way in which the Strategy can impact on ageing New Zealanders and their families as consumers of District Health Board policy and practice.

We are pleased to make this Report available in the hope that its findings will be of value to decision-makers in the District Health Boards and in government. It is evident that there are considerable variations in the response of Boards to implementing the Strategy.

Ageing is arguably the most important challenge facing this country now and over the next 25 years. It is important to make use of the current window of opportunity to develop appropriate responses to the challenge rather than just hoping that it will go away if it is ignored.

David E. Richmond MD FRACP FRCP(Lond.) Inaugural Masonic Professor of Geriatric Medicine, The University of Auckland Chair of The HOPE Foundation for Research on Ageing

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Executive Summary

In May 2002, the New Zealand Government launched the Health of Older People (HOP) Strategy to address the needs of an increasingly ageing population. The District Health Boards (DHBs) have a deadline of 2010 to plan and report changes in service delivery that incorporate the principles and Objectives outlined within the Strategy. Determining how and when this will occur has been left to the discretion of the individual DHBs, however there is an expectation that each DHB will document its planning and progression towards the HOP in its annual and strategic planning documents.

The purpose of this Report is to present the findings from research commissioned by The HOPE Foundation for Research on Ageing in which progress made by DHBs in implementation, progression and service alignment to the HOP Strategy was explored. The importance of such an evaluation is significant and timely in determining accountability, ownership and commitment to the Strategy by the DHBs, and also in identifying real or potential barriers that could impact on full compliance with and sustainability of the HOP Strategy.

A qualitative organisational evaluation that incorporated the balanced scorecard methodology *(*Kaplin & Norton, 1992) was conducted to evaluate DHB implementation and service alignment in relation to the HOP Objectives and Action Plans. The study was divided into two phases; Phase I involved a content analysis of the 2006/2007 District Annual Plans (DAPs) from all the 21 DHBs. Phase II explored the perceptions of three key stakeholder groups from within the DHBs and the community and included:

- DHB Chief Executive Officers / Senior Executive Managers (n=12);
- DHB older People's Health Service Managers (n=11) and;
- Age Concern Local Area Managers (n=13).

Guided telephone interviews with DHB staff and self-completion questionnaires for the Age Concern participants were used. Analysis of the data was performed either in relation to the Action Plans incorporated in the HOP Strategy or through inductive analysis, depending on the data set.

The study showed that the key stakeholder groups were positive about the planning and progress being made towards implementation of the Strategy, however the DAPs showed minimal evidence of planning for implementation of the HOP Action Plans, whereas on the other the key stakeholder groups reported has occurred. Inconsistencies between the data sources in relation to the extent of service alignment were evident. Other key findings related to barriers to implementation and service alignment. These

included resource shortages and in particular, funding and workforce. Other barriers such as time, inflexibility of policy and internal and external organisational culture were also identified by participants.

Progress in planning and implementation of the HOP Action Plans appears to be occurring in the DHBs included in this study. However, discrepancies in the findings, as already noted, have made it difficult to determine the actual extent to which services are aligned to the Objectives and overall vision of the HOP Strategy. The need for more research to explore actual service alignment and effectiveness of meeting the needs of older people is evident.

Lisa Stewart
Faculty of Medical and Health Sciences
The University of Auckland
August 2008

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SECTION 1: INTRODUCTION

With limited healthcare resource and the evolving complexities of the health needs of an ageing population it is becoming increasingly crucial that the services supplied are carefully focused on meeting the demands of the population. In May 2002, the New Zealand Government launched the Health of Older People (HOP) Strategy as a means of addressing the needs of the ageing population in an efficient and effective way. The Strategy provides a framework for future directives in health and disability support services for older people and encompasses the principles of positive ageing. The vision of the HOP Strategy is twofold: that older people should participate to their fullest ability in decisions about health, well-being and community life and in so doing should be supported by coordinated and responsive health and disability support services. The Strategy consists of eight Objectives (Table 1.1) that identify the healthcare needs of older people and in broad outline, what health and disability services need to do to meet those needs. Within each objective, key Action Plans and steps (Appendix 1) towards the attainment of the Strategy are outlined along with designated responsibilities for the implementation which involves both the Ministry of Health (MoH) and the District Health Boards (DHB).

Table 1.1: Key Objectives of the HOP Strategy

1.	Older people, their families and whanau are able to make well-informed choices about options for healthy living, health care and/or disability support needs
2.	Policy and service planning will support quality health and disability support programmes integrated around the needs of older people
3.	Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whanau and carers
4.	The health and disability support needs of older Maori and their whanau will be met by appropriate, integrated health care and disability support services
5.	Population-based health initiatives and programmes will promote health and wellbeing in older age
6.	Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning
7.	Admission to general hospital services will be integrated with any community-based care and support that an older person requires
8.	Older people with high and complex health and disability support needs will have access to flexible, timely and coordinated services and living options that take account of family and whanau carer needs

Reference: MoH, 2002

The DHBs have a deadline of 2010 to plan and report changes in service delivery that incorporate the principles and Objectives outlined within the Strategy. Determining how and when this will occur is left to the discretion of the individual DHBs; however there is an expectation that each DHB will document its planning and progression towards the HOP in its DAPs, annual strategic plans and annual reports.

The MoH is responsible for monitoring the progress of DHBs in their implementation of the HOP Strategy. However, this monitoring process is assisted by a set of performance indicators that focus on set outputs. Allen and Stevenson (2006) highlight that service organisations tend to focus on what is most tangible, such as numbers of patients served, the cost of providing the service and the revenues generated. These indicators of performance provide evidence of activity but not quality. Furthermore, as Herbert and Veil (2004) point out measuring the effects or outcomes of an intervention that has not been sufficiently implemented is in effect pointless.

The potential for widespread variation in implementation and alignment to the HOP Objectives in the service provisions for older people across New Zealand was recognised by The HOPE Foundation for Research on Ageing. The foundation deemed it both significant and timely for a comprehensive evaluation of DHB progression and service alignment towards the HOP Objectives and commissioned this report. The ability to understand the impact of health policy lies in part, in the ability to follow and monitor the process of change (Casebeer & Hannah 1998). The importance of an implementation evaluation is essential to determining accountability, commitment and alignment to the policy by the DHBs and also in identifying real or potential barriers that could impact on implementation, service alignment and sustainability of the HOP Strategy.

This report presents the findings from research undertaken in which progress by DHBs in implementation and service alignment to the HOP Strategy was explored. A review of the 2006/2007 DHB DAPs and the perceptions of three key stakeholder groups from within the DHB and community were utilised in the evaluation. The methods used to perform the study are discussed in Section 2 of the report, followed by the findings in Section 3. A discussion based on the findings and study limitations is presented in Section 4.

1.1 Research Objectives

The aim of this research was to gain insight into DHBs' implementation, progression and service alignment to the HOP Strategy. The following specific objectives were explored:

1. The extent that DHB DAPs reflect the HOP Objectives and Action Plans;
2. Key stakeholders' perceptions of DHB implementation and service performance in relation to the HOP Objectives.

SECTION 2: METHODS

2.1 Research Methods

Qualitative evaluation methods were used for this analysis of progress towards implementing the health of older people (HOP) Strategy because they are recognised to be more suitable for understanding phenomena than are quantitative methods (Polit & Hungler, 1999). While qualitative research usually focuses on the experiences and perceptions of the participants through the use of observations, interviews and questionnaires, documents can also be a rich source of research data (Government Research Unit, 2004; Punch, 2005).

As it is important to evaluate organisational performance and service delivery on a wide range of financial and non-financial factors (Brooks, Milne & Johansson, 2002) a 'balanced scorecard' approach to data collection was used. This recognises the different organisational perceptions that can impact on performance and the success or otherwise of service delivery (Kaplin & Norton, 1992). The four perceptions incorporated were of the customer, the internal business processes of the provider organisation, opportunities for innovation and learning, and finance (Ameratunga et al 2002). A wider community view is also useful particularly in relation to integration of health delivery systems (Leggart & Leatt, 1997). It enables a form of 'triangulation', multiple perspectives on a topic, which strengthens the credibility of the research by balancing out any distortion due to reliance on a single source of data (Morse & Richards, 2002; Murphy & Dingwall, 2003). Hence in addition to interviews with District Health Board (DHB) stakeholders (CEO and Service Managers) and a documentary review of the District Annual Plans (DAPs), the perceptions of representatives of the community advocacy organisation Age Concern, were included to provide an external viewpoint.

2.2 Research Design

The study was divided into two distinct phases. Phase I was a documentary evaluation of the DAPs from each DHB\. An evaluation tool was designed to explore the achievement of the specific Objectives highlighted within the HOP Strategy within the DAPs. Phase II incorporated a qualitative organisational evaluation to provide descriptive data about the implementation of the Strategy. This approach was based on the balanced scorecard method of evaluation.

A combination of data collection methods was employed to obtain a snapshot of DHB implementation and alignment to the HOP Objectives and Action Plans. These included document evaluation, telephone interviews and self-completion questionnaires that utilised a standard open ended question format. Depending on the data set, analysis was performed either in relation to the Action Plans incorporated in the HOP Strategy, or through a general inductive approach to reflect the emergence of key themes.

2.3 Phase I: District Annual Plan Evaluation

All 21 DHBs were involved in Phase I of the research (DAP evaluation). The 2006 / 2007 DAPs for 19 out of the 21 DHBs were accessed via the DHB web pages. Contact was made with the communication department of the remaining two DHBs and subsequently copies of their DAPs were provided. The DAPs were evaluated against the Action Plans from the HOP Strategy using three main criteria:

- Not included in DAP;
- Highlighted as needing to be addressed or;
- Implementation plan provided.

Due to the length of each document, the evaluation was only completed on those sections within the DAP that specifically pertained to older people's health. Each of these sections within the DAP was reviewed several times to allow the researcher to become familiar with the content. The DAP evaluation tool provided a framework in which the content of the DAP was explored and analysed in relation to the concepts and themes presented in the HOP Action Plans. This first phase of analysis occurred simultaneously with the data collection. A second phase of analysis involving an investigation of the data obtained from all of the DAP evaluations was undertaken to determine the presence of any recurring themes.

2.4 Phase II: Data Collection from Key Stakeholders

Three key stakeholder groups were selected for the second phase of the research:

- The DHB Chief Executive Officer (CEO) or a delegated Senior Executive Manager to represent the financial and long term projections (innovation and learning) aspects of the balanced scorecard method;

- The Manager responsible for Older People's Health Services Portfolio within the DHB for the internal business processes and;
- Age Concern Local Area Managers representing the community / customer perspective.

2.4.1 Interview and Questionnaire Design

The design of the CEO level interview was based around the components of the balanced scorecard and was developed under the following headings identified within this model:

- The financial perspective;
- The internal processes;
- The long-term projection (innovation and learning);
- The consumer perspective and satisfaction and;
- The community perspective.

Open ended questions were utilised to elicit formative and descriptive data. However, one question in the interview utilised a 5 point Likert scale to obtain a rating of perceptions of progress by DHBs in implementing the HOP Strategy.

The Age Concern questionnaire linked closely to the design of the CEO interview. However, the questions relating to internal organisational processes and financial aspects were not included as these were not relevant to commentators external to the DHBs. The aim of utilising similar questions for these two stakeholder groups was to provide comparative data on DHB performance.

The design of the Service Manager interview was based on the DAP evaluation tool which was modified by turning the HOP Action Plans into a positive statement which could then be evaluated by the participant using three criteria:

1. Not included in services;
2. Partially developed or implemented into services and;
3. Fully integrated into services.

These interviews followed a structured interview design. Respondents were also able to share their perceptions and elaborate on their response by providing examples of models in place,

projects in progress and if relevant, why particular Objectives were not included in service planning or delivery.

2.4.2 Recruitment

The CEOs for all 21 DHBs were contacted via e-mail. From this point 'chain sampling' occurred in which the CEOs recommended who would be the best people within their organisation to engage with. E-mail or phone contact was then made with these nominated people to arrange an interview which was conducted via telephone or face to face. The contact details for the Age Concern managers were obtained from the Age Concern website which listed 32 agencies nationwide. Self-completion questionnaires were sent to all 32 agencies.

2.4.3 Data Analysis

The data analysis for the CEO level interview and the Age Concern data involved a general inductive process which provided a systematic method of identifying key and relevant themes that emerged from the raw data. Repeated examination of the responses within each data set established elements of similarity which enabled the clustering of data into categories and then sub-themes and finally into main themes.

The analysis of the Service Manager data followed a similar process to that of the DAP evaluation in which the questions asked provided a framework against which the information obtained could be analysed in relation to the concepts and themes of the HOP Action Plans. A second phase of analysis of this data set was conducted to highlight the additional information obtained from this data source in relation to implementation and actual service provisions.

2.5 Credibility and Trustworthiness

- The use of triangulation within the research design has allowed a more rounded exploration of the implementation and service alignment of the HOP Strategy by the DHBs than would have been provided by a single method approach.
- Pre-evaluation testing of the DAP evaluation tool and beta testing of the interview questions were performed to ensure relevant data would be obtained to address the research questions.

- The use of structured interview guides made certain that the same basic line of inquiry occurred within each stakeholder group providing consistency in approach while still allowing the freedom for participants to provide their views.
- The data analysis process was checked by an independent researcher to determine the congruency of data categories and emerging themes.

2.5.1 Ethics

Ethical approval was sought from The University of Auckland Human Participants Ethics Committee and was granted in September 2006 (Reference No: 2006/253). The guidelines provided by this authority that are relevant to this research, such as informed consent of participants, and storage and disposal of material, have been adhered to.

SECTION 3: FINDINGS

3.1 Findings from District Annual Plan Evaluation

The District Annual Plans (DAPs) provide formal documentation of a District Health Board's (DHB) financial, operational and resource planning and management for a 12 month period. The aim of these documents is to demonstrate what the organisation intends to do in order to meet both community and ministerial accountabilities. Health of Older People (HOP) is only one of many ministerial objectives that DHBs need to address within these documents, and therefore there are many sections within the DAPs that focus on aspects of health unrelated to the older population. This research only evaluated those sections in the DAPs that pertained specifically to older people's health. Table 4-1 lists each DHB, the percentage of their population that are older people and whether there was a section within their DAP that was specific to older people's health.

Table 3-1 DHB Regions, Percentage of Population 65+ and Inclusion of an Older People's Health Section in DAP

DHB Region	Percentage of people aged 65+	Older people's health section
Northland	12	√
Waitemata	11	√
Auckland	11	√
Counties Manukau	9	√
Waikato	11	√
Lake District	10	√
Bay of Plenty	14	√
Tairawhiti	11	√
Taranaki	13	√
Hawkes Bay	13	√
Whanganui	13	√
Mid Central	12	√
Capital Coast	10	√
Hutt Valley	11	√
Wairarapa	14	√
Nelson-Marlborough	14	√
West Coast	12	√
Canterbury	13	√
South Canterbury	16	√
Otago	14	X
Southland	11	√

3.2 Inclusion of HOP Action Plans in DAPs

Collective findings from across all of the DHBs rather than individual DHB findings are presented in this report. Figures 3-1 to 3-4 present the findings from the content analysis undertaken on the older people's health sections within the 2006 /2007 DAPs. These figures show the inclusion of HOP Action Plans in the DAPs using three criteria:

- Not included in DAP;
- Highlighted as needing to be addressed and;
- Implementation plan provided.

The details, the HOP Objectives and Action Plans used in the evaluation are shown in Appendix 1.

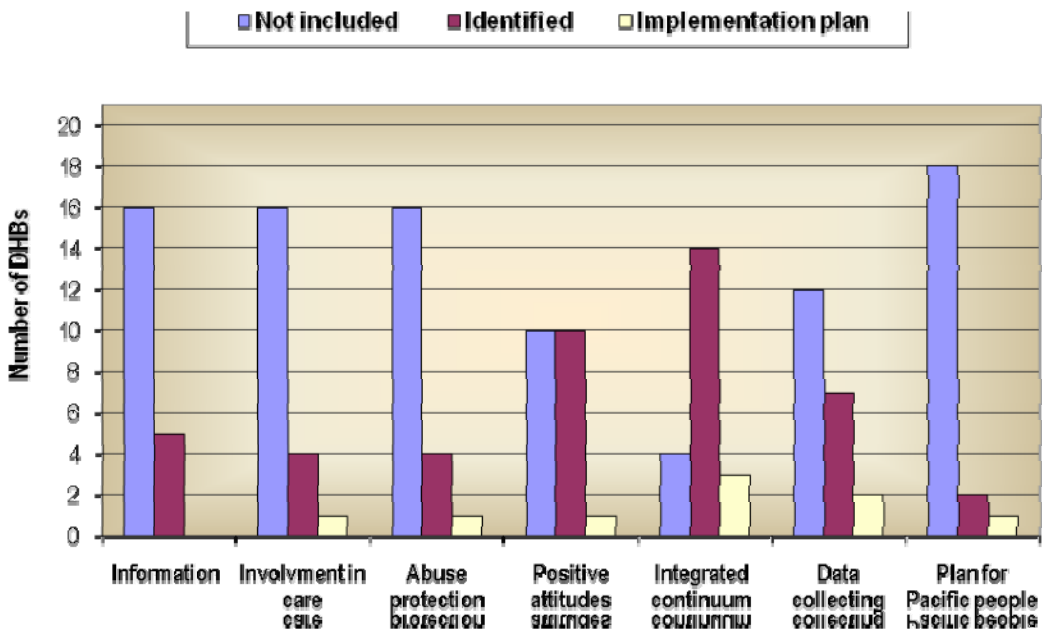

Figure 3-1: DHB Inclusion in the DAPs of Action Plans from Objectives 1 and 2 of the HOP Strategy (See Appendix 1)

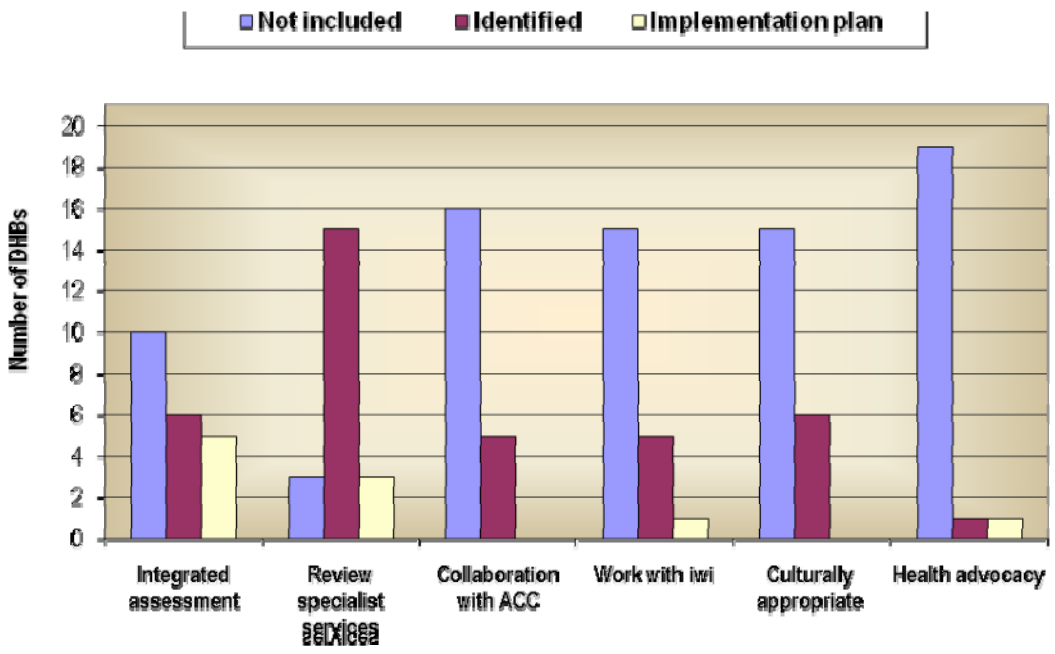

Figure 3-2: DHB Inclusion in the DAPs of Action Plans from Objectives 3 and 4 of the HOP Strategy (See Appendix 1)

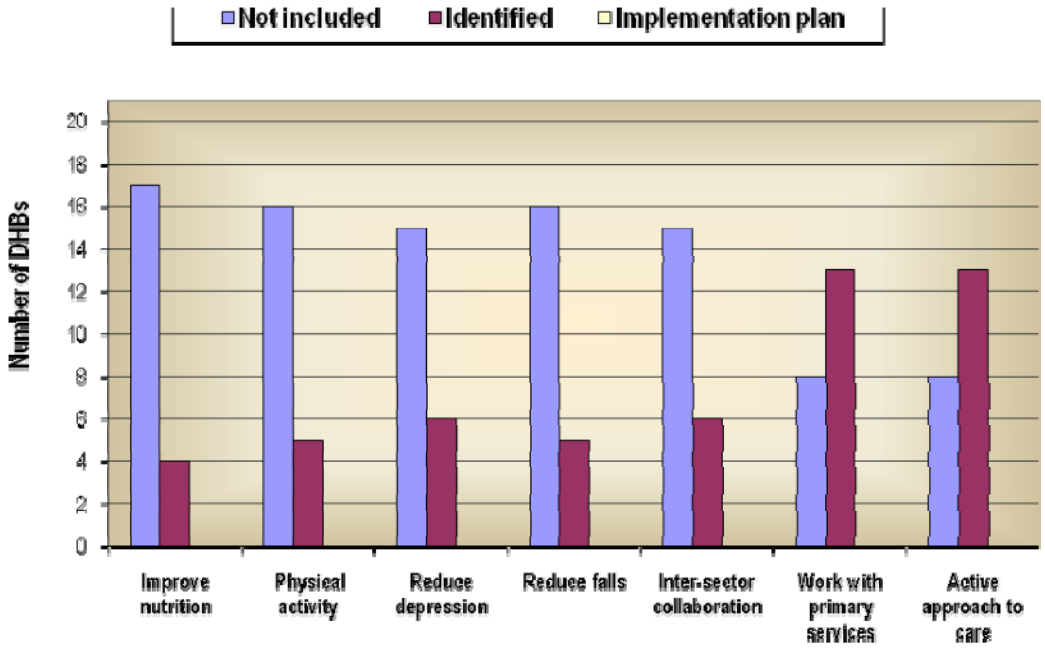

Figure 3-3: DHB Inclusion in the DAPs of Action Plans from Objectives 5 and 6 of the HOP Strategy (See Appendix 1)

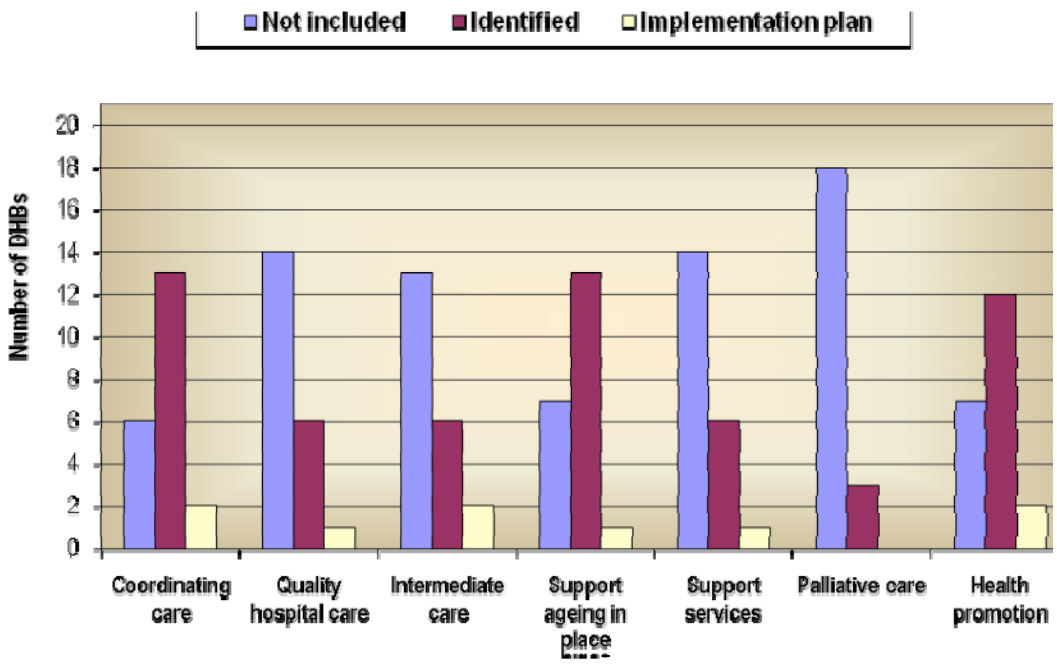

Figure 3-4: DHB Inclusion in the DAPs of the Action Plans from Objectives 7 and 8 of the HOP Strategy (See Appendix 1)

3.2.1 Summary of findings from the DAP evaluation

The findings presented in Figures 3.1 to 3.4 show that many of the HOP Action Plans were not included in a number of the DAPs. Furthermore, where Action Plans were included there was often no documentation around how the Action Plan would be incorporated into service delivery, just that this was something that needed to be done. In this evaluation, this type of information was put into the category of 'identified in DAP'. It was also recognised during the evaluation that a number of DAPs (nine) referred to a DHB specific strategic plan or document for older people. A number of DHBs had already developed these and referred to them within the DAP while others discussed the development of, or near completion of, a strategic plan for older people. These strategic plans were not evaluated or incorporated into the research. This study also revealed that there was no uniform approach to documentation, either in the DAPs or in addressing the Objectives across the DHBs.

3.3 Findings from Key Stakeholders

3.3.1 Response Rate

The response rate from the three stakeholder groups for each DHB is presented in table 3.2. Overall, 12 responses from the CEO level interview, 11 responses from the Service Manager interview and 13 responses from Age Concern were obtained. As indicated in table 3.2 a response from all three stakeholders was only obtained in the case of three DHBs.

Table 3-2: DHB Stakeholder Participation

DHB	CEO level	Service Manager	Age Concern
Northland	√		
Waitemata	√	√	√
Auckland	√		√
Counties Manukau	√	√	
Waikato		√	
Lakeland	√		
Bay of Plenty	√	√	√
Tairawhiti	√		
Taranaki			
Hawkes Bay	√	√	√
Mid Central			√
Whanganui		√	√
Capital Coast	√	√	
Hutt	√	√	
Wairarapa			
Nelson-Marlborough		√	
West Coast	√	√	
Canterbury			√
South Canterbury	√	√	
Otago			√
Southland			√

3.4 Service Manager Interview

The Service Manager interview requested respondents to categorise whether each of the relevant HOP Action Plans were fully integrated into services, partially developed / implemented, or not included in services. These findings are presented utilising the same diagram format as the DAP evaluations; however an additional category has been included which indicates that a respondent did not know, or felt it was not within their area of responsibility within the DHB (not able to comment). The findings from this group of participants are presented in figures 3.5 to 3.8 and as the opportunity to elaborate, provide examples or explain their answer was offered summaries of this data are also presented (see Appendix 2).

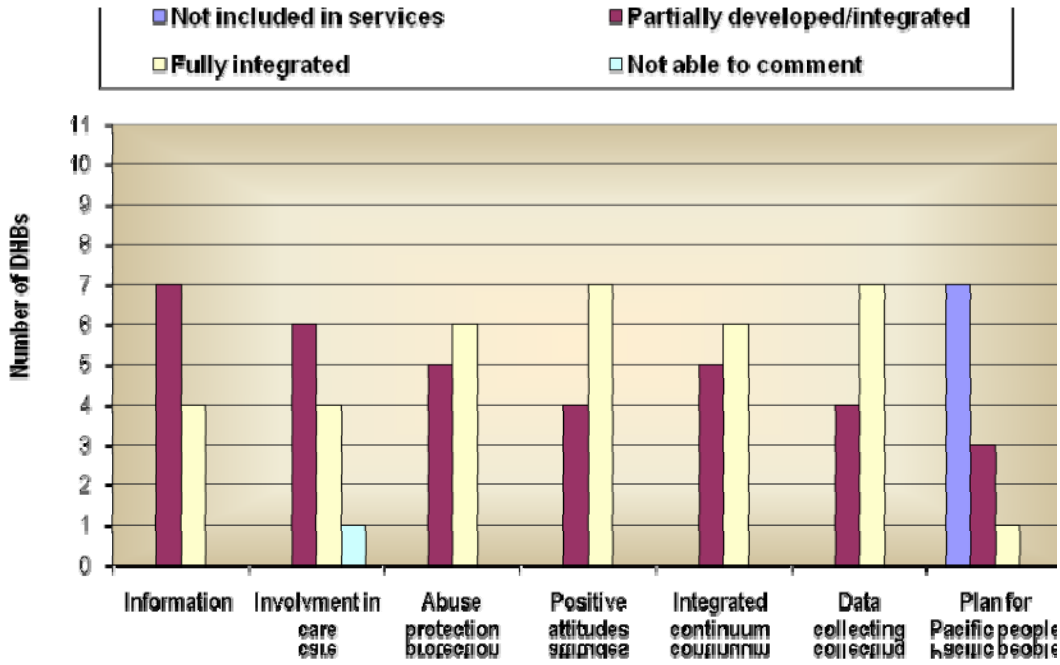

Figure 3-5: DHB Inclusion into Service Provision of Action Plans from Objectives 1 and 2 of the HOP Strategy (see Appendix 1)

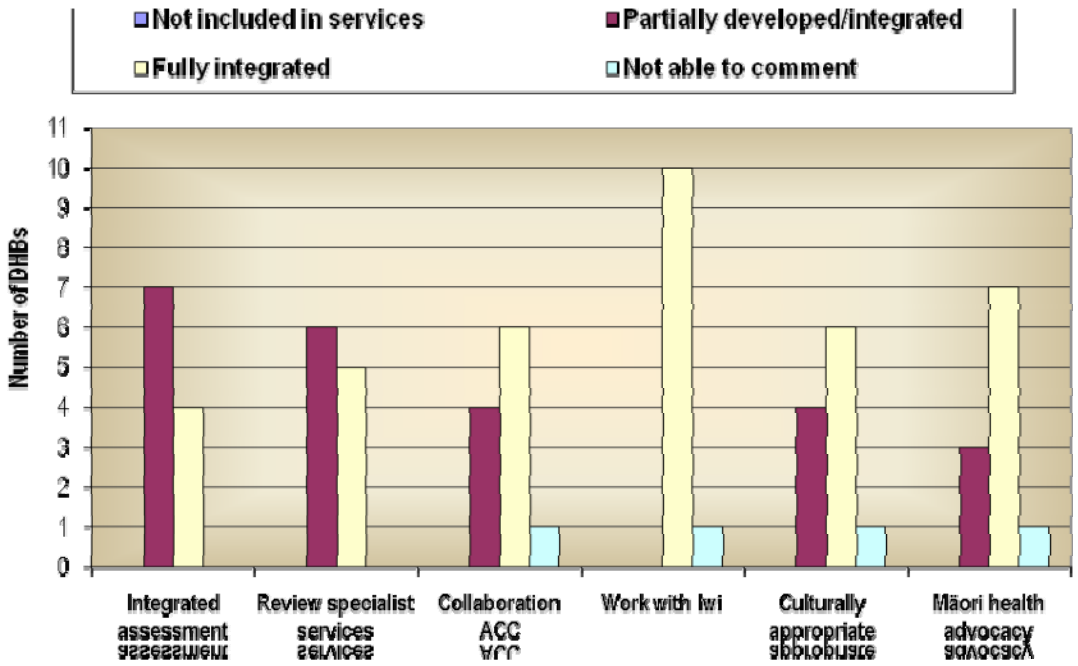

Figure 3-6: DHB Inclusion into Service Provision of Action Plans from Objectives 3 and 4 of the HOP Strategy (See Appendix 1)

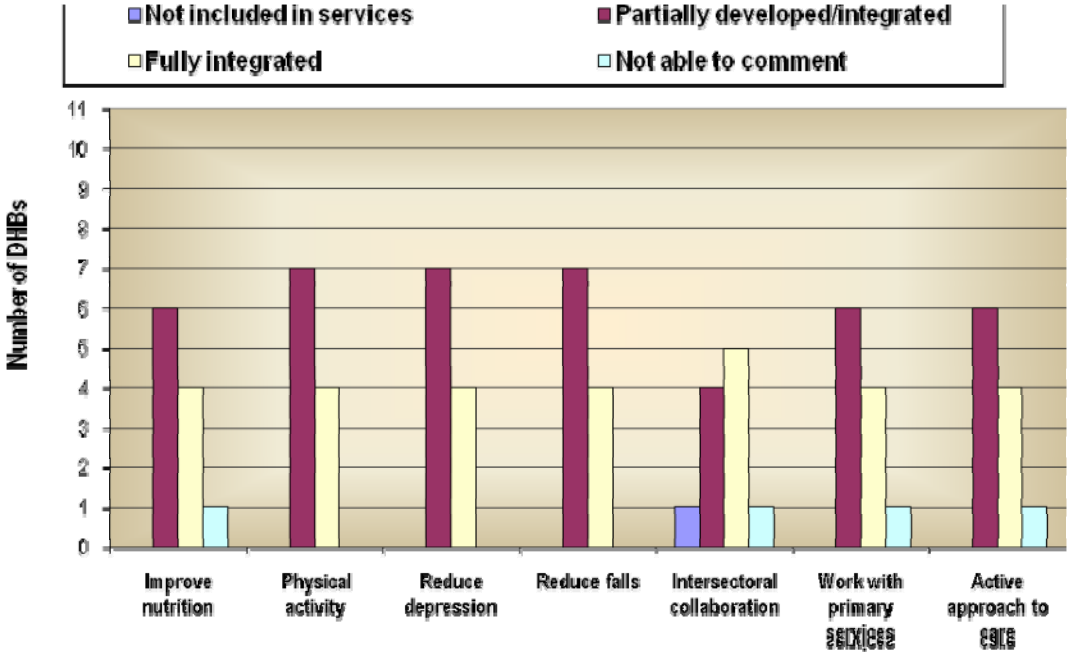

Figure 3-7: DHB Inclusion into Service Provision of Action Plans from Objectives 5 and 6 of the HOP Strategy (See Appendix 1)

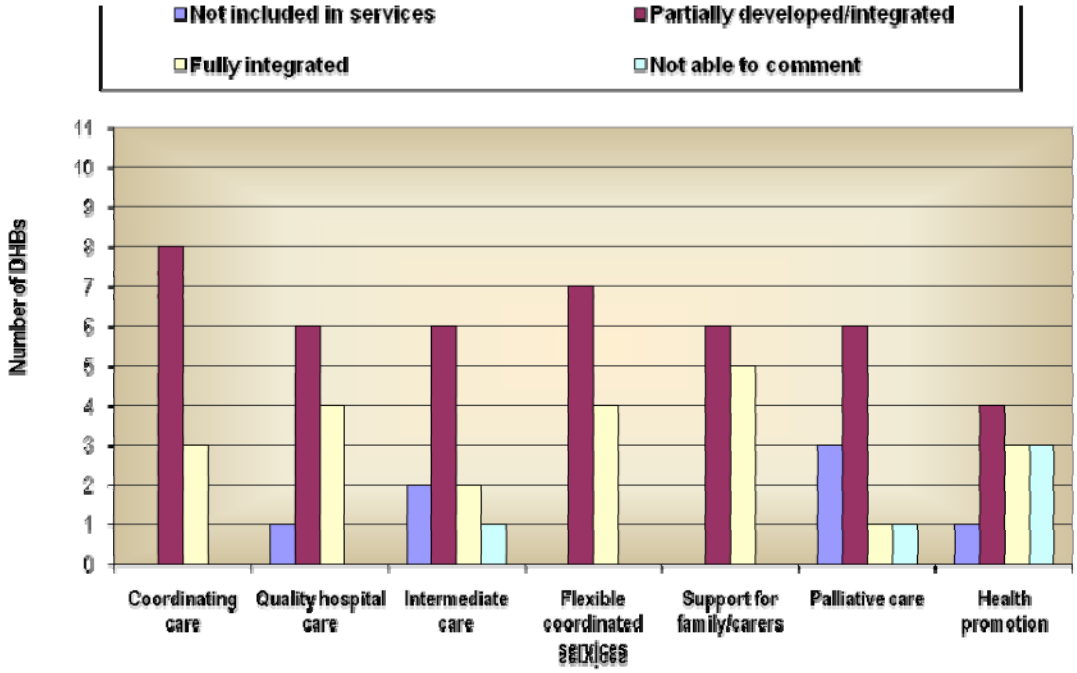

Figure 3-8: DHB Inclusion into Service Provision of Action Plans from Objectives 7 and 8 of the HOP Strategy (See Appendix 1)

3.4.5 Summary of Service Manager Interviews

The findings presented in figures 3.5 to 3.8 indicate that most of the HOP Action Plans were reported to have been either partially or fully implemented into services within the DHBs represented by this group of respondents. This is further supported by the examples of service delivery provided. Overall the findings from these interviews provided a detailed look at what was actually happening with DHB service provision in relation to the HOP Objectives and Action Plans. It was noted during the interview process that the respondents from this group had varying levels and areas of responsibility within the DHBs with some being involved in the providing of services and others in the funding and planning of services. This may have affected the consistency of information provided by this group.

3.5 Findings from the CEO Level Interview

Analysis of the data obtained from the CEO level interviews revealed five broad themes relating to the implementation of the HOP Strategy; they were:

- Implementation process and strategic alignment;
- Workforce;
- Cost;
- Diversity and;
- Roles and responsibilities.

3.5.1 Implementation Processes and Strategy Alignment

Aspects relating to implementation and alignment to the HOP Strategy such as planning, community participation and evaluation processes were included under this theme.

> *"I think a priority is to support the ageing in place model, to do that well and to give people choices" (Quote from CEO)*

- All of the respondents reported that older people's health was well integrated into their strategic planning.
- The concepts of integrated and restorative models of care and chronic disease management were reported as being significant to meeting the health needs of older people.
- Priority issues for service provision were: supporting ageing-in-place, ensuring appropriate community based services, home help services and primary care.
- Implementation of service provisions to address ageing-in-place, chronic disease management, care coordination and the development of a continuum of care were all reported to be central to current planning and implementation processes.
- Service improvements that were not specifically aimed at meeting the HOP Objectives were also reported as being beneficial to older people.
- All respondents reported a robust community consultation process for service planning that included HOP steering groups, community questionnaires and public meetings.
- Overall, the respondents felt that older people were satisfied with service provision, however this tended to be based on informal assumptions rather than actual evidence of

consumer focused feedback. For example one respondent stated: *"We're not getting a huge public outcry".*

Table 3.3 highlights the results from the 5 point Likert scale utilised to measure respondents' perceptions relating to DHB progression in implementing the HOP Strategy. Many respondents found it difficult to score their DHB's progression as a single number response on the progression scale because of the complexity involved in the implementation process. Responses ranged from two (little progress) for actual implementation, to a score of four plus which is between the categories of some progress and significant progress.

Table 3.3 Perceptions of DHB Implementation Progress

District Health Board	Progress (1= no progress, 5= significant progress) significant progress)
Auckland	*Overall* 3 to 4
Bay of Plenty	3.5 to 4 (*we are making significant investments)*
Capital and Coast,	4.5 (*I think we are leaders*)
Counties Manukau	3
Hawkes Bay	4
Hutt Valley	3 (*upwards)*
Lakes District	3
Northland	3 (*upwards I think we're well positioned*)
South Canterbury	3 (*it would be no higher*)
Tairawhiti,	3 (*I think we are above the middle*)
Waitemata	3.5 to 4
West Coast	*Implementation* = 2 *Commitment to planning and implementation* = 3

3.5.2 Workforce

Key sub-themes relating to workforce included cost, training, ensuring quality, attracting and retaining the right workforce; either skilled or unskilled, and resistance to change by the current workforce.

> *"It's about managing to attract people into those positions; it's not just about money, but workforce and resistance to change" (Quote from CEO)*

- There was a consensus by all respondents that workforce issues posed a barrier or challenge to successful implementation and future capability.
- The need for government intervention relating to the improvement of wages for HBSS workers was identified by respondents.
- Smaller DHBs reported current difficulties with attracting both a skilled and unskilled labour force.
- The larger and more urban DHBs reported issues of labour force costs and ensuring quality, especially in Home Based Support Services (HBSS) in which there could be a number of different providers.
- The need for an increased labour force to meet both the needs of older people and the concept of ageing-in-place was identified by all respondents.
- Resistance to change by the current work force was identified to be a setback to successful implementation throughout the health service sector.

3.5.3 Cost

> *"Funding the appropriate models, [such as] ageing-in-place, the restorative model getting HBSS appropriately funded" (Quote from CEO)*

> *"The biggest cost would be in not implementing the Strategy.....We simply can't afford not to do it" (Quote from CEO)*

- Implementation of the Strategy was viewed by some as costly in terms of providing the necessary services, implementing change and shifting financial resources from current services to new models.
- Costs associated with providing an adequate workforce and the information technology (e.g. the *interRAI* assessment tool) required to support new models of care were reported as key factors in the implementation of the Strategy.

- Levels of MoH funding had a significant impact on whether the costs of implementation were identified as a barrier.
- The cost associated with not implementing the Strategy and the impact on older people and the health system were also identified by some respondents.

3.5.4 Diversity

Diversity was identified as being significant in relation to the implementation of the HOP Strategy and was discussed in relation to population, providers and geography.

"Variable catchment area with a changing population" (Quote from CEO)

"[We have a] disparate group in terms of wanting to implement, wanting to change, wanting to move forward". (Quote from CEO)

- Population diversity was a significant factor in determining what services should be provided and planned for both within and across DHBs. In particular, this related to ethnic or socio-cultural differences in the population.
- For the larger and more densely populated DHBs, diversity of providers was reported to be cause problems with implementation and in particular, ensuring quality, appropriateness of services and managing change.
- Geographic diversity was also highlighted by some DHBs, especially those spanning rural areas with low population numbers, in which the issues of access and cost effectiveness of implementation were identified as needing consideration.

3.5.5 Roles and Responsibilities

Various roles and responsibilities were identified as being significant to the implementation of the Strategy and included; CEO / Senior Management, the DHB, community and primary healthcare providers, Ministry of Health and government policy.

"Building a coalition of support agencies not just in health but elsewhere and seeing our services becoming more efficient and more effective". (Quote from CEO)

- The role of the CEO in implementation was identified as providing leadership in supporting, influencing, prioritising and driving policy and strategic planning within the organisation.

- The management and staff of the DHB had major responsibility for ensuring appropriate service delivery that provided both quality and cost effective care, and working collaboratively with other sectors in implementing the Strategy.
- Attitudes of personnel within the DHB, community and primary based services were reported to act as a barrier to implementation in some jurisdictions.
- Primary care was seen to have a significant role in the implementation of the Strategy, however some respondents perceived that section of the health sector did not always accept its responsibilities in this respect.
- Some respondents felt it was up to primary care providers to change attitudes and services, while other respondents saw it very much as part of the DHB responsibility to support and develop these areas.
- The role of the community was also identified as being significant and evidence of robust community consultation on service planning was reported.
- Ministerial responsibilities such as providing support with national guidelines, and workforce development were reported by several respondents to be significant to successful implementation of the Strategy.
- The role of national policy was highlighted by several respondents as not accommodating the diversity in funding, population and geography found across the DHBs.
- The inflexibility of policy was seen by some to create inequalities rather than address them.

3.6 Age Concern Self-completion Questionnaire

The DHBs represented by this group are shown in Table 3.2. A total of 13 questionnaires were completed and returned. One respondent provided information for two DHBs. One DHB region had responses from three different Age Concern agencies and another had two responses. Summaries of the data relating to the three themes revealed by this group are presented under the following theme headings:

- Resource;
- Access and;
- Service improvement.

Information was also obtained relating to community involvement in DHB service planning, overall satisfaction with the DHB performance, and perceptions of the DHB's progress in implementing the HOP Strategy. This information is presented in Tables 3.4 to 3.6.

3.6.1 Implementation Progress

The respondents were asked to rate the DHB progression in implementing the HOP Strategy using the same five point Likert scale used in the CEO level interview. The results are presented in Table 3-4 which shows the majority of respondents gave a rating of four indicating progress had been made.

Table 3.4: Age Concern Perceptions of DHB Implementation Progress

District Health Board	Progression (1= no progress, 5=significant progress)		
Auckland	3		
Bay of Plenty	4		
Canterbury	4		
Hawkes Bay	4	4	2
Mid Central	4	4	
Otago	1 - 2		
Southland	4		
Whanganui	4		
Waitemata	4	4	

The Age Concern respondents were also asked to provide a 'yes' or 'no' response as to whether they thought older people were satisfied with the services being provided by the DHB. The results from this question are presented in Table 3.5 which indicates that less than half of the respondents felt older people were satisfied with current services. This group were also asked if they thought older people and the community were consulted or involved in service planning. Table 3.6 shows eight of the respondents felt older people and the community were consulted about service planning and five felt that they were not. A variety of examples of how the process of community consultation was achieved were provided and included advisory committees, submission papers, focus groups, working /planning groups, workshops and Huis.

Table 3.5: Extent to which older people are satisfied with the services provided

District Health Board	Yes	No	Not sure
Auckland			√
Bay of Plenty		√	
Canterbury	√		
Hawkes Bay	√ (2)	√	
Mid Central		√	√
Otago		√	
Southland		√	
Whanganui	√		
Waitemata	√		√

Table 3.6: Community Consultation in Service Planning

District Health Board	Yes	No
Auckland		√
Bay of Plenty	√	
Canterbury	√	
Hawkes Bay	√	√ (2)
Mid Central	√ (2)	
Otago		√
Southland		√
Whanganui	√	
Waitemata	√ (2)	

3.6.2 Resource

"It's a good initiative but generally it is not realistic given the increasing ageing population and limited health care resources". (Quote from Age Concern)

- Staffing shortages particularly in HBSS were a key issue with respondents feeling there were inadequate numbers of workers to allow people to age-in-place safely.
- Poor workforce education and inadequate supervision of HBSS workers were identified by respondents as significant drawbacks to good service provision.
- The recruitment and retention of New Zealand trained healthcare professionals were seen as a concern for some respondents in relation to services for older people.
- The need for increased nursing services in the community was highlighted, with District Nurses, Community Nurse Clinics and Gerontology Nurse Practitioner roles specifically identified.
- The attitudes of staff were thought to be inappropriate at times. There was need for increased awareness, patience and respect for older people. Healthcare workers needed to listen more to the client and offer a more holistic service.
- Many respondents felt that older peoples' healthcare services were under-funded either because of a lack of funds at source or the DHB not filtering funding to the services.
- Inadequate funding for community services especially HBSS was identified, causing staff shortages.
- Funding of Non Government Organisations (NGOs) and community groups was viewed as an important element of ensuring additional support for older people in the community; however it was also felt provisions were not adequate to enable this to be done effectively.
- A lack of funding for specialist in-patient services was also highlighted; one example given was the lack of specialised stroke services.

3.6.3 Access

Several issues relating to access were identified which included bed shortages, long waiting lists, inadequate information being provided, appointment times and transport.

> *"Older people are often unaware of what they are entitled to and GPs don't tell them" (Quote from Age Concern).*

- Many centres had inadequate public transport and the cost of ambulances for people being admitted to and discharged from hospitals was excessive.
- Inappropriate times for specialist or outpatient clinic appointments were identified as being significant to accessing services. An example given was *"eight am in rush hour traffic for a frail elderly person".*
- Waiting lists, a lack of available respite beds, rest home placement and in-patient Assessment Treatment and Rehabilitation (ATR) services were all linked to delayed access to services for older people.
- Communication and availability of information about services was identified as being inadequate both within hospitals and primary health care services.

3.6.4 Service Improvement

> *"More community assistance and early intervention would lead to less long term health problems for older people" (Quote from Age Concern.)*

- Discharge planning, communication and coordination between hospital, community and primary care services were identified as areas needing to be improved.
- The need for more primary and preventative type services to be established with a focus on health promotion was reported by respondents.
- Increased flexibility of services was viewed as significant to improving service delivery.
- Services to address social isolation, loneliness and depression in older people living both at home and in residential care, were felt to be important by some respondents.
- Most respondents felt that increased information should be given to older people by service providers.
- Re-designing of Specialist Health Services was reported as being a significant aspect of service provision for older people.
- More support for frail older people in the community was reported to be needed.

3.7 Summary of Findings

The findings presented are from three different perspectives (DAPs, DHB Management and Age Concern observers) they show congruence in some respects and divergence in others in relation to DHB implementation and service alignment with the HOP Strategy. Areas of agreement include:

Issues on which there was congruence included:

- CEO / Senior Management and Age Concern responses indicating that there is reasonable progression towards implementation. This is supported by service manager reports of the level of implementation of HOP Action Plans.
- The recognition of barriers in relation to implementation of the Strategy, service alignment and sustainability.
- Weak agreement with respect to the adequacy of community engagement and consultation in the planning of services. Some from Age Concern felt this had not occurred.

Issues on which there was divergence included:

- Whilst the DAPs show minimal inclusion of HOP Objectives into service planning, the DHB management is of the opinion that the majority of HOP Action Plans are partially or fully implemented into services.
- The level of satisfaction with service delivery indicated by Age Concern is much less than that perceived by the CEO / Senior Management group.
- In the opinion of Age Concern representatives, improvements to health services for older people are less than those reported by the Service Managers.

SECTION 4: DISCUSSION

4.1 District Annual Plans

The Health of Older People (HOP) Strategy states that District Health Boards (DHBs) must signify in their District Annual Plans (DAP) progress towards implementing the eight Objectives (Ministry of Health, 2002). The role of the DAP is to present information about service planning and operations for a 12 month period.

Little actual operational planning or implementation planning for meeting the HOP Objectives was found in this evaluation. Indeed, the majority of DHBs failed to include more than a small minority of HOP Action Plans in their DAPs. Furthermore, where the Action Plans were included, although they were often highlighted as an area that was deemed important, very few DHBs had clear documented planning or implementation processes as to how the Action Plan or objective would be achieved.

The preparation of a plan is a significant indication of commitment, strategic alignment and direction towards an overall vision (Burke, 2002). On the other hand, the relationship between documented performance and actual performance within organisations, especially when output targets have been highlighted, can vary greatly from what the actual performance is (Murphy, 2003). While there was minimal evidence of clear implementation planning found in this evaluation of the DAPs, comments by some DHBs recognising the need for service alignment to HOP Action Plans could be interpreted as an indication of their awareness and intent to include, at some point, aspects of service delivery as outlined in the Strategy. As noted earlier, nine DHBs were in the process of preparing a Strategy document for older people and it may be that material from these will appear in the DAPs of future years. This then raises the issue of how DHBs use the DAPs and how accurately the latter reflect on-going services as opposed to new service initiatives.

This study showed that there was no uniform approach to documentation, either in the DAPs or in addressing the objectives. However, this finding is consistent with the fact that each DHB is a separate organisational entity with different priorities depending on the needs of its population.

4.2 Key Stakeholder Perceptions

The three key stakeholder groups were congruent in their perceptions that progress is being made by DHBs towards implementing the HOP Strategy. The CEOs / Senior Executives were consistent in their belief that the HOP Strategy was already integrated into their organisation's strategic planning. They also seemed confident that progress towards implementing the Strategy had been made (Table 3.3) and this was supported, in general, by Age Concern observations (table 3.4). The Service Managers interviewed also reported that progress has been achieved, giving as evidence verbal assurance that the majority of HOP Action Plans had been implemented. What is disconcerting is the lack of evidence from the DAPs to support the DHB management's contention that the HOP Strategy is being satisfactorily rolled out. This is an issue that needs to be addressed in more depth.

There was also a general consensus by the three groups that community engagement and consultation in service planning for older people had been undertaken by the DHBs. However, what was not so clear was the level of consumer or community feedback sought by DHBs on satisfaction with service delivery. Interestingly, some of the Age Concern responses indicated dissatisfaction by older people with the services being provided. This study also suggests that while some progress in planning and implementing of the HOP Strategy has occurred, the alignment of the actual Older People's Health (OPH) services provided by the DHBs with the HOP Strategy is not consistent. Hence, while Service Managers reported aspects such as positive attitudes, the development of an integrated continuum of care and quality care from hospitals to be fully or partially implemented into services, Age Concern observers highlighted that poor coordination of services, discharge planning, and attitudes of staff were all areas needing to be improved. Health promotion was identified as a priority, said to be incorporated into strategic planning goals by the CEO /Senior Executive group and reported to be partially of fully implemented by the Services Managers. However, Age Concern highlighted this as an area needing improvement. There are, therefore, apparent discrepancies between the perceptions of the healthcare providers and the experience of the consumers.

Issues that may hinder the implementation of the HOP Strategy by DHBs were identified. Workforce and funding shortages were identified by both the DHBs and Age Concern. Other barriers identified include time, inflexibility of policy and internal and external organisational culture.

4.3 Study Limitations

- While evaluating the DAPs addressed one of the initial research objectives, it did not give a clear indication of service provision. While this is a finding in itself, it is also recognised that an evaluation of annual reports in conjunction with the DAPs, or an evaluation of strategic planning documents may have provided richer data on the planning and operational provisions of the implementation of the HOP Strategy. The HOP Action Plans are now four years old and the possibility that these have been addressed in previous DAPs, with only new initiatives being addressed in the current DAPs, cannot be ignored.

- There are limitations in drawing conclusions from the results, particularly from comparisons of the different stakeholder groups, which were not consistently from the same DHB but rather spanned across several. The accuracy with which Age Concern is able to represent the older consumer of healthcare may also be a limiting factor.

- The different roles and levels of responsibility within the DHBs of the respondents involved in the Service Manager interviews, may have introduced discrepancies between DHBs in what they were reporting. On some issues a response could not be obtained due to insufficient knowledge. This indicates a gap in information relating to possible service provisions within the DHB.

- A less structured interview format exploring the planning, service provision and evaluation relating to each Action Plan with the Service Managers would have provided a much more comprehensive view of the DHBs' implementation and service alignment to the HOP Strategy by DHBs.

- There are many variables that can create bias in research findings. Of particular significance to this research is self-report bias. Research participants want to respond in a way that makes them and their organisation look as good as possible (Donaldson and Grant-Vallone, 2002). This is further compounded by the fact that participants run the risk that their employer could gain access to their responses. Hence a tendency to over-report on positive aspects, and under-report on negative behaviours or processes.

4.4 Implications for Future Research

- Additional research exploring the links between other relevant organisational documents such as previous DAPs, Annual Reports and Strategic Plans could provide a more comprehensive insight into the level of inclusion of HOP Objectives into service planning and implementation.

- A replication of this study which is able to incorporate all stakeholder groups, including those from primary and community health services, and which spans across all DHBs would provide much more insight into the progression and effectiveness of the implementation of the HOP Strategy across New Zealand.

- The potential for misalignment between the perceptions of healthcare providers and consumers in relation to appropriateness of service provision has been identified in this study. Without adequate measures of patient satisfaction it is difficult to objectively assess whether the services provided do what they are intended to. There is a need for longitudinal studies that follow consumers' journeys within the health care system. Such data would provide greater insight into service provision, which could be utilised to guide service delivery for future cohorts of older people.

4.5 Conclusion

The vision of the HOP Strategy is that older people participate to their fullest ability in decisions about their health and well-being and in family and community life. Furthermore, that they are supported to do this by coordinated and responsive health and disability systems (MoH, 2002a). For this to be achieved changes to the provision of health services have been highlighted through the key Action Plans within the Strategy.

The evaluation has revealed that overall, in the DHBs included, some progress towards implementing the Strategy has occurred. However, this implementation when evaluated from a variety of viewpoints is found to be poorly documented by the DHBs and failing to meet consumers' expectations in the opinion of consumer advocates, suggesting that service provision is not yet fully aligned with the Strategy. The DHBs have less than two years to demonstrate that they have fully implemented the provisions of the HOP Strategy. This survey suggests that there is still considerable planning and implementation required by DHBs if they are to meet this goal.

APPENDIX 1

HOP Objectives and Action Plans Utilised in this Evaluation

Objective 1

Older people, their families and whanau are able to make well-informed choices about options for healthy living, health care and/or disability support needs

- 1.1 Appropriate information about health and services are easily available to older people, their family and care givers
- 1.2 Older people, their families and carers are able to be involved in decisions about care and support
- 1.3 Provisions for protecting vulnerable older people from abuse are in place
- 1.4 Positive attitudes to ageing and older people are role modelled

Objective 2

Policy and service planning will support quality health and disability support programmes integrated around the needs of older people

- 2.1 An integrated continuum of care has been developed
- 2.3 Reliable data collecting for current and projected service demand has been established
- 2.5 There is a plan for older pacific people and their families

Objective 3

Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whanau and carers

- 3.2 A plan for comprehensive integrated assessment for older people and carers has been developed
- Reviews of specialist health service for older people
- 3.7 Collaboratively work with ACC to manage access and transition between services

Objective 4

The health and disability support needs of older Maori and their whanau will be met by appropriate, integrated health care and disability support services

- 4.1 Work with local iwis to establish culturally appropriate services
- 4.2 Funding of a range of providers to give older Mäori culturally appropriate choices
- 4.3 Development of health advocacy structures for older Mäori

Objective 5

Population-based health initiatives and programmes will promote health and wellbeing in older age

Improve nutrition

- 5.1 improve nutrition
- 5.2 Increase physical activity
- 5.3 Reduce depression, social isolation and loneliness
- 5.4Reduce falls
- 5.5Promote intersectoral collaboration on housing and transport

Objective 6

Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning

- 6.1 Work with primary and community health providers to reinforce their role in health improvement
- 6.2 Active approaches to care management

Objective 7

Admission to general hospital services will be integrated with any community-based care and support

that an older person requires

- 7.1 Develop systems for planning and coordinating care between hospital and community based services
- 7.2 Hospitals will provide quality aged appropriate care and treatment of older people
- 7.3 Assess options for intermediate care to bridge the gap between hospital and home based care

Objective 8

Older people with high and complex health and disability support needs will have access to flexible, timely and coordinated services and living options that take account of family and whanau carer needs

- 8.1 Fund and provide a range of flexible coordinated services
- 8.2 Specify support services available to family and other carers
- 8.4 Smooth access to palliative care for older people receiving long term care
- 8.5 Long term support providers will build in health promotion, disability prevention and rehabilitation

APPENDIX 2

Additional Findings from Service Manager Interview

Additional findings relating to HOP Objectives 1 and 2

- A directory of health services, health service websites, pamphlets and brochures, a care coordination centre, Needs Assessment Service Coordination (NASC) and General Practitioners (GPs) were examples given of ways to provide information about health and services for older people
- Family meetings provided a means for older people and their families to be involved in care.
- Provisions for protecting older people from abuse included training of clinical and NASC staff regarding identification of abuse, employment of an elder abuse coordinator, and maintaining strong links with Age Concern.
- The development of a single point of entry to services and care coordination centres were key aspects to providing a continuum of care.
- Several methods of data collection for current and future service demand were enumerated by respondents which included census information, population data, patient data and ministry projections.
- Data collection that links community, hospital and primary health services was an area of service planning that some respondents identified as "*still having gaps"*.
- The DHBs that did not have a plan for older Pacific people explained that it would not be relevant to their particular population.

Additional findings relating to HOP Objectives 3 and 4

- The *interRAI* assessment tool was recognised by most respondents as a useful aid to integrated assessment. Some DHBs had been involved in the *interRAI* implementation pilot, while others were either currently implementing it or planning to do so. It was noted to be expensive.
- Reviewing of Specialist Health Services for Older People (SHSOP) was reported to have been addressed 'early on' by some of the respondents; one stating that while work had been done *"it is very much a work in progress".*
- Falls prevention projects and implementing a pilot of *interRAI* were examples given of working collaboratively with ACC.
- Delivering culturally appropriate services was reported to be met through Mäori advisory groups, iwi local council and Kaumatua.
- DHBs that reported partial implementation of culturally appropriate services tended to explain this on the basis of small numbers of elderly Mäori in their DHB population.
- Examples of health advocacy structures for older Mäori, included a General Manager position for Mäori within the DHB, Marae based clinics and the development of a liaison role to promote older person's services and support for accessing the right services for older Mäori.

Additional findings relating to HOP Objectives5 and 6

- Examples provided for improving nutrition included the healthy eating healthy activity policy, reviews of meals-on-wheels services (MOW) utilisation of a malnutrition screening tool and the inclusion of a dietitian as part of the multi-disciplinary team.
- Examples of increasing physical activity included the use of a restorative model of care, particularly in Home Based Support Services (HBSS), Tai Chi, walking groups and exercise programmes.
- Exercise groups were also linked to reducing loneliness / social isolation and falls in older people.
- Falls prevention policies, falls risk assessment tools, provision for hip protectors, and physiotherapy referrals and / or involvement in patient care were provided as examples of falls prevention strategies.

- Two DHBs discussed projects currently in place to explore social isolation in relation to the availability of housing and transport within their regions.
- Some examples of inter-sectoral collaboration included supportive housing development and design, and the healthy homes project in which the DHB contributed funding for housing insulation.
- Examples of working with primary and community care included the use of the *interRAI* assessment, medication card standards, seminars in geriatric medicine and geriatrician or clinical nurse specialist support in the community.
- The use of a restorative model was provided by many respondents as an example of an active approach to care management.

Additional findings relating to HOP Objectives7 and 8

- Examples of coordination of care included the development of a rapid response nurse role in the emergency department, community rehabilitation teams and NASC involvement in the acute care setting.
- The use of electronic discharge summaries and a single entry system approach were examples provided to ensure appropriate discharge and community support.
- Some respondents would have preferred a single system entry to services via primary care rather than via the hospital
- The incorporation of a restorative model of care into acute services was the main example provided to demonstrate the provision of quality hospital care.
- Examples of intermediate care (bridging services) included 'step-down' services and the use of short term transition beds in private hospitals. However, other DHBs cited problems with equipment and community provisions in the past as rationales for not including intermediate care into services.
- Examples of flexible coordination of services included more readily available HBSS, an increase in the range of respite offered, one point access to community services and moving away from a day hospital focus to visiting at home.
- Funding was identified as a barrier to providing both a full range of flexible services and in providing support to family and care givers.
- Support to family and care givers ranged from providing an interpreter service at family meetings through to proactive packages of carer support and improvements in respite care services with dedicated respite beds and dementia day care services.
- Some DHBs worked collaboratively with non-government organisations (NGOs) as a means of providing additional support to care givers. However, more rural and geographically isolated DHBs had fewer NGOs available to support family or care givers.
- A number of the respondents highlighted the difficulties in defining the term 'palliative', with confusion arising because there were different pathways for 'end of life' care and 'palliative' care.
- Examples of providing smooth access to palliative care included education and support to residential care providers, and the development of a palliative care liaison role.
- Health promotion, disability prevention and rehabilitation by secondary care providers were areas of concern identified by some respondents with variability in providers and services being highlighted.
- Some respondents reported the use of a restorative model by HBSS and secondary care providers and that support by the DHB to this part of the sector included education, community nursing development and the availability of Geriatrician or Nurse Specialists.

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