

QUALITY OF LIFE IS ... : THE VIEWS OF OLDER RECIPIENTS OF LOW-LEVEL HOME SUPPORT

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Abstract

A qualitative study explored the perceptions of quality of life of older people receiving low-level home support in a selected locale in New Zealand. The results shed light on the role that home support at the “lower” end of health resource allocation plays in elderly recipients’ quality of life. They also provide insights into these elders’ perceptions of current national policy, which advocates both for “ageing in place” and for targeting support to those with higher-level need. Six themes emerge from how these elders talk about and define what quality of life means to them: good people, day-to-day life, keeping healthy, living with loss, at my age, and the future. An in-depth understanding is thus presented of the views of this group of elders in relation to a question of high priority in current economic, health and social debates in New Zealand.

INTRODUCTION

As a concept, quality of life has been subject to considerable academic gaze from many disciplines: philosophy, literature, geography, psychology, health, health economics, advertising and marketing, politics, and the medical and social sciences (Bowling 2001, Hunt 1997, Rapley 2003). Through these diverse lenses, quality of life is viewed from global, national, individual, health-related and social perspectives, contributing to an extensive body of work on quality of life, biased significantly towards quantification (see Bowling 2005, 2001, Hellstrom et al. 2004, Higgs et al. 2003, Hunt 1997, McDowell and Newell 1996, Raphael 1996, Wade 1992). A plethora of measurement methods are used in this literature (Joyce et al. 1999, Rapley 2003, Veenhoven 2005), telling more about quantification than exploring understanding.

Despite all this work, the concept of quality of life has consistently evaded consensus (Albrecht 2006, Clarke 1994, Hunt 1997, Victor et al. 2000). The only apparent agreement is that it is a multi-dimensional construct, although the number and kind of dimensions remain controversial (Haas 1999, Hagerty et al. 2001, Rapley 2003, Smith et al. 2004). Relatively little attention has been paid to understanding quality of life as it is experienced, perceived and interpreted by older people (Farquhar 1995, Gabriel and Bowling 2004, Hendry and McVittie 2004).

Recently, researchers have found that social relations, functional ability and activities may influence the quality of life of older people as much as health status (Wilhelmson et al. 2005). Lawton (1999) has argued that the non-health-related areas of older people's lives may well override the negative aspects of chronic illness and poor health. Quality of life has been identified as a dynamic concept that has the capacity to respond with great fluidity as people's values and priorities change in response to life circumstances and events over the life course (Carr and Higginson 2001).

The silence is overwhelming on the quality of life experience of elders who access home-based support services (Wainwright 2003). This is an interesting predicament here in New Zealand (and elsewhere) considering the prominent place home support (as defined by the Home Support Services National Service Specification 2002) plays as a community service model, in direct response to the international demographic phenomenon of population ageing and the policy directive of ageing in place (Schofield et al. 2006). A recent trial of alternative models of home support driven by a rehabilitative/restorative philosophy has been targeted at high-needs older service users (see ASPIRE 2006). Government funding pressure is already having an impact on this level of home support service, with evidence that the number of people receiving low-level home support is dropping (Chal et al. cited in Wainwright 2003), despite evidence that low-level home support can be effective in preventing entry to institutional care (Cohen cited in Wainwright 2003). All these changes take place without the voice of the largest group of home support users in New Zealand,¹ and in the knowledge that elders' values and how they construct their quality of life remains internationally a neglected area of research (Gabriel and Bowling 2004, Lawton 1999).

This phenomenological study aimed to explore and describe the quality of life of a small group of older people accessing low-level home support in a selected locale in New Zealand. The broad research question to be answered was: How does the provision and delivery of low levels of home support feature in the overall experience of quality of life of older people, including the ability to remain "ageing in place" (Ministry of Social Development 2001) in their community?

1 That is, mostly women aged over 75 years of European descent who access home support for less than two hours per week (Chal et al. 2004).

Semi-structured interviews explored three broad areas:

- How do older people conceptualise and express quality of life?
- What part does low-level home support play in the experience of quality of life for these older people?
- What is understood by low-level home support and what are the policy development implications?

RESEARCH DESIGN

This study involved nine participants recruited through a local home support provider. The lead researcher is a registered nurse graduate student in gerontology with two academic supervisors. The participants were seven women and two men who lived in their own homes, and from whom data were collected from audio-taped face-to-face interviews. Participants' chronological ages ranged from 79 to 91 years. Ethical approval for the study was granted by the Lower South Regional Ethics Committee.

Thematic analysis was used on the qualitative data (following Crotty 1998), and six themes emerged from how these elders talked about what quality of life means to them. These themes were identified as good people, day-to-day life, keeping healthy, living with loss, the future, and at my age. These themes and their meanings are now discussed, and verbatim quotations from the participants' narratives are used to illuminate key points. Pseudonyms have been used to protect the privacy and confidentiality of elders in this study.

GOOD PEOPLE

The "good people" in participants' lives – their family, friends, neighbours and home helpers – was the quality of life experience participants talked about most. Having good people around was fundamental to their quality of life experience. "Good people, you couldn't do without them" (Jack).

Family

Family dominated the participants' conversations: spouse, daughters, sons, daughters-in-law, sons-in-law, grandchildren and great-grandchildren. Family members were valued for being there, being with, helping out and feeling included. Family members provide practical, emotional and social support, often reciprocal in nature, translating into a sense of identity, belonging and personal security.

"I always get my hair done on a Friday, and I do my shopping, and my daughter picks me up and we have lunch. Then she brings me home with my groceries and takes me to the hairdresser at one o'clock." (Emma)

"My son lives not too far away and he comes at least once a week and we go up to the supermarket and I just hand him my list. I push the trolley and he does the shopping, I do the paying at the finish [laughter]. He does his shopping at the same time. He works during the week so it works out we can either do it at night or in the weekend. We mainly do it on the Saturday or Sunday when we're not watching football." (Jack)

Friends

While less predominant than family, the place of friends was a clear feature in the quality of life experience of eight of the nine participants. As one participant put it, "quality of life depends on one's friends" (Brownie). Similarly to family relationships, the dimensions of close and active ties along with giving and receiving support were evident in these friendships. Friends are discussed here in three different ways: close friends, romantic friends and club friends. Close friends were typically described in terms of informality and easy interactions.

"I've always got friends that ring me up to see how I am and I can ring people any old time. They're sort of all scattered all around. I never know – there might be just a knock at the door and an 'oooh whooo are you at home?' and in they come. They don't ring up and say, 'Well are you going to be at home today?'" (Susie)

Two participants spoke of a "romantic friendship". For Maggie, this has developed since her divorce. "One man lives not far from me. He's a wonderful friend to me. He takes me shopping and he's very good company". Since the death of his wife, Jack reflected, "My wife was a good talker, we talked, we schemed, and we laughed. That's why the lady I see is important. She's like my wife. It makes a terrible difference."

Several participants spoke of their regular social gatherings or interest group meetings.

"There are about 10 to 12 of our ladies meet on the day. We always meet in a local cafe at half past ten on the second Tuesday of the month, and that's another thing that I go to, I never miss, and that's wonderful. We've known each other for a long, long time and it's just lovely." (Emma)

While not a club as such, the three retirement village settings did provide for the maintenance of old friendships and the establishment of new ones.

"Then I have three close friends here, and that's fine, we have a chat every morning on the phone and do things together. Go out to lunches and things like that, you know." (Brownie)

In contrast, one participant conducted his life in an almost friendless state. Earlier life experience in the Air Force appeared to have set Peter into more of a pattern of disconnection with people than one of connecting and sustaining friendships.

Neighbours

All of the participants talked about their neighbours: some just in terms of being there, others described how neighbours just dropped in on them, and about supporting each other.

"There are four flats here and we're all like me, fairly elderly people and grand people to get along with. We help each other. I grow a lot of vegetables and I've got to get rid of them, so I distribute them among the neighbours." (Jack)

Home Helpers

The people who provided formal help to these elders were definitely viewed as good people in their lives. Home helpers² featured in over half of the narratives before participants were posed the specific question: "How does your home support contribute to your experience of quality of life?"

With the exception of one participant, who received 1½ hours of personal care per week, all of the home help was domestic. To have regular help with the household things which they could no longer manage physically was a source of great relief for the older women, who had predominantly held traditional homemaking roles. For the men who no longer had wives in these roles, the home help also contributed greatly to their quality of life.

"Oh it contributes greatly. There are so many things about housekeeping that I, I'll put it this way – I had a very good wife for 60 years and didn't have to worry about a house. I was a farmer and I can handle gardens and I've never had to handle housework. I'm not terribly good at it. So it makes a great difference." (Jack)

In Emma's view, without her home helper she would not have the energy reserves to keep doing other things she valued greatly or, which, as she put it, "gives me a life". "Well it does relieve me, you know, I wouldn't be able to do what I do – I would be just too exhausted".

2 Despite the policy and research use of the term "home support", the elders generally used the terminology of "help" or "helper".

Home helpers were not only seen as good people for the physical help they gave, but were also appreciated for their emotional and social support. For example, Jack always sat with his home helper and had a cup of tea and a talk: it's a social ritual he had maintained with three home helpers in recent years. Doreen said she curled up in the chair as her home help ironed and they just talked. As Peter, a fairly recent widower, said, "it sort of helps, you know, having somebody else for a wee while to talk to".

These social practices combined with the regular practical household help gave some insight into the nature of the relationships that developed. "You become friends, you know, from week to week" (Jack). Home helpers are seen as becoming part of the household, but the nature of the service-recipient relationship was not appreciated or understood by the agency.

"You get close. They are pretty rigid at the place where they are sent from about this sort of thing. But it is all very well, you know, when there's so much personal things that they do, you can't help but becoming part of the household." (Emma)

Some home support relationships had become enduring friendships that continued long after the formal arrangement had finished. As a result, these good people remained and added to the "good life" of these elders.

Even in situations where it was thought the home help arrangement was less than desirable (for example, as a result of temporary or permanent changes), participants were uncomplaining and remained grateful for the support they got.

"I don't like it in the Christmas holidays when there's one after the other sort of comes and tries to fill in. By the time I show them where everything is or tell what I would like, I would sooner do it myself. But no, the help that I get is absolutely indispensable ...I'm very happy and very grateful for the support I get." (Brownie)

"I'm not complaining or that sort of thing, but I do think they could get girls that would stay longer. I have had three in three weeks this last year." (Mary-Lee)

As for the Home Support Agency, little mention is made of this service structure by participants except to say they could make contact if there were problems.

DAY-TO-DAY LIFE

Woven through the participants' narratives on quality of life were features of the "dailiness" of their lives. About quality of life, Brownie simply said, "It's just day-to-day living, isn't it?"

Looking after oneself, one's home and getting out and about in their community kept participants meaningfully busy and active for a big part of each day. All of the participants spoke freely about the minutiae of their day-to-day life, and they did so with an unmistakable pride in their voices of the daily things accomplished. This pride in taking care of the everyday things spoke directly to the issue of continued independence. Independence with matters of daily living was clearly an important aspect of their quality of life experience.

Oneself and Home

Participants talked about the ordinary things that are commonly part of everyday lives: getting up, showering, dressing, making food, reading newspapers, making beds, cleaning and tidying. However, they said these basic matters of daily living took up more of their time. They seemed in no way fazed by these developments and in fact seemed to relish the dailiness of their own lives, as Susie explained.

"I enjoy, you know, so much of life. I can't get out the same but I can still get up the street and do my shopping and carry on here and cook meals and do a bit of baking. It takes me longer but I get there."

Peter also offered insight into the fact that "there is just not enough time", as well as his changing roles. Since his wife's death two and a half years before Peter had become fully responsible for both the inside and outside of his home.

"Well there are some things like mowing the lawn. I can do them but I've found that with other jobs, you know, preparing meals, washing and, well, the old saying, 'A woman's work is never done'. You just don't always have the time and you've got to get down to the shops and that to get stores."

Taking care of the everyday things could be a source of worry. Doreen (the most physically restricted of the participants) depended greatly on her husband for both personal and domestic support. This dependency worried Doreen as her husband's health was only slightly less vulnerable than hers.

Getting Out and About

Taking care of the day-to-day things took participants out of their homes and into their community. The weekly grocery shopping, "popping out" to get occasional small items, and visiting the doctor and the hairdresser took all of the participants into the community regularly. Three of the participants continued to drive their own cars and one was very mobile with his scooter. The others relied on family, friends or the retirement village for transport.

Participants were also very much socially and creatively engaged, continuing to participate actively in lifelong pursuits, which gave much pleasure. Emma was a musician for all her adult life and now led a local choir and attended concerts with her daughter. Maggie continued to host a gathering fortnightly and regularly met two friends over a common interest in art.

Also keeping some participants busy and bringing quality into their lives was the continued ability to get out into their vegetable gardens. Jack, previously a farmer, proudly showed off his large and productive vegetable garden. Susie described her vegetable garden as “a great part of my life” and said “I’d be lost if I didn’t have my little vegetable patch”.

KEEPING HEALTHY

Participants spoke about their health-related experiences both in terms of being healthy and managing ill-health. Keeping healthy both “brought” quality of life and “took away” from quality of life. Health was often compared to that of other older people, and participants thought they were relatively better off.

Being Healthy

Being and keeping healthy was important to all of the participants, and they all took a serious interest in their own health. Some mentioned good food, some talked of the pills they took, and most talked of participating in some form of regular exercise. Walking was a popular form of exercise, either as part of getting out and about to do everyday things or as a dedicated activity. Jo made time each day for walking and said her health felt better for it. Brownie had a stepper exerciser and Doreen and Maggie had leg exercisers.

Managing Ill Health

From the outset reference was made to participants’ ill-health. Mary-Lee mentioned “my disposition”; Susie, “a touch of arthritis”; Brownie, “a lot of silly little things wrong”; Jack, “my eyesight”; Peter, “trouble with a leg”; Emma, “the problem with my heart”; and Jo, “my stupid legs”. But ill-health developed a very specific focus for most of the participants when they considered the question of what takes away from or has a negative impact on their quality of life. Ill-health was the most cited reason for what reduces participants’ quality of life, potentially or actually. It was even considered in terms of whether life is worth living. Brownie said, “I think health is the main thing to pray for and to be independent and self sufficient. If I lose that, I wouldn’t want to live, you know”.

But health was also weighed up carefully with other important and valued dimensions of life, such as family, friends and neighbours.

“If you can get around without too much pain, if you can sleep reasonably well, can eat reasonably well, which I’ve always been able to do, enjoy going out to dine – but I wouldn’t put that ahead of your friends, relations and neighbours because you’d be wasting your time having a good life.” (Jack)

LIVING WITH LOSS

When speaking about their quality of life, participants made immediate and continued reference to the losses in their lives. Along with ill health it was the only other major topic that participants recounted specifically in response to the question, “What reduces or has a negative impact on your life quality?” Participants spoke both of the loss of important people in their lives and of varying degrees of physiological functioning.

People

All of the participants but one mentioned the loss of a long-term partner, either by death or (in one case) divorce. Apart from Peter, who had relatively recently lost his wife, the loss of husbands and a wife through death was brought into focus as they spoke of other quality of life experiences.

Physiological

All of the participants spoke of the impacts of changing health and the physical effects of growing older and being old. Things such as changes in energy, feelings of pain and weakness, diminished sensory acuity and physical strength were described as part of participants’ everyday lives. There was a sense of loss conveyed as part of these descriptions which could be seen as taking away from their quality of life. Emma was no longer able to walk as far as she used to and the diuretics she needed to take daily meant that she was no longer able to attend church.

“I don’t go to church now because it’s the walking and because of my water pill, it’s not easy. Once it gets started it’s every quarter of an hour, but I can’t not take it. So on Sunday I must have my shower by half past seven because telly, the *Hour of Power* at eight o’clock, and then it’s *Praise Be* at nine.”

THE FUTURE

As part of their quality of life experience, participants were thinking and talking about their future. However, looking forward was contemplated almost entirely in terms of personal health and what future support may be required. All considered the prospect of having to move to residential care.

For participants who lived in a retirement village, with its capacity to cater for higher levels of support, residential care held no particular fear.

“When the time comes I’ll go because in a certain way – we can turn to quality of life. I don’t know if I would lose it all if I had somewhere to go like that. I would be very grateful. Just another step isn’t it?” (Mary-Lee).

In contrast, those participants who lived in their own suburban homes did not relish the thought of having to move to residential care, particularly, as Maggie said, “Just being in one room and then seeing others perhaps more incapacitated than I was”. Doreen and Jack each saw residential care as “the last resort”.

“I am considering, asking if they can give me a bit of help in the garden. Instead of going into a home. I’ve no ambition to go into a home or a very small flat. I’d have to be very desperate before I went into a home because I’ve been through them to see other people and I wouldn’t be very keen on the lifestyle ... but it does worry me a bit because you could say I’ve been a free person all my life and the thought of sitting around in a home and having nowhere to go, no people, no relatives, it’s not very inviting.” (Jack)

AT MY AGE

Quality of life was also considered by many of the participants within the context of age. There was surprise at having reached this particular age; there was a sense of expectation that certain things happen as a result of being this age, and there were feelings that they were good for their age and lucky. “I mean, at my age ... I’ve got an awful lot of silly things wrong with me but really I’m very good you know” (Brownie). Susie, “past 84”, said, “I think that I do very well”, as did Jack: “at my age I feel very lucky at having what I’ve got”.

DISCUSSION

Quality of Life

These elders were clearly willing to talk about their quality of life, as other researchers have also found (Farquhar 1995, Hendry and McVittie 2004). In addition, these elders’ narratives showed that the concept of quality of life was well understood. Unlike the conceptual elusiveness that has plagued academics and professionals (Albrecht and Devlieger 1999, Clarke 1994, Farquhar 1995, Hunt 1997, Victor et al. 2000), quality of life in no way seemed to be a tricky or slippery notion to these older people (see also Wilhelmson et al. 2005).

Giving meaning to quality of life for the participants were good people, day-to-day life, keeping healthy, living with loss, the future, and being the age they are. These views

were closely interlinked, as in research analysis of the interconnectedness of quality of life dimensions (Gabriel and Bowling 2004, Hendry and McVittie 2004, Higgs et al. 2003).

The elders in this study reflected on quality of life from many angles. It was not just a health-related experience, as might have been assumed for recipients of a health service. Their shared perspectives on having good people in your life, being able to take care of the day-to-day things, keeping healthy, living with a sense of loss, and contemplating the future went well beyond a narrow clinical focus, and were akin to identified dimensions found in other studies on quality of life in old age (Farquhar 1995, Bowling and Windsor 2001, Gabriel and Bowling 2004, Raphael 1996). Also consistent with previous studies on quality of life and ageing is the multi-dimensional nature of the phenomenon (Haas 1999, Hagerty et al. 2001, Keeling 1998, Rapley 2004, Smith et al. 2004, Wilhelmson et al. 2005).

Dominating the quality of life experience for these elders were the good people in their lives – their family, friends, neighbours and home helpers. The predominance of family is in accordance with other studies (Bowling 1995, Farquhar 1995, Gabriel and Bowling 2004, Smith et al. 2004, Wilhelmson et al. 2005). Being able to take care of the everyday things in their lives was an important and valued element of quality of life, as has also been confirmed by Wilhelmson et al. (2005).

Farquhar (1995) had previously found that quality of life is both a positive and a negative experience for older people, and this was a central finding in this study. Participants' narratives detailed the good and not so good aspects that formed their quality of life experience. Two major dimensions were noted as detracting from quality of life: ill-health and loss. The experience of ill-health was spoken about both in the context of health now and the possible effect of future health changes. Ill-health was also considered in terms of decreased functional ability, often associated with a sense of loss. However, the negative impact of either present or anticipated ill-health was mitigated to some degree by the other positive quality of life experiences in their lives. Participants were highly motivated to keep healthy, adopting a positive attitude to their own ageing and changing circumstances. Having good health has been identified by other researchers as being a key constituent of quality of life for older people (Gabriel and Bowling 2004, Grundy and Bowling 1999, Smith et al. 2004).

These elders' stories also demonstrated that quality of life in old age is very much influenced both positively and negatively by events over the life course. Quality of life was also considered relative to the age the person was right then, and relative to other older people's lives. This "relativity to others" (Hendry and McVittie 2004) seemed to act as a barometer to help determine the quality of their own lives.

It was apparent that given the opportunity to express their views, elders did have definite opinions on what they thought constituted quality of life, what mattered most, and what both brought quality into their lives and took it away. This suggested that these elders were in fact the experts on their own quality of life and ageing (Farquhar 1995).

Home Support

All of the participants were seasoned recipients of home support, with longstanding arrangements of six years or more. Home Support to the elders in this study was largely thought of as the good people that come to help them in their homes, and not the agency that was responsible for the service provision. The agency was a background feature.

It was an unequivocal finding in this study that the home helpers made a vital contribution to participants' quality of life experience, rather than home support being seen as just a service.³ When asked, "How much does your home support contribute to your experience of quality of life"? participants were unanimous in their response that having their home helpers made a positive difference to their quality of life. This was the case even in situations where it was thought that the home support arrangement was less than desirable for reasons of high turnover, or temporary and non-performing staff. These industry issues have been highlighted in another New Zealand study (Chal et al. 2004). The elders in this study did not complain to the agency about these matters; they were too grateful for the help they received.

Home support is designed to meet the most basic of human needs (Ministry of Health and DHBNZ 2002), but this study demonstrates that participants used it in a very socially constructed way as well. Not only did they receive benefit from the physical support; these elders also found ways to engage socially and emotionally with their home helpers in ways that enhanced their quality of life experience as a service recipient. Some home helper relationships had become enduring friendships that continued long after the formal arrangement finished. As a result, these good people remained and added to the good life of these elders.

It was because of ill health and the physical effects of growing older that participants needed home support. At no time did these elders want to relinquish full domestic responsibility for their home. Homemaking had been a key role in all the women participants' lives and the men had wives who had held this role. Sharing these

3 Contrasting findings of a Swedish study that receiving help with daily living was related to lower quality of life (Hellstrom et al. 2004b) could possibly be explained by the choice in that study of quantitative over qualitative methodology, with limited capacity to shed light on the subjective experience of individuals.

household roles allowed home support recipients to devote their precious energy to other enriching experiences. In this way, low-level home support can be considered an enabling experience, contributing to people's sense of continued autonomy, independence and self.

Ageing in Place

Nourishing and shaping service provision to older New Zealanders is a strategic national policy that advocates for ageing in place, as evidenced in the Positive Ageing Strategy (Ministry of Social Development 2001) and the Health of Older People Strategy (Ministry of Health 2002). To the elders in this study, ageing in place was both a taken-for-granted and an invisible concept. Despite their lack of articulation of this concept in terms comparable to the policy rhetoric, the practical reality was that these elders with their low-level home support were ageing in place.

These elders were the recipients of the most minimal amount of weekly support, which was predominantly domestic in nature, and they clearly held the view that the next step from low-level home support would be institutional care. There was no acknowledgement of being able to access more support in their homes if and when more support was needed. This seems an extraordinary and contradictory situation at a time of unconditional policy support for ageing in place (ASPIRE 2006).

Why this situation exists could be explained by a historical care model for older people in New Zealand that has been dominated by institutional placement. As a result, this is all that is known and understood by elders themselves with regard to other support options. It may conceivably colour the judgment of those charged with needs assessment, or be directly connected to the rationing of services (Wiles 2005).

A lack of knowledge about services leads to lack of use, and this in turn creates budgetary or economic advantage in the short term and supports the interpretation that the economic discourse on ageing in place is the predominant policy driver. Victor (2005:305) has already warned that the financial implications of population ageing have placed economic concerns before the "humanitarian dimensions" found in the social discourse on ageing in place. However, it seems counterproductive if the perception of service users is one that starts at very low-level home support and moves straight to the most expensive service option (residential care), and the one that is most difficult to reconcile with the concept of ageing in place.

Ageing in place prioritises the choice that the support and care of older people can take place in their home and community (Ministry of Health 2002, Schofield et al. 2006). The problem is that these elders perceive the choice as extreme. The reluctance with

which most of the participants spoke about the prospect of moving to institutional care indicated a desire to remain at home, and in familiar neighbourhoods and communities – the social backbone of ageing in place policy (Dwyer et al. 2000, Gallagher et al. 2004, Keeling 1998, Marek and Rantz 2000, Reed et al. 2003, Rosel 2003). Researchers and older people agree that home is a place of significant and unique meaning, very much part of how quality of life is experienced.

IMPLICATIONS FOR POLICY AND PRACTICE

Some policy and practice implications can be drawn from this research. First, elders who access low-level home support will do better when service professionals appreciate the meaning of quality of life as it is experienced and defined by the elders themselves. The elders in this study confirmed that quality of life is a dynamic concept considered from many angles. It is made up of interlinked elements which can be regarded as extraordinary for their ordinariness. It is an experience that is both positive and negative, and where the whole is greater than the sum of its parts. Quality of life is influenced by events over the life course and viewed relative to other older people's lives.

Next, it is home helpers in person rather than home support as a service that is integral to the quality of life experience for these elders receiving low-level home support. This formal relationship is highly valued and meaningful, and extends to include emotional and social support as well.⁴ This remains the case even in situations where the home help arrangement is thought to be less than optimal. Home help at this lower end of the allocation scale was not seen as encroaching on these elders' independence, identity, autonomy and control. Rather, it was seen as an enhancement and contribution to their overall quality of life, enabling these older people to remain active, interested and positive in their ageing. They are not in need of a rehabilitative or restorative model of home support.⁵ The low level of domestic help they receive now is sufficient to support their rehabilitation needs in ways that are normal to them. This study suggests that low-level home support plays an important and effective role in enhancing quality of life and the experience of ageing in place for older people in New Zealand, earning the retention of its place on the continuum of care, and should be acknowledged and valued as a critical ageing in place strategy.

4 The implications of this point for training of staff involved in the home care and disability support sector goes beyond the scope of this present study.

5 Based on the ASPIRE (2006) study, national extension of this model of care for older people with high and complex needs is envisaged beyond the pilot phase.

Population ageing acts as the catalyst for ageing in place policy development and implementation. To be a successful policy initiative, ageing in place is not only highly reliant on the capacity and capability of community services to be able to respond authentically to the long-term needs of older people in their homes and communities, but elders themselves need assurance that they can do so. Older people need to be informed when accessing this low level of home support that there are options to access more support of this kind, as well as the other ageing in place initiatives that are available if ever needed. This would be an important step in allaying the current fears held by older recipients of low-level home support that a direct move to institutional care is their only option, one of last resort. Acknowledging the possibility of enhanced support at home if their health needs change may add to what is already a richly meaningful ageing in place for this group of elders.

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