▨▨ 연구논문 ▨▨

ASSESSMENT OF THE NEEDS OF SELF-CARING RETIREMENT VILLAGE RESIDENTS FOR COMMUNITY SERVICES*

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INTRODUCTION

1. Background of the study

As the numbers and proportion of the elderly population increase, service support for them has been an important issue in contemporary health care. Physio-psychosocial decline with ageing (Yates, Benton & Beck, 1993) and increasing incidence of chronic conditions among the elderly (Johnson, 1990) have particular significance in relation to support services for them.

Retirement village accommodation is a popular option for elderly people because of convenient access to services(Low, 1993). Three types of accommodation in retirement villages are identified in the form of nursing homes, hostel units and self-care units(New South Wales(NSW) Department of Housing, 1990). Each type of retirement village is differently assisted by government institutions and organizations and provides different levels of services to their residents.

Continuous nursing and personal care for frail elderly people are available in nursing homes. This includes bed, cleaning and laundry services, meals, and help to perform daily tasks like eating, bathing and toileting, dressing and moving around(Orme, McKenzie, Kearney & Hayward, 1994).

Hostel units are also available for frail elderly people needing a comparatively high level of care and who have difficulty managing at home, but they are not available for individuals requiring twenty-four hour nursing care(Commonwealth Government, 1992). If necessary, assistance to carry out daily living activities such as bathing, dressing and eating are provided(Community Development and Service Division, 1992).

Self-care units are designed for independent living with only limited levels of care or emergency care granted(Gibson, 1990). Private cooking, sleeping and washing facilities are available or relevant facilities may be provided on a shared basis (Gibson, 1990). Although some retirement villages provide optional services to the self-caring residents as needs arise(Gledhill, 1993), the actual responsibilities are most likely entailed to the residents as the charges are incurred to the residents (Illawarra Retirement Trust(IRT), 1996a). There is no apparent community support in association with self-care units in retirement villages.

Accommodation allocation of retirement village residents is determined with respect to the personal health status of the individual(IRT, 1996a). However, it is reported that in some retirement villages, once accommodation is decided upon, then transf-

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er is difficult due to inflexible regulations restricting transfer by retirement village agencies (NSW Department of Housing, 1990). That is, if self-caring residents cannot be transferred to hostels or nursing homes when they need more assistance for living, they can be in difficulty. Moreover, some villages do not have enough hostel or nursing home facilities(Gledhill, 1996). Then, health service support may be necessary for the elderly who are living in self-care villages but who have health problems.

All these issues need clarification, because no studies of service needs of self-caring retirement village residents have been conducted. It is thus important to identify the needs of self-caring retirement village residents for services, in particular community services. The results gained from the study would be used to assist developing community service programs in community organizations, for the elderly people.

2. Aim

The present study aimed to assess the needs of self-caring retirement village residents with regard to community services in the Illawarra area.

3. Objectives

This study had five objectives as follows.

1) To identify functional status of elderly people who live in self-care retirement villages in the Illawarra area.

2) To identify their knowledge of community services.

3) To identify the extent to which they use community services.

4) To describe their current satisfaction with services used.

5) To identify their potential needs for community services.

LITERATURE REVIEW

1. Self-care and elderly people

Self-care can be conceptualized as independent living. Granger and Hamilton(as cited in McDowell & Newell, 1996) identify self-care capacity in terms of a person's independence, and a situation in which no carer is required for individual functioning. Retirement village booklets use this concept of self-care for describing self-care retirement villages(Illawarra Retirement Trust(IRT), 1996b). Not many services are provided to the self-caring retirement village elderly people(Gibson, 1990; Gledhill, 1993).

The concept of self-care can also be considered in terms of capabilities of learning, empowering and performing for one's health and well-being (Hartweg, 1995). This self-care conception is consistent with Orem's definition of self-care. Orem (1991) defines self-care as an activity practice that individuals initiate and perform on their own, concerned with maintaining life, health and well-being. In other words, self-care compounds both "knowledge, attitudes and skills" (Hartweg, 1995: p. 163), to fulfil an individual achievement. Brown (1995), similarly describes self-care as a complex of both knowledge and action to accomplish positive goals. That is, self-care is a capability governing one's knowledge as well as empowerment and performance for maintaining and improving individual health and well-being. This ability is important for independent living elderly people. Consequently, self-care can be defined as an individual's capabilities for maintaining and improving their health status while living independently.

The physical decline of elderly people as part of the aging process may be inevitable. However, this inevitability of the elderly person's physical de-

cline has been questioned and may be causally linked with a dependent life style(Manton, Corder & Stallard, 1993). Physical declines may be therefore minimized by an independent living style. DeFriese, Konrad, Woomert, Norburn and Bernard (1994) argue that self-care functioning with installed grab bars in one's home for example enhances physical mobility, and therefore minimizes physical deterioration. A study of Mendes de Leon, Seeman, Baker, Richardson and Tinetti (1996), also shows that high self-efficacy of daily living activities can minimize the functional decline of community residing elderly people. In-home interviews and physical assessments by trained nurses of 1,103 community-residing elderly people in New Haven, Connecticut, were conducted for this study. The large sample size and methodology combining participant interview and physical assessment by experts, contributes to the validity of Mendes de Leon et al.'s study.

Minimizing physical decline by self-caring in elderly people may help to prevent psychological health problems. Cutillo-Schmitter(1996) sees the elderly feel panic, depression and defeat about their declining physical stamina and abilities, so minimizing physical decline can be significant in reducing those negative feelings. Physical deterioration of elderly people can be minimized as a consequence of appropriate modes of self-care (DeFriese et al., 1994; Mendes de Leon et al., 1996). As a result of this, the associated negative feelings can be reduced.

Likewise, adequate psychosocial functioning is important for a better quality of life in elderly people(Caplis, 1990). Psychosocial interaction can be influenced by physical functioning status. Immobility in severely obese elderly people for example results in depression and social isolation and emphasizes the significance of psychosocial interaction for elderly people(Caplis, 1990). Substantially increasing the elderly person's mobility can decrease their social isolation and reduce depression. Thus, minimizing elderly people's physical decline by self-care improves their psychosocial health status.

Self-caring elderly people may have higher self-esteem, as they can then be of service to others. Kincade, Rabiner, Bernard, Woomert, Konrad, DeFriese and Ory(1996) examined whether self-caring elderly people, by providing assistance to others can benefit themselves. Providing personal care and child care on a volunteer basis and offering advice and support were identified as important roles for self-caring elderly people as help providers. Four reasons for these findings were suggested: a) an egoistic reason for social approval which means "I am a good person"; b) altruistic motivation; c) social equity or responsibility; and d) activity maintenance and promoting morale(Kincade et al., 1996: pp. 474-475). Self-caring then may assist in maintaining and improving physical, psychological and social health status in elderly people.

On the other hand, there are other previously undiagnosed health problems both physical and psychological identified in self-caring elderly people in the community(Williamson, Stokoe, Grey, Fisher, Smith, McGhee & Stephenson, 1964). Williamson et al.(1964), in their study in Edinburgh, Scotland examined physical, mental and social health status of 200 randomly selected elderly residents. A research team including two specialists in geriatrics, a psychiatrist and a social worker visited the elderly people. The elderly people were given a full clinical examination by the geriatricians and a screening examination by the psychiatrist and social worker at home. The study found that the elderly people had many previously undiagnosed physical and psychiatric problems. It was considered that general practitioner services based on self-reported conditions of elderly people were more like-

ly to be severely handicapped in meeting the needs of elderly people, because many elderly people didn't report their complaints to their doctors until the condition was well advanced. So more multi-dimensional supports including medical, nursing and social services for self-caring elderly people were identified as necessary. This study using a multi-dimensional screening method, clearly identified the health care needs of self-caring elderly people. This study is rather old, thus an up-dating study might be required. Nevertheless, elderly people's reluctance to report may still be considerable in the present day.

Physical and psychiatric health problems of self-caring elderly people are also identified by Neufeld and Hobbs(1985). They interviewed 133 self-caring elderly people while running a counselling service called "HIGH-RISE" which was set up for the health promotion of self-caring elderly people living in a small city in Canada(Neufeld & Hobbs, 1985). Blood pressure checks, visual and hearing problems, foot and dental care problems and dietary and mobility concerns were identified as physical concerns. Bereavement, cultural and religious differences and individual coping with chronic diseases were identified as psychosocial concerns by the clients. Moreover medication was raised as an important issue for elderly people who are caring for themselves at home. Education and counselling services for complicated medication regimes and medication side effects are emphasized as needing constant follow up.

As revealed so far, self-caring elderly people's physical and psychosocial health problems are found in rather old studies. Thus, a need for more studies about current self-caring elderly people's health problems are endorsed. Nonetheless, it can still be said that current care services may need to engage with these potential health problems of self-caring elderly people in the present.

2. Community services and self-caring elderly people

The word "service" is defined as "something that the public needs, such as transport, communications facilities, hospitals, or energy supplies, which is provided in a planned and organised way by the government or an official body"(Collins & University of Birmingham, 1995: p. 1515). That is, services for elderly people may be described as a number of programs provided by government or other service providers in response to the needs of elderly people. Therefore, services include supports that are provided by both profit and non-profit organizations. In addition, the term "services" in this study also include help or care provided by all formal and informal care sources. However, "community services" in this study are defined as services provided by non-profit bodies and other formal service sources.

The Aged and Community Care Division, Department of Human Services and Health(1994) demonstrates that service supports are significant in maintaining the independence of self-caring elderly people. The example was given earlier that installing grab bars in elderly people's homes could be of benefit to the elderly by maintaining independent living(DeFriese et al., 1994). However, elderly people might have difficulties in obtaining information, which is needed and in the planning and installation process for which they might need assistance. This could be settled with support services. New housing with for example no stairs, may give more chance of mobility and independent living for severely obese elderly people (Williamson et al., 1964). During the rehousing process they might need assistance and advice, for example the need to install grab bars. Consequently, supports from services to elderly people can be advantageous.

A community service program might be important in disease prevention and functional health maintenance of elderly people by encouraging healthful beliefs and healthy behaviours. Brice, Gorey, Hall and Angelino(1996) suggest that service programs encouraging healthy beliefs and behaviours of elderly people could diminish disease incidence rates and maintain healthy functioning. Their study with the "STAY WELL" program which re-enforces healthy beliefs and behaviours constantly, results in benefits of disease prevention, better physical functioning and willingness to accept and maintain treatment. Such service programs which encourage healthy beliefs and behaviours benefit elderly people.

Community service benefits to single elderly persons also are reported by Iliffe, Tai, Haines, Gallivan, Goldenberg, Booroff and Morgan(1992). They surveyed 120 elderly people living alone and 119 elderly people living with others. They investigated mobility, major physical problems, levels of prescribed drug taking, urinary incontinence levels, alcohol consumption, general practitioner contacts, in and outpatient service use and community service use. The study results showed that the overall health status was not statistically different between the two groups. Single elderly people more often made contact with community health and social workers than others. Because of this, the authors concluded that single elderly people were not particularly at risk compared with those living with others. Nevertheless support from community health and social workers seem to be important for single elderly people.

O'Connor and Parker(1995) cite a study of Shapiro in support of community service benefits. Shapiro's study tested initiative community programs in terms of informative news letters on health, safety, fitness and local community services. The study found that these programs supported the maintenance and improvement of elderly people's health status improving their quality of life. Furthermore, more activity programs such as tai chi, work shops and seminars as well as bus trips, a home maintenance team and school help teams were developed, as a result of the study feed back.

Semnani(1994) discusses informal carers as important resources for elderly care. Informal carers may be family members such as a spouse, adult children or relatives, as well as friends and neighbours(Semnani, 1994). Traditionally, those resources have cared for elderly people in the community. According to McCallum and Brown(as cited in Semnani, 1994), 66% of elderly care is arranged by informal care sources. However, family care for elderly people at home has apparently diminished during recent decades(Clarke, 1995). Changes of family structures such as nuclear families, lone parent families or reconstituted families due to divorces and remarriages have been partly responsible for this. Consequently, community services may be necessary for the elderly lacking informal care sources.

In a great many cases the carer of an ill elderly spouse is another elderly person. Elderly person's health status may have an effect on family care givers' well-being. Field(1993) in her study, assessed health and family relationships using an interview method. She reports that the burdens of caring for an ill spouse can result in depressing the health and intellectual functioning of the care giver. Consequently, community services can also be of benefit to the elderly caring for ill spouses.

As reviewed previously, community services for elderly people are significant because they support maintaining and improving physical and psycho-social health status of self-caring elderly people in the community. Also, a lack of informal service sources and a need for supporting elderly informal service sources increases the value of community services.

METHODS

A quantitative descriptive survey was conducted.

1. Population

The target population, 1187 self-caring retirement village residents in the Illawarra area, were identified by consulting local telephone directories, a community directory and a retirement village directory. Persons in-charge of retirement villages were contacted by letter, resulting in an accessible population of 367 at 8 retirement village complexes in 2 retirement village agencies. In total, 98 self-caring retirement village residents aged between 61 and 92 participated.

2. Data collection

A questionnaire using the items of Activities of Daily Living(ADLs), health status, community services, transport and demographic sections was developed in order to collect data. Methods for collecting questionnaires were discussed with village managers of the retirement villages selected, thus different data collecting methods were used at the different agencies. At one, the questionnaires were distributed through residents' mail boxes. Sixty one(61) completed questionnaires were collected in this way. At others, the subjects were visited by the researcher. Thirty seven(37) questionnaires were collected in this way.

3. Data analysis

Collected data was analysed using JMP Statistics Made Visual Version 3.0™ program distributed by SAS Institute Inc(1989-94). Frequencies for all variables were computed. These frequencies were mostly described for achieving the study objectives. Mean and Standard Deviation (SD) were used. The Analysis of variance (ANOVA) and chi-square statistics were used to examine relationships between variables. These relationships are however not stated on this present paper.

4. Validity and Reliability

The content of the questionnaire was validated to some extent in a small pilot study. A retirement trust care policy manager and a community nurse were also consulted in this process. In addition, face and content validity, data entry and analysis were verified by consultation with academic staff of the Nursing and Applied statistics Departments at the University of Wollongong. Reliability of the questionnaire was not tested.

RESULTS

1. Demographic details

About two-thirds of respondents were females whereas one-third of respondents were males. Respondents' ages were distributed between 61 and

Table 1 Demographic details of the respondents

Q Please	answer	the following questions.	Response		
n	%		n(%)		
98	100	Gender	F66(67.3%)	M32(32.7%)	
97	100	Year of birth	Mean 1920.56	Mean age 76.44	
97	100	Country of birth	Australia 63(64.9%)	Other country 34(35.1%)*	
97	100	Living arrangement	Alone 44(45.4%)	With spouse 52(53.6%)	With others 1(1.0%)

* Britain 25(25.9), Holland 4(4.1), Germany 2(2.1), Indonesia 1(2.1), Lithuania 1(1.0), and New Zealand 1(1.0)

92. The mean age was 76.44(SD: ±6.23). Male respondents were older than females. Approximately two-thirds of respondents were born in Australia and most of the others were European. Slightly more than half of respondents were living with spouses and the others were living alone. (Table 1)

2. Activities of Daily Living(ADLs)

ADLs were assessed by asking participants to indicate whether they could manage(or could manage with help) or could not manage various activities(Figure-1). Ninety two to ninety four participants(93.9%-95.9%) responded to this question. As shown in Figure 1, more than eighty one respondents(88%) managed their own meal preparation, toileting, dressing, bathing, shopping and transport without help. Slightly fewer respondents were capable of managing their own washing & cleaning(80.8%) and home maintenance(67.4%) without help. Seventeen respondents(18.1%) indicated they can manage their washing & cleaning with help. Twenty four respondents(26.1%) indicated they can manage their home maintenance with help. Six respondents(6.5%), on the other hand, indicated their inability to manage home maintenance. There were two respondents(2.2%) who were unable to manage transport, shopping and meal preparation. One respondent(1.1%) was unable to manage toileting, dressing or bathing. (Figure-1)

3. Health status

Health status was assessed by asking participants to indicate whether had any problems and the extent of such problems, with various functions(Figure 2). Eighty five to eighty nine participants responded to this nine item question. More than 80% of the respondents had no difficulties with speech, sight, diet, mobility, continence or mood. Most(approximately 70%) of respondents indicated no problems with their hearing, forgetfulness and tiredness/ fatigue items. Fewer respondents reported some problems (forgetfulness 28.4%, n=25; tiredness/ fatigue 28.1%, n=25; hearing 27.0%, n=24; & mobility 15.9%, n=14). Very few respondents reported having a lot of problems with mobility(2.3%, n=2), sight(2.3%, n=2), hearing(1.1%, n=1), diet(1.2%, n=1), and mood(1.2%, n=1).(Figure-2)

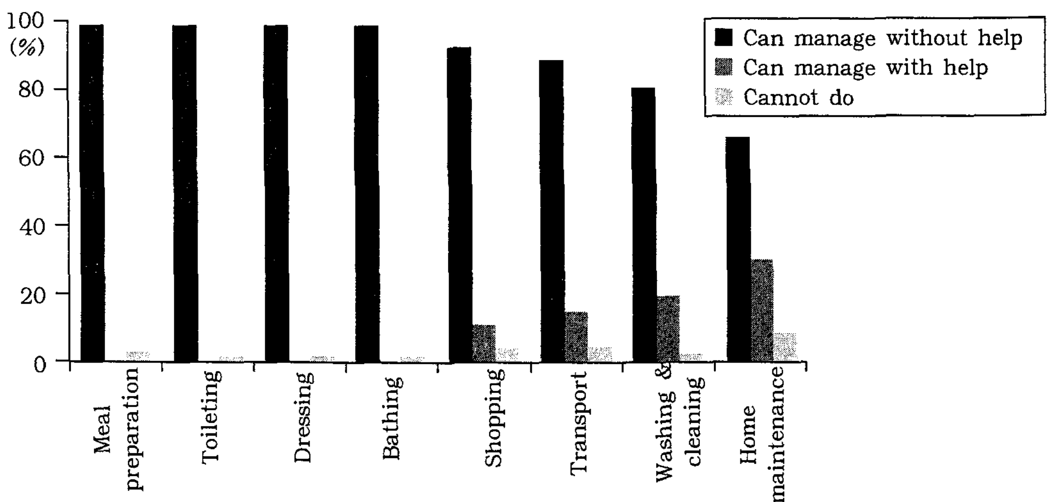

Figure 1. ADLs self-managing status of the respondents

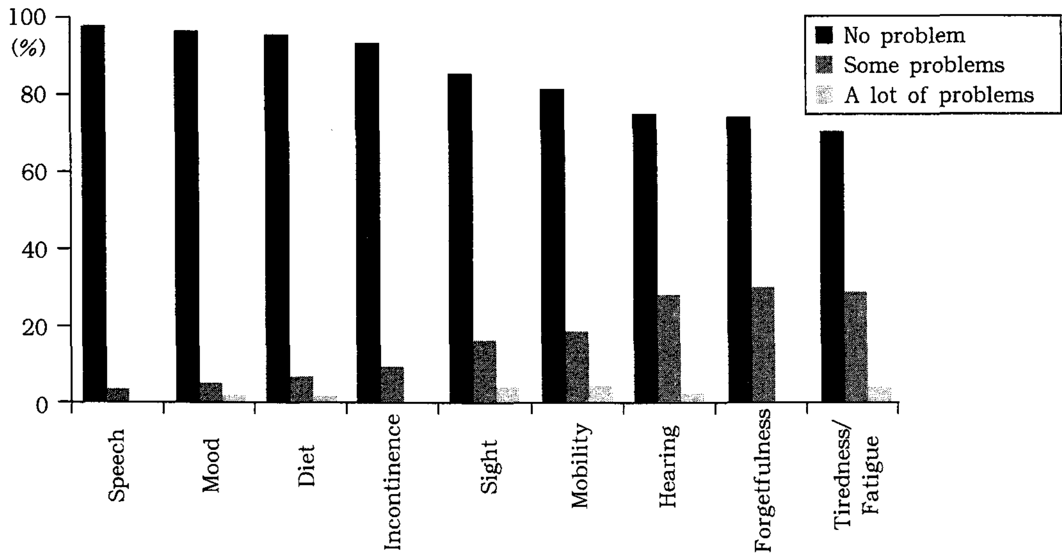

Figure 2. Health status of the respondents

4. Transport

Participants were asked to identify their transport needs. Frequency of transport need and sources of transport used were asked(Table 2). Forty four(47.9%) respondents needed transport everyday. Twenty seven respondents(29.3%) needed transport more than once a week. All respondents (n=94, 100%) had access to transport. All of them selected more than one available source and none of them indicated that no transport was available. Respondents were most likely to use their own car (n=66, 67.3%), but there was also quite a high rate of use of public transport(n=44, 44.9%).(Table-2)

Table 2. Transport provision of respondents

Q How frequently do you need transport? (Private and/ or Public).					Q If you require transport which of the following do you normally use?(Tick as many boxes as necessary).				
n		n	%	Mean age	n		n	%	Mean age
92	Almost everyday	44	47.9	75.70	94	Own car	66	67.3	74.76
	More than once a week	27	29.3	76.41		Family/Relative's car	20	20.4	77.95
	Once a week	6	6.5	82.17		Friend's car	21	21.4	79.24
	Less than once a week	4	4.3	79.15		Retirement village provider	17	17.3	77.59
	Don't need	11	12.0	72.73		Taxi	13	13.3	78.15
			(100)			Train	27	27.6	73.93
						Bus	44	44.9	76.89
						No transport available	-	0	-
						Other	2	2.0	75.00

5. Awareness of and sources of information about community services

The majority of respondents were well aware of community services available. As shown in Table 3, between 5 and 26 respondents(5.1-26.5%)(mean 14.7%) indicated they didn't know about one or more of the eleven community services identified. Ignorance of some services by some respondents

was apparent. In particular, washing & cleaning services(n=15, 15.3%), help with big cleaning jobs (n=22, 22.4%), other medical services(n=17, 17.3%), personal care services(n=26, 26.5%), day care centre(n=26, 26.5%) and counselling services (n=25, 25.5%).

Village information was the most significant source of information about community services in general. In particular, village information was the commonest source of knowledge about home repair(n=55, 56.1%) and transport(n=41, 41.8%) services. Word of mouth was also a common source of information about community services. Thirty respondents(30.6%), obtained information in this way about washing & cleaning services, 14(14.3%) help with big cleaning jobs, 22 food services (22.4%), 21 transport(21.4%), 16 doctors(16.3%) and 15 nursing services(15.3%).(Table 3)

Table 3. Awareness of and sources of information about community services

Q If you know about community services that are available to help with the following, please indicate how did you find out(Tick as many boxes as necessary).		Word of mouth		News papers		Village information		Health centre/ Doctor		Other		Don't know	
n		n	%	n	%	n	%	n	%	n	%	n	%
75	Washing & cleaning	30	30.6	11	11.2	24	24.5	9	9.2	1	1.0	15	15.3
70	Home repair	7	7.1	6	6.1	55	56.1	-	0	-	0	5	5.1
68	Big cleaning jobs	14	14.3	8	8.2	26	26.5	-	0	2	2.0	22	22.4
72	Food services	22	22.4	12	12.2	34	34.7	4	4.1	2	2.0	10	10.2
68	Transport services	21	21.4	7	7.1	41	41.8	4	4.1	2	2.0	6	6.1
67	Doctor services	16	16.3	3	3.1	12	12.2	25	25.5	4	4.1	10	10.2
72	Nursing services	15	15.3	5	5.1	34	34.7	14	14.3	1	1.0	13	13.3
68	Other medical services	9	9.2	2	2.0	18	18.4	22	22.4	3	3.1	17	17.3
61	Personal care services	9	9.2	2	2.0	21	21.4	6	6.1	3	3.1	26	26.5
59	Day care centre	7	7.1	4	4.1	20	20.4	4	4.1	3	3.1	26	26.5
60	Counsellor	8	8.2	1	1.0	22	22.4	4	4.1	4	4.1	25	25.5
10	Other	-	0	-	0	-	0	1	1.0	1	1.0	9	9.2

6. Ease of obtaining information about community services

Most respondents stated that to obtain information about each community service identified was very easy or easy.(Table 4) Most items were rated as easy or very easy to obtain information about by nearly 60% of respondents. However, approximately 35% of respondents answered 'don't know' to this question: help with big cleaning jobs (36.8%, n=32), other medical services(35.3%, n=30), personal care services(38.1%, n=32), day care centre(42.2%, n=35) and counsellor(45.7%, n=37), were the highest rated don't know responses. Between 2.2% and 9.5%(n=2-8) of respondents found it was difficult or very difficult to obtain information about community services. Personal care services were noted as being most difficult to obtain information about(9.5%, n=8).(Table 4)

Table 4. Ease of obtaining information about community services

Q How easy is it to obtain information about each of the community services below?			Very easy		Easy		Difficult		Very difficult		Don't know	
n	%		n	%	n	%	n	%	n	%	n	%
89	100	Washing & cleaning	18	20.2	35	39.4	4	4.5	2	2.2	30	33.7
86	100	Home repair	20	23.3	34	39.5	3	3.5	2	2.3	27	31.4
87	100	Big cleaning jobs	18	20.7	30	34.5	5	5.7	2	2.3	32	36.8
86	100	Food services	19	22.1	36	41.8	3	3.5	-	0	28	32.6
85	100	Transport services	20	23.5	37	43.5	3	3.5	-	0	25	29.5
87	100	Doctor services	24	27.6	37	42.6	1	1.1	1	1.1	24	27.6
84	100	Nursing services	20	23.8	34	40.4	3	3.6	2	2.4	25	29.8
85	100	Other medical services	19	22.4	30	35.2	4	4.7	2	2.4	30	35.3
84	100	Personal care services	15	17.9	29	34.5	6	7.1	2	2.4	32	38.1
83	100	Day care centre	15	18.1	30	36.1	2	2.4	1	1.2	35	42.2
81	100	Counsellor	15	18.5	25	30.9	2	2.5	2	2.5	37	45.6
19	100	Other	-	0	5	26.3	2	10.5	-	0	12	63.2

7. Use of community services

Community services were not much used by the respondents in general(Table 5). Approximately, 90% of the respondents did not use community services with the single exception of doctor services. Twenty eight respondents(33.3%) used community doctor services on a monthly(n=16, 19.0%) or quarterly(n=12, 14.3%) basis. Other details are shown in Table 5.

Table 5. Frequency of community services used by the respondents

Q How often do you currently use community services for the following?			Everyday		Weekly		Monthly		Quarterly		Yearly		Don't use	
n	%		n	%	n	%	n	%	n	%	n	%	n	%
86	100	Washing & cleaning	-	0	6	7.0	2	2.3	-	0	-	0	78	90.7
81	100	Home repair	-	0	-	0	3	3.7	9	11.1	1	1.2	68	84.0
84	100	Big cleaning jobs	-	0	1	1.2	1	1.2	5	6.0	2	2.4	75	89.2
83	100	Food services	1	1.2	1	1.2	-	0	1	1.2	-	0	80	96.4
84	100	Transport services	1	1.2	7	8.3	1	1.2	2	2.4	-	0	73	86.9
84	100	Doctor services	-	0	1	1.2	16	19.0	12	14.3	2	2.4	53	63.1
81	100	Nursing services	-	0	1	1.2	2	2.5	-	0	-	0	78	96.3
81	100	Other medical services	-	0	-	0	5	6.2	3	3.6	5	6.2	68	84.0
82	100	Personal care services	-	0	-	0	-	0	-	0	-	0	82	0
82	100	Day care centre	-	0	1	1.2	-	0	-	0	-	0	81	98.8
80	100	Counsellor	-	0	-	0	1	1.3	-	0	1	1.3	78	97.4
92	100	Other	-	0	-	0	-	0	-	0	1	3.6	27	96.4

8. Current satisfaction with services used

Satisfaction with community services was ascertained in terms of the variety of choice and quality of community services(Table 6 & Table 7). About 60% of the respondents(n=29-40) answered "don't know" about the variety of choice of each service. Most of the rest of the respondents indicated they were either very satisfied or sa-

tisfied from 27.3% to 42.6%(n=15-24). Very few respondents indicated that they were "unsatisfied" or "very unsatisfied": 1 response(1.6%) washing & cleaning services, 1(1.7%) home repair services, 2(3.4%) food services, 2(3.2%) doctor services, 1(1.7%) nursing services and other medical services(Table 6). Those respondents who used services were either "very satisfied" or "satisfied" with the quality of community services(Table 7). Only one response each indicated "unsatisfied" with food services(1.6%), transport(1.5%) and nursing service(1.6%) items. Most of the respondents, about 80%(n=35-56) indicated "don't use"(Table 7).

Table 6. Variety of choice of community services

Q If you needed these services, how satisfied are you with the variety of choice for each of the community services below?			Very satisfied		Satisfied		Unsatisfied		Very unsatisfied		Don't know	
n	%		n	%	n	%	n	%	n	%	n	%
61	100	Washing & cleaning	11	18.1	10	16.4	1	1.6	-	0	39	63.9
60	100	Home repair	15	25.0	9	15.0	-	0	1	1.7	35	58.3
58	100	Big cleaning jobs	11	19.0	8	13.8	-	0	-	0	39	67.2
59	100	Food services	8	13.6	11	18.6	2	3.4	-	0	38	64.4
61	100	Transport services	15	24.6	11	18.0	-	0	-	0	35	57.4
64	100	Doctor services	21	32.8	12	18.8	1	1.6	1	1.6	29	45.2
60	100	Nursing services	12	20.0	12	20.0	-	0	1	1.7	35	58.3
60	100	Other medical services	15	25.0	9	15.0	-	0	1	1.7	35	58.3
56	100	Personal care services	7	12.5	9	16.1	-	0	-	0	40	71.4
55	100	Day care centre	9	16.4	6	10.9	-	0	-	0	40	72.7
54	100	Counsellor	8	14.8	8	14.8	-	0	-	0	38	70.4
23	100	Other	-	0	1	4.3	-	0	-	0	22	95.7

Table 7. Quality of community services perceived by the respondents

Q How satisfied are you with the quality of each of the community services below?			Very satisfied		Satisfied		Unsatisfied		Very unsatisfied		Don't use	
n	%		n	%	n	%	n	%	n	%	n	%
63	100	Washing & cleaning	5	7.9	4	6.4	-	0	-	0	54	85.7
63	100	Home repair	11	17.5	6	9.5	-	0	-	0	46	73.0
63	100	Big cleaning jobs	7	11.1	3	4.8	-	0	-	0	53	84.1
62	100	Food services	3	4.8	4	6.5	1	1.6	-	0	54	87.1
66	100	Transport services	10	15.2	6	9.1	1	1.5	-	0	49	74.2
66	100	Doctor services	18	27.3	13	19.7	-	0	-	0	35	53.0
63	100	Nursing services	11	17.5	6	9.5	1	1.6	-	0	45	71.4
64	100	Other medical services	12	18.8	6	9.4	-	0	-	0	46	71.8
61	100	Personal care services	3	4.9	2	3.3	-	0	-	0	56	91.8
60	100	Day care centre	4	6.7	1	1.7	-	0	-	0	55	91.6
61	100	Counsellor	4	6.6	3	4.9	-	0	-	0	54	88.5
61	100	Other	-	0	-	0	-	0	-	0	21	100

9. Potential needs for community services

Respondents' potential needs for community services were assessed in terms of interest in community services(Table 8). Although many respondents were not interested in community services some showed considerable interest in them. While about two-thirds of the respondents who were not using community services answered "don't need" or "not interested", approximately a quarter were interested in some community services, as they indicated "very interested", "interested" or "slightly interested". Respondents showed interest in washing & cleaning services(28.7%, n=23), help with big cleaning jobs(28.2%, n=24) and nursing services(27.1%, n=22) at slightly higher rates; and day care centre(14.1%, n=12) and counselling (15.4%, n=21) at relatively low rates(Table 8).

Table 8. Interest in community services

		Q If you need a community service, but are not currently using one, please indicate how interested you are in each of the following.	Already using		Very interested		Interested		Slightly interested		Not interested		Don't need	
n	%		n	%	n	%	n	%	n	%	n	%	n	%
80	100	Washing & cleaning	4	5.0	6	7.4	16	20.0	1	1.3	5	6.3	48	60.0
77	100	Home repair	3	3.9	7	9.1	9	11.7	1	1.3	6	7.8	51	66.2
85	100	Big cleaning jobs	5	5.9	7	8.2	14	16.5	3	3.5	6	7.1	50	58.8
83	100	Food services	1	1.2	6	7.2	13	15.7	2	2.4	7	8.4	54	65.1
81	100	Transport services	7	8.6	7	8.6	13	16.0	1	1.2	5	6.2	48	59.4
81	100	Doctor services	14	17.3	7	8.6	12	14.8	1	1.2	4	4.9	43	53.2
81	100	Nursing services	5	6.2	8	9.9	13	16.0	1	1.2	4	4.9	50	61.8
81	100	Other medical services	5	6.2	8	9.9	12	14.8	1	1.2	3	3.7	52	64.2
81	100	Personal care services	1	1.2	6	7.4	11	13.6	1	1.2	4	4.9	58	71.7
78	100	Day care centre	1	1.3	5	6.4	6	7.7	1	1.3	5	6.4	60	76.9
78	100	Counsellor	2	2.6	6	7.7	6	7.7	-	0	5	6.4	59	75.6
26	100	Other	-	0	1	3.8	3	11.5	-	0	-	0	22	84.7

DISCUSSION

1. Functional status

Good functional status of self-caring retirement village residents, in terms of ability to carry out ADLs and maintain manage normal physical functioning, was clearly identified from the study results. A major proportion of respondents reported that they were capable to carry out their ADLs by themselves and they had no health problems. Greater proportions of the sample were using their own cars and often had social contact. These findings explain that self-caring retirement village residents literally can look after themselves well, so they do not need many services. In only small proportions, needs arose with home maintenance, washing & cleaning, hearing, forgetfulness, tiredness/ fatigue and mobility. Thus, it can be concluded that self-caring retirement village residents do not need many community services, as they are in good functional status.

2. Knowledge of community services

The study results found apparently high levels

of respondents' awareness about community services. The ease of obtaining information about community services was also identified. These findings are reasonable when considering that retirement villages were the best information source among the respondents. A few respondents didn't know about some community services and found difficulty in obtaining some community service information. Nevertheless, it is concluded that self-caring retirement village residents do not generally need more information about community services.

3. Use and current satisfaction with community services used

The study results also showed low levels of community service use among respondents. In spite of considerable levels of respondents' positive perceptions towards community services in terms of satisfaction with quality and variety of choice, only small proportions of respondents used community services. Only doctor services were used at a relatively high level. This is because most respondents were capable of caring for themselves, as they were in good functional status. They were also able to manage transport for themselves, as they frequently used their own cars or used public transport. Higher proportions of respondents felt that they did not need community services. Altogether, these outcomes show that not many community services are needed by self-caring retirement village residents.

4. Potential needs for community services

In terms of potential future needs, the study results showed that a major proportion of respondents were not interested in community services. Even so, there was still considerable level of respondents' interest about community services for washing & cleaning services, help with big cleaning jobs and nursing services. These figures may be significant, as there is a deficit of approximately 20% between the proportions of "don't need" responses and those of "don't use" responses. Thus, it can be suggested that self-caring retirement village residents may possibly need these community services.

In addition, self-caring elderly people tend to have higher self-esteem by providing assistance to others(Kincade et al., 1996). Substantially, service use may cultivate to lower self-esteem and not using services may bolster self-esteem. A CEO (Personal communication) of a retirement village accessed for this study, also accounts that "The elderly seem to want to do everything as much as they can. This is different to young people's attitudes. If young people can have services, they will feel free to use them. But elderly people are different. They may feel they are useless." From this point of view, a caution that a high level of self-esteem of self-caring elderly people, may result in the low level of interest about community services, even though needed. Community service providers may need be aware of this possibility for their service plan and provision for these elderly people.

CONCLUSION AND RECOMMENDATION

In general, this study has concluded that the majority of self-caring retirement village residents do not need many community services. Their good health status could explain the low levels of community service use even though they were well aware of community services and they were satisfied with the quality and variety of choice of community services. However, there was a small numbers of respondents with unmet service needs

yet, as they do need some services and were interested in some community services. So self-caring retirement village residents should not be excluded from community service planning and provision. Even though these numbers and proportions are small, since community services for elderly people should address the elderly's individual achievement for a better quality of life, this small number might need to be considered in community service planning and provision.

Further in-depth studies about elderly people's service needs in relation to their self-esteem are suggested as service use in elderly people may impede having higher self-esteem of their own.

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<국문초록>

RETIREMENT VILLAGE에 거주하는 자가 돌봄이 가능한 노인들의 지역사회 서비스에 대한 욕구 사정

이 현 주

지역 사회 서비스는 노인들이 질적으로 보다나은 삶을 영위할 수 있도록 돕는 기능을 해야 한다. 적절한 서비스의 공급을 위해서는 지역사회 서비스 욕구 사정의 과정이 우선적으로 요구되어지며, 이에 본 연구는 호주 NSW주 Illawarra지역내의 retirement village에 거주하는 자가 돌봄이 가능한 노인들의 지역사회 서비스에 대한 욕구를 평가하는데 그 목적을 두었다.

Illawarra지역내의 여덟개 retirement village에 거주하는 98명의 자가 돌봄이 가능한 노인들을 대상으로 그들의 1) functional status; 2) 지역 사회 서비스에 대한 지식정도; 3) 지역 사회 서비스 사용정도; 4) 지역 사회 서비스 만족도; 5) 잠재적인 지역 사회 서비스 욕구 등에 대한 자가 보고형 설문조사가 이루어졌다. 수집된 자료들은 JMP(for Mackintosh) program으로 통계 처리되었고, computed frequencies가 본 연구의 목표 달성을 위해 주로 사용되었다.

연구 결과를 요약하면 아래와 같다.

1. 평균 연령 76세인 대상자들의 80% 이상이 그들의 일상 생활 운영에 다른 사람의 도움을 필요로 하지 않으며 건강상태 또한 양호하다고 자각했다.
2. 90% 이상의 대상자들이 지역 사회 서비스를 이용하지 않았다.
3. 70% 이상의 대상자가 지역 사회 서비스의 존재에 대해 지각하고 있었다.
4. 60% 이상의 대상자가 필요시에는 지역 사회 서비스에 관한 정보를 어렵지 않게 얻을 수 있다고 생각했다.
5. 40%의 대상자가 기존의 지역 사회 서비스에 대한 양과 질에 만족을 나타냈고, 그 외의 대상자들 (60%)은 그 지역 사회 서비스에 대한 구체적인 지식이 없다고 보고했다.
6. 25%의 대상자들이 여러 지역 사회 서비스에 관한 관심을 보였다.

결론적으로 대다수의 대상자들은 대부분의 지역 사회 서비스들을 필요로 하지 않았고, 이러한 결과는 현재 자가간호가 가능한 retirement village 거주 노인들에게 당연한 것으로 보여진다. 그러나, 자존감이 강한 노인들에게 서비스 욕구는 자가 돌봄이 건강에 대한 포기정도로 왜곡되어 자각될 가능성이 있는 만큼, 본 연구를 통해 보고된 대상자들의 지역 사회 서비스에 대한 관심도는 고려해 볼만한 가치가 있다고 여겨지며, 이에 노인들의 자존감이 서비스 욕구에 미치는 영향에 대한 연구를 제언하는 바이다.