RESIDENTIAL AND SUPPORT SERVICES FOR OLDER PEOPLE IN THE WAIKATO, 1992-1997: PRIVATISATION AND EMERGING RESISTANCE

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INTRODUCTION

The "experiment" in neo-liberal structural adjustment (Kelsey 1997) that began with the election of a reform-minded Labour government in 1984 has touched virtually every aspect of New Zealand life and reached into every corner of the country (Britton et al 1992, Le Heron and Pawson 1996). One of the hallmarks of the adjustment process has been the unevenness of impacts (Moran 1999); some population groups have been affected more by economic and social restructuring than others (Kelsey 1997), as have some regions and localities (Le Heron and Pawson 1996). In this paper, we focus on older people as a group affected by economic and social restructuring, and relate their experience to the explicit views expressed by the state since 1984. It is arguable that older people are much more sensitive to changes in social policy than are the great majority of younger New Zealanders. This sensitivity amounts to virtual "dependency" for many in the areas of income support and age-targeted accommodation and caring services (Saville-Smith 1993), Older people, as disproportionate users of services, are also affected by shifts in policy on health care and social support in general (Richmond et al. 1995).

We use a case study of the Waikato to anchor a commentary on the implications for older people of shifts in policy on the provision of residential and caring services. In earlier work, we analysed the impacts of changes in the provision of residential care on the evolving geography of population ageing in the region (Joseph and Chalmers 1996); assessed the implications of service-sector restructuring for the in-place experience of ageing (Joseph and Chalmers 1995); and presented "insider" views of what it means to be old in a service-depleted community (Chalmers and Joseph 1998). Through this research, we developed an appreciation of the implications for older people of the "first wave" of economic and social restructuring that swept over the region between 1984 and 1992. We turn here to the "second wave" of restructuring, which we consider to be prefigured by a series of critiques within government of the health care system, beginning in earnest in 1991 (Barnett and Barnett 1997). We seek to identify the reactions of older people to changes in housing and service availability, which we see as constituting an evolving "politics of resistance" to social policy change.

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The remainder of the paper is organised in three major sections. The first of these reviews the evolution of pervasive and complex relationships between social policy and the lives of older people. The year 1984 is used to divide the review of developments in the welfare state into "historical" and "contemporary" components. Assessments of the implications of shifts in social welfare policy are then moderated against an awareness of the changing needs of older people and of the capacity of their families and communities to respond to demands for assistance. The second section presents the methods and results of the Waikato case study, with interpretation of the latter organised around the emergent themes of *privatisation* and *resistance.* In a concluding section, we place the main arguments into their wider, national context, emphasising implications for social policy.

SOCIAL POLICY AND THE WORLDS OF OLDER PEOPLE

In this section we summarise the history of support for older New Zealanders in the century prior to 1984, and assess the impact of these changes.

Building the Welfare State: 1885 to 1984

The main streams of social support for older people in New Zealand society can be traced to two pieces of nineteenth century legislation. The Hospital and Charitable Institutions Act of 1885 was a significant step in the medicalisation of ageing (Saville-Smith 1993). The local boards set up to provide hospital and charitable relief under the Act initially distinguished systematically between financial assistance related to indigence ("outdoor relief") and residential care provided because of illness ("indoor relief"). However, boards later adopted *residential* solutions to both problems. The impetus for institutionalisation was strengthened further by the Old Age Pensions Act of 1898. The Act provided income support for older people, thereby further reducing the apparent need for hospital boards to sponsor outdoor relief (Saville-Smith 1993).

The establishment of a statutory age for commencement of retirement pensions over the next half century ensured the growing dependence of older New Zealanders on pensions as a source of income. Contemporaneously, the widespread adoption and acceptance of *medical* filters for determining access to *social* support in the home, such as assistance with housework, and (significantly) qualification for special accommodation, reinforced the association of ageing and disability.

The four decades following 1945 witnessed a growing complexity in social policy. For older people, the state began to withdraw from direct provision of services (Saville-Smith 1993). In 1951 religious and welfare organisations became eligible for subsidies to build accommodation for older people. The year 1961 saw the establishment of the Rest Home Subsidy Scheme in Auckland. The aim of this programme was to free up public hospital beds occupied by older, long-term patients through support for private rest home providers. The level of the private financial contribution from older people was

determined by the Department of Social Security. This programme was introduced progressively in New Zealand from 1966.

By 1970 a complex range of "partnerships" between hospital boards and a range of religious and welfare organisations had emerged. While hospital boards continued to take responsibility for medicalised care for the "older old", they also worked with the voluntary sector in responding to growing needs for care in the community, with various domestic assistance schemes and meals-on-wheels programmes that had first emerged in the 1950s (Saville-Smith 1993). The 1950s and 1960s also saw the increasing use of the social security special assistance provisions to enable older people to meet the cost of essential services subject to user pay regimes such as home help and private rest home services.

In the 1970s, and particularly the 1980s, the private, for-profit sector became a growing provider of residential care services, although the important principle of subsidising patients in private geriatric hospitals via the budgets of hospital boards had been established years earlier in the Social Security Act of 1938 (Joseph and Flynn 1988). The now-defunct Geriatric Hospital Special Assistance Scheme (GHSAS) was the mechanism for directing public funds to private geriatric hospitals run by religious and welfare organisations and commercial operators. Geriatric long-stay beds in public hospitals were available (at no charge other than loss of pension) in some board areas, albeit subject to waiting lists. In others, older people and their families turned to private hospitals, with access to subsidies from the GHSAS subject to income testing (Joseph and Flynn 1988). The financial attractions for area health boards of subcontracting geriatric hospital care to private hospitals were such that the supply of long-term geriatric beds in private hospitals increased by 258% between 1978 and 1984 (Saville-Smith 1993:90). In contrast, the number of licensed (private) old peoples' homes increased by a more modest 35% between 1981 and 1985, rising from 410 to 522 (Social Monitoring Group 1987:73).

Restructuring the Welfare State: 1984-1997

The retreat from state provision of services (as against funding) to older people was already well underway in 1984 (Kelsey 1997). We have emphasised the recruitment of the voluntary sector (in the 1950s and 1960s) and private sector (in the 1970s and early 1980s) as partners in the provision of residential care, but the state had also demonstrated ambivalence in the area of income support. From the early 1950s on, relative to the average wage, there was an erosion of the level of financial support to retired people, and much experimentation with targeting mechanisms, second-tier provisions and superannuation contribution plans (St. John 1993). After 1984, the retreat from state provision of services continued and the private sector became identified as the "provider of choice" within an increasingly complex system.

In the area of residential care, the 1987 review of rest home subsidy saw religious and welfare rest homes being brought into line with private rest homes and forgoing their salary subsidy and access to capital subsidies for buildings, in place of a fee for service for financially eligible residents. The extension of the rest home subsidy scheme to all

parts of New Zealand provided opportunities for private providers to offer services to clients attracting state subsidies (Joseph and Chalmers 1996), and contributed to a rapid rise in rest home numbers (Bonita and Richmond 1991, Baskett et al. 1994). Undoubtedly the lower cost of private and religious and welfare sector beds, as compared with public hospital beds, contributed significantly to the contracting out of long-stay geriatric hospital services by area health boards.

In the area of health care, two sources of complexity were introduced in 1993: the split between health care purchaser and provider (Ashton 1998, Barnett and Barnett 1997) and the separation of funding for the care of older people into personal health ("acute care") services and disability support ("chronic care") services (Richmond et al. 1995). These changes left Regional Health Authorities (RHAs) contracting with largely public providers for acute care, rehabilitation and clinical services, embracing both personal health and disability support services, and a large number of religious/welfare and private providers for disability services offering long term care and support. Richmond et al. (1995) have characterised this system of discrete funding streams and multiplicity of providers as excessively complex.

In state housing, the transformation of the Housing Corporation of New Zealand into the commercially-driven company Housing New Zealand prefigured a series of substantial rent increases (to match local private-sector levels) and property sell-offs aimed at producing a profit for the state (Murphy and Kearns 1994). Housing tenants rather than housing units were to be subsidised, through the Accommodation Supplement (from July 1993), with stringent controls on eligibility.

Assessing the Implications of Restructuring

While the emphasis here has been on changes in policies affecting accommodation, care and support, and health services for older people, it has not been our intent to imply that such changes occurred in isolation. Indeed, we have already noted that shifts in policies on accommodation and caring services for older people can be seen as part of a broader, neo-liberal social experiment. We suggest four important reference points for appreciating the impacts of such policy changes. These are:

- shifts in general health care and housing policy;
- the cumulative impacts of restructuring on the ability of families and communities to cope;
- evolving patterns of disability in the older population; and
- the (emerging) resistance of older people to privatisation.

Trends toward the state consolidating its role as a funder rather than a provider in some aspects of health care, and state housing (Murphy and Kearns 1994), provide a troubling backdrop for the specific concerns of older people. Statements in the popular press such as "(h)ealth is no longer about people. It's about criteria, cost-efficiency, categories and contracts" *(The Waikato Times,* 18 October 1997), have both recognised and contributed to personal fears about budget limitations and service rationing in the public sector. At

the same time, well-publicised waiting lists for surgery, amounting to more than 99,000 people on September 30, 1997 *(The Waikato Times,* 24 October 1997), have acted as an advertisement for the advantages of private health care. However, as Peter Smith, the retiring president of Southern Cross noted in 1995, "... they [older people] won't be able to afford health insurance and won't be able to get satisfaction from a public hospital" *(Sunday Star-Times,* 10 October 1995). He noted that the introduction of limited user-pay charges in public hospitals in 1992 contributed to 100-300% increases in *private* health insurance premiums.

In the Waikato, the number of private rest homes increased by 460% between 1981 and 1991, and total capacity by 397%, while the comparable rates of increase in the religious/ welfare sector were only 27% for facilities and 36% for capacity (Joseph and Chalmers 1996). During the same period, the number of long-stay geriatric beds in private hospitals increased by 201%, while public sector capacity fell by 19% and that in the religious/ welfare sector remained about the same (Joseph and Chalmers 1996).

The changes to income support for accommodation have produced uncertainly among older people. Some fear that sell-offs or moves to market rents will force them from their homes *(The Waikato Times,* 20 June 1996). Similar concerns amongst homeowners flow from fears of the level of asset reduction necessary to qualify for the Residential Care Subsidy (Age Concern New Zealand 1998).

The impacts of shifts in policies on accommodation and caring services must also be seen against the broader backdrop of changes in the communities in which older people reside. In earlier work (Joseph and Chalmers 1995), we presented data for Tirau, a village of 700 people in the Waikato, to show the impact of restructuring on the ability of older people to sustain their day-to-day lives and to carry on in their own homes, to "age in place". Across all communities, the ability of older people to age in place, usually with assistance from family members, has been made more problematic by increased mobility in the restructured labour market and by the high level of female participation in the workforce (Abbott and Koopman-Boyden 1994, Saville-Smith 1993). While volunteer groups may step in to help, this is often problematic in rural communities where the supply of volunteers has been depleted by job losses and subsequent out-migration (Joseph and Chalmers 1998).

The ability of families and communities to do more for older people, to come forward to meet the unmet needs exposed by changes in state provided services, especially health outreach services, is made even more problematic by the increasing levels of disability within the ageing population (Green 1993). Dementia is particularly difficult for families to handle, even with professional support, and incidence levels are increasing (Abbott and Koopman-Boyden 1994). This raises questions about the limits of community care and re-emphasises the importance, for a growing number of older New Zealanders, of the changing geographical and financial accessibility of residential care.

Given the breadth of change in social policy affecting older people, and specifically the implications of privatisation, it is not surprising that *resistance* has begun to emerge. This

resistance is exercised collectively through organisations such as Grey Power and Age Concern New Zealand, and individually through participation in broader discussions and protests. In exercising their democratic rights of protest, older people emerge from the anonymity of discourse on service restructuring which speaks of disembodied *consumers* and *providers* of services (Kearns and Joseph 1998). We now turn to our case study and outline the antecedents and manifestations of resistance to such changes in the Waikato.

THE WAIKATO CASE STUDY

The results of our analysis of the Waikato case study data are presented in three parts. We focus initially on residential care and provide an update of the results presented in Joseph and Chalmers (1996).[3] We then describe shifts in the supply of age-targeted housing and community support services. In both cases, we note the continuation of trends toward reduced involvement by the state. Finally, we document the emerging resistance of older people to change, drawing on newspaper reports to develop our narrative.

Residential Care Trends, 1992-97

Shifts in the supply of long-term geriatric beds in the Waikato are summarised in Table 1. The data reveal that while the total number of beds in the region remained virtually the same between 1992 and 1997, there were some notable changes in supply by sector. Capacity in the public sector continued to decline, as it had in the decade prior to 1992 (Joseph and Chalmers 1996). However, the earlier, very rapid expansion of capacity in the private sector is not carried into the subsequent five-year period. Instead, capacity loss in the public and private sectors is almost perfectly balanced by an expansion in the religious/welfare sector.

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[3] As in the earlier study (Joseph arid Chalmers 1996), we break down the supply of residential care in geriatric hospitals and rest homes by sector. For geriatric hospitals, we distinguish between public, religious/welfare and private providers, and for rest homes between religious/welfare and private providers. As outlined in Joseph and Chalmers (1996), information on residential care beds in late 1991/early 1992 was obtained in part from a database maintained by the (now-defunct) Waikato Area Health Board and in part through a telephone survey of providers. Comparable data for late 1997 were accumulated in the same way, with the starting point being a database maintained by the (now-defunct) RHA, Midland Health.

In this paper, we draw on two portions of our 1992 database that were not included in the earlier analysis. One of these relates to accommodation for older/retired people, and it distinguishes between (public sector) pensioner housing and (religious/welfare and private sector) "retirement housing". We have considerable confidence in the information on pensioner housing. However, the retirement housing data are somewhat problematic because the term "retirement housing" is subject to self-definition by operators, and it is quite possible that our database under-reports the supply of religious/welfare and private-sector housing targeted to older/retired people. The second "un-analysed" portion of the 1992 database contains information about the supply of community support services, and it distinguishes type of provider (public, religious/welfare, private) and type of service, and also notes geographical availability.

Table 1 Geriatric Long-Stay Beds in Public, Religious/Welfare and Private Hospitals, 1992 and 1997

	1992		1997		% Change
Sector	Number	%	Number	%	1992-97
Public	111	(23.0)	96	(20.1)	-13.5
Religious/Welfare	148	(30.7)	171	(37.8)	15.5
Private	223	(46.3)	211	(44.1)	-5.4
Total	482	(100.0)	478	(100.0)	-0.8

In part, we attribute the loss of momentum in the expansion of the private sector to the spectacular growth (200%) in the period 1981-91. However, we also see it as a reflection of pressures on profitability. The 34-bed Pohlen Hospital in Matamata, which offers general surgical and maternity services alongside 14 geriatric long-stay beds, typifies the problems of small private providers. In 1996, the hospital found itself in serious need of refurbishment and in danger of closure. The hospital trustees launched an 18-month $750,000 community appeal, featuring a professional fundraiser from Australia *(The Waikato Times,* 30 October 1996). Support for the appeal was such that it raised $460,000 in just 13 weeks *(The Waikato Times,* 15 February 1997).

The Pohlen Hospital case is indicative of the importance of community support for small town hospitals, including those in the private sector. This theme emerges even more strongly within the "stories" that lie behind the transfer of capacity from the public to the religious/welfare sector. Closures of hospitals and geriatric wards in the 1980s (Joseph and Chalmers, 1996) meant that in 1992 the public sector remained as a provider of services in only a few Waikato towns. By 1995, pressure was building up to close small public hospitals (like those in Morrinsville and Te Aroha) providing long-term geriatric beds *(The Waikato Times,* 15 November 1995). The threat to Rhoda Reid Hospital elicited organised opposition from Morrinsville Grey Power and other local groups. In nearby Te Aroha, in response to similar threats of closure, a community trust was organised to lease the hospital building from Health Waikato (the local CHE) and to contract with Midland Health for the provision of geriatric long-term care services *(The Waikato Times,* 23 October 1996).

The supply of rest home beds increased between 1992 and 1997, as shown in Table 2.

Table 2 Rest Home Beds in Religious/Welfare and Private Facilities, 1992 and 1997

	1992		1997		% Change
Sector	Number	%	Number	%	1992-97
Religious/Welfare	622	(50.0)	657	(44.7)	5.6
Private	621	(50.0)	813	(55.3)	30.9
Total	1,243	(100.0)	1,470	(100.0)	18.3

At 30.9%, the growth of private sector capacity is small relative to the nearly 400% increase (from 121 to 601) recorded over the earlier decade (Joseph and Chalmers 1996), when subsidies were restructured. While assessment before admission to residential care

had been a factor since 1987, from 1994 a more standardised approach was applied. In addition, from 1994 residential care subsidy ceased being demand driven through the social security system and became a charge on the capped Disability Support Services budget administered by regional health authorities.

Closer examination of these data also reveals some signature characteristics of what Phillips and Vincent (1986) refer to as "petit bourgeois care" for older people. Of the 28 private rest homes in 1992, two changed ownership (and the name under which they operated) and four went out of business. Of the latter, only one facility had more then 12 beds, while the other three had four, six and eight respectively. At the same time, five new businesses were opened. Three of these were large, with capacities of 25 beds or more. However, the remaining two were of only five beds each, which suggests that residential care was still attracting some small investors. A sixth "new" private facility was created through the sale of a rest home that had previously been operated by the religious/welfare sector.

In summary, between 1992 and 1997 the overall number of geriatric long-stay beds was static in the Waikato, with modest distributional changes from the public sector to the religious-welfare sector. Numbers of rest home beds for older people continued to grow, particularly in the private sector, albeit at a slower pace than previously.

Community Accommodation and Support Services

Table 3 shows that between 1992 and 1997 the private sector became a much more significant provider of targeted housing for the older/retired population of the Waikato.

Table 3 Rest Home Beds in Religious/Welfare and Private Facilities, 1992 and 1997

| | 1992 | | 1997 | | % Change |
Sector	General	%	General	%	1992-97
Public	1,058	(68.5)	1,029	(55.1)	-2.7
Religious/Welfare	321	(20.8)	404	(21.7)	25.9
Private	166	(10.7)	433	(23.2)	160.8
Total	1,545	(100.0)	1,866	(100.0)	20.8

In contrast to residential care, where the state is now primarily a hinder of services, the public sector retains more than a 50% direct presence in the targeted housing sector. As yet, there has been no concerted dis-investment in pensioner housing, with the number of units remaining virtually fixed from 1992 to 1997. However, such a dis-investment has been mooted, and this is central to our discussion of emerging resistance in the next section.

There exist some important contrasts between the two sectors, both in the type of housing provided and the population to which they cater. Pensioner housing units are operated by local authorities and by Housing New Zealand (although the latter does not explicitly divide its housing stock between older people and younger families) and their residents

constitute the most financially vulnerable segment of the older population. Units are generally in small clusters, but there are many of these, such that Hamilton City Council is "landlord" for more than 450 pensioner units. In contrast, retirement housing is usually owner-occupied and caters to retired people with more financial resources. Some developments, such as the 148-home Alandale and the 90-home Netherville in Hamilton, constitute considerable investment by the private sector. Their size indicates the potential for rapid growth in age-targeted housing; these two developments together contribute more than half of all the 433 retirement housing units in the Waikato.

There were several important changes in community support services in the Waikato between 1992 and 1997. In 1992, all three sectors were active in providing support in the home to older people. The public sector was dominant, providing a range of nursing, therapeutic and domestic services, primarily though the Community Health Service, although it is significant that fee-for-service was being introduced while data were being collected in 1992. Home-help services were subsidised on an income-tested user pays basis by the Department of Social Welfare. Three religious/welfare organisations (Presbyterian Home Support Services, the Red Cross and the Waikato Regional Women's Division Federated Farmers) provided personal care, meals and companionship at low cost In addition, three private operators offered nursing and domestic services to paying customers. In principle, public and private services were available across the Waikato, thereby supporting "ageing in place". However, religious/welfare sector initiatives were often highly localised because of their dependence on volunteers. Similarly, private-sector initiatives were geographically uneven because demand thresholds could not be met in all communities.

By 1997, home support assistance had been consolidated within RHA funding with contracting-out arrangements to the religious/welfare and private sectors. However, the Aid to Families or relief care scheme and the Intermittent Care Scheme remained, with the former having a mixed range of providers and the latter focused on hospital providers. The religious/welfare sector essentially retained its focus on providing a mix of meals and domestic help, for which subsidies were clearly available. In contrast, the private sector expanded its provision of nursing and domestic services. As in 1992, support in the home was supplemented by organisations providing "day care" and social activities for older people and their families affected by arthritis, stroke and Alzheimer's Disease. Two private providers of "day clubs" also emerged, and this may signify a broadening of private-sector interest in community support.

Although the data on community support are not as easily quantified as those for residential care, the range of services available to older people broadened, with home helpers assisting with personal care tasks, and became much more complex between 1992 and 1997. This is consistent with national trends (Richmond et al. 1995). It also appears as if financial and geographical accessibility became a greater issue. The ability to pay for services, whether through qualification for subsidies or through personal finances, was elevated in importance because of the withdrawal of the state from direct involvement in the delivery of community support services. Increased geographical variability in accessibility flowed from the same source: the ability of the

religious/welfare sector to replace the state as the provider of services in particular places depended on local initiative and the availability of volunteers. Similarly, the private sector found it difficult to provide services at reasonable cost in many situations.

The Emergence of Local Resistance

We illustrate the emergence of local resistance with reference to media-facilitated public debate. The debate focuses on public opposition to attempts by Waipa District Council to extract greater income from its pensioner housing. By 1996, local authorities like Waipa were looking to divest themselves of "non-strategic assets" such as pensioner housing. Indeed, many local politicians felt that the provision of such accommodation was a social responsibility of central government *(The Waikato Times,* 20 June 1996). Waipa mayor John Hewitt summed up the new attitude amongst some municipal politicians toward subsidised housing for seniors when he noted, "(w)e don't have the right to take from one section of the community to give it to others" *(The Waikato Times,* 23 May 1996). Opinions like this provided the impetus for two proposals aimed at extracting a financial return from pensioner housing in Waipa District.

The first proposal, in May 1996, was to increase rents in the 139 pensioner units owned by the District Council in Te Awamutu, Cambridge and Kihikihi. The increases (of up to 200%) would turn an annual loss of $150,000 (previously referred to as a subsidy) into a surplus of $600,000 *(The Waikato Times,* 23 May 1996). Hostile opposition from tenants forced a partial backdown a week later - only new tenants would be charged full market rent, but the rent for a single unit would still rise from $40 to $90 per week *(The Waikato Times,* 30 May 1996). A petition was organised and a further backdown occurred on June 18 a $76,000 subsidy would be maintained and the rent of a single unit would increase by only $10 per week, from $40 to $50.

However, celebrations among Waipa older people were premature. Only eight months later, in February 1997, plans were announced to sell 127 of the 139 units, with a valuation of $5.5 million *(The Waikato Times,* 21 February 1997). A protest by older residents was quickly organised and pressure was such that Council rejected the plan on February 26 *(The Waikato Times,* 26 February 1997). This marked an important milestone for local older people, but it is salutary to remember that a similar protest in Hamilton failed to stop the 1996 sale of the Riverlea Apartments owned by the Waikato District Council *(The Waikato Times,* 21 February 1997).

DISCUSSION

The period 1992 to 1997 saw a consolidation and broadening of privatisation trends in the provision of residential and caring services for older people in the Waikato that began in the late 1970s and burgeoned in the 1980s (Joseph and Chalmers 1996). It also witnessed the emergence of opposition to the consequences of such change on the part of older people. In this concluding discussion, we place our observation of resistance at the

community level into the broader sweep of social policy development, recognising that social policy has impacts in particular sequences and at a variety of geographic scales.

We contend that older people have been significantly politicised by social policy shifts since the last flourish of the welfare state in the decade following 1975. It is worth remembering that those becoming superannuitants 1975 had "built" the welfare state for 40 years, and had expectations based on a highly developed policy framework and a significant role for the state. Ten years on, government was arguing that this commitment to the welfare state was neither sustainable nor efficient and needed to be restructured.

The first wave of restructuring was essentially economic, with the initial alienation of older people based on significant changes in superannuation policy. Organised opposition to this challenge to income support emerged strongly for the first time in 1984/5 with the imposition of a tax surcharge on the then National Superannuation and the establishment of groups such as the New Zealand Superannuitants Association. Our focus has been on the second wave of restructuring, which was aimed more at social services. It involved the targeting and withdrawal of the state from the direct provision of services, and we have offered a summary of trends and outcomes as they apply to older people in one region.

The single-issue resistance expressed by organisations such as Grey Power and Age Concern New Zealand broadened as older people organised to contest the consequences of the "hollowing out of the state" (Jessop 1994a, 1994b). As we have noted in this and earlier case studies, this process has involved three simultaneous and widely-reported actions by government agencies (see Boston 1995 and Easton 1997 edited collections): the introduction of contracting as a means of instituting tighter financial controls on a shrinking public sector, the "downloading" of responsibilities to local government, and the emergence of the non-government sector as a significant provider on ongoing support services. In the Waikato, as in other regions, power displacement has seen the state transferring responsibilities for the delivery of accommodation and caring services to a host of alternative agencies such as corporate, local government, religious and voluntary providers while itself, through the RHA/HFA, maintaining a role as hinder.

The "second wave" social policy direction between 1991 and 1996, and its continuation under the National/New Zealand First Coalition Government, led to the further alienation of older people on the basis of deteriorating access to resources. It is worth noting these reactions and manifestations of resistance at a variety of scales. At the individual level, the case of Harry Findlay was widely publicised as that of a "battling kiwi" who, personally affronted by the injustice of family assets being run down in order for a spouse to qualify for the residential care subsidy, challenged the CHE's legal rights to make charges against personal assets *(The Press,* 29 August 1997). At the local government level, the Waipa District case presented older people "digging in" to oppose a specific initiative that threatened their homes and feelings of community. At the national level, resistance was promoted by organisations like Grey Power and manifested in calls to support political parties which advocated an alternative social policy agenda acceptable to older people *(The Sunday News,* 29 September 1996).

Our research suggests that social policy needs to address two important consequences of first and second wave restructuring: issues of accessibility and feelings of alienation. While the total supply of accommodation and residential caring services has increased since 1984, accessibility has also become re-defined, both in financial and geographical terms, In the world of user-pays, financial accessibility is determined by assets/income or by qualification for subsidy, with a major concern of older people being that the latter often involves the loss of the former. Geographical accessibility is a familiar issue in rural New Zealand, but its renewed importance flows from the difficulties encountered by religious/welfare and private providers which attempt to take the place of the state in small towns and isolated communities which do not have economies of scale to make them financially viable. Many communities may have experienced only the withdrawal of the state and are still waiting for the offsetting expansion of the religious/welfare and private sectors.

Society has moved on from 1984, as a consequence of both long-term demographic and social change and the pervasive impacts of 15 years of restructuring. This must be acknowledged in the development of policy options to address the accessibility issues noted above. While families and communities may want to do more for older people (Chalmers and Joseph 1998), in the absence of formal support services, opportunities are clearly constrained. Families are smaller and more geographically dispersed than in earlier generations and women are more likely to be at work than in the home.

Older people are left bemused by the ideology of "self-help" and confused by the complexity of processes governing access to a plethora of service providers. "Worry" may be the order of the day. As Leone Shaw, a spokesperson for Age Concern New Zealand noted, "(w)hen you're older and frail, you sit for longer, it's hard (for them) to stop worrying" *(The Waikato Times,* 20 June 1996). We argue that there is a sense of abandonment and betrayal among older people. They feel threatened by the changes to their pensions and the health and social support infrastructure since 1984, and this has soured their attitude towards innovation in social policy.

As organisations like Grey Power have been unable to achieve clear success in advancing their agenda, older people have become cynical about the political process. Indeed, the apparent failure of MMP to provide a vehicle through which older people can challenge the ideological stance of government has given rise to considerable anxiety, amounting at times to disillusionment with the democratic process, as conveyed in this Grey Power statement from 1998:

> The electorate expected MMP to deliver moderation and consensus, bringing a shift from the extreme, right wing, free market policies that have undermined the caring social values characterising New Zealand society for much of this century.

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