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Identifying service needs from the users and service providers' perspective: a focus group study of Chinese elders, health and social care professionals

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Aim. This is a preliminary study to identify older people service needs in Hong Kong from the users' and service providers' perspective.

Background. As the Hong Kong population is ageing rapidly, it is important to identify the needs for care of older people. Although a wide variety of medical and social services have been provided to meet the needs of older people, there has been little evaluation from the users' or service providers' perspective regarding what the needs are and how well current service provisions match their needs. In recent years the importance of patient-centred care has been emphasised, where patient's expectation of care has been given a central role in guiding and improving the provision of health. However few studies have been carried out with respect to services for older people.

Design. To identify the service needs, a focus group study was conducted. Both service providers and older people were interviewed. This preliminary study used a qualitative research method to identify older people's service needs, generating rich information which could be used to inform older people care service development.

Method. Data were collected by conducting eight focus group discussions. The focus group interviews were audio-taped. Interviews were then transcribed and themes were identified.

Results. The study identified several areas for improvement in services for older people, covering adequacy, accessibility and affordability of medical services, coordination of health and social care, quality of long-term care, negative perceptions and training needs. Some themes such as service adequacy and negative staff attitudes occurred in both older people and health professional focus groups. The themes of fast access, continuity of care and smooth transition, affordability, provision of information of available health and social services appear to be universal as these have also been identified in similar studies in other countries.

Conclusion. In addition to other objective outcomes, such as duration of stay in hospital or re-admission rates after hospital discharges, changes in service provisions towards improvement should be evaluated from the users as well as professional care providers' perspectives.

Relevance to clinical practice. Areas of improvement in service delivery include timely access, continuity, affordability, better coordination of health and social care, quality of care particularly in the long-term residential care setting and healthcare professionals' communication and caring skills and attitude.

Key words: elderly, focus group, nurses, nursing, service needs, users' perspective

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Introduction

Hong Kong is experiencing a rapidly ageing population. To meet the challenges it will bring for Hong Kong, a systematic evaluation of services for older people needs is required because it is useful for planning of service provision. Hong Kong has a comprehensive range of medical and social services, partly modelled after the UK. The key organisations providing care are the Hospital Authority, the Social Welfare Department, various subsidised non government organisations and the Department of Health. Direct financial assistance is provided in various forms, such that eight out of 10 elders aged 65 and above receive assistance: 460,901 receiving non-means tested Old Age Allowance; 52,216 receiving non means tested disability allowance; and 186,938 receiving means-tested Comprehensive Social Security Assistance (Social Welfare Department, Hong Kong Government, Hong Kong, unpublished data). In addition, the government subsidises about 90% of elders living in Residential Care Homes for the Elderly (RCHE). Approximately 9% of the older population reside in RCHEs. Community-based services are also available, consisting of Day Care Centres and home-based care teams (social and health care support). The current government policy is to promote ageing in place in the community and reduce the demand for RCHEs. Primary care is predominantly provided by the private sector (> 85%) while hospital services are largely provided by the government (> 95%) at very low cost. Health care is free for those who cannot afford to pay (Woo 2007). Long-term institutional care is provided by social services and to a small extent the hospital service, the private sector providing more than half.

For people aged 65 or above, comprehensive preventive healthcare services are offered by the Department of Health through 18 health centres for older people and 18 visiting health teams supporting Residential Care Homes. The services include health assessment, physical check-up, counselling, health education and some curative treatment. The visiting health teams reach out to the community and residential care settings to conduct health promotion activities for older people and to provide training to carers to enhance their health knowledge and skill in caring for older people.

Although a wide variety of medical and social services have been provided to meet the needs of older people, there has been little evaluation from the users' perspective regarding what their needs are and how well current service provisions match their needs. In recent years the importance of patient centred care has been emphasised, where patient's expectation of care has been given a central role in guiding and improving the provision of health care (Coulter & Ellins 2007, Richards & Coulter 2007, Levy 2008). However, few studies have been carried out with respect to services for older people from the users' perspective. These few include a focus group study among older people in the UK, which highlighted a desire for better service matching practical needs and coordination and difficulties in transport and accessing information (Hayden *et al.* 1999). Gaps in service provision have also been reported among older patients aged 60 years and above in Australia (Grimmer *et al.* 2004). In Hong Kong, a recent survey found that an automated telephone booking system for general outpatient clinics originally intended to avoid queuing in person, has caused much difficulty among older people who preferred a personal dialogue (Hong Kong Society for Community Organization 2007). These studies suggested that users may find the current services inadequate (Chan & Phillips 2002, Tong *et al.* 2006, Woo 2008). Furthermore, there have been few studies seeking the opinions of professionals involved in frontline care of older people. Therefore we carried out a study to identify the needs for older care services from the perspective of older people as well as that of service providers, by means of focus group methodology. The information obtained would be useful in informing older people's service development.

Method

Design

This is a preliminary study to identify older service needs in Hong Kong from the users' and service providers' perspectives. Focus group was used because it is an appropriate technique to provide an insight into the elder's needs regarding services and also to gather opinion from frontline health and social service providers working with older people (The PLoS Medicine Editors 2007). A key strength of focus group is that it allows an in-depth exploration of the participants' perspective and understanding through group interaction (Krueger 1988).

Participants

Eight focus groups with a total of 48 participants were arranged. Aiming for a minimum focus group size of six people, six to eight people were invited to each of the eight focus group discussions.

For older people, four focus groups with a total of 24 participants aged 65 years and over (mean age 74·6 years, 13 men, 11 women) were conducted. Participants were identified through purposive sampling through social service agencies and units. We recruited both older people and health

professionals from two contrasting regions of Hong Kong that cover a broad spectrum in terms of socio-economic background such as education and income. For older people, the two largest non government organisations that provided community social services were approached for potential interview with their clients on a voluntary basis. For health professionals, we included staff from the major regional hospitals.

For service providers, four focus groups (two for health care workers and two for social workers) with a total of 24 participants were conducted. In health care groups, doctors, nurses, physiotherapists and occupational therapists who were specialised in care of older people were recruited for interviews. In social worker groups, registered social workers who worked in centres for older people, day care centres and old age homes were recruited.

Procedure

The research protocol was approved by The University of Hong Kong Human Research Ethics Committee. Each focus group was conducted by two members of the research team. One member served as the facilitator and the other member served as an observer/note-taker. The facilitator engaged the participants with active listening, sought clarification and ensured adequacy and accuracy of content where appropriate. The observer/note-taker took field notes during the focus groups and also immediately afterwards.

The facilitator began each group session after explaining the purpose of the study to the participants and obtaining their written consent. Participants were then asked to discuss their views on current older people's services, for example, the services they would like to have but were not currently available. The facilitator encouraged participants to discuss freely and took steps to involve all participants in the discussion. Each session lasted for approximately 60 minutes. With the participants' permission, the focus group interviews were audio-taped for data analysis.

Transcripts were reviewed and analysed by two members of the research team. Recurring themes within and among groups were identified through a process of framework analysis (Ritchie & Spencer 1994). In framework analysis, transcripts were read a few times and field observation notes were studied. Key ideas and recurrent themes were recorded as research notes. Main issues, concepts and themes were identified, drawing on the original research aims, emergent issues raised by respondents and themes arising from patterns of particular experiences, which eventually formed a thematic framework. Relevant passages of transcripts were then extracted from the original context and rearranged according to the appropriate thematic reference. In the analysis stage, charts of themes and extracts, research notes and field notes were reviewed. Comparisons and contrasts were made between perceptions, accounts and experiences both within and between participants. Patterns and connections were noted and accounted for in the final results.

To ensure the descriptive validity of results, audio-recordings of focus group sessions were made which were then transcribed verbatim. Interpretative validity of results could be ensured as the chosen themes were supported by the participants' own words. Observation field notes were referred to when selecting quotations to illustrate a theme and when making associations between themes, to ensure theoretical validity (Chioncel *et al.* 2003).

To ensure reliability, data were analysed by the two research team members respectively to know that no themes were overlooked. In case of discrepancy in opinion between the researchers, discussions were made until a consensus was reached.

Results

Observations of focus group dynamics and interactions

Rapport and participation

In a relaxed atmosphere, participants were able to exchange opinions freely. After warming up initially, the participants openly shared their opinions with the group facilitator and also with other participants. Interactions were frequent and complex, for example, participants were able to elaborate on their comments when prompted by the facilitator and they were also able to express their own opinions to further the comments of others.

Group conformity

Uniformity of responses did not become an issue as a variety of different attitudes and opinions were elicited from participants.

Dominance vs. withdrawal

To the talkative/dominating participants, the facilitator gave less attention and reinforcements in dialogue. On the other hand, the less out-spoken were given more encouragements and sometimes actively invited to express their opinion.

Interpersonal conflict

In one of the focus groups, when an older person from Shenzhen commented on the lack of respect for older people in Hong Kong society, another Hong Kong older person expressed strong disagreement. The facilitator acknowledged

both sides of the argument and reminded participants not to take such oppositions personally, before swiftly moving on to the next topic of discussion.

'Flow' of opinions

At times when participants dwelled on a topic for a prolonged period, the facilitator intervened to diverge the discussion, by summarising previous points and moving on to the next topic of interest.

Older group

The main themes regarding service needs were: 'Medical services', 'Attitude of medical staff' and 'Homes for older people'.

Medical services

The most frequently expressed opinion was that government medical services were inadequate. First, the time for accessing medical services provided by the government was too long:

> For some medical services you need to wait for a year, or two. How the disease would have progressed, you would not know.

Second, the current medication fees were too expensive for older people to afford. Some suggested that a discount scheme should be offered to older people admitted to hospitals and emergency service:

> The problem is, the diseases that we get require long-term medication. Things like diabetes and high blood pressure medicines…some you need to buy for yourself…I'm retired without any income and I don't have the resources.

> Take going into hospital for example, staying for a fortnight would cost more than a thousand and some elderly find it really difficult to pay for. They should give 50% discount to elderly inpatients and for emergency cases, I hope they could give a discount for those older than eighty.

Third, older people urged for better medications to be prescribed by doctors. Public hospital doctors were viewed as unwilling to prescribe better medications to the patients because of cost constraints. They tended to prescribe medications that were cheaper but had side effects and then prescribe another drug to deal with the side effect. The cheaper medications were usually viewed as ineffective.

Attitude of medical staff

The attitude of medical staff was not friendly or helpful towards the elders. The staff may shout at them or were rude towards them. Some staff gave the impression that they did not really care about the health conditions of the elders and sometimes ignored their needs. Elders often had to put up with the rudeness of medical staff and they found it very disturbing. They commented that staff should learn how to be polite and respect elders:

> Well some are really rude. Once I was asked how I was doing, so I told him about my different conditions and whatever else related. He then said, hey I just asked you one thing, what about your eye and your blurred vision and all that? I wasn't asking you about those, I was asking about your stomach…I got the guts to answer back and I said, hey doctor you know that I have a heart problem and you scared me, please don't shout at me like that 'cos I've palpitations. You didn't specifically ask me about one thing, so I just told you whatever I know, why are you shouting at me so loudly? So he apologised and did better next time. Some nurses act the same and shout at us. Alright sometimes we haven't a clue about things, but then you should be polite to older people as long as you are a medical personnel…you should respect the elderly.

Homes for older people

The common opinion on homes for older people was that government old age homes had much better quality than the private operated ones in terms of hygiene and cleanliness:

> We lack residential care homes. If you really want to live in a care home, you need to wait for a few years. The private ones are really expensive and unaffordable and the government ones are hard to get into. Even care homes have problems of their own…The government subsidised ones like Po Leung Kok or Tung Wah Group of Hospitals, they have great facilities and they are clean and modern. The private ones have low quality in comparison…First of all for their bad hygiene.

The quality of the private homes varied according to the fees charged. In general, the higher the quality home being more expensive and largely unaffordable for many people. As it is very difficult to obtain a place in government homes; they suggested that more land should be allocated for building government old age homes:

> In my opinion, I hope the government could build more care homes. Like now, most of them are subsidised. I hope the government could run their own. I hope the government can allocate more land for building care homes, since private homes are predominant at present.

More supervision should be imposed on private homes by the government. In addition, lack of resources has caused the poor quality in private homes. Some subsidised services had abundant resources while the private homes had little, which resulted in their poorer quality. Apart from allocating more land, the government should also provide resources to

facilitate improvement, such as providing training for workers. The workers in private homes were usually not trained with older people care skills and were mostly housewives:

You can go into a private care home any time, but the facilities are lacking and the general knowledge of personal care workers are inadequate. If the government wish to improve on this aspect, (they should) increase training for their staff.

Service provider group

The emerging main themes regarding service needs were: 'Service gaps', 'Preventive care', 'Training for professionals' and 'Educating the general public'.

Service gaps

Disconnection between different services needed for older patients was agreed by all providers. Patients who were discharged from the hospital often needed home care and home help service. Yet many of these were not immediately available. Elders who had immediate need for services would suffer as a result of the long waiting time:

The problem is linkage between different services. When the patient is discharged to the community, often they need home care. However, except for the meal delivery service which is immediately available, other services are not – the day care centre, for example, has a waiting time of six months. It isn't so easy to relieve the caregivers' burden as we thought.

Because of the long waiting time for day care, patients were often forced to stay at private homes, which providers believed has created a mismatch between service and actual needs:

Most elderly discharged from the hospital expect to be taken care of during day time and they don't actually need residential care, but a lot of people would hire a domestic helper or send the elderly straight to a private home while on a year-long waiting list for the scarcely available government care homes.

The idea of continuity of care was supported because coordinated services from different providers would provide convenience and comfort for users. However, participants reflected that services for older people in Hong Kong were in fact fragmented by barriers between social and medical sectors. Post discharge services were not taken care of by any specific organisation. Instead, the elders were bombarded with many services by different organisations:

I agree with 'continuity of care' but I don't think it's very successful. Take community service for an example, although there are more collaborations with hospitals now… Services are split amongst a number of organisations, so (the elderly) will need to be assessed by each of the different organisations that provide the services. It would be ideal if one organisation can provide all the services needed. In fact it's a problem of supporting measures in health services.

The lack of coordination between organisations has adversely affected the elders particularly when they were repeatedly enrolled and reassessed whenever they used new services provided by a different institution:

The whole geriatric sector seems so fragmented right now… and how do these providers collaborate? It is the elderly who suffer the most, they would have had many social workers in their life time, with numerous intakes, but I would question whether one single social worker would be better.

Preventive care

The importance of preventive care was also stressed. More cost-effective resources should be allocated for preventing deterioration of health, such as day care facilities or home help services to retain the elders in the community:

Resources used for prevention have been scarce. When the elderly becomes frail, the resources poured in are double, even triple the amount needed for prevention, is that even worthwhile? Day care service and home help service could keep the elderly in the community longer, before the decline to frailty.

One should not ignore measures for maintenance of function, unless elders become so frail that long-term residential care placements must be arranged:

More prevention work should be done to keep the elderly in the community, then even very frail elderly may not need to be placed in residential homes. Intensive care should be reserved for those with real need, for example if the family couldn't care for them, or those with pain disorders who need professional care.

Prevention should also include educating the soon-to-be-old population to keep a healthy lifestyle and delay the onset of chronic diseases or functional impairment:

It's too late to start prevention in geriatric care. The really frail elders that we have now, it's difficult to provide for all their needs. It would be more practical if we start preventing chronic diseases in the younger population…but even so, do people in their forties or fifties realise that they need to be prepared? Do we have supporting measures to help this age group exercise more and stay active, to prevent future degeneration.

Training for professionals

Some participants commented that the negative attitude of some health care workers could be an area of improvement.

Some of their colleagues tended to view older people as being frail and weak and lacked respect for them. Education and training are needed in this aspect so that staff could have better communication skills and attitude towards older people:

Educating the right attitude is more important than anything else. There are so many things to learn in elderly care…dementia, care skills for different diseases and everything, but if you have an attitude of respect for the elderly, caring with an elderly-centred attitude isn't that hard to learn at all.

Perceived needs for professional training were not entirely focused on clinical skills in geriatric care. Rather, participants believed that training should target the lack of communication and management skills specific to handling situations relating to older people, for example, psychiatric co-morbidities. Targeted training was expected to increase the competency of front line staff, with further benefits in job satisfaction:

Those used to working in acute care may not have the communication skills specific for elderly care. Depression actually brings about many behavioural problems which colleagues may find difficult to handle. They may have attributed the depressed or angry mood of elderly to their own wrong-doings and feel they have a problem in caregiving. Training up more front-line staff may enhance their sense of satisfaction.

Educating the general public

All providers agreed that family carers of older people lacked support and resources. They might not have relevant medical knowledge and were under great pressure when taking care of the elders. More training should be given on caring skills for older people in addition to basic medical knowledge for home helpers or knowledge regarding available resources for common conditions. If sickness occurs, then family carers would be able to take care of older people or to seek appropriate health and social care in the community without being over dependent on hospitalisation. This may also help to relieve the burden on carers:

We need to educate the public on attitude towards the elderly. There are talks on caregiving skills in the community for carers. If they send the elderly to hospital for chronic recurrent conditions like low back pain, that would burden the hospital in terms of admission rate. On the other hand, if they could get information or contacts from community or NGOs, then they could manage their own conditions at home. That way the hospital admission rate could be lowered and they wouldn't need to depend on other people. It would be much better for them to have that self-help attitude of finding resources for themselves to tackle the problem.

Education should start early for the younger generations to cultivate respect for older people and a perception that the aged are not inevitably useless and frail. Early education allows the young to grow up with a positive image of ageing and also encourages families to take care of older people:

The whole society considers the elderly to be useless, the family considers them useless and one more burden, even the elderly themselves consider staying at home to be adding to the burden of the family, so this kind of thinking runs through from those providing care and the elderly themselves, they all think, I'm useless and it's a really heavy thought.

I wish for enlightenment in society's attitude towards the elderly. The elderly can be full of wisdom in their late stage of life, but turns out the society at large consider the elderly to be very stubborn and burdensome.

Many families are not willing to participate in courses about skills on caring for older people and more promotion is needed so that families may acknowledge their responsibility for the aged in their families:

A lot of elderly centers are required to provide caregiver services and we know we have to organise a lot of training courses for elderly caregivers, but the response was never very impressive. The family caregivers would always push the frail elderly to care homes for us to care for… even sometimes when we invite family caregivers to come (to the care home) and teach them (caregiving) skills they wouldn't have any interest at all, because they think that's not their responsibility.

Specific groups of caregivers, for example, spousal caregivers of stroke patients are in need of support in terms of information, training and services:

Apart from asking them to go to St. Jacob's, not much seem to be offered to the caregiver, considering the magnitude of care-giving stress that they experience. This is true for women caregivers in particular. Very often if the stroke patient is a man, his loving wife would take him home to care for, but without first considering for her actual ability to provide for his care needs. They most likely would ignore their own stresses and the relevant support services are inadequate.

Discussion

Analysis of findings from the focus groups showed some similarity between older people's views of medical service needs and professional frontline service providers' views. From the older users' perspective, with respect to medical services, the long waiting time and affordability issue is also reflected in the professionals group, expressed in terms of

gaps, discontinuity and long waiting time for services. This problem reflected the lack of a well developed primary care system, since it is mainly provided by an essentially profit driven private sector, thus excluding many services for older people which may not be sustainable on a fee-charging basis. The users' perception that government provided drugs may not be as good as more expensive ones is an interesting concept. It may represent current consumer attitude that the more expensive, the better the quality. Unfortunately, this view may be based on patient's real life experience of lack of effect with drugs prescribed by government clinics compared with the private sector, particularly regarding generic drugs. This view may also be the result of health resource limitations, where drug budgets are necessarily restricted, with some items requiring additional payment by patients themselves. Both older people and service providers commented on staff attitude, which may represent the pervasiveness of ageism or a negative perception of ageing. Alternatively, the problematic attitude may be a result of manpower shortage where additional time and patience for looking after older people are not available. The service provider group thought that negative attitudes and perceptions could be minimised by providing education and training.

Comments from users and health care providers differed in two aspects. The users group raised concerns regarding the quality of long-term care. It is interesting that there is a wide spread perception that government subsidised residential care homes have better quality than privately run institutions. This view may account for the long waiting list for government subsidised homes while there are vacancies in the private sector. This may not be explained entirely by the cost of private homes, since welfare allowances may cover most of the cost of care in private homes. The public appear to consider that long-term residential care should be provided directly or indirectly by the government, who should also be responsible for the quality of care. This issue may need to be addressed in the future in the context of healthcare financing reforms and development in linking quality assurance to licensing regulations. The desire for better communication with and respect from health care providers was raised by older participants, suggesting that this is an area that could be improved with elder care training. Service providers also discussed the importance of prevention in terms of maintenance of health and function to prevent decline in the community setting, as well as the importance of empowerment through raising health literacy with respect to ageing issues.

While the findings from this study may not be directly comparable to the majority of studies from the users' perspective only, some comments in relation to findings in Europe, the USA and Australia may be made. The findings of the focus group are similar to a community-wide study showing that there is a discrepancy in the perception of service needs between health care providers and older people and that a major concern was effective communication regarding how to locate and access the necessary services, the need for home-based support services, health promotion and education (Sixma *et al.* 2000, Nolina *et al.* 2006). A qualitative study of older people's experience of institutional care in Finland highlighted ethical problems in the physical, psychological and social domains, such as lack of dignity, choice and staff rudeness (Teeri *et al.* 2006). The importance of maintaining the dignity and autonomy of older people in the healthcare setting as a component of quality care has also been pointed out in the UK (Lothian & Philp 2001). The authors also documented stereotypical negative attitudes towards older people held by many healthcare professionals and suggested that tackling negative attitudes through exposure and education may help to preserve older patients' dignity and autonomy. Three studies of older people living in the community highlighted the lack of information that may help them manage their health, availability of functional and social support, mismatching service needs and available services, rigidity in service provisions, inability to cope with complexity of services or informational technologies required for accessing services and lack of community organisational support such as better lighting, provision of more benches in public places and longer duration of pedestrian lights for crossings roads (Gallagher & Truglio-Londrigan 2004, Grimmer *et al.* 2004, Valokivi 2004). With reference to our current findings, the themes of fast access, continuity of care and smooth transition, affordability, provision of information of available health and social services also appear in studies from other countries, suggesting that strategies for meeting the needs and aspirations for older people may be applicable across different societies.

The findings point to the following directions for improvement in service provisions for older people. Firstly, the development of a primary care system not dependent on the private sector, with integrated medical and social services in one site, may address the issue of accessibility and provide more coordinated care. Efforts are required to bridge the gaps between medical and social services so that resources can be used more effectively (Woo 2007). Secondly, an emphasis should be placed on providing preventive care for older people and support to family carers. With respect to prevention and health promotion, an alternative ecological approach where health promotion is integrated into community and health care settings similar to the Health Promoting Schools, following the settings approach advocated by the

World Health Organization, has been proposed in the Australian Context (Harris *et al.* 2008). In terms of the actual care process, the responses from participants emphasised the need for patient-centred care. A recent review highlighted that while this approach covers many dimensions, the interaction between nurse and patient is central to the effective study and application of patient centred care, with improved outcomes (Hobbs 2009). Training on skills and knowledge of taking care for older people, for both formal and informal carers can provide some measure of empowerment and reduced dependence on the government medical system. In addition, behavioural and psychosocial interventions for family caregivers developed in other countries would be an important component for informal care-giving (Zarit & Femia 2008). Initiatives to counter the negative perception of older people may address the issue of poor attitudes. Negative stereotypical views have been shown to be linked with vulnerability associated with old age. It has been pointed out that understanding the concept of vulnerability should enable nurses to promote the centrality of older people in service provision and to empower them (Brocklehurst & Laurenson 2008). More training needs to be provided to change the misconception of older people as frail and useless (Chau *et al.* 2010) and education should start early for younger generations about respect for older people and the responsibility to take care of the aged in their families. New initiatives should be evaluated, so that any new developments should be based on evidence.

There are limitations in the present study, in that older people recruited form non government organisations may not be representative of the Hong Kong older population, because those in the higher socioeconomic groups are less likely to be members of such centres. However, older people in the lower socioeconomic groups will be more likely to be dependent on government provided services rather than entirely on the private sector. A major strength of the study is the use of a qualitative research method to identify service for older people needs from the perspective of service providers as well as older people, generating rich information which could be used to inform service development for older people and form a basis for future research and study (The PLoS Medicine Editors 2007). Nevertheless, the use of focus groups alone as a research tool has its limitations and future studies may include population-wide surveys using questionnaires based on information generated from these results.

In conclusion, we have identified considerable areas for improvement in services for older people in Hong Kong, covering adequacy and accessibility of medical services, coordination of health and social care, quality of long-term care, negative perceptions and training needs. Changes in service provisions towards improvement should be evaluated from the users as well as professional care providers' perspectives, in addition to other objective outcomes.

Relevance to clinical practice and service delivery

- Health care professionals involved in care of older people could improve on their communication and caring skills and attitudes. Training programmes should emphasise these aspects.
- Key features in service delivery include timely access, continuity, affordability, better coordination of health and social care and quality of care particularly in the long-term residential care setting.

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Contributions

Study design: JW, BM; data collection and analysis: JW, BM, EC and manuscript preparation: JW, BM, JC, EC.

Conflict of interest

None.

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