ABSTRACT

Objective: To identify, assess, and rank the importance of health care needs of community-dwelling older adults.

Method: A structured telephone interview with 107 respondents (physicians, direct service providers and administrators) about the importance of a list of 31 health care needs of older adults. Respondents also identified the single most important health issue facing local older adults now and in the next 5 to 10 years.

Results: The five most important health care needs, in descending order, are: care-giver support services, community long-term care services, services for people with dementia/Alzheimer's disease, palliative/end-of-life care, and services for cancer patients and their families. Community long-term care services were identified as the single most important health issue both now and in the next 5 to 10 years.

Conclusion: The study findings should be of value to health and social service researchers, planners, providers and administrators regarding the needs of community-dwelling older adults.

ABRÉGÉ

Objectif: Définir, évaluer et classer par ordre d'importance les besoins de soins de santé des personnes âgées résidant dans la communauté.

Méthode : Entrevue téléphonique dirigée auprès de 107 répondants (médecins, prestataires de soins de première ligne et administrateurs) sur l'importance de 31 besoins de soins de santé chez les personnes âgées. Nous avons aussi demandé aux répondants d'indiquer l'enjeu le plus important pour la santé des personnes âgées de leur localité, aujourd'hui et pour les cinq à dix prochaines années.

Résultats : Les cinq principaux besoins en matière de soins de santé sont les suivants (par ordre d'importance décroissante) : services de soutien aux soignants; services de longue durée dans la communauté; services aux personnes atteintes de démence ou de la maladie d'Alzheimer; soins palliatifs ou au terme de la vie; et services aux cancéreux et à leurs familles. L'enjeu des services de longue durée dans la communauté est considéré comme le plus important aujourd'hui et pour les cinq à dix prochaines années.

Conclusion : Les constatations de l'étude devraient être utiles aux chercheurs, aux planificateurs, aux administrateurs et aux prestataires de services sociaux qui se penchent sur les besoins des personnes âgées résidant dans la communauté.

Health Care Needs of Community-dwelling Older Adults

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Health care restructuring has placed increased emphasis on service development and management at the regional and community levels. If decision makers are to be effective, locally relevant information must be available to identify health service priorities. Needs assessment is a tool to determine a community's service needs, identify gaps in service provision, and establish priorities for funding. As part of the planning process, it also helps determine whether or not a health or social problem is a concern of the community. Therefore, needs assessment is often the first phase of a process that includes service planning, implementation, and evaluation.^{1,2}

Needs assessments can be done in a variety of ways. Health planners generally select a method or methods that can achieve the goals of the study without being too financially or politically costly. In situations where needs assessments provide a basis for allocating scarce resources, they must not only provide valid information, but also be implemented efficiently and the results used appropriately.^{3,4}

The purpose of the present article is to describe a recent community needs assessment that was conducted to identify health care needs of older adults living in a mid-sized Ontario community. Brant County, located in Central West Ontario, contains

both urban and rural areas and a population of approximately 125,000 people. The focus of the health needs assessment was older adults (people aged 55 years and older) living in Brant County. The primary objective of this research was to identify, assess, and rank the importance of health care needs of older adults living in Brant County.

METHODS

Questionnaire design and implementation

This investigation used a cross-sectional telephone interview of people knowledgeable about the health care needs of older adults in Brant County. A draft list of health care needs was compiled after reviewing the literature and consulting with a variety of key informants including academics involved in aging research and those providing health and social services to seniors. Preliminary drafts of the list of items, questionnaire and implementation strategy were then reviewed again by these key informants. The revised questionnaire was pilot tested with several St. Joseph's Hospital employees known to be well informed about the needs of older adults in the community. Minor modifications were made based on these pilot interviews.

The final questionnaire included 12 closed-ended or partially closed-ended questions, one of which was to rate the importance of 31 listed health care needs of older adults from very important to not at all important using a five-point scale (very important, fairly important, neutral, not very important, not at all important). In addition, respondents were given the opportunity to list "other" potential health care needs and to rate the importance of

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those needs. Respondents were also asked to state the health care need they believed to be the *single* most important health issue facing older adults now and in the next 5 to 10 years. Trained interviewers recorded respondents' answers to the closed-ended and partially closed-ended questions.

Approximately one week prior to the interview, each potential respondent was mailed a personalized letter to explain the purpose of the study and allow respondents sufficient time to think about issues prior to the interview. Several media releases (local newspapers and radio) were also made during the early stages of the study to inform the community about the research.

Telephone calls to respondents began by asking them to confirm that they, or the organizations they worked in, provided services for older adults, and that they were the most appropriate contact person. Respondents who did not meet these eligibility criteria were recorded as inappropriate. Alternate respondents in the same organization, if identified, were later contacted and interviewed, if eligible. A telephone interview log sheet was completed for each respondent. Up to seven follow-up calls were made to contact respondents.

Selection of respondents

Respondents, both internal and external to the community, were selected on the basis of their role, expected knowledge of, and experience meeting the health care needs of older adults. Potential respondents were identified through a review of community directories⁵⁻⁹ and by personal recommendation with other respondents (snowball sampling). Community leaders and organizations involved in the planning and administration of services for older adults in Brant County were also included. Two research assistants independently selected respondents from all local social and health organizations whose clientele could be expected to include older adults. Each assistant's list was then combined and cross-referenced to produce a comprehensive list of people knowledgeable about the health care needs of older adults in Brant County. External respondents (primarily geriatricians and/or university faculty with a research focus on aging from McMaster University,

University of Guelph or University of Waterloo) were identified through snowball sampling, a review of directories at a local university,^{10,11} and a directory of national organizations and associations involved in health promotion.¹²

Data analysis

All open-ended responses were entered into a wordprocessor along with questionnaire identification numbers. Open-ended data were independently coded by the two research assistants. Disagreements in coding were resolved by consensus and then converted to numeric codes. The numeric data were then entered and analyzed using the SPSS statistical software package (version 7.5.1 for Windows, SPSS Inc., Chicago, 1996). Closed-ended responses were entered directly from the questionnaires into SPSS. Frequency counts and percentages were calculated prior to ranking the health care needs from most to least important (1 to 31). The rankings for each of the 31 listed health care needs were calculated separately by type of respondent (physician, direct service provider, and administrator) and for all respondents combined. Chi-square analyses or, when appropriate, Fisher exact tests, were used to determine whether the responses differed by type of respondent for each of the 31 listed health care needs. Odds ratios (ORs) and 95% confidence intervals (CIs) were also calculated, and are reported when appropriate. A probability level of 0.05 was used to determine statistical significance. SPSS and Epi-Info (version 6.04a, Centers for Disease Control and Prevention, Atlanta, 1995) were used for statistical computations.

RESULTS

Respondent participation rate

Of the 139 people the research assistants attempted to contact, 122 were eligible and 107 completed the interview. Nonrespondents were classified as refusing or not returning calls ($n=15$), inappropriate contacts ($n=11$), or not reachable ($n=6$). This resulted in a total participation rate of 77.0% (107/139), or an adjusted participation rate (excluding ineligible) of 87.7% (107/122).

Respondent characteristics

Respondents were grouped into one of the following three categories: physicians (12.1%), direct service providers (36.4%), and health agency administrators (51.4%). Table I provides a more complete description of these categories. Of the 107 respondents, 90 (84.1%) were situated in Brant County, and 17 (15.9%) were researchers or physicians located in other Central West Ontario communities.

Importance and ranking of health care needs

Table I lists the 31 potential health care needs, the percentages of each respondent group who felt the health care need was *very* important, and the overall ranking of each health care need, from most to least important. The percentage of all respondents who indicated a particular health care need was *very* important ranged from a high of 86.1% for caregiver support services such as respite care, day care, counselling, and self-help/support services (ranked #1) to a low of 21.6% for speech services (ranked #31). In addition to the 31 listed items, respondents also identified and rated accessibility of services (15.0%) and health promotion services (5.6%) as very important.

In order to determine if there were differences in responses based on the type of respondent, we compared the responses of physicians, direct service providers, and administrators by calculating separately tests of statistical significance for each of the 31 listed health care needs. There were statistically significant differences for only three of the listed health care needs. Service providers and administrators combined were more likely to report the need for physicians specializing in geriatric medicine as very important than were physicians (OR 6.38, 95% Exact CI 1.57 to 30.37). Respondents also differed on their rating of the importance of pain management services ($p=0.028$) and respiratory disease services ($p=0.049$). Compared to physicians, administrators and service providers were both more likely to rate pain management services as a very important need of older adults (OR 2.84, 95% CI 0.67 to 14.04; OR 5.73, 95% CI 1.23 to 29.91, respectively).

TABLE I
Percentage (and rank) of Key Informants Who Felt the Health Need was Very Important to Older Adults, by Type of Key Informant

Potential Health Care Need	Physicians* (n=13) Percent	Direct Service Providers† (n=39) Percent	Administrators‡ (n=55) Percent	Combined (n=107) Percent (Rank)
Caregiver support services such as respite care, day care, counselling, and self-help/ support services	76.9	94.7	82.7	86.1 (1)
Community long-term care services such as homemaker services, meals-on-wheels, home help for personal tasks, and in-home nursing care	76.9	84.6	81.1	81.9 (2)
Services for people with dementia/Alzheimer's Disease	84.6	86.8	76.9	80.8 (3)
Palliative/End-of-life care	76.9	82.1	79.2	80.0 (4)
Services for cancer patients and their families	66.7	70.3	76.9	73.3 (5)
Training and upgrading for professionals working with older adults	76.9	71.1	71.7	72.1 (6)
Long-term care facilities	61.5	84.6	64.7	71.8 (7)
Services for detecting and managing abuse and neglect	46.2	78.9	67.9	69.2 (8)
Physicians specializing in geriatric medicine	30.8	78.9	69.1	67.9 (9)
Services for people with physical disability and assistive devices	46.2	73.7	66.7	66.7 (10)
Transportation services	69.2	66.7	62.3	64.8 (11)
Mental health services	53.8	73.0	61.5	64.7 (12)
Medication use awareness	61.5	76.9	53.9	63.5 (13)
Relocation planning services such as CCAC, discharge planning	46.2	61.5	60.4	59.0 (14)
Pain management services	30.8	71.8	55.8	58.1 (15)
Housing	54.5	63.9	53.1	57.3 (16)
Facilities for socializing and recreation	53.8	64.1	50.0	55.7 (17)
Services for diseases of the cardiovascular system	41.7	52.6	54.9	52.5 (18)
Services for diseases of bones and joints	38.5	58.3	45.1	49.0 (19)
Respiratory disease services	23.1	61.1	44.0	47.5 (20)
Incontinence services	53.8	48.6	40.8	45.5 (21)
Nutrition services	30.8	55.6	41.5	45.2 (22)
Foot care services	38.5	44.7	44.2	43.7 (23)
Vision services	46.2	40.0	41.5	41.6 (24)
Injury prevention services	38.5	38.5	44.2	41.3 (25)
Hearing services	46.2	37.8	39.2	39.6 (26)
Physical fitness	41.7	41.0	37.7	39.4 (27)
Services for substance abuse	30.8	40.5	37.3	37.6 (28)
Dental health services	53.8	32.4	32.0	35.0 (29)
Financial management	27.3	33.3	15.7	23.5 (30)
Speech services	33.3	22.2	17.0	21.6 (31)

* Includes all physicians regardless of their affiliation (such as hospital, public health, private practice) or specialty (geriatrics, general practice, research)

† Includes those having direct contact with older adults in the community

‡ Includes those who held an executive, managerial, research, or political position but were not physicians or direct service providers

Administrators and service providers were also more likely than physicians to rate respiratory disease services as a very impor-

tant need (OR 2.62, 95% Exact CI 0.57 to 16.36; OR 5.24, 95% Exact CI 1.06 to 33.63, respectively).

Of the 101 respondents, 20 (19.8%) indicated that community long-term care services (e.g., homemaker services, Meals-

on-Wheels, home help for personal tasks, and in-home nursing care) is the single most important health issue facing older adults now in Brant County. This was followed distantly by accessibility to services (9.9%), services for people with dementia/Alzheimer's disease (7.9%), facilities for socializing and recreation (6.9%), long-term care facilities (6.9%), and availability of services (6.9%). Of the 103 respondents, 19.4% believed that community long-term care services will still be the most important health issue in the next 5 to 10 years, followed by accessibility to services (16.5%), availability of services (12.6%), long-term care facilities (9.7%), services for people with dementia/Alzheimer's disease (9.7%) and housing (6.8%).

DISCUSSION

This community health needs assessment attempted to obtain a comprehensive view of the health care needs of community-dwelling older adults in a mid-sized community in Central West Ontario according to family physicians, geriatricians, health and social service researchers, providers and administrators. Items included in the interview were based on a review of the literature and consultation with a variety of key informants.

Perceived needs are a good indicator of actual client need when they are obtained from people experienced in and knowledgeable about the issues and geographic area under study. For this reason, the primary information source was a comprehensive list of respondents knowledgeable about the health care needs of older adults. Our high response rate (87.7%) indicates that the findings were likely representative

of those who were asked to participate in the study, and that the study was perceived as important by those respondents we contacted.

The wide range in percentage of respondents who indicated a health care need was very important (21.6% to 86.1%) reflects the variation in opinions of what are very important health needs, as well as the questionnaire's ability to discriminate between the importance of health needs. One caveat, however, is that although the list of health care needs is quite comprehensive, not all items are mutually exclusive. This may not be a limitation of the questionnaire, but rather an indication of the complexity of health problems and interrelatedness of existing programs and services.

As expected, there was a great deal of variability in responses about the *single* most important health issue facing older adults now and in the next 5 to 10 years. This may be the result of the widely variant backgrounds, interests, and personal biases of the study participants. Overall, however, two findings were apparent from the responses. First, community long-term care services were identified as the single most important health issue facing older adults both now and in the near future. Second, respondents were also quite concerned about the accessibility and availability of services for older adults both now and in the future.

The findings from this study should provide valid, reliable, useful, and timely information to health and social service researchers, planners, providers and administrators regarding the needs of older adults living in Brant County. The study findings should also be of value to similar groups of people in other communities.

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