National Council for the Elderly

Voluntary-Statutory Partnership in Community Care of the Elderly

NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on

- *measures to promote the health of the elderly,*
- *the implementation of the recommendations of the Report,* ***The Years Ahead - A Policy for the Elderly,***
- *methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,*
- *ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,*
- *meeting the needs of the most vulnerable elderly,*
- *ways of encouraging positive attitudes to life after 65 years and the process of ageing,*
- *ways of encouraging greater participation by elderly people in the life of the community,*
- *models of good practice in the care of the elderly, and*
- *action, based on research, required to plan and develop services for the elderly.*

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VOLUNTARY-STATUTORY PARTNERSHIP IN COMMUNITY CARE OF THE ELDERLY

VOLUNTARY-STATUTORY PARTNERSHIP IN COMMUNITY CARE OF THE ELDERLY

By

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NATIONAL COUNCIL FOR THE ELDERLY
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Foreword

This study, *Voluntary-Statutory Partnership in Community Care of the Elderly,* comprises a census survey of voluntary organisations providing services for the elderly at local level. It is primarily intended to fill a gap in our knowledge of the nature and extent of voluntary provision. The study is the most extensive profile of voluntary organisations undertaken in Ireland and provides information based on over 850 organisations which, the authors estimate, represent over seventy per cent of such provision. A wide range of activities are profiled ranging from daily domiciliary services to less frequent social activities and annual events.

The study estimates that some 94,000 elderly people (24%) receive voluntary services and that almost 30,000 people are involved in voluntary work in these types of organisations. It explores the nature and sources of funding, the degree of formalisation of the sector and the extent of statutory involvement, and it analyses specific services provided by the voluntary sector in order to generate a typology of these organisations.

It is hoped that the study will help to illuminate discussions of partnership by providing the empirical data required to inform policy making. As the study reveals, the voluntary sector is composed of a variety of types of organisation and service provision. All of these services are important in offering support to and improving the quality of life of the vulnerable elderly. At the same time certain services are more essential than others and it is vital that a policy for partnership takes account of the differences in order to ensure that the essential or "core" services are maintained and improved. The Council has considered the findings of the study and has developed this and other points in its *Comments and Recommendations on Partnership* which are presented below.

Special thanks are due to the author of the Report Mr. Ray Mulvihill and to Ms. Sarah Craig, who worked on the inventory and first stage of the postal survey. I would also like to thank Professor Joyce O'Connor of the National College of Industrial Relations Policy Research Centre for agreeing to undertake the research project. Contributions made at various stages by Ms. Maureen Lyons and Dr. Helen Ruddle and other staff of the Policy Research Centre are also gratefully acknowledged.

I would like to express the Council's gratitude to the members of our consultative committee which in this instance was ably chaired by Mr. Michael White. The committee included Mr. Pat Clarke, C.E.O of the North Eastern Health Board, Mr. Patrick Madden, Programme Manager, Southern Health Board, Mr. Michael McGinley, Programme Manager, North Western Health Board, who represented the Chief Executive Officers of the Area Health Boards. Thanks also to Mr. John Brady, Department of Health, Mr. Terry Allen, Department of the Environment, Mr. Tom Whelan and Mr. Declan O'Brien, Department of Social Welfare and Ms. Geraldine Cullen, National Social Service Board. I would also like to thank Mr. Jim Cousins, Mrs. Ann Dillon, Ms. Angela Kerins, Mr. Paddy O'Doherty and Mr. Bernard Thompson, Council members, and Mr. Michael Browne for their valuable contributions to the work of the committee.

As always, without the dedicated efforts of our staff it would be impossible to accomplish research tasks such as this. I would like to express my thanks to Mr. Bob Carroll, Secretary to the Council, Mr. Joe Larragy, Research Officer, for their work in initiating and progressing this research. I would also like to express my appreciation of the work of our office staff Ms. Celine Kinsella, Ms. Maria Blake and Ms. Carol Waters for their meticulous work in producing documentation and finalising the report for publication.

Lady Valerie Goulding
President
National Council for the Elderly

Comments and Recommendations of the National Council for the Elderly on Voluntary-Statutory Partnership in Community Care of the Elderly

1. Community Care: The Contribution of the Voluntary Sector

There has been a general acknowledgement in recent years that comprehensive community care is a key element in the provision and development of health and welfare services. The need to shift the direction of health care provision and, consequently, the allocation of health care resources towards community care has been recognised (Department of Health 1986). The concept of care in the community has been an underlying feature of many of the policy recommendations in respect of the elderly since *The Care of the Aged* report (Department of Health 1968). *The Years Ahead* report (Department of Health 1988) stated that:

> a comprehensive service for the elderly would ensure whatever help an old person needed to live at. or return to. the community by way of suitable housing, medical or welfare services was provided (p. 39).

Despite the apparently general acceptance of the community care approach, developments on the ground have not lived up to aspirations. A Department of Health consultative statement on Health Policy (Department of Health 1986) identified definite weaknesses in the existing community care system with many of the services operating very much under strength. The Department noted that:

> many of the social support services, such as home helps and meals-on-wheels, which are vital to maintaining the independence of particularly vulnerable groups, such as the elderly and the handicapped, are very much underfunded and must in the future be seen as priority areas for development (p. 58).

Despite the crucial importance of services such as home helps, meals-on-wheels and day care in maintaining the elderly at home and in preventing institutionalisation. the National Council for the Elderly

considers that such services continue to be largely underfunded. *The Years Ahead* report (Department of Health 1988), commenting on the home help service, stated that "despite its importance in maintaining the elderly at home in a cost effective way, the evidence suggests that the service is contracting" (p. 97) and, also, that "real public expenditure on home helps and meals has declined significantly in recent years" (p. 96). The National Council for the Elderly takes the view that the purposeful development of community care policies for the elderly requires comprehensiveness and uniformity embracing all contributors to the caring system. Community care by definition implies the involvement of a number of parties providing a range of support services. Its effectiveness depends on a complementarity between the community (family, neighbourhood and voluntary organisations) on the one hand and the State and its institutions on the other. The voluntary sector is an essential resource in the community care system and must be regarded and developed as such. To date this has been an under-resourced and under-utilised sector. Throughout the country there are some excellent examples of what can be achieved by the voluntary sector in respect of service provision for the elderly when given the appropriate context and support — housing schemes, day centres and home help services.

The framework for community care must be such as to stimulate and support the family and voluntary caring networks in the community. In this context, the Council believes that the statutory sector must develop further strategies and establish additional structures for involving the voluntary sector in the provision of services.

This requires:

(i) the identification and definition of core community care services for the elderly and the rationalisation of administrative arrangements and levels of funding available for voluntary bodies willing to provide them;

(ii) the fostering of an ethos of statutory-voluntary partnership at both national and local levels;

(iii) the creation of a context and a structure for the planned development of the voluntary sector.

2. Core Service Provision for the Elderly in the Community

The development of the voluntary sector and the realisation of its potential, in the Council's view, would be enhanced by an acceptance of the concept of core services as a basic element in the care of the elderly and other dependent groups in the community. Core services

can be defined as support services which are essential for elderly persons to maintain a quality of life and a level of functional autonomy which enables them to live independently in the community and, consequently, to avoid unnecessary hospitalisation or admission to long-stay institutions. Such core services would augment the general practitioner and public health nursing services and would include appropriate housing, home help, meals-on-wheels and day care facilities (including occupational therapy and physiotherapy). Such core services may be distinguished from other important support services, (e.g. social outings, holidays, home visitation) on the basis that core services are an integral and planned part of the community care system and must be provided to a certain standard in all areas to be availed of by elderly persons as appropriate. Other support services might be more variable and more dependent on local factors.

Funding of core services should be based on criteria and norms defined nationally and should allow for the provision of such services either by statutory bodies or by voluntary bodies as appropriate. Where the service is provided by a voluntary body contracts of service should be drawn up which set out the obligations on the part of both the funding agency and the service provider. It is the essence of partnership that all obligations under such contracts be honoured.

3. Voluntary Organisations: Their Role and Potential

The importance of voluntary organisations in the provision of social services in the Republic of Ireland has been widely and consistently acknowledged. Voluntary organisations play a major role in the provision and development of health, housing and welfare services for the elderly. Funding of the voluntary sector in respect of the provision of such services has been provided for under various Health Acts (especially Section 65 of the *1953 Health Act):* under the *Plan for Social Housing* under the auspices of the Department of the Environment; and under Department of Social Welfare grant schemes.

Despite such acknowledgements and existing funding mechanisms the voluntary sector has not to date realised its full potential and there exists a somewhat piecemeal and tentative approach to the development of the voluntary sector. The National Council for the Elderly considers that planned development of the voluntary sector and the clear articulation of a policy framework for voluntary-statutory partnership must go beyond the aspirational language and the rhetoric frequently used to describe it. The diversity of the voluntary sector is such that its effective development and integration requires a structured and planned approach permeating all levels of the organisational and administrative system. It

requires an approach based on the concept of developmental pluralism, as outlined in this study, which seeks in an active way to promote and stimulate the voluntary sector and to establish a place for it within an integrated pattern of service provision.

The need to develop the voluntary sector was identified in *The Care of the Aged* report (Department of Health 1968). The report recommended the establishment of a National Social Services Council to co-ordinate the work of voluntary bodies and, also, the establishment of social service councils to co-ordinate voluntary and statutory services at local level. The National Social Service Council was established in 1971 to stimulate and encourage the development of voluntary bodies in the area of social services provision and to promote liaison between central and local authorities and voluntary organisations providing social services. However, in 1988 the functions in respect of developing the voluntary sector and of co-ordinating the voluntary and statutory sectors were not included in the terms of reference for a newly constituted National Social Service Board. *The Years Ahead* report (Department of Health 1988) referred to the uneasy relationship between voluntary organisations and statutory bodies and recommended that the Government should undertake a formal review of the relationship between the voluntary and statutory sectors with a view to establishing national guidelines for the development of a more constructive relationship between the two sectors. The Department of Social Welfare is currently engaged in the preparation of a White Paper and a Charter for the voluntary sector.

The National Council for the Elderly has as one of its Terms of Reference the function of advising the Minister for Health on ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly. The Council believes that the development of the voluntary sector requires (i) a clear recognition of the policy vacuum in which voluntary bodies currently operate; (ii) an appreciation of the role and contribution of the voluntary sector in the context of voluntary-statutory partnership; (iii) a commitment to promote and develop the voluntary sector throughout the welfare system: and (iv) an across the board standardisation of core services in respect of caring for elderly and other dependent groups in the community.

4. Policy Vacuum

While the voluntary sector has played a significant role in the provision of health, housing and welfare services in the Republic of Ireland, particularly in relation to the elderly, its effective integration into the

policy-making process has not been achieved. The problems of voluntary-statutory relationships have already been documented extensively. The National Council for the Aged (1983) referred to the policy vacuum in which voluntary bodies operate and the National Social Service Board (1982, 1986) highlighted the absence of a coherent policy regarding the voluntary sector. O'Connor (NESC 1987) referred to the absence of an agreed framework for the involvement of the voluntary sector either in consultation or planning. Browne (1992) highlighted a number of issues in respect of involving the voluntary sector in a co-ordinated approach to service provision and referred to the difficulty of representing a voluntary sector whose diversity significantly belies the unity implied in the concept. The present study shows that the extent of involvement of voluntary bodies in policy development and planning is very limited. Such involvement as there is tends to be of a rather *ad hoc* nature and does not extend to the smaller, less structured voluntary body. It bears out the conclusion of *The Years Ahead* report (Department of Health 1988) that "voluntary organisations have little opportunity to influence health board or local authorities in their plans for services" (p. 170).

The present study confirms O'Mahony's (1985) finding of a voluntary sector marginal to the mainstream of service provision. The picture of the voluntary sector which emerges is one in which voluntary organisations involved with the elderly concentrate in the main on the provision of services of a social nature to counter loneliness and social isolation. Only a minority of organisations are involved in the provision of what can be termed core social services — home helps, sheltered housing, day care services and meals-on-wheels. The average number of clients in receipt of these services is small and the number of services provided is also small. Voluntary organisations were found to have relatively few resources with only a minority employing staff. This is the picture which emerges despite a significant transfer of exchequer funds to voluntary bodies engaged in the provision of social services totalling over nine million pounds in 1990. (See p. 143 of this report). The present study also shows that while some organisations expressed satisfaction with the level of support received from statutory bodies there would appear to be a strong demand for more statutory support and, specifically, a more streamlined system of funding. The authors also report that some statutory personnel interviewed felt that the statutory sector should do more than respond, however comprehensively, to the requests made by voluntary bodies and should actively promote the establishment and development of appropriate voluntary organisations.

5. Voluntary-Statutory Partnership: The Context

The National Council for the Elderly takes the view that consideration of the voluntary-statutory partnership issue must be governed by the following principles:

(i) There are distinct social, historical and organisational reasons for a strong voluntary sector.

(ii) The ethos of partnership strongly underpins current social policy thinking at EC level and provides the basis for a range of developmental structures.

(iii) The concept of partnership presupposes a relationship between equals and, consequently, a well organised and strong voluntary sector.

(i) The involvement of the voluntary sector in the provision and development of services is important for a number of reasons. Firstly, it offers the possibility for direct involvement by people in devising systems to meet their own needs and those of others. In the case of the elderly voluntary activity offers them the opportunity to participate in shaping the services they receive). In this way it gives citizens an opportunity to shape the society in which they live.

> Those involved will not only feel less alienated from the society in which they live, but they will also be engaged in altering its nature both directly through the activities they undertake and. less directly, through the signals sent by these activities to the statutory system or the nature of shifts in public interests. In the process, those participating in the voluntary system often acquire experience and skills that enhance their capacity to contribute in roles they fill in other sectors of society. (Wolfenden 1978: 29).

It is thus likely that people's involvement in voluntary services does much to promote social cohesion and community integration and voluntary activity has a significance far beyond the actual level of helping the elderly or other client groups.

Secondly, certain services are more appropriately provided by volunteers than by statutory service personnel. For example, social contact, support services can be provided more flexibly and with greater sensitivity to individual needs by locally-based volunteers. Voluntary bodies in many instances may be free from the bureaucratic procedures and strict accountability which inevitably characterise statutory agencies and thus can respond

more quickly and in certain instances more efficiently to needs than can statutory bodies.

Thirdly, the opportunity to concentrate more specifically and more single-mindedly on particular issues means that voluntary bodies can frequently be innovative in a way in which statutory bodies can not and can be instrumental in pioneering new approaches to service provision and development. It is also the case that a voluntary body can carry out an important and necessary "watchdog" role in respect of the area in which it specialises. Fourthly, voluntary organisations can contribute much to the quality of service provision by increasing choice and overall resources in the social services. Statutory services are thus enhanced and extended by the presence of a dynamic voluntary sector.

(ii) The concept of partnership between the statutory and voluntary sectors is one which is likely to feature prominently in future EC social policy and resource allocation. Already, there are a number of such partnerships in place, for example. Leader and Horizon programmes and the Poverty III Programme. Partnership is an underlying theme of Section 6 of the *Housing Act 1992* which empowers local authorities to assist non-profit housing organisations, including voluntary bodies involved in housing provision for certain categories of people. The concept of partnership is also in theory an underlying feature of many of the community schemes promoted under the aegis of *Fas* even though frequently in practice the voluntary sector has little say in the conditions of the partnership. The Programme for Economic and Social Progress (PESP) promised the publication of a White Paper as the first stage in the development of a charter for voluntary social services in Ireland which will set out "a clear framework for partnership between the state and voluntary activity". (PESP: 24). The recent establishment by Government of Community Enterprise Partnership Boards at County level also aims to promote the concept of partnership in the context of general socio-economic development. The integration of the non-statutory sectors into the planning, policy-making and policy implementation processes of the State is a basic ingredient in the context of a mixed economy of welfare provision which characterises most Western countries.

(iii) The concept of partnership implies a certain type of relationship between the parties involved. It presumes a certain level of equality between the partners and operates on the basis that

each party has a degree of autonomy in its own sphere of activity. Effective partnership between the statutory and voluntary sectors is, therefore, dependent in the first instance on the presence of a strong, organised and articulate voluntary sector. It further requires a planning capability in the voluntary sector as well as in the statutory sector. A key component of voluntary-statutory partnership is real participation by voluntary bodies in the decision-making process. "There is surely a crucial difference between voluntary agencies submitting their views, and being actively involved as partners in the decision-making process". (Brenton 1985: 126). Such participation requires a clearly recognisable statutory planning and policy-making framework in which the voluntary sector has a structured and systematic involvement.

6. Promoting the Voluntary Sector

The National Council for the Elderly takes the view that the long-term development of the concept of voluntary-statutory partnership can only occur if there is a basic policy commitment to the promotion of the voluntary sector. In this context the Council believes that the analysis contained in the report of the Wolfenden Committee in the United Kingdom (Wolfenden 1978) has much to offer in the Irish context. This report sets out the development of the voluntary sector in terms of national intermediary bodies, local intermediary bodies and local service organisations.

(i) National Intermediary Bodies

These types of bodies serve a development function for affiliated organisations, providing services to them and acting in a liaison role between their member organisations and the statutory sector. They also serve as a representative of their members in articulating their viewpoints and in pressing for policy changes. Examples of these bodies include the National Social Service Board, the Disability Federation of Ireland and the Irish Council for Social Housing.

National intermediary bodies may be established on a statutory basis or independently. They may be relatively specialized or generalist. They may have several functions such as

- development of new services and identification of needs;
- providing services to existing organisations, e.g., training and secretarial support;

- liaison between voluntary sector bodies;
- representation of the voluntary sector to the statutory sector and more generally to the public;
- providing direct services to individuals;
- funding of voluntary agencies;
- regulation of voluntary agencies.

(ii) Local Intermediary Bodies

Such organisations devote their efforts to co-ordinating the local voluntary sector. In addition they may provide services directly themselves. Examples of local intermediary bodies in Ireland include the Association of Services to the Aged (AOSTA) in Cork and some of the larger social service councils.

The functions of local intermediary bodies, as defined by Wolfenden, are broadly similar to those of national bodies though usually with the exception of the funding and regulation of voluntary-agencies.

(Hi) Local Service Organisations

These are generally small, loosely knit groups of volunteers who come together to provide services, frequently for a particular client group. They are usually not affiliated to a national organisation although they may be federated at area or regional level. The majority of the social services voluntary sector falls into this category (e.g. Care of the Aged Committees).

There is evidently some variety in the way national and local intermediary bodies may emerge in practice depending on the nature of the services provided, the scale of operations and the statutory agencies from which the voluntary organisations seek support.

In the context of the services described in this study it is obvious that the provider organisations operate largely in conjunction with local authorities and health boards. In the case of the latter, services are provided at community care area level for the most part.

Thus a clear need exists for appropriate intermediary structures or mechanisms which will address the issues of development of core services and other services including the stimulation of innovative services, liaison between service providers and representation of voluntary bodies *vis a vis* the community care administrations of the health boards. Such

structures or mechanisms are essential to the achievement of a model of service provision based on developmental pluralism.

The establishment of suitable intermediary mechanisms at local level would provide the context for dealing with many of the problems associated with voluntary sector provision, *viz:*

- unsatisfactory statutory funding procedures;
- lack of co-ordination between voluntary and statutory bodies and between voluntary bodies themselves;
- absence of a structured forum whereby the voluntary sector can be involved in the decision-making process;
- significant variation from area to area in the type of voluntary provision that is funded and in the level of such funding;
- a feeling of powerlessness on the part of some voluntary bodies and of the voluntary sector in general.

However it is vital too that national level mechanisms are established in order to ensure consistency across health board regions in eligibility for and accessibility of "core services". Indeed it should be acknowledged that the operational concept of core services could be more satisfactorily arrived at and implemented if the voluntary organisations providing such services could participate in the process of defining them — a task which should be undertaken at national level.

The establishment of such mechanisms is a difficult and complex task, particularly at the national level. We are also conscious that there are a number of alternative mechanisms through which voluntary organisations might achieve a more meaningful role in the planning and provision of services at national level. The precise mechanism to be established should be given detailed consideration by the Department of Social Welfare Working Party on Partnership. It is important that such a national mechanism not be counterposed to locally based models of partnership. The two levels should operate in a complementary way.

The establishment and development of intermediary mechanisms at national and local level requires not only a commitment from Government to such a policy but, also, a concentrated and substantial effort organised by professional catalysts over a period of years. The crucial role played by such catalysts in developing a co-ordinated approach to service provision at local level has already been identified by the National Council for the Elderly on the basis of the experience of two pilot co-ordination projects, (Browne 1992).

Success in achieving partnership between voluntary and statutory agen-

cies at local level requires that health boards in particular promote in their own organisations a greater understanding of the role and potential for development of voluntary sector activity. They must develop a willingness to co-operate with voluntary agencies in a planned and sustained way. They should also actively assist the voluntary sector in becoming a partner in local planning and service delivery through the provision of secretarial backup, education and training. They should designate a named development officer and resources in each community care area for this purpose.

Such a professional and pro-active approach to voluntary sector development on the part of statutory agencies is a necessary prerequisite to a more professional and consistent pattern of voluntary sector service delivery within and across health board regions.

Recommendations

Based on the analysis set out above the National Council for the Elderly makes the following recommendations in respect of voluntary-statutory partnership.

1. Developing the Voluntary Sector in the context of Community Care Service Provision for the Elderly

Health boards and local authorities should actively encourage voluntary bodies to become more involved in the provision of core services for the elderly in the community (for example, housing, home help, day care and meals-on-wheels). This requires a pro-active approach in terms of:

(i) defining core community care services;

(ii) funding, development and involvement in planning structures of the voluntary sector.

Defining Core Services for the Elderly

The Department of Health, in consultation with the eight regional health boards, should define core community care services for the elderly and should set down standard criteria for their provision and development.

The Department of Health and other relevant Departments should set down agreed criteria for the provision of core support services in sheltered housing schemes for the elderly provided by voluntary bodies.

Funding of Core Services

Funding procedures for voluntary bodies providing core social services (for example, housing, home help, day care, meals-on-wheels) should be formalised and standardised across the country and should be based on the following criteria:

- *clearly defined levels and methods of grant payment;*
- *standardised grant application procedures;*
- *clearly defined criteria for grant eligibility;*
- *further clarification of the terms 'similar or ancillary to' as used in section 65 of the Health Act, 1953;*
- *an elimination of the practice of deficit funding of voluntary bodies.*

Health Boards and the Development of the Voluntary Sector

In the short-term health boards should assign personnel, one in each community care area, to work with and facilitate the development and organisation of voluntary bodies and networks providing services for the elderly and to facilitate their more effective and representative involvement in service planning and provision.[1]

District Teams for the Elderly

The Council recommends that the concept of the district team for the elderly for areas covering a population of 25 — 30,000 proposed in *The Years Ahead* report (Department of Health 1988) should provide for a stronger involvement of the voluntary sector. Specifically, the district care team should be allocated a developmental brief in respect of the voluntary sector at district level.

Funding of Innovative Development in the Voluntary Sector

In addition to the standardised funding of core social services provided by voluntary bodies, statutory bodies should also make available funds to encourage voluntary bodies to engage in innovative methods of service provision and to pioneer new approaches.

'Such personnel would work under the direction of the Director of Community Care and the Co-ordinator of Services for the Elderly.

Discretionary Funding

Discretionary funding of voluntary bodies should operate in addition to the standardised funding of core services recommended above so as to assist voluntary bodies providing a range of social and support services which may not be regarded as core services but are nonetheless important in maintaining elderly people in the community.

Education and Training of the Voluntary Sector

Health boards and local authorities should allocate funds for educating and training volunteers in the areas of service provision and development. Such education/training might be part of the role of the development personnel recommended above.

2. Organisational Structures

The National Council for the Elderly considers that the forthcoming White Paper on voluntary-statutory partnership should make provision for developing the voluntary sector, as follows:

National Level

Appropriate mechanisms with a specific brief to develop the voluntary sector and to liaise between the voluntary and statutory sectors should be established with appropriate funding from Government at national level.

Local Intermediary Bodies

Local Intermediary Bodies should be established, one in each health board community care area (which are usually co-terminous with local authority functional areas). These intermediary bodies would have as their function the development and co-ordination of the voluntary sector at local level and should be staffed accordingly. They would also have a role in liaising with the national body proposed above and with local statutory bodies (health board and local authority) as appropriate.

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Many people provided the information required for the compilation of the database. These included numerous priests and other members of the clergy throughout the country, health board staff and members of voluntary organisations. Health board staff, in particular community care programme managers, and representatives of the Departments of Environment, Health and Social Welfare generously made themselves available for interview. Moreover, representatives of the health boards and of these government departments readily made requested information available to the study.

The respondents, the volunteers who provided the information on which the report is based, clearly played the most important part. In addition to replying to many detailed questions, many of them included very encouraging and supportive comments on the study in their replies. Their response to the study was in itself evidence of the practical concern for elderly people felt by so many throughout Ireland. Ms. Columba Faulkner of the Society of St. Vincent de Paul was very helpful in ensuring the inclusion of relevant conferences of the Society in the survey.

Professor Joyce O'Connor provided supportive direction throughout the course of the study. Dr. Helen Ruddle also provided support and encouragement. Ms. Sarah Craig, a member of the research team until September, 1991, initiated the database, interviewed representatives of the statutory sector, undertook stage one of the survey, and prepared a preliminary report on its findings. Ms. Maureen Lyons initiated the Literature Review. Ms. Niamh Flanagan and Ms. Angela Canny assisted with the statistical analysis and coding respectively. Ms. Maureen Ryan, field supervisor for the project, together with Ms. Barbara Crowley and other members of the PRC's fieldwork team, made a very substantial contribution. Ms. Dervla Byrne and Ms. Catriona O'Neill made active and skilful contributions to the production of the report; however, most credit for transforming an often difficult manuscript into a legible report must go to Ms. Carol Phelan.

All errors of fact or opinion in the report remain the responsibility of the author.

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CHAPTER 1

Introduction

Section 1: Aims of the Study

The aims of this study are to provide information about the nature and activities of voluntary organisations engaged in the care of the elderly throughout the State, in particular to investigate the nature of their current partnership arrangements with statutory bodies, and to make recommendations about the future direction of voluntary-statutory partnerships in the care of the elderly. These aims are more explicitly stated in the objectives listed below.

Objectives of the Study

- to compile a nation-wide, computer-based inventory and profile of all voluntary organisations providing care and/or services for the elderly;
- to provide a profile of the kind of care and services provided by all the organisations listed in the inventory;
- to detail the nature of the funding arrangements of the organisations in the inventory — whether in receipt of statutory funding or not;
- to examine and evaluate the support given by health boards to voluntary organisations, in particular by means of grants paid to them under Section 65 of the Health Act 1953;
- to examine and evaluate the support given by other statutory agencies (particularly those with responsibilities in the fields of housing and social welfare) to voluntary organisations providing care and/or services for older people;
- to identify potential for development and make recommendations for future policy developments.

Section 2: The Context

Partnership

The concept of partnership is posited as the ideal way in which local and central government agencies can involve voluntary organisations in the planning and delivery of services.' In relation to the social services, the issue of partnership has begun to receive considerable attention. The increased involvement of the voluntary sector in the provision of services previously undertaken by statutory agencies has created a shift in opinion concerning roles and expectations. The voluntary sector is no longer considered as a mere receiver of State funding and provider of services at a reduced cost to the Exchequer. Instead, there have been calls for increased involvement of voluntary organisations in planning and decision-making and in the development of close partnerships between the two sectors.

Partnership has been defined as a contract between people engaged in a common purpose or business. It assumes agreed objectives, joint planning and decision-making, frequent consultation and discussion, shared evaluation and agreement as to the progress and continuation of any joint venture.[2] Partnership is therefore concerned with more than funding, it is concerned with styles of interaction and the sharing of power and responsibility.

In relation to the social services, a partnership would imply a co-operative and consultative relationship with both parties working towards common, agreed objectives. This would suggest the necessary involvement of voluntary organisations or their representatives in the planning and policy-making process.[3] In reality, this type of relationship does not currently exist but aspects of consultation and joint planning are being introduced into the relationships currently existing between voluntary and statutory bodies. In keeping with this partnership has been practically defined as:

> ...the arrangements made to facilitate, enable and assist a practical involvement by the voluntary sector in both policy development and planning as well as the actual operation of services.[4]

In this context partnership has been portrayed as a:

> mechanism, by which a "third arm" is created to work between the public and private sectors, drawing skills and resources from both as a means to make suitable responses to perceived socio-economic, welfare and care needs.[5]

Acceptance of partnership requires the adjustment of centralist administrative systems to allow for participation by organisations at the appro-

priate level.[6] It has implications for local government, as structures are necessary to facilitate the consultation required for effective partnership in the planning and delivery of services.[7]

Voluntary and Statutory Organisations

While health boards and local authorities have statutory obligations to provide services for the elderly, it is well recognised that voluntary organisations play a very significant role in ensuring that elderly people are cared for. The Report of the Working Party on Services for the Elderly advises that there are many advantages in having voluntary organisations involved in providing care for the elderly, it recommends that their contribution should be formally acknowledged and that they should be given encouragement and support by all possible means from statutory agencies.[8] At present, voluntary activities may receive financial support from the health boards through grants paid under Section 65 of the Health Act (1953) for providing a service which is similar or ancillary to a health board service and the Housing Act (1988) places a statutory obligation on local authorities to consult with voluntary organisations when assessing housing needs. Generally, however, the relationship between the voluntary and statutory sectors may be described as "uneasy" and voluntary organisations have little opportunity to liaise with or influence health boards or local authorities in planning and delivering services to the elderly. Clearly, the provision of effective care for the elderly requires integration and co-ordination of services.

The Report of the Working Party on Services for the Elderly recommends that in order to develop a true working partnership between the voluntary and statutory sectors, each health board and local authority should agree with the voluntary organisations working in their functional area their respective responsibilities in the delivery of services, and this agreement should be formalised as a contract between them for a period of 2 or 3 years.[9] The proposed contract of care would set out the services to be provided by the voluntary organisation, the financial and other resources which are to be provided to it and the method of accountability to be used.

In considering the development of an effective working relationship between the voluntary and statutory sectors, it is important to recognise that the voluntary organisations involved in care of the elderly vary greatly on a wide range of factors. Voluntary organisations may provide any of a number of services; they may provide a short or long-term service; they may focus exclusively on the elderly or may cater for a variety of client-groups; they may or may not be receiving funding from

statutory agencies. Proper development of the voluntary sector in the care of the elderly requires knowledge of the number and type of organisations involved and the services they provide.

The Elderly

In Ireland, according to the 1991 Census, there are 394,830 people aged 65 years or more, 11.2 per cent of the total population.[10] Women account for 56.8 per cent of the 65+ age group. In 1986, about 145,000 people were aged 75 years or more, 4.1 per cent of the total population, women accounted for 60 per cent of this group. Also, in 1986, about 70,000 people were aged 80 or more, women accounted for 65 per cent of this group. It is expected that the numbers of elderly people, particularly in the 75+ and 80+ brackets, will increase substantially. By the year 2011 the number aged 65 or older could rise to 437,000, 12.8 per cent of the population.[11]

The majority of older people live in the community outside institutions. In 1986, 91.5 per cent of the elderly lived in private households. In recent decades there have been substantial changes in the nature of households within which the elderly live, especially during the period 1961-1981. During this period the number of older people (65 or more) living in multi-person households (3 persons or more) declined from 229,000 (73 per cent) to 203,000 (55 per cent). The number of elderly people in households consisting only of man and wife increased from 30,000 (9.5 per cent) to 65,000 (18.5 per cent). The number of elderly people living alone increased from 32,000 (10 per cent) to 81,000(21 per cent).[12]

A small proportion of those in the 65 or older age group, between four per cent and five per cent, are accommodated in long-stay geriatric care — geriatric hospitals, welfare homes, long-stay district hospitals, private and voluntary nursing homes. In addition, at any one time, approximately three and a half per cent of elderly people will be in short-stay general hospital care, psychiatric hospitals or hostels, retirement homes or other unspecified non-private households.[13]

Though Ireland's elderly population is substantial and increasing it is low in comparison with the European Community. In 1980 the population aged 65 and over constituted a smaller proportion of the population in Ireland than in any of the other 11 EC countries. Moreover, it was estimated that it would have a smaller proportion of its population in that age group in the year 2040 than any of the other EC countries.[14]

A substantial proportion of those who provide informal care for the

elderly, family members or voluntary workers in the community, are women and are in the 20-44 age group.[15] Increasingly women in this age group are remaining in or returning to paid employment outside the home and are accordingly likely to be less able to make such commitments. Reductions in fertility rates over the last three decades and consequently smaller families will diminish the supply of potential informal carers in the future. Both emigration and internal migration add to the problem. This has resulted in increased concern for the effectiveness of the voluntary sector and a growing realization that its development must be given more consideration.

The age distribution of the national population in 1991 was as follows:[16]

Age Group	*Per Cent*
0-24	44.4
5-44	26.9
45-54	9.7
55-64	7.8
65 +	11.2

The age distribution of the population by county largely conforms to this. The biggest differences arise in the 0-24 and the 65+ age groups (See Table A1.1). The proportion of population in the age group 0-24 ranges from 38.6 per cent (Leitrim) to 48 per cent (Kildare) while that of the 65+ age group ranges from 7.1 per cent (Kildare) to 18.3 per cent (Leitrim). The proportion of population in the age group 25-44 ranges from 23.7 per cent (Leitrim) to 30.3 per cent (Kildare). Nineteen counties have more people in the 65+ category than the national average. Six of these have at least 14 per cent of their population in that category, one and a quarter times the national average of 11.2 per cent; these six are Leitrim, Roscommon, Mayo, Cavan, Kerry and Sligo. Only one county, Leitrim, has more than one and a half times the national average in the 65+ category, 18.3 per cent.

The six counties with more than 14 per cent of their population in the 65+ age group are now further disadvantaged by having a significant deficit in the age groups from which voluntary workers are likely to be drawn. As indicated, Leitrim, the county with the lowest proportion of its population in the 25-44 age group has 23.7 per cent of its population in that category compared with the national average of 26.9 per cent.

Notwithstanding this the six counties with more than 14 per cent of their population in the 65+ category, and Leitrim in particular, are probably under greatest pressure to provide voluntary services for the elderly.

Variations in the age composition of population at sub-county level may

be of greater significance for the provision of voluntary services as the operational region of most voluntary organisations is in general likely to be rather restricted.

There are signs that the elderly themselves are becoming more organised and actively engaged in the promotion of their mutual interests. Higher standards of social welfare provision, health, education and income have all contributed to this. Earlier retirement and changing attitudes, in particular the increasing awareness of the heterogeneous nature of the elderly, have contributed to an erosion of the boundary between the "middle-aged" and the "elderly".

Section 3: Research Design and Methodology

The study was divided into two phases of research consisting of a series of stages. Prior to Phase I meetings with the consultative committee established by the National Council for the Elderly were held to help determine the focus of the study and to explore the conceptual arena of research. The members of the consultative committee included representatives of both the statutory and voluntary sectors.

Phase I

Inventory of Voluntary Organisations

Phase I of the study consisted of the development of a nationwide inventory of voluntary organisations which provide care and/or services for the elderly. The inventory was developed to provide a computer based, national database of voluntary organisations for the National Council for the Elderly and to form the basis of Phase II of the study.

A number of sources were used to compile the inventory. First, a number of lists were available from the Departments of Health, Environment and Social Welfare and the health boards which indicated those organisations who receive funding. Also used was the most recent edition of the "Directory of National Voluntary Organisations" compiled by the National Social Services Board. Since all of the organisations listed did not provide services to elderly people, those who obviously did were included in the inventory and the remainder were contacted by post and asked to complete and return a slip indicating whether they did/did not include the elderly as a client group. On that basis organisations were included or excluded from the inventory. Only organisations providing services of a community-based nature were considered. Nursing homes and residential care facilities were, therefore, omitted.

Priests and ministers throughout the country were the second most significant source of information. The names and addresses of parish priests were obtained from the most recent edition of the Irish Catholic Directory. In all, 1,028 parish priests and ministers were contacted. They were asked to supply the names, addresses and telephone numbers of persons in their parish who were involved in the provision of care or services to elderly people. In response to the first written request 42.5 per cent of parish priests replied, returning lists of one to six contact persons in their vicinity. A reminder letter was sent to non-respondents three weeks after the initial contact and the response rate was increased to 80.3 percent.

As an additional means of contacting voluntary agencies throughout the country, all of the Community Information Centres (CICs) were written to and asked to provide details of organisations providing services for the elderly. In total, 75 CICs were contacted of which 43 responded representing a 57.3 per cent response rate. Many of the organisations returned by the CICs were eliminated on the basis that they had already been included by parish priests in the area. This served as a check on the accuracy and extensiveness of the information provided by both sources.

Initially 2,380 organisations were entered into the data base. These organisations were then coded by Health Board Area (1 - 8) and inputted onto computer. Organisations were then sorted alpha-numerically, by county, and within county by name of the organisation. The format of the inventory then contained six categories of information across 8 fields:

- Name of Organisation (1 field)
- Contact Address (3 fields)
- County (1 field)
- Health Board (1 field)
- Telephone Number (1 field)
- Contact Person (1 field)

Phase II of the project, the survey, was used to validate the inventory. All duplications detected and organisations not considered relevant were removed from the inventory. Some organisations were added to the inventory. Information on the activities of organisations, whether or not they were engaged in each of 24 activities (one field each), was included in the data base. On completion the inventory consisted of information relating to 1.551 organisations, including information on the activities of 937 of these.

Phase II

Survey of Voluntary Organisations

In Phase II of the research a survey of the organisations listed in the inventory was undertaken to obtain detailed information on the services provided by the organisations and the nature of their funding, and to investigate the current state of the partnership between the voluntary and statutory sectors.

A questionnaire was designed to include the following areas (see outline of questionnaire design in the appendix):

- year organisation was founded
- parent organisation
- nature and frequency of care/services provided, e.g., transport, day-care, meals-on-wheels, residential care, social contact client group
- number of clients
- funding arrangements
- applications for funding — where and for what purpose
- funding, if any, provided by statutory agencies
- funding provided by other than statutory agencies staffing arrangements
- total number of volunteers engaged in organisations providing care and services for the elderly
- resources other than funding provided by statutory agencies
- types and forms of liaison with statutory agencies in the planning and delivery of services
- extent of once off funding to the voluntary organisations by means of covenants, etc.
- committee/management structure of voluntary organisations

A combination of open and closed questions was used. Before administering the survey a pilot study was carried out to test the accuracy and validity of the questionnaire. Copies of the questionnaire were then sent with an accompanying letter and prepaid envelope to all of those organisations listed in the inventory.

Response to the Survey

The survey consisted of two stages as the response rate arising from the first stage was insufficient. Details of the survey, including the nature of the response to each of the two stages, are presented in the Appendix. Questionnaires were issued to 2,442 organisations, the target population, the 2,380 organisations initially entered into the database together with 62 detected in the course of the fieldwork. A substantial number of these, 864, were discovered to be duplicates or not applicable, resulting in a survey population of 1,578. The majority of the survey population, 937. returned questionnaires and 27 refusals were encountered. These categories are set out below for clarification:

Target population —2,442
Survey population — 1,578
Returns — 937

The response rate achieved is just under 60 per cent (937 /1,578 = 59.4 per cent). No statistical information was received in respect of the 614 non-responding organisations (1,578 less 937 returns and 27 refusals). Although the response level was high for what was mainly a postal survey the number of non-respondents was initially a matter for concern. However, a number of factors diminished this concern and supported confidence in the representativeness of the response to the survey. Internal and external evidence pointing to the representative nature of the response to the survey included the following.

(i) A comparison of respondents to stage one and stage two of the survey revealed that they were similar. Thus all those not responding to stage one were not substantially different from respondents. Though it cannot be inferred that this is equally true of those not responding to stage two it is a positive sign.

(ii) The estimated response rate for each health board area is broadly similar. This reduces the likelihood that the response to the survey is regionally biased.

(iii) By applying a grossing up procedure (see below) the survey data generated estimates in respect of a number of variables or items which were in very good agreement with those yielded by a recent study based on a 1,000 person randomly selected sample of the national population aged 18 years and over.[17] The items referred to include the following estimates which are further elaborated in Chapters Three and Four:

(a) Number of volunteers engaged in the caring for the elderly throughout the Republic of Ireland.

This study —29,700
National sample —33,000*
*Not necessarily members of voluntarv organisations.

(b) Number of volunteers engaged in the provision of meals-on-wheels.

This study —9,925
National sample —9,440

(iv) Similarly by applying a grossing up procedure (see below) the survey data generated estimates in respect of a number of variables or items which are in reasonable agreement with estimates made by the Department of Health. These estimates which are necessarily given a more detailed explanation in Chapter Four refer to the number of beneficiaries of the home help service and the meals-on-wheels service.

The grossing up procedure employed required making a judgement about the characteristics of the 614 organisations from whom no response was obtained. Given that at each of the two stages of the survey 24 per cent and 26 per cent respectively of the target population were discovered to be either duplicates or not applicable, it seemed unrealistic to assume that all of these 614 outstanding organisations were relevant and a valid part of the survey population. On completion of both stages of the survey a total of 864 organisations were discovered to be either duplicates or not applicable. This number is nearly as great as the total number of responses (937) and refusals received (27). It was accordingly assumed for grossing up purposes that a similar proportion of the outstanding 614 organisations. 290 or 47 per cent of them, could be treated as duplications or not applicable. Support for this judgement was given by the field-workers engaged in attempting to increase the response rate in the second stage of the survey. Moreover, the difficulties encountered in fieldwork outruled any further development of the survey because of the difficulties encountered in attempting to increase the response rate.

The reduction of the survey population of 1,578 by 290 results in an estimated survey population of 1,228, for grossing up purposes. Dividing the number of respondents, 937. by the latter figure, 1,288, results in an estimated response rate of 73 per cent to be used for grossing up purposes in estimating characteristics of the survey population.

Apart from the overall response rate some reference should be made to responses to individual questions. The number of respondents who failed to make any response to some of the questions is high. Accordingly response levels to all questions asked are made clear throughout the report. *Great caution should be exercised regarding judgements con-*

cerning financial matters as the number of responses to some of these matters was unfortunately especially low. An assessment was made of the answers to some of the questions concerning financial matters and this is referred to in Chapter Six.

While there were 937 responses to the survey 69 of these, seven per cent, are not included in the analysis. These organisations were not actively engaged at the time of the survey in the provision of services for the elderly. The analysis is confined to the 868 organisations that at the time of the survey were actively engaged in the provision of community based services for the elderly.

Estimates of Regional Response Rates

To estimate the regional response rates the number of organisations in each health board area was extracted from the database. The number of returned questionnaires from each health board area was then subtracted from the total number of organisations in each area. The balance was then multiplied by 0.53 to estimate the number of valid cases outstanding in each health board area as it was calculated that 47 per cent of the outstanding cases were invalid (see above). These cases are listed in column two of Table 1.1. The number of valid cases outstanding was then added to the number of returned questionnaires to provide an estimate of the total number of valid cases in each health board area. The number of returned questionnaires was then expressed as a percentage of the total number of valid cases to yield a response rate for each health board area. It can be seen in Table 1.1 that the estimated response rates in each health board area are similar, ranging from 68 per cent in the Midland Health Board area to 78 per cent in the Western Health Board area.

TABLE 1.1: Estimates of regional response rates

Health Board	Returned Questionnaires	Outstanding Valid Cases (Est).	Total Valid Cases (Est.)	Response Rate (per cent)
Eastern	215	65	280	77
Southern	160	71	231	69
South Eastern	146	47	193	76
Mid-Western	109	52	161	68
North Eastern	87	32	119	73
Western	84	23	107	78
Midland	63	31	94	67
North Western	73	30	103	71
Total	937	351	1,288	73

The uniformity of the estimated regional response rates is a positive feature of the survey as it suggests that distortions arising from variations in regional response rates may have been avoided. However, it is possible that the kind of organisations that responded from within the different health board areas varied. Accordingly, *any inter-regional comparisons made within this report must be treated with caution.*

Interviews with Service-Providers

The second part of this phase of the research involved the interviewing of service-providers from a variety of statutory agencies in order to assess their views on their role in relation to voluntary organisations and on what partnership arrangements currently exist with the voluntary sector. The community care programme managers from each of the health boards, two community care administrators, two co-ordinators of services for the elderly and representatives from the Departments of Social Welfare and the Environment were interviewed. The main purpose of these interviews was to inform the discussion of policy issues and assist the interpretation of results. Some of the matters discussed are referred to in Chapters Four, Five and Six. A semi-structured interview schedule was designed to guide the interviews with the service-providers. The general areas covered in the interviews were as follows:

- general information relating to voluntary organisations in the area
- types of organisation
- views of voluntary service provision
- the role of the statutory agency in voluntary service provision
- partnership arrangements
- funding arrangements
- training and other resources
- future development of voluntary activity

Each individual was contacted by letter and asked if they would participate in the study. All agreed to be interviewed.

Data Preparation and Analysis

Returned census forms were checked for accuracy and completeness and responses were coded and prepared for computer analysis. Throughout the coding process it was observed that there was a significant amount of missing data, particularly in relation to the financial affairs of the organisations.

The computer data files were compiled and checked for accuracy **and** an analysis was carried out using the Statistical Package for the Social Sciences (SPSSX).

Transcripts were made of the taped interviews with service providers and content analysis was carried out on responses to each of the topics covered.

Section 4: Organisation of the Report

This report is organised into nine chapters. Chapter One provides an introduction to the study, setting out its context, and describes its design and research methodology. The main themes that have emerged from the literature on Voluntary Organisations and Partnership are discussed in the Literature Review, Chapter Two. These themes relate to the issue of Partnership generally rather than to Partnership between voluntary organisations concerned with the care of the elderly and the statutory sector only. Consideration of partnership has been made in general terms rather than focused on specific applications of it. The themes addressed in Chapter Two include volunteering, the rationale of voluntary service provision, typologies and models of the voluntary-statutory relationship, funding and accountability and contracting out and finally a brief account of voluntary service provision in Ireland. In Chapter Three the voluntary organisations providing services for the elderly are described. This description includes a reference to the resources of the organisations, other than financial, and some aspects of their organisational and management structures. In Chapter Four the services for the elderly provided by voluntary organisations are described, the number of clients served by them is considered as is the frequency of service provision. In Chapter Five a functional based typology of voluntary organisations engaged in the provision of services for the elderly is presented. This brings together the information presented in Chapter Three and Chapter Four and relates the characteristics of organisations to the services they provide. The funding of voluntary organisations is discussed in Chapter Six. Such information obtained from the voluntary organisations and directly from statutory bodies is presented. In Chapter Seven relations between voluntary and statutory bodies are examined. This includes information on interaction between the management of voluntary organisations and statutory bodies and the input made by voluntary organisations into the planning of services for the elderly. In Chapter Eight the conclusions arising from the study are considered. Finally in Chapter Nine a summary of the findings of the study is presented, issues are identified and overall conclusions are made.

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CHAPTER 2

Literature Review

Introduction

This Chapter is divided into five Sections. The first Section presents an overview of the historical development of voluntary service provision in Ireland. The second Section defines voluntary organisations, considers the nature of voluntary work and describes the characteristics of volunteers. The third Section considers the rationale of voluntary service provision, it examines some of the arguments made in favour of the replacement of statutory provision by the voluntary sector and outlines reasons for government support of the voluntary sector. Section Four outlines typologies of voluntary/statutory service provision; it goes on to examine important models of the voluntary/statutory relationship in service provision, in particular welfare pluralism, subsidiarity and partnership. Section Five deals with some issues associated with these models, funding and accountability and contracting out.

Section 1: The Development of Voluntary Service Provision in Ireland

The history of charitable giving and volunteering in Ireland has been shaped both by developments in statutory service provision and by the economic and religious climates prevailing in Ireland throughout the last two hundred years.[1]

Because of the political system that prevailed until 1922, the pattern of development of statutory and voluntary service provision in Ireland is broadly similar to the British system. The Poor Law Act 1834 introduced welfare provision by the State in both Ireland and Britain and established the ideology by which statutory services were to be administered. Eligibility for services was so rigidly enforced that only those most in need qualified. Concomitant with the establishment of the Poor Law system was the establishment in Ireland and Britain of voluntary hospitals and

other charitable institutions. The foundation of these was either inspired by 19th century philanthropy motivated by an acceptance of a duty by the rich to the poor, or was the result of a religious commitment to charity. The co-existence of both statutory and voluntary services helped to shape the welfare pluralist perspective which was to operate in Ireland and more particularly in Britain.

Faughnan identified three factors which have helped contribute to the current operation of voluntary bodies in Ireland today:[2]

- the influence of religious orders
- the tradition of community self-help
- the development of community-based statutory services

The Influence of Religious Orders

Following independence in 1922, the State began to build on the health and welfare services already in existence and a myriad of welfare schemes was introduced. The development of services was influenced by Catholic social teaching and by the principle of subsidiarity.[3] Catholic social teaching advised that services should be provided at the lowest level of community, ranging from family to voluntary organisation to Church and finally to State. The Church did not agree that the State should accept responsibility for the provision of services until the family and the community had failed to do so. While this ideology helped to enhance the role of voluntary service provision generally it is unlikely to have had much impact on the development of voluntary organisations engaged in the care of the elderly, especially when most of these were formed after 1967.

Tradition of Community Self-Help

The growth of agricultural co-operatives at the beginning of the twentieth century marked the emergence of community-based endeavours at local level. In 1931, a further initiative in community self-help presented itself in the establishment of Muintir na Tire. Described as "a national voluntary organisation based on the parish unit with the aim of reviving the community spirit of the Irish countryside through co-operative effort",[4] Muintir na Tire sought to apply Christian social principles in promoting the welfare of the rural people in Ireland. It has been suggested that the tradition of community self-help encapsulated in organisations like Muintir na Tire, provided a background for the many community-based voluntary services in existence today.[5]

The Development of Statutory Support for Community-Based Voluntary Services

The 1953 Health Act empowered health authorities, the predecessors of the health boards, to give financial and other forms of aid to a voluntary body providing a service similar or ancillary to a service which they themselves might provide.[6] The way in which such aid might be given is as follows:

- by contributing to the expenses incurred by the body;
- by supplying to the body fuel, light, food, water or other commodity;
- by permitting the use by the body of premises maintained by the health authority and, where requisite, executing alterations and repairs to and supplying furniture and fittings for such premises;
- by providing premises (with all requisite furniture and fittings) for use by the body;
- A health authority may, with the approval of the Minister contribute to the funds of any society for the prevention of cruelty to children.

During the 1960s an emphasis on community care was evident. According to Lavan[7] alternatives to institutional provision can be traced to recommendations contained in four separate reports in the 1960s:

- The Commission of Inquiry on Mental Handicap, 1965
- The White Paper on the Health Services and Their Further Development, 1966
- The Commission of Inquiry on Mental Illness, 1966
- The Inter-departmental Report on the Care of the Aged, 1968

Also, under the 1962 Housing Act, local authorities were enabled to introduce special grants to encourage philanthropic and charitable bodies to make a contribution to housing for the elderly.[8]

The Care of the Aged report, published in 1968, had as one of its main recommendations the encouragement of voluntary activity in the provision of services for the elderly. In relation to service provision the Committee recommended the setting up of a National Social Service Council to coordinate the efforts of voluntary bodies.[9] The report also recommended that social service councils be established to coordinate voluntary and statutory services at local level. Following the general guidelines laid out by the report, there was significant growth in the number of social service councils and in the development of localised services for elderly people. The National Social Service Council was set

up in 1971 "to stimulate and encourage the formation of new voluntary bodies engaged in social service provision, and to promote liaison between central and local authorities and voluntary organisations providing social services".[10] The councils — which were representative of voluntary agencies in a geographical area — worked together to "co-ordinate activities and respond to unmet needs".[11]

The Health Act 1970 provided a structure for community care.[12] The establishment of health boards, and in particular the creation of the Community Care Programme Manager function in them, gave an impetus to the aspiration to seek greater involvement of the voluntary sector in community care. This aspiration to involve the voluntary sector had received particular attention in the inter-departmental report on *The Care of the Aged* (1968). It was envisaged that the Community Care Programme Manager would discuss the objectives of the community care programme with the heads of voluntary agencies. The Programme Manager would agree with voluntary agencies the funds they would receive together with the contribution they would make to the community. The Community Care Programme embraced all health services in which care was provided outside institutions — this included the provision of services to the elderly.[13]

The 1988 Report of the Working Party on services for the elderly — *The Years Ahead* — described the services available to the elderly in the community and made many recommendations. Non-residential services identified include:[14]

- special and sheltered housing
- repair and maintenance of houses
- shelter for homeless elderly
- material aid
- day care services
- transport
- support groups
- information and advice
- surveillance
- visitation
- social contract

The Report made specific recommendations on how co-ordination and collaboration can be established between the providers of care for elderly

people. It cited many examples which show that, at present, co-operation is deficient. For example, local authorities are responsible for providing for the elderly living in inadequate housing, and although many of these clients also have health problems, there is no formal co-ordination between local authority and health board services. Frequently elderly patients may be discharged from hospitals without notifying the community care services. Informal carers who play a huge role in the care of the elderly receive little support from health board personnel. In order to improve this situation the Working Party made many recommendations for change. These recommendations were guided by their objective to maintain elderly people in their own homes as far as possible and to mobilise all the resources in the community to achieve this objective by supporting family, neighbours and voluntary bodies. They also made explicit the principles which should underlie services for the elderly, comprehensiveness, equity, accessibility, flexibility, responsiveness, co-ordination, cost effectiveness and planning. The Report found that where co-ordination between the different providers was exhibited — for example, in the case of Cork Corporation, Share (voluntary organisation) and the Southern Health Board — a more effective service was provided in terms of the stated objective of keeping the elderly out of long term institutional care where possible.

Several recommendations were made concerning the co-ordination of services between voluntary and statutory agencies. Firstly it was recommended that a district health nurse should be made responsible for co-ordinating services for the elderly and for organising district teams consisting of representatives from all the major groups involved in providing services for the elderly including matron, housing official. G.P., community welfare officer and representatives of local voluntary organisations. These teams would service a population of approximately 25-30,000 people. It was also recommended that co-ordinators or co-ordinating bodies be appointed at county, regional and national level. At the regional level each health board would appoint an Advisory Committee on the elderly whose function would be to:

- Identify the needs of the elderly and advise on how they could be met;
- Represent those working with the elderly;
- Plan for the future provision of the services;
- Encourage statutory and voluntary coordination at national level[15]

Increased cooperation was recommended between the Departments of Health. Environment and Social Welfare. They are to be assisted in this in an advisory capacity by the National Council for the Elderly.

While the co-ordination of services was one of the major issues with which the *The Years Ahead* was concerned it was also concerned with partnership. Co-ordination is concerned with organisation, planning and communication in the pursuit of efficiency. It is concerned with relationships within and between organisations and individuals. Partnership is also concerned with organisational structures, planning and communication; however, it goes beyond this, it implies the sharing of power and responsibility and places an emphasis on the quality of the interactional process itself.

In the *The Years Ahead* some shortcomings in the relationship of voluntary and statutory organisations were identified. These were seen to prevent the development of a partnership between voluntary statutory bodies.

The following shortcomings were identified:[16]

(i) the contribution of the voluntary sector has been largely taken for granted and has not been sufficiently recognised or supported by statutory authorities. Health boards do not always give sufficient support to voluntary organisations providing high-quality services. Some voluntary groups providing services receive no health board aid, although such aid might enable them to make a more effective contribution;

(ii) there is inadequate co-ordination of services at the point of delivery and a lack of integration of the voluntary sector;

(iii) in some instances volunteers are being asked to take on too much responsibility without adequate direction, funding or support from health boards and the rationale may not be apparent;

(iv) the development of voluntary activity around the country is uneven both geographically and in terms of function and structure. In some areas there is a serious dearth of volunteers;

(v) many voluntary organisations spend much of their time and energy raising funds and, as a result, lose their enthusiasm and momentum;

(vi) voluntary organisations in recent years may have tended to concentrate on services which are more likely to attract statutory funding than on those considered by the organisation to be of most value to the community;

(vii) There appears to be a great variation in practice from one area to another, even within health boards, as to the kinds of activity that are grant-aided and the level of grants paid. Branches of

the same organisation may receive different levels of support depending on the health board region in which they are located;

(viii) in dealing with statutory bodies, the voluntary sector lacks influence relative to other interest groups such as unionised workers;

(ix) some groups (the Alzheimer Society of Ireland) experience great difficulty in getting health board support for setting up innovative services (such as day centres);

(x) some voluntary organisations experience difficulty in liaising with health boards in respect of the home help service;

(xi) provision of housing for the elderly by voluntary groups is greatly hindered by problems in fund-raising in respect of the balance of capital expenditure not met by existing government subsidy schemes and funds required to meet ongoing maintenance and service provision costs;

(xii) voluntary organisations have little opportunity to influence health board or local authorities in their plans for services. Voluntary organisations do not have access to information or to discussions on the allocation of resources. They are kept at arm's length from the decision-making process. Few health boards invest time, resources, staff or energy in consultation with voluntary bodies.

(xiii) Some voluntary bodies experience difficulty in getting and/or paying for insurance in respect of their activities.

The Report recommended that cooperation should be actively pursued, with health boards and local authorities encouraging by "all possible means, the involvement of voluntary organisations in caring for the elderly".[17] The respective responsibilities of the two sectors in each area should be worked out by the voluntary bodies, health boards and local authorities and this should be formalised in a contract over two or three years. Health boards were advised to set up a fund for the development of voluntary organisations indicating that the State should take a positive stance in regard to the voluntary sector, encouraging it to grow rather than just responding to it. In addition it was recommended that the Government would undertake a formal review of the relationship of the statutory and voluntary sectors with a view to establishing national guidelines for the development of a more constructive relationship between the two sectors.

The Housing Act 1988. Section 5. empowered local authorities to assist non-profit housing organisations (i.e., housing associations including

voluntary organisations involved in housing services) by way of a grant, loan, periodic contribution, interest subsidy or loan guarantee. Section 5 of the 1988 Act has since been reapealed and replaced by Section 6 of the Housing Act 1992. The 1992 Act has a number of provisions of special interest to voluntary bodies: Section 6 provides for the capital assistance of housing projects by voluntary bodies: Section 7 provides for the rental subsidy scheme for voluntary housing projects; Section 11 is concerned with the considerations under which block loans will be available to non-profit housing co-operatives when regulations are in place: Section 26 allows for the disposal of tenanted local authority houses to voluntary bodies approved of under Section 6 and Section 32 extends Section 6 of the Landlord and Tenant (amendment) Act. 1980. concerning tenants' rights, to lettings by voluntary bodies approved of under Section 6.

The Extent and Nature of Voluntary Service Provision in Ireland Now

The voluntary sector in Ireland consists of hundreds of very different organisations. Precise figures on the number of organisations are not available. It plays a major role in complementing and supplementing state provision and it is the dominant or sole provider of particular services. In relation to care of the elderly, in 1978 the National Social Service Council listed nearly 300 organisations providing voluntary services, mainly for elderly people. It has been estimated[18] that upwards of 200.000 persons are actively involved in voluntary work with religious bodies and charities concerned with welfare. A large proportion of these volunteers work with the elderly. It is agreed that the voluntary sector has seen huge expansion in the 1970s and 80s. Between 1972 and 1976. for example, the number of social service councils and Care of the Aged Committees increased substantially.[19]

Voluntary organisations range in size from national bodies to small locally-run community groups. Some voluntary agencies include the elderly as one of the client-groups they serve while others are dedicated to providing services for the elderly only. Many elderly people are themselves involved in such voluntary organisations.[2]" Most voluntary efforts in relation to the elderly take place at a local level.

Social service councils and care of the aged committees are distributed throughout the country, each generally associated with a town or small district of a particular county. However, according to Lavan social services councils did not prove to be satisfactory coordinating structures for voluntary organisations — "service delivery was most often the key goal to the new community — based initiatives which had gained

momentum in the 1960s and 1970s". Furthermore, Lavan observed the initiatives of Kilkenny Social Services, Limerick Social Services and others did not result in the articulation of an unambiguous community care goal for personal welfare.[21] Though acknowledging the successes of such initiatives as Clarecare, Lavan noted the significant absence even there of formal procedures in relation to planning, consultation and funding. In her view the solution to this problem is dependent on the formulation of clear policy goals for personal social service provision, the voluntary sector and the voluntary-statutory relationships.

To formulate policy concerning the voluntary sector it is clearly essential to have good information about it. Lavan suggested there is confusion about the extent and nature of the "so-called" voluntary sector.[22] O'Mahony. in a study of social need in rural areas found the voluntary sector to be static, marginal and neither reflective nor engaged in formal planning.[23] The National Social Services Board characterised many voluntary organisations as institutionalised and lacking the ability to critically examine themselves and the society in which they function.[24] An absence of evaluation procedures within their own organisational structures was also reported. Faughnan referred to a remarkable sparsity of general information and documentation in respect of voluntary organisations.[25]

Government Funding

As indicated above the statutory sector has become more empowered to fund voluntary organisations. Grants are available to voluntary organisations from the health boards under certain sections of the 1953 and 1970 Health Acts. In 1988, it was estimated[26] that Section 65 grants to voluntary organisations amounted to £33 million. A significant amount of the revenue was deployed to organisations providing services for the elderly. It should be noted that government funding of the voluntary sector represents only a small proportion of what is spent on mainstream services. For instance, in 1989 expenditure on the health services totalled £1.3 billion.[27] Aside from the health boards there are several other sources of funding available to voluntary organisations. The main sources have been identified as:[28] the European Social Fund, the Combat Poverty Agency. FAS training and employment schemes, the Department of Education, the Department of the Environment and the Department of Social Welfare. An additional source of statutory funding available to voluntary agencies dealing with the elderly and other disadvantaged groups is the National Lottery. In 1990 £3 million was designated for the implementation of the recommendations of the Working Party on Services for the Elderly. The area-based response to long-term

unemployment, under the *Programme for Economic and Social Progress*,[29] will be of further assistance to voluntary organisations.

The potential impact of European integration on voluntary effort and social services in general has been alluded to in the literature.[30] One factor within the European Community (EC) which is significant for the care of the elderly, is that an increasingly mobile workforce would lead to greater social isolation of the elderly as traditional family groups become more dispersed. The elderly will constitute a larger proportion of the populations both in Ireland and in the EC as a result of the decreased birth rate in recent decades together with increases in life expectancy. Selective emigration of younger age groups has and will contribute to changing the age profile of the Irish population. The EC also has implications for voluntary organisations including the opening up to new sources of funding. This could lead to a more international focus or to cross-national co-operation and amalgamation. Also noted[31] is the likelihood of a voluntary sector explosion in Eastern Europe and the concern that this could result in the diversion of funds previously granted to Ireland.

Section 2: Volunteering

Voluntary Organisations

Voluntary organisations are not-for-profit non-governmental organisations. Such organisations are formed to pursue specific objectives in accordance with the wishes of their members. Many voluntary organisations are formed to benefit the community rather than their members. This study is focused on such organisations. Voluntary organisations may consist entirely of voluntary workers. Alternatively, they may employ staff on a full-time or part-time basis, with a governing body or board of management whose members receive no remuneration or financial profit from the organisation.[32] Some voluntary organisations providing social services are focused on the provision of a single service, for example, "meals-on-wheels", while others may offer a comprehensive range of services. Some voluntary organisations do not deliver services themselves but may rather co-ordinate the activities of other organisations — this was a role intended for social service councils in Ireland. The scale at which voluntary organisations operate varies considerably: some like the Cheshire Homes are international in scope, many, like social service councils or care of the aged committees, are focused on the local area.

A distinction can be made between statutory and non-statutory care.

Statutory care represents those services provided by government and which are paid for by the Exchequer. Non-statutory care consists of either formal or informal voluntary work. Formal voluntary care is work undertaken by voluntary organisations. Informal voluntary care entails care in a family setting and is generally provided by women. However, in this case the role of the carer is sometimes described as "involuntary" voluntary care as, quite often, such carers have limited choice, if any, in undertaking that role.

The above distinction between statutory and non-statutory requires further qualification. First, the non-statutory sector does not consist of voluntary organisations only. Increasingly, profit-orientated private companies or persons are providing social services. Second, non-statutory organisations may be funded in part or in whole by statutory organisations. Third, there may be mergers at the operational level between statutory and non-statutory organisations. For example, care on a neighbourhood basis may involve individuals, communities and statutory agencies working jointly in the provision of services.

The main types of organisational structure have been classified as follows:

(i) national organisations running local offices and raising funds for local work.

(ii) national organisations who operate from a headquarters and provide support services to autonomous local groups which raise their own funds.

(iii) self standing local bodies with no head office to provide support. These bodies generally meet a local need.

(iv) national or local intermediary bodies which provide support services to a range of voluntary bodies.[33]

Faughnan provides the following classification to serve as a framework for the wide variety of voluntary action in Ireland:[34]

- Mutual support and self-help groups
- Local development associations
- Resource and service providing associations
- Representative and co-ordinating organisations
- Campaigning bodies
- Funding organisations

These classifications recognise the considerable variations in scale and function which are found.

Voluntary Work

It is possible to identify some commonly agreed characteristics of voluntary work and volunteers. The Volunteer Centre's definition of voluntary work is

> work undertaken on behalf of self or others outside the immediate family, not directly in return for wages, undertaken by free choice, not required by the State or its agencies.[35]

A study carried out in Britain in 1981 distinguished between voluntary action, "help given through relatively formal channels such as voluntary or statutory organisations", and neighbourhood care, "help given voluntarily to neighbours and friends".[36] The definition employed excludes voluntary giving within the family but includes those activities which involve self-interest, e.g. sports organisations.

> The definition . . . was of voluntary action as time spent, unpaid, in doing something that aimed to benefit someone — individuals or groups — or something — such as the environment — other than, or in addition to. the volunteer and his or her immediate family.[37]

The 1981 General Household Survey adopted a relatively wide definition of voluntary work, including informal help (but not towards family or friends), political and religious activities but excluding giving blood, jury service and work for animal charities. The Charity Household Surveys tended to have no explicit definition but the definition was implicit in the list of voluntary activities cited. In a study of voluntary work in four EC countries — Britain, the Netherlands. Belgium and France — certain common elements were apparent in the definitions employed. Voluntary work was taken to be unpaid, organised, with a social aim and done by free choice. While the organised nature of voluntary work was stressed, some types of informal care were included: typically help to neighbours and friends was taken to be different from voluntary work.[38]

In a qualitative study of volunteers and non-volunteers, all respondents basically agreed that voluntary work has three components: it benefits all or part of the community: it is done by choice "from the goodness of one's heart": and it is unpaid.[39]

While certain elements are common to all of these definitions, the boundaries of voluntary work are often blurred. Halfpenny identifies three problems in defining voluntary work: the distinction between self-help and voluntary service: the distinction between informal volunteering and formal voluntary activity; and the distinction between work for non-statutory and for statutory bodies.[4*1]

In particular, problems arise in deciding what forms of informal care

constitute voluntary work. Typically kinship relationships have been the predominant source of informal care but have been excluded from discussions and measurement of voluntary work. Hadley and Hatch have indicated some of the potential problems:

> How far can they [informal carers] be regarded as volunteers in the sense that they have freely chosen to give their help, and how many might more appropriately be called in Abram's term "conscripted volunteers" — people forced by a sense of obligation and by family pressures into the role of carer?[41]

Increasingly the boundaries between unpaid volunteers and paid professionals has become unclear. There is a difficulty in distinguishing payment and expenses. The Kent Community Care Project, for example, pays helpers at a rate that is more than expenses but less than the market rate: in spite of this payment, many helpers perceived themselves to be volunteers.[42] Furthermore, "voluntary" does not cover all forms of unpaid work, only unpaid work that is not socially required as a duty or responsibility.[43]

Sail argues that it is useful to view voluntary help as a continuum ranging from the professional at one end through the "paraprofessional who works within the professional social service institutions to the member of the community or neighbourhood care group.[44]

Leat discusses the lack of clarity in the definition of basic concepts in writing about voluntary activity. She argues that no set criteria for "voluntary" work can be specified as voluntary activity covers a number of activities related to one another in different ways. Volunteering takes place in a social context and is only definable within a broader context of norms and values that define actions, rights, duties and responsibilities.[45]

Characteristics of Volunteers

Empirical studies have found that volunteers differ from the rest of the population in relation to the following characteristics:

- Gender
- Age
- Family Structure
- Socio-economic status
- Other factors

Gender: A number of studies have shown that women and men are equally likely to do some kind of voluntary work.[46] In contrast, the

Charity Household Survey found that women were more likely to be involved in a voluntary activity and were likely to make a more intensive time commitment.[47] However, the type of voluntary work tends to be highly differentiated by gender. A number of British studies, for example, have shown that male volunteers tend to be involved in practical help, advice-giving, transport and committee work while women volunteers tend to be involved in fund-raising and direct caring services.[48]

Age: Volunteers tend to be drawn from the 25-44 age-group,[49] While this is the case, increasing attention has been focused on the role of elderly volunteers, especially in the United States. Chambre found that *379c* of the over 65s in the US engaged in some kind of voluntary work (whether formal or informal).[50] She argues against the view that elderly people volunteer to compensate for the loss of work and family but maintains instead that volunteering is one facet of a more general style of higher social participation by many older adults.

Family structure: The highest rates of volunteering are found among men and women with dependants.[51]

Socio-economic status: Differences in socio-economic status sharply differentiate volunteers from the rest of the population. Studies from four EC countries reveal that voluntary workers are drawn disproportionately from higher income groups, from professional and managerial occupations and from highly educated groups.[52] A similar pattern is apparent in the Charity Household Survey.[53] Informal volunteering, in contrast, tends to be broadly representative of the population in class terms.[54]

Other factors: The strength of people's attachment to the area (and length of residence) seem to make little difference to their tendency to volunteer.[55]

In a study of elderly volunteers, Chambre found that the strongest influence on volunteering is a person's overall activity level.[56]

While these findings apply to the volunteer population as a whole, the characteristics of volunteers have been found to differ by type of organisation and type of voluntary activity. For example, older volunteers are more likely to be involved in religious activities and visiting the old/sick while younger volunteers are more likely to participate in sponsored events.[57] Particular organisations have drawn their volunteers from outside the "mainstream" volunteer population. For example. Task Force, a voluntary agency set up to mobilise the work of volunteers caring for the elderly, have used school volunteers who were more likely to be working-class than the volunteer population as a whole.[58] The Kent Community Care Project, in contrast with other projects, tends to

draw on a relatively high proportion of working-class women in their twenties and thirties.[59]

Studies tend to focus on providing a profile of the "typical" volunteer. Leat argues that it would be more useful to examine the underlying motivations for volunteering and how these interact with particular social, gender and age groupings.[60]

Problems arise, in trying to classify the boundaries of voluntary work since within formal organisations, the role of the volunteer can vary significantly. In some voluntary bodies, for example, volunteers play key roles in administration and policy-making while in others the role of volunteers may be reduced to marginal tasks and their assigned status is low. Another difficulty in clarifying voluntary work lies with organisations themselves. Because of the nature of their work, voluntary bodies do not represent a static field of study. Populations served by each organisation can vary in "size, demographic composition and social need"[61] and these differences are reflected in the varying levels of service provision and expectation of services.

Irish Research on Volunteering

There has been very little research carried out in Ireland on the extent of volunteering or on the characteristics of volunteers. What information is available is derived from the European Value Systems Study.[62] The survey questioned respondents on membership of and voluntary work for seven types of voluntary organisation. Half of the adults in the study were members of at least one voluntary organisation (including political parties and trade unions). This is a higher membership rate than that for Europe in general and is largely attributable to a much higher membership of religious organisations. One person in five did some voluntary work for one of these organisations, a broadly similar level of participation to Europe in general. The largest part of voluntary activity was concentrated in religious, charitable and youth work (with 7-8% of the sample involved in each of these activities).

As was the case on other studies, voluntary activists tended to be middle-class (in professional or managerial occupations) and highly educated. In addition, students showed high rates of involvement in charity and youth work. Those aged 45-54 were most likely to be involved in charitable and religious work while those involved in youth work tended to be drawn from the younger age-groups. Men were more likely to do voluntary work in general but women were equally involved in charity and religious organisations; women who were not "housewives" were more likely to participate than men.

Lavan provides some information on a sample of volunteers.[63] The majority of them were female, aged 25-40 and were married with children. Two-thirds of the sample were in paid employment. Motivations for volunteering showed a mixture of altruistic and expressive reasons, with the main reasons cited as wanting to help others in the community and wanting to do something with their spare time.

Section 3: The Rationale of Voluntary Service Provision

The value of voluntary activity may be assessed on a number of levels. On a broad level, voluntary service-provision offers people the chance to exercise their rights as citizens and this helps to promote social integration. The voluntary sector often offers opportunities for individuals to participate in service delivery whether by donating their time or by donating money.[64] Through participation the voluntary sector can also enhance the potential of individuals to be involved in decision-making about service delivery thereby encouraging greater levels of partnership and co-operation. Furthermore, it has been suggested[65] that participation results in an important role for the consumer since voluntary organisations are likely to respond more readily to clients' needs.

Voluntary service also promotes or sustains the idea of a caring community[66] by allowing people the opportunity of directing their altruistic tendencies into practical tasks. In Ireland, for example, the Christian commitment has provided motivation for many of those engaging in voluntary work.

A discussion document on voluntary service[67] identified three roles which voluntary organisations can fulfil most usefully:

- A Creative Role
- A Service Role
- An Economic Role

The Creative Role: of voluntary agencies include three related aspects. First, the provision of services allows for the development of both those who receive a service and those who offer it in that the services provided empower the community in relation to identifying and meeting their own needs and in giving them a degree of independence. Second, the "pioneering aspect" of voluntary organisations allows them to stimulate initiative to meet needs as yet unprovided for by legislation. Finally, voluntary organisations may act as mediators between the community and statutory agencies both in terms of referral for other services and in their capacity to act as a pressure group for change of policy.

Sen'ice Role: The service role assigned to voluntary activity is generally viewed on the basis that voluntary organisations provide services complementary or supplementary to those provided by statutory agencies. The services provided in voluntary organisations are also considered to be spontaneous, flexible and mobile in meeting needs. Voluntary organisations, because they operate in highly localized fields, and meet specific priorities, are more amenable to the broader concerns relating to community participation than are statutory agencies. As voluntary organisations grow, it is suggested[68] that they face more difficulties than statutory agencies if they are unsuccessful because of their closeness to the community and because they are expected to be exponents of the classic features of voluntary activity, namely, versatile, flexible, pluralistic and innovative.

Economic Role: The third role generally seen as being fulfilled by voluntary organisations is in relation to the savings to Central Government due to the fund-raising efforts employed by voluntary organisations. These three roles encompass the mainstream of opinion regarding the voluntary sector.

The report of the Wolfenden Committee[69] had significant implications for the development of voluntary work in the United Kingdom and, subsequently, in Ireland. The Committee saw voluntary organisations as providing a valuable link between the individual and the statutory services since they are close to people "on the ground" and are largely free from bureaucratic constraints. The report suggests three ways in which the voluntary sector can make a constructive contribution to welfare provision. First, the voluntary sector can be involved in extending government provision by increasing choice and overall resources in the social services. Second, voluntary organisations can actually improve government provision through their role as independent critics and pressure groups. Finally, the voluntary organisations themselves can act as sole providers in situations where they identify new areas of need.

Criticisms of the Advantages of the Voluntary Sector

Brenton considers that the voluntary sector is often considered to have three major advantages over the statutory sector — that it is essentially innovative, participatory and cost effective.[70] However, he suggests that "the attribution to voluntary agencies of a unique capacity to innovate . . . perpetuates a stereotype of their early history as forerunners of the statutory services". According to Kramer[71] the pioneering role attributed to voluntary organisations serving the physically and mentally handicapped derives from the pioneering work of voluntary agencies during

the nineteenth century. The then prevailing philosophy of *laissez-faire* assured them a virtual monopoly on the provision of services. Since the 1960s, after local authorities in Britain had accepted most of these responsibilities, established voluntary organisations have not been engaged in significant pioneering work. The creation of public awareness of under-served groups usually comes from new self-help associations. The maintenance of an innovative role by voluntary organisations in general after their formation was questioned by the Wolfenden Committee.[72] It is suggested that the high "birth rate" of voluntary organisations rather than any continuing inventiveness results in them contributing to change.[73]

A number of researchers have argued that the public sector is at least as innovative as the voluntary sector.[74] Schorr argued that most significant attempts at pioneering in the social services during the 1960s were largely inspired and implemented by government.[75] However, there is agreement that some "innovatory forces within the statutory sector" are more easily channelled through voluntary agencies and that the voluntary sector can serve as the creative arm of the statutory sector.[76]

Voluntary groups and agencies can offer people opportunities for participation. However, formal voluntary agencies delivering specific services may be no more open to popular participation than a statutory body.[77] Though such organisations are relatively free from the constraints of the public accountability framework and therefore have more potential for shared decision making by members, staff and mutual aid groups in particular provide opportunities for participation. However, domination or patronisation by small elites may counter this.[78]

According to Brenton the greater "cost effectiveness of the voluntary sector in comparison with the statutory services has the status of a widely held, but untested myth". A significant difficulty here is that those comparisons that are made may not be valid. Cost differences may be attributable to the payment of lower wages by voluntary agencies or lower standards in the operation of voluntary agencies. It is argued that there is little demonstrable fiscal advantage for government in transferring existing social service functions from the statutory sector to voluntary agencies unless paid workers are being replaced by voluntary workers.[79]

The transfer of responsibility to voluntary organisations envisaged by the New Right, and to a lesser extent by the welfare pluralists. has been questioned[80] on the basis of the shortcomings of voluntary service provision — its unevenness, its fragmentation and its lack of clear financial and political accountability. Also questioned are some of the stereotypes frequently attributed to voluntary organisations like, for

example, their participatory nature which is emphasised by the welfare pluralist model. It has been suggested in the literature that larger formal organisations often have hierarchial management structures and are no more open to participation than statutory bodies. Another argument raised is the greater cost effectiveness of voluntary organisations. A 1982 article on daycare of the elderly[81] claims to provide clear evidence to refute the often-made assumption that voluntary services are universally cheaper than their statutory counterparts. Based on empirical evidence, the authors conclude that small voluntary units enjoy a cost advantage but that larger voluntary units are unlikely to be cheaper and are probably more expensive than local authority units of a similar scale. A further issue of concern raised is the question of quality of service. It has been found that as agencies become established, cost in terms of expenditure — regardless of the source of funding — is very similar.

Reasons for Government Funding of the Voluntary Sector

Closely related to the above debate is the question — why should the government fund voluntary agencies. Seven rationales have been identified; consumer choice, specialization, cost-effectiveness, flexibility, innovation, advocacy and participation.[82] In addition to these rationales there are other reasons that may not be regarded as '"rational", e.g. '"because they are there", historical accident and the power that some voluntary agencies have to generate political pressure. As innovation, participation and cost effectiveness have already been discussed they will not be dealt with here.

It is argued that the voluntary sector can respond flexibly to different consumer tastes. Consumers may benefit from a choice between a publicly provided and voluntary sector service or from a choice between a number of suppliers within the voluntary sector. Because voluntary sector provision is unlikely to be evenly distributed across the country, or to be sufficient for the groups concerned, or because of economies of scale, governments may subsidise it to preserve choice. Governments may fund consumer choice through grant aid, tax exemptions and production subsidies on the supply side, and through consumer subsidies on the demand side.

A benefit of specialization is that funding authorities can obtain services of agencies catering for people with special needs for which they have responsibility but would be unable to provide themselves. Such agencies often organise and deliver services on a national basis and occasionally do so on an international basis. Specialized provision of this kind by voluntary agencies is often cost effective. While it is sometimes supported by tax exemptions it is mainly funded by purchase of service contracting.

Flexibility permits responding to differences and changes in need in a way that large bureaucracies cannot do. Voluntary agencies are often portrayed as being less bureaucratized than statutory agencies and accordingly more flexible. However, evidence for these differences is not readily available. It is argued that these beliefs about the sectors are based on "invidious organisational stereotypes whereby government is perceived as intrinsically rigid, riddled with bureaupathology, and offering mass standardised services that are dehumanizing."[83] It is however considered debatable that voluntary agencies with unelected management committees are necessarily more responsive to the views of users and citizens than are elected public sector policy makers.[84] Flexibility in itself may be associated with undesirable characteristics such as inconsistency and unaccountability. Public funding may in itself limit the flexibility of voluntary organisations.

Policy advocacy, the campaigning role of voluntary bodies is fundamental to all discussions of the role of the voluntary sector. The voluntary sector can add to the stock of knowledge regarding what services are required, can bring a different perspective to bear on policy issues, can present a critical view and can campaign for change. Independence from government is a desirable attribute in respect of each of these attributes.

Section 4: Typologies and Models of the Voluntary/Statutory Relationship

Typologies of the Voluntary/Statutory Relationship

Bauer identifies a pattern in the changing role of non-profits; in times of economic and social crisis their importance has increased and in times of economic and budgetary expansion it has decreased.[85] He suggests a typology of regimes in which non-profits/voluntary organisations operate. He distinguishes between three major regulation and distribution regimes — the conservative, the liberal and the social democratic. The conservative type is strongly influenced by paternalistic reformism and the social doctrine of subsidiarity. The conservative type prevails in West Germany. France, Italy, Belgium. Austria and to some extent. Japan and Turkey, where aspects of this system were adopted in the early twentieth century. The liberal tradition, "welfare capitalism", dates back to the Poor Law Act of 1601 in England, and exists today in countries such as the United Kingdom, the United States, Canada and Australia. In these countries non-profits are market-oriented and emphasize the principle of voluntarism. The social democratic regime, characteristic of the Scandinavian countries, emphasises the State's social responsibility and therefore provides a relatively less developed and less important non-profit sector. According to Bauer "Ireland combines the

tradition of the Poor Law with Catholicism, where Catholic non-profits dominate the welfare system".

A widely used social policy model is proposed by Wilensky and Lebeaux.[86] They identify two major conceptions of the role of social welfare — the residual and the institutional. The residual conception holds that social welfare institutions should come into play only when the normal structures of supply fail. The institutional conception sees the welfare services as normal, first line functions of modern industrial society. Welfare systems based on the residual model imply a minimal role for the State in the provision of welfare services. Any services provided are of poor quality and any cash benefits are of minimum subsistence level. Eligibility for services is means-tested and users of services are deliberately stigmatised. The institutional model is almost the reverse of this. No societies conform precisely to either of these models. However, if capitalist societies are arranged along a continuum, the United States would be placed near the residual end and Sweden would be placed near the institutional end.

Titmuss incorporates three models in his typology: the residual, the industrial achievement-performance and the institutional redistributive.[87] The first and third of these correspond to Wilensky and Lebeaux's residual and institutional models. The industrial achievement-performance model holds that social needs must be met on the basis of merit, work and productivity. "Welfare capitalism" implies the industrial achievement-performance model; this gives priority to "society-first" social policy and relies on work-related social provision — with equality of opportunity and the encouragement of competition as the objective. This type of policy is intended primarily to support and reinforce the capitalist system. West Germany, with high social expenditure, and the United States, with low social expenditure, fall into this category.

Among the factors which decide the nature and extent of voluntary activity are included the prevailing ideology of the country, the values of its people and the economic and demographic factors which influence policy making procedures. Robbins argues that in each society, by way of these factors, statutory and voluntary elements work together to achieve the most appropriate balance for the context.[88]

The voluntary/statutory relationship within the European Community can be regarded as a continuum which ranges from complete state control of service-provision to complete voluntary control with the majority of cases clustered in a variety of partnerships around the middle. Denmark is an example of an EC country where the state is the sole provider of many services.** As a consequence, voluntary organisations have remained relatively unimportant in the provision of many kinds of

welfare. Where voluntary agencies do exist, they do not replace State provision but supplement existing provision to meet needs which may have been overlooked. The Danish experience shows that even with the State as the dominant social provider there is still a role for voluntary organisations to play, like for example, in the provision of emergency help when the State machinery moves too slowly, and in providing services which are qualitatively different from those administered by the state, for example, those of self help groups. One area where the voluntary sector in Denmark plays an especially important role is in the area of housing provision. Voluntary housing bodies in Denmark have been responsible for an estimated 300,000 dwellings. The Netherlands is an example of a country at the other end of that particular spectrum. There the State finances the voluntary sector through open-ended, government subsidies which account for approximately 90 per cent of the income of voluntary agencies. Voluntary agencies are the primary deliverers of social services with the government as financier, having only a residual role in service provision.

Models of the Voluntary/Statutory Relationship

Welfare Pluralism: The welfare pluralist approach to service-provision suggests a partnership between statutory and voluntary organisations in which the administration of services is the responsibility of voluntary organisations but finance for those services is provided by the State.[90] The welfare-pluralist viewpoint of service-provision envisages a level of welfare through which the State and voluntary organisations play different but interdependent roles in providing social services.

In Britain the relationship between voluntary and statutory sectors involves mutual dependency — many voluntary agencies are dependent on public funding and the public sector is dependent on the voluntary sector to provide services and manpower which otherwise the State could not supply. Government influence is rooted in its provision of finance and legislation while voluntary organisations exert some influence on government through formal channels like invited consultation (usually on an *ad hoc* basis), and informal means through pressure groups, lobbying and public support mobilised through media campaigns.

The Wolfenden Committee was a leading proponent of welfare pluralism. It recommended the strengthening of the pluralist perspective through collective action and the encouragement of public participation. However, since 1978 when the Report was published, the growth of the New Right philosophy on welfare provision has inhibited the development of the welfare pluralist approach.

In Belgium voluntary organisations share with statutory authorities the implementation of State policy and in some fields of social welfare they are the main, if not the sole providers of services.[91] In this regard the Belgian system of social service-delivery may be viewed as pluralist with its shared roles for statutory and voluntary sectors. Since approximately three quarters of the population in Belgium are Catholic, the role of the Church in providing welfare services is a significant one. Funding for services is similar to Ireland, with grants being channelled through the State and through local authorities. However, the income of voluntary organisations is increasingly dependent on charges from recipients of the services offered. In relation to services for the elderly, informal care by families, in Belgium is marked. It is estimated, for example, that more that half the number of elderly people who need constant personal care are looked after by their families rather than by State or voluntary services.

The New Right Model: The New Right philosophy emerged against a backdrop of cuts in public expenditure and the privatisation of some of the social service areas. The New Right approach differs fundamentally from the welfare pluralist model in its vision of the role of the State. Welfare pluralists support a transferral of responsibility to voluntary organisations in the area of service delivery but believe the financing of these services should remain the responsibility of the State. The New Right, however, view the voluntary and informal sectors as substitutes for State provision and support these sectors only as a means for realising the policy of "rolling back the welfare state". The state would, therefore, play a more residual "enabling role" making it possible for voluntary organisations to do their job more effectively.[92]

In the United Kingdom, until recently, voluntary organisations were regarded as supplementing partners who fill gaps in service-provision in a system of primarily statutory responsibility for social services.[93] However, with the emergence of New Right thinking and the consequent cuts in public expenditure, a policy of "privatising the public sector" has taken place. This means, in effect, limiting the growth of the Welfare State and the contracting out of services to private agencies. Funding of voluntary activity in the UK is mainly through statutory grants with local authority payments for service on a deficit-financing basis.

A distinction has been made between the privatisation of welfare provision in the economic sphere and measures which are changing how people perceive the Welfare State — "the ideological restructuring of state responsibility". It has been suggested that the importance of privatisation measures in Britain to date is in the fostering of public

disenchantment with public services and the creation of an ideological climate favourable to radical dismemberment of the welfare state in the future. The effect of privatisation in the personal social services area is to force people to depend on non-market forms of privatisation. These include personal resources, help from their families, friends and neighbours, if any. or the services supplied by the voluntary sector. Increased political rhetoric in support of the voluntary sector and community care in Britain has been associated with the desire of the conservative government to promote a residual role for the state in respect of personal social services.[94]

Subsidiarity: Subsidiarity is the principle that a larger unit only assumes functions to the degree that the smaller units of which it is composed are unable or less competent to do. This is an old principle and was used by Aristotle. Aquinas. Proudhon. De Tocqueville and others. In this century it is strongly associated with the papal encyclical " *Quadragesimo Anno*[95] of 1931. The relationship between the State and individual members and other social groups is perceived as follows.

> The State must take account of the principles of subsidiarity and supplementation: the State does not exist to do for individuals and families and other associations what they can do reasonably well for themselves; the State should not supplant them when they can partly do things but should supplement their efforts: finally the State is there to do for them what they cannot at all do for themselves.[96]

This principle has been influential in the formation of social welfare throughout much of Europe, including Ireland, and is being employed now in the development of EC policies.

Within the EC partnership was viewed as a reconciliation of enhanced action by the community together with decentralisation to the most effective decision-making levels. However, the concept of partnership has to some degree been replaced by that of subsidiarity.

> ... the notion of partnership to some extent anticipated the debate on subsidiarity, which has since been emerging as a more explicit concept in the institutional structure of the community.[97]

Lavan observes that the principle of subsidiarity is viewed by the EC as a mechanism for achieving a balance between the centre and the periphery and for distributing public authority among different levels of government.[98] Since 1984 this principle has been involved in the Delors Report on the EMU. in the Social Charter on the Fundamental Rights of Workers and in the Single Act on environmental policy.

The German system is based on the principle of subsidiarity where the

State intervenes only when other alternatives like the informal and voluntary sectors have been exhausted.[99] The state retains overall responsibility for welfare but the subsidiarity principle gives voluntary agencies a high status and provides them with a strong claim on public resources while protecting their independence. In Germany the state has a positive relationship with voluntary institutions, often inviting Non-Governmental Agencies to set up institutions and services. The German state is legally prohibited from setting up a service if an adequate voluntary service exists. In such a system where responsibility for provision is spread over thousands of groups the main problem is. predictably, co-ordination and co-operation to ensure a comprehensive, consistent and equitable system.

Partnership: In Chapter One reference was made to the view that partnership is an ideal way for statutory and voluntary bodies to co-operate in the planning and delivery of services.[100] Partnership assumes co-ordinated activity at all stages of the planning, decision-making, evaluation and review process. If voluntary and statutory organisations are to have partnership arrangements the voluntary organisations must share in the planning and policy-making process.[101] It was suggested that partnership can be practically defined as the set of arrangements designed to enable such a practical involvement by the voluntary sector.[102] Partnership can be seen as having a synergistic effect, resulting in a "third arm" structure which makes optimum use of both the voluntary and statutory sectors.[103] It was also indicated that acceptance of partnership requires the adjustment of centralist administrative systems to allow for participation at local level and has in particular implications for local government.

With regard to the issue of partnership, four positions have been presented in the literature[104] which represent differing approaches to how statutory agencies view and work with voluntary bodies. The first position involves the distribution of negligible grants and little direct work with volunteers. This position has been termed the *statutory monopolist* approach. Implicit in this approach is the view that whatever is necessary will be done by statutory personnel without the help of volunteers. The *enhanced monopolist* position is a development of the previous approach, differing only in the greater involvement of voluntary effort within a tightly controlled statutory framework. The third and fourth approaches may be considered in contrast to the first and second. For example, the *responsive pluralist* position is adopted in cases where statutory agencies welcome voluntary action but do not want to impinge on the independence of voluntary bodies, or. where the statutory agency adopts a non-interventionist perspective and does not seek to actively

promote and develop the voluntary sector. Alternatively, the fourth category — *developmental pluralism* — does seek in an active way to promote and stimulate the voluntary sector and to establish a place for it within an integrated pattern of service provision.

While currently there is much enthusiasm for the idea of partnership it can be difficult to put into practice. It requires that individuals or organisations with differing views or ideologies find a common ground on which to work together. Estivill equated the concept of partnership with participation.[105] He suggests that participation in social policy is subject to cyclical movements. He attributes its current popularity to "the stagnation and crisis of the welfare states", excessive bureaucracy, the fragmentation, cost and lack of responsiveness of social services together with the decrease in their legitimacy.[106] The public administration is responding to this either because of a growing conviction about the value of deepening democracy or in the hope of reducing public expenditure.

Models of the Voluntary-Statutory Relationship in the Irish Context

It is clear from the above that many of the issues currently being raised about the voluntary-statutory relationship in the provision of services in Ireland are also being debated in other European countries and elsewhere. All of the European countries referred to here have some mix of voluntary and statutory provision whether in the conservative, liberal or social democratic traditions. The nature and extent of voluntary activity in any country is shaped by the prevailing ideology which in turn is influenced by economic and demographic factors. Overall both the conservative and liberal traditions would appear to have been most influential in Ireland.

It would appear that the model of the voluntary/statutory relationship which approximates most clearly to the provision of community based services for the elderly in Ireland is Welfare Pluralism. According to this model the administration of services is largely the responsibility of voluntary organisations while finance for service provision is provided by the state. This would describe to a considerable degree the current arrangements for the provision of many of the community based services for the elderly. The character of the prevailing relationship between voluntary and statutory bodies has been shaped in the main by the 1953 Health Act. the 1970 Health Act. *The Years Ahead* and the 1988 and 1992 Housing Acts. Clearly the Welfare Pluralism model is not a perfect fit as voluntary organisations engage in fund-raising, many receive no financial support from statutory bodies, and in some instances health boards administer these services directly. Moreover, while the voluntary

sector has some influence on statutory bodies, such influence is largely *ad hoc* and the development of structures to promote debate and consultation between the voluntary and statutory sector is still at an early stage. It is. however, clear from the comments of observers of the voluntary sector (see The Extent and Nature of Voluntary Service Provision in Ireland Now in Section 1 above) that the lack of these structures is not at all solely the responsibility of the statutory sector. The principle of subsidiarity would appear to be consistent with Welfare Pluralism, though the degree to which it has consciously shaped its development is a matter for debate.

The New Right model, a tool for "rolling back the welfare state", does not appear to have received substantial support in Ireland. In any event, in the provision of community based services for the elderly there is limited scope for statutory bodies to withdraw services, other than in the curtailment of financial support. Moreover, the scale of such service provision throughout most of the Republic of Ireland is such that there is limited scope for the contracting out of services to private agencies, a development associated with New Right thinking. The ideological dimension of the New Right, the fostering of public disenchantment with public services and the creation of a climate supportive of radical dismemberment of social welfare services, would appear to have limited acceptance only in the Republic.

Four approaches to partnership were outlined. It would appear that the approaches which most closely approximate to the Irish voluntary-statutory relationship are the second and third of these. Practice in Ireland would appear too lie somewhere between these two: the *enhanced monopolist* position, which provides for the involvement of the voluntary sector but only within a tightly controlled statutory framework, and the *responsive pluralist* position, in which statutory agencies welcome voluntary activity but do so without impinging on the independence of voluntary bodies. The fourth and the most complete form of partnership outlined, *developmental pluralism* — where effort is made to promote and stimulate the voluntary sector and establish a place for it within an integrated pattern of service provision, is largely aspirational in the Irish context. It is notable that the advocacy of partnership is not without its detractors and is equated by some with participation which is valued sometimes only as a means of reducing public expenditure.

Section 5: Funding and Accountability and Contracting Out

Funding and Accountability

Funding arrangements are often controversial and existing practices in Ireland and elsewhere are subject to criticism. In the absence of a clear

policy framework in relation to the voluntary/statutory relationship, including its funding, the State exercises a position of power over the voluntary sector. Dependency on funding from the statutory sector by voluntary agencies has. in the past, reinforced feelings of helplessness on the part of the voluntary sector in relation to future development of their own service delivery. It has been suggested[107] that the current method of funding in Ireland has also operated as an obstacle to the development of partnership arrangements since voluntary agencies cannot plan adequately.

Section 65 funding has been the subject of much criticism, in so far as the absence of guarantees of funding from year to year creates planning problems and delays in decision-making relating to services[108] (see discussion in last Section of this Chapter). It has been pointed out in the literature[109] that the lack of a coherent funding framework has lead to uncertainty, mistrust and competition and inhibits the formation of good working relationships between different voluntary organisations and with the State. It has been pointed out by the National Social Services Board,[110] that the grant-aided funding of voluntary effort is, at times, an over-simplified view of partnership on the part of the State. Instead, what is required is a clarification of the role of the voluntary sector as to whether it is an inferior service provider or a partner with particular strengths, energies and talents, which can be deployed to provide specific services perhaps more satisfactorily and with greater flexibility than the State.

To address the issue of continuity and predictability of funding the Working Party on Services for the Elderly recommended that voluntary agencies, local authorities and health boards should enter contractual arrangements over two or three years.[111] However, this raises the issue of accountability and control of voluntary organisations.

It is argued that funding of voluntary organisations by statutory bodies has not resulted in the development of integrated approaches in the social services field.

> In the field of the elderly, for example, voluntary organisations play a major part in the provision of housing, health and welfare services. However, their role has not been integrated into an overall care delivery service. The Report of the Working Party for the Elderly (1988) claimed that voluntary organisations have little opportunity to influence health boards or local authorities, they do not have access to information or to discussions on the allocation of resources and they are kept at arms length from the decision making process. "[2]

The influence government has over voluntary agencies through funding

and legislation can be considerable. For example, it has been observed that in Britain government ability to grant or withhold aid can influence the nature and priorities of voluntary organisations. In the literature cases of the "bandwagon effect" have been noted, with agencies subscribing to policies which are currently in vogue with grant aiding authorities. Even if voluntary agencies are free to spend the money as they like, the government can influence the overall character of voluntary organisations by only supporting those who are non-confrontational and uncontroversial. This conservatism tends to be reinforced in Britain in particular by the Charities Law which excludes organisations of a "political" nature which aim to change structures and attitudes directly. Therefore, an increased dependence on government funding might result in voluntary organisations losing their independent voice and their ability to criticise government and highlight its failings in public welfare. For a healthy partnership to exist, it is argued that the voluntary sector should have more say in the context and direction of government programmes and the public sector ought to be willing to fund their critics as well as their supporters."[3]

It has been argued[14] that the independence of voluntary agencies working under a contracting out system is endangered, since they become over-dependent on state-funding and hence lose some of the characteristics that distinguish voluntary action (for example, increased accountability may stifle the flexibility and creativity of voluntary organisations).

However, it has been suggested that voluntary agencies" fears of loss of autonomy arising from reliance on government funding in the context of contracting out systems is unsupported. One study of 80 voluntary agencies serving the physically and mentally handicapped in England, the Netherlands. Israel and the United States indicated that reliance on government funding does not seem to constrain voluntary agency autonomy. The organisations that were most actively engaged in advocacy, particularly in the United States, were among those who received the highest percentage of government funds. Four sets of factors protective of the autonomy of voluntary organisations were identified: the payment for service form of most fiscal transfers, the diversity of the income sources (of the voluntary organisations), the countervailing power of a service monopoly (of voluntary organisations) and low levels of accountability due in large part to the trade-off in a relationship of mutual dependency. The low levels of accountability were seen to result from "bureaucratic symbiosis" — "a mutual cooptation in which both parties recognise their independence and are careful not to disturb \l".[u>]

A survey of agencies in receipt of substantial public funds in the USA was undertaken by Hartogs and Weber to assess whether demands for

greater accountability threatened their autonomy or survival. It was concluded that "rather than leading voluntary agencies into oblivion, government funding permits their survival". [116]

It has been suggested in the literature[117] that voluntary organisations tend to have difficulty in acknowledging that the price to be paid for accepting grant aid is accountability for the quality of service provided and the manner in which resources are used. It has been argued that the tensions associated with defining the appropriate parameters of accountability are rooted in the ill-defined relationship between statutory and voluntary organisations.

Accountability arises from the demands placed upon voluntary organisations by the rise of pluralism, professionalism and consumerism.[118] The new "planned" or "assisted" pluralism raises the issue of funding. From the statutory sectors* viewpoint "assisted pluralism" creates a potential gap between responsibility for provision and provision itself. A way of closing this gap is to demand close accountability for moneys disposed and for services provided. From the voluntary sectors" viewpoint, statutory funding separates the control of policy from the control of resources. Ways of closing this gap include the achievement of independence and autonomy in policy making and management or the diversification of the sources of funds so that the influence of any one funder is limited.

Three kinds of accountability are identified:[119]

- explanatory accountability — being required to give an account;
- accountability with sanctions — right to require explanation and impose sanctions;
- responsive accountability — views of those accounted to must be taken into account.

Accountability may be required for fiscal management, conforming with procedures, quality of work and relevance of work.

Voluntary organisations cope with this multiple accountability by working in the spaces between the theory and practice of accountability. The system works because the funding agencies have insufficient time, knowledge or standards of evaluation to put it into practice. This together with an acceptance of risk taking creates the conditions for a conspiracy of silence. This silence is rarely broken because spending in the voluntary sector is marginal in relation to total welfare expenditure.[120]

Contracting Out

The contracting out or purchase of service contracting (POSC) has been defined[121] as a set of policies and practices on the part of the government contracting agency which views government and the private sector as part of a comprehensive system. In this model government contracts the necessary services out to voluntary organisations who provide services at a fixed price.

In the private contractual model there is a strong tendency to separate financing from administration by purchasing services from both non-profit and profit-making organisations. It has been suggested in the literature[122] that in order to survive the competitive elements generated by this model of service-provision, voluntary agencies have to become more opportunistic, entrepreneurial and political than those represented in other welfare states. While the purchase of service model requires the voluntary agencies involved to direct their energies into services which are seen by government as worthwhile, there is generally room for negotiation. It has been argued,[123] that this model of contracting for the purchase of service is the best means of balancing the voluntary agencies' independence with the government's need for accountability.

In terms of social service provision and delivery, the United States has adopted a system of "contracting out". This involves a more formal business-like partnership between the different social actors. Social service agencies tender competitively for funds, and a written contract is prepared between the State and the agency chosen to provide the service.

Contracting out is not a new development and has been practised for many years in the United States. In the United States purchase of service contracting (POSC) was a common practice during the colonial period and in the early nineteenth century.[124] As towns and cities grew contracting out was replaced by poorhouses directly funded by government. At the end of the nineteenth century, coincident with the private charities and settlement house movements, contract arrangements again became popular. A popular view of the time was that private charitable groups and organisations could provide better quality human services at lower cost than the public authorities. Eventually controversies arose over quality control and accountability and contracting out declined for 50 years. In the 1960s many of the programmes initiated contained explicit provisions for contracting out. Though sizeable grants are paid to voluntary agencies for non-residential services, contracting out is mainly concerned with residential services.

Two models of POSC or contracting out have been defined: a partnership

model and a market model. The partnership approach to contracting out is defined as:[125]

> A set of policies and practices (on the part of the government contracting agency) which views government and the private sector as part of a comprehensive human services system, and where the determining factor in selection of contractors is a concern for the development and maintenance of the human services system.

In following the partnership model of contracting out the government concerned would:

(i) be concerned with strengthening the working relations between the government funding source and the service delivery agency,

(ii) be flexible in the development, negotiation and administration of contracts.

(iii) make contracting decisions primarily on the basis of concern for the stability of the human services system.

(iv) be cautious about experimentation with different modes of service provision.

(v) favour specialization, rather than competition, among contractors in order to capitalise on public/private sector strengths.

In the partnership model of contracting out government and the private sector are viewed as partners engaged in a joint venture. The process is viewed from the perspective of two equal partners each of whom are attempting to maximise the human service systems outputs through joint action. This model of contracting out requires a high degree of interaction between government agency staff and private agency staff in respect of planning, designing, budgeting, monitoring and evaluation.

The market model is defined as[126]

> a set of policies and practices (on the part of the government contracting agency) which encourages competition among potential contractors and, where both contractors are competing to provide a like service, price is the determining factor.

In following the marketing model of contracting out the government concerned would:

(i) develop criteria for measuring efficiency and effectiveness.

(ii) be highly specific during negotiation on issues of performance expectations, programme design and budget.

(iii) make contracting decisions primarily on the basis of cost and price.

(iv) encourage experimentation with alternative methods for delivering services,

(v) devote resources to recruiting and developing a pool of potential contractors.

In the market model of contracting out. the government contracting agency is viewed as a purchaser of human services and the private sector contractor is viewed as the vendor. Generation of competition and lowering of cost is an intended outcome of the market approach.

Contracting systems are rarely pure types but possess characteristics of both the partnership and market model. Fourteen factors have been identified as relevant in the determination of how government services should be delivered and which model should be employed; these are categorised as follows.[127]

- productivity, fiscal and cost considerations
- planning, designing and funding considerations
- improving services to clients
- government organisational and policy considerations
- legal requirements
- policies and loyalties

A study of contracting out in Britain indicated that as yet "contract culture" is more talked about than practised there.[128] Quite different reactions to their experience of contracting were expressed by spokespersons of voluntary agencies. Those who were aware of a condition of mutual dependency between themselves and the funding authority appear to be positive towards the contracting system.

Contracting out is a form of delegation. Leat suggests[129] that the reasons given by Smith and Hague for delegation to quangos underly governments deciding to opt for accountability rather than direct contract. These are:

- Buffer theory: protecting activities from political interference.
- Escape theory: escaping weaknesses of government departments and achieving independence.
- "Corson" theory: spreading power.

- Back double theory: if governments cannot do what they want within existing structures — find a way of doing it outside.
- Too many bureaucrats: extending government activities without increasing the number of government employees.

The broad conclusion of various studies undertaken in the USA to identify the rationale for contracting out was that "there are no consistent policies governing purchase of services".[130] The reasons most commonly given included:

- their traditional availability
- they facilitate provision of specialised but essential services
- costs are lower and they provide better value for money
- they are more flexible, innovative and participative
- they promote consumer choice and better access to services.

Funding, Accountability and Contracting out in the Irish Context

In considering funding and contracting out it was evident that the fear sometimes expressed in Ireland that voluntary organisations lose self determination as a result of planned funding from statutory agencies is not supported. The distinction made between the partnership and market models of contracting out is illuminating and pertinent. The partnership model of contracting out, which would appear to be the form of contracting out advocated in *The Years Ahead,* seems to be compatible with the *developmental pluralism* style of partnership. The partnership model of contracting out has a number of positive features including the following: the strengthening of working relations between the government funding source and the service delivery agency; flexibility in the development, negotiation and administration of contracts; the encouragement of specialization rather than competition among contractors in order to capitalise on the benefits deriving from the public and private sector working together.

Although contracting out has been receiving a considerable amount of attention it would appear that in the area of non-residential services it is at an early stage of development. Nonetheless, a number of studies suggest that the fear of loss of autonomy by voluntary agencies as a consequence of entering contracts with statutory agencies is not supported. Furthermore, international studies show that those organisations most actively engaged in advocacy were among those in receipt of the

highest percentage of government funds. A number of factors were seen to be protective of the autonomy of voluntary organisations. These factors included the diversity of the income sources of the voluntary organisations and the power resulting from their service monopoly.

Summary

Important aspects of the development of state welfare provision in Ireland in recent decades, especially in respect of community based services, include the provision of structures and funding for the support of the voluntary sector, and the expression of aspirations for greater sharing of responsibility with the voluntary sector. In recent years, in particular, a high level of partnership between the voluntary sector and the statutory sector has been sought in the planning of and delivery of services to the elderly. However, some uncertainty has been expressed about the level of development of the voluntary sector in Ireland and the level of voluntary/statutory cooperation achieved. Furthermore, attention has been drawn to the absence of information regarding the activities of voluntary organisations.

Voluntary organisations are defined as not-for-profit, non-statutory organisations. Voluntary work is unremunerated work, freely undertaken, and is often motivated by altruism. While several studies show that men and women are equally likely to engage in voluntary work the type of work tends to be differentiated by gender. Male volunteers tend to be more involved in practical help whereas women volunteers are more likely to be engaged in fund-raising and direct caring services. Some major studies show that the majority of volunteers are in the 25-44 age group and have dependants; they have higher than average incomes, are drawn disproportionately from professional and managerial occupations and are highly educated.

Certain advantages have been attributed to voluntary organisations, for example, it is claimed they are better than the statutory sector in respect of their creative, service and economic functions. However, some of these advantages are contested. Apart from historical accident and the political power of voluntary agencies seven reasons are advanced in justification of government funding.

One categorisation of voluntary/statutory relationships distinguishes between them on the basis of the regulation and distribution regimes in which they operate, the conservative, the liberal and the social democratic. One social policy model presented distinguishes between two conceptions of the role of the State in the provision of social welfare, the residual and the institutional. Many factors account for the diversity

of social welfare systems, they include ideology, values and economic and demographic factors. There is considerable diversity within Europe concerning the level of responsibility for social welfare provision accepted by the State, whether in respect of funding services, delivering them, or both. Contemporary influential models of the voluntary/ statutory relationship include Welfare Pluralism, the New Right. Subsidiarity and Partnership. The first three of these envisage the State limiting its role in service provision while the fourth implies a greater sharing of responsibility.

It is suggested here that some mixture of both the conservative and liberal traditions have been influential in welfare provision in Ireland. Of the models of the voluntary-statutory relationships outlined Welfare Pluralism would appear to approximate most closely to the interaction between the voluntary and statutory sectors in the provision of community based services for the elderly in Ireland. The New Right model would appear to have limited applicability in Ireland and support for its ideological dimension is not evident. The typology of partnership outlined would appear to position voluntary-statutory relationships in Ireland somewhere between the *enhanced monopolist* approach and the *responsive pluralist approach.* This position would take account of the fact that voluntary activity is welcomed but only within a tightly controlled financial framework. So far the most complete form of partnership, *developmental pluralism* — where effort is made to promote and stimulate the voluntary sector and establish a place for it within an integrated pattern of service provision is aspirational.

Contracting out of services is a much debated issue. Resultant advantages for the voluntary sector include greater predictability and security of income. However, the effect such funding has on the independence and advocacy role of voluntary organisations is debated. This will depend to some degree on the model of contracting employed, contracting of services can operate under a partnership or a market model. The implications such arrangements have for the consumer of services is also debated. The question of accountability is closely associated with this issue. The forms it can take and the limitations on its effectiveness, including "bureaucratic symbiosis" are discussed. Accountability is associated with the advent of pluralism, professionalism and consumerism. Three kinds of accountability are identified: explanatory, accountability with sanctions, and responsive accountability. A major reason why accountability doesn't overload administrative systems is because it is not rigorously applied. It is notable that partnership model of contracting out, implied in *The Years Ahead,* would appear to be consistent with Developmental Pluralism.

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CHAPTER 3

The Nature of Voluntary Organisations Providing Services for the Elderly

Introduction

An overview of the voluntary organisations[1] providing services for the elderly is presented in Chapter Three. This overview describes the geographical distribution of respondents, their legal status and objectives and their resources other than financial. This information is of value in assessing what contribution voluntary organisations might make to the welfare of the elderly and what degree of partnership with statutory bodies might be practical. Section One. distribution of voluntary organisations providing services for the elderly, describes the distribution of respondents by health board area and county. Section Two. the status and objective of voluntary organisations, explores the organisational nature and purposes of voluntary organisations. In Section Three, the staffing and resources of the organisations, the number of volunteers and their tasks, the number of staff employed by organisations, both full-time and part-time, and those engaged in collaboration with FAS or other organisations are described. The sources of funds for payment of staff are also described. In addition, the availability of offices and other premises are explored together with the nature of tenure attaching to those properties which are available. Sources of funding for offices and what improvements in them are required are described. In Section Four, management structures of voluntary organisations and a brief description of the characteristics of committees of voluntary organisations is presented. A summary is provided at the end of the chapter.

Section 1: Distribution of Voluntary Organisations Providing Services for the Elderly

The location of the organisations is shown in Table 3.1 below.

TABLE 3.1: Distribution off respondent organisations and national population over 65 by health board area (Q.2)

Health Board	Number	Per cent	National Population over 65 per cent
Eastern	200	23.0	29.1
Southern	145	16.7	16.3
South Eastern	133	15.3	11.1
Mid-Western	99	11.4	9.1
North Eastern	81	9.3	8.4
Western	78	9.0	12.4
Midland	58	6.7	6.1
North Western	69	7.9	7.5
(no answer)	5	0.6	
Total	868	100.0	100.0

Nearly a quarter of the organisations have an address in the Eastern Health Board area. The Southern and South Eastern Health Board areas together account for nearly one-third of the total. The five remaining health board areas account for similar proportions, within the range of 6.7 per cent to 11.4 per cent. There is a close correspondence between the distribution of respondent organisations and the population over 65 years old by health board area. This does not indicate that the level of service available is proportionately distributed but it does suggest that organisational "presence" is.

Table 3.2 facing shows the distribution of respondent organisations by county.

TABLE 3.2: Distribution of respondent organisations by county (Q.2)

County	Number	Per cent
Dublin	158	18.2
Cork	93	10.7
Limerick	62	7.1
Kerry	52	6.0
Donegal	46	5.3
Galway	37	4.3
Waterford	31	3.6
Mayo	31	3.6
Wexford	31	3.6
Kilkenny	29	3.3
Meath	27	3.1
Tipperary S.R	25	2.9
Louth	24	2.8
Wicklow	22	2.5
Clare	20	2.3
Kildare	20	2.3
Westmeath	19	2.2
Carlow	17	2.0
Laois	17	2.0
Monaghan	16	1.8
Tipperary N.R	16	1.8
Offaly	14	1.6
Cavan	14	1.6
Sligo	13	1.5
Leitrim	11	1.3
Longford	9	1.0
Roscommon	9	1.0
No Answer	5	0.6
Total	868	100.0

Organisations in every county have responded to the survey; those in Dublin account for almost one-fifth of them. A further third of replies is accounted for by organisations in five counties; Cork, Limerick, Kerry, Donegal and Galway. Each of 13 counties account for between 2.0 per cent and less than 4.2 per cent of replies. Each of eight counties account for less than 2.0 per cent of replies.

Section 2: The Status and Objectives of Voluntary Organisations

Most of the respondents, 728. indicated the year in which the organisations were established. Seventy seven per cent of these, were established later than 1967; 17 of these were established in the last year. Four per cent and 19 per cent were established in the last century or in the period 1901-1967 respectively (see Table A 3.1).

Most of the respondents, 698, describe the legal status of their organisations. Of these, 21 per cent, are registered with their own constitutions and 12 per cent are incorporated. A further 24 per cent are both registered with their own constitutions and incorporated and 43 per cent are neither of these (see Table A 3.2).

The organisations were categorised by 785 respondents as shown in table 3.3 below. (Q.6(a))

TABLE 3.3: Categorisation of organisations «L6(a))

Category	Number	Per cent
Care of the Aged Committee	208	26.5
Social Service Council	90	11.5
Association of Older People	87	11.1
Voluntary Housing Agency	32	4.1
Local Committee/Organisation/Other than above	148	18.8
Other	135	17.2
Two or more of above	85	10.8
Total	785	100

More than one-third of the organisations were categorised as either care of the aged committee or associations of older people. Many of the organisations are either branches of or affiliated to a larger organisation; 286, 40 per cent of those who replied, indicated they were branches; 211, 35 per cent of those who replied, indicated they were affiliates. Forty eight per cent are branches, affiliated or both (see Table A 3.3). The larger organisations of which they are branches, or affiliated to, are presented in Table 3.4 below.

TABLE 3.4: Organisations of which respondent organisations are branches or affiliates (Q-6(b))

Name of Organisation	Number	Percentage
St Vincent De Paul Parish	98	11.3
organisation/committee	19	2.2
Muintir na Tire	15	1.7
National Org. (Exc. V.De P)	115	13.2
Fleligiouscommunity/parish	25	2.9
Community Care Group	59	6.8
Other	57	6.6
No answer/not applicable	479	55.2
Total	868	100.0

Table 3.5 shows the distribution of organisations by health board area that are branches, affiliates or both.

TABLE 3.5: Distribution of branches or affiliated organisations by health board areas* (Q.2. Q-6(b))

Health Board	Per cent	n
Eastern	33	200
Southern	50	145
South Eastern	44	133
Mid-Western	49	99
North Eastern	49	81
Western	44	78
Midland	64	58
North Western	75	69

'Because of non-response regional comparisons must be treated with caution

As can be seen in Table 3.5 the variation in the reporting of some kind of affiliation is considerable, from 33 per cent in the Eastern Health Board area to 75 per cent in the North Western Health Board area.

The first and second organisational objectives listed by more than five respondents are presented in Table 3.6 below.

TABLE 3.6: Organisational objectives (Q.7(b))

Objective	First Number	Per cent	Second Number	Per cent
Help/Care for Elderly	164	18.9	38	4.4
Helppoor/needy	123	14.2	26	3.0
Enjoyment for Elderly	111	12.8	37	4.3
Meals for Elderly	53	6.1	19	2.2
Services for Elderly	47	5.4	19	2.2
Meet needs of Community	44	5.1	14	1.6
Housing for Elderly	40	4.6	8	0.9
Religious/Spiritual	30	3.5	2	0.2
Elderly get together	30	3.5	33	3.8
Provide for special group	17	2.0	12	1.4
Relieve suffering	16	1.8	8	0.9
Day care for Elderly	14	1.6	7	0.8
Community development	13	1.5	8	0.9
Help living alone	11	1.3	15	1.7
Information/Advisory	9	1.0	12	1.4
Provide essential services	5	0.6	9	1.0
Give material help	4	0.5	9	1.0
Other answer	64	7.3	17	2.0
No answer	73	8.4	575	66.3
Total	868	100.0	868	100.0

Three objectives were given as the first objective by more than 10 per cent of respondents: they are help/care for elderly, help poor/needy and enjoyment for elderly. Eight of the objectives listed above are focused

on the elderly. These are; help/care for elderly, enjoyment for elderly, services for elderly, meals for elderly, housing for elderly, elderly get together, day care for elderly and help living alone. One of this group of objectives is given as a first objective by 470 respondents, 54 per cent of the total; or as a second objective by 176 respondents, 20 per cent of the total.

Section 3: Staffing and Resources of the Organisations

The numbers of volunteers engaged in providing services are presented in Table 3.7 below. The majority of organisations, 72 per cent, have less than 21 volunteers providing services, and only 12 per cent have 50 or more.

TABLE 3.7: Number of volunteer* providing services (Q.13(a))

Number of Volunteers	Organisations Number	Per cent*
Less than 10	189	33
10-20	227	39
21-50	89	16
50 or more	66	12
Varies	3	1
No answer/not applicable	294	
Total	868	100

*Of those for whom information is available, rounded to nearest whole number.

The number of volunteer members of voluntary organisations in the State engaged in providing services for the elderly is estimated to be 29,700. The average number of volunteer members per organisation engaged in providing such services is estimated to be 25.

The average number of volunteers per organisation was calculated as follows. The mid-points of the numerical categories in Table 3.7 were calculated, these are 5, 15 and 35.5 respectively. The average number of volunteers of those organisations reporting 50 or more volunteers was calculated, this was 104. These values were then multiplied by the number of organisations within each category and the products were added. This sum was divided by the total number of organisations (571) that had provided an estimate of the number of volunteers. This resulted in an average of 25.

The procedure involved in the calculation of the total for the State was as follows. First, the average of 25 was multiplied by 868 to yield an estimate of the number of volunteers in the respondent organisations; this resulted in a total of 21,7000. Second, this latter number was

multiplied by 1.369 to take account of non-respondents.[2] This resulted in the estimate of 27,700 (to the nearest 100).

Support for this estimate of volunteers is available from a recent study of charitable giving and volunteering.[3] In that study a random sample of 1,000 persons, representative of the national population 18 years of age and over, were asked about their participation in a wide range of voluntary activities including caring for elderly persons other than family members. The proportion of persons who reported they engaged in caring for the elderly on a voluntary basis was 1.4 per cent. Given that in 1991 the number of persons in the State aged 18 years and over was 2,360,000* this indicates that approximately 33,000 people were engaged in such activities. This estimate is in good agreement with that derived here, 29,700, especially taking into account the likelihood that all those engaged in such voluntary activities may not be members of organisations.

Five hundred and twenty three respondents provided some description of the time that volunteers providing services typically give. In the majority of organisations, 66 per cent, volunteers on average give less than five hours weekly, eight per cent contribute between five and ten hours weekly, two per cent contribute between ten and nineteen hours weekly, and two per cent give twenty or more hours weekly. Of the remainder, two per cent give time "when needed", one per cent does so annually, in six per cent of cases the time given varies and 14 per cent gave some other reply (see Table A 3.4).

The tasks volunteers engage in are listed below in Table 3.8.

TABLE 3.8: Tasks in which volunteers are engaged (Q.13(b))

Task	Task 1		Task 2	
	Number	Per cent*	Number	Per cent*
Entertainment	94	16	92	24
Fund-raising only	21	4	15	4
Day to day / All tasks	234	38	87	23
Admin./Office work	16	3	21	6
Home and hospital visits	131	21	75	20
Catering/helping	95	15	59	16
Information provision	12	2	26	7
Assessing needs	5	1	—	—
Total	608	100	375	100

*Of those who gave a reply, to nearest whole number: 260 organisations did not reply to this question.

Volunteers are engaged in wide ranging activities. In 38 per cent of organisations the primary task of volunteers is day-to-day duties/all

tasks. In 21 per cent of cases the primary task of volunteers is home and hospital visits, this is followed closely by entertainment and catering/helping, 16 per cent and 15 per cent respectively. In 24 per cent of organisations the secondary task of volunteers is entertainment. Home and hospital visits account for the secondary task in 20 per cent of organisations; these are nearly equalled by day-to-day duties/all tasks and catering/helping, 23 per cent and 16 per cent respectively. Only one per cent of organisations identify the primary task of their volunteers as needs assessment.

Full-time staff are employed by 127 organisations. 16 per cent of the 774 who replied to the question. Of these, 73 per cent employ less than 6 persons, seven per cent employ between six and ten, eight per cent employ between 11 and 20 and seven pecent employ more than 20 (see Table A 3.5). Information on who pays the wages of the full-time staff is supplied by 123 organisations. In 59 per cent of cases the organisation itself pays the wages. The wages are paid by the Health Board in 13 per cent of cases and by another statutory agency in eight cases. They are paid by the parent organisation in four per cent of cases and by some combination of two or more of these in 10 per cent cases. In respect of four per cent of cases some other arrangement was referred to (see Table A 3.6).

Part-time staff are employed by 150 organisations, 21 per cent of the 700 who replied to the question. Information on the number of part-time staff employed is provided by 138 organisations. Of these, 77 per cent employ less than six, 11 per cent employ between six and ten, six per cent employ between 11 and 20 and six per cent employ more than 20 (see Table A 3.7).

As in the case of full-time staff the organisation itself pays the wages of part-time staff in the majority of cases. Of the 144 organisations who provide the requested information 58 per cent pay the wages of part-time staff themselves. The wages of part-time staff are paid by the Health Board or another statutory agency in 17 per cent and ten per cent of cases respectively; they are paid by the parent organisation or by fund-raising in three per cent and one per cent of cases respectively. They are paid jointly by two or more of these in eight per cent of cases. Two per cent of respondents referred to some other source of the wages of part-time staff (see Table A 3.8).

Eighty seven organisations, 13 per cent of the 683 who replied to the question, employ people who are on FAS courses. Apart from staff, either full-time or part-time, and volunteers; 110 respondents, 16 per cent of the 687 who replied, report there are other persons working within their organisations. Of the 104 organisations who reported the

number of such persons, 66 per cent indicated there were less than six, 15 per cent reported between six and ten, 13 per cent reported between 11 and 20 and five per cent reported more than 20 (see Table A 3.9). The primary and secondary tasks such people are engaged in are presented in Table 3.9.

TABLE 3.9: Tasks of persons working in voluntary organisations other than staff or volunteers «Q2O(b))

Task	Primary Task		Secondary Task	
	Number	Per cent	Number	Per cent
Drivers/Transport	13	15	—	—
Medical	17	26	—	—
Decision making etc.	29	7	—	—
Entertainment	8	4	2	2
Cleaners	4	—	—	—
Admin/Office work	—	—	4	4
Assessing needs	—	34	11	10
Other	36	7	6	6
No answer	8		87	78
Total	n 110	100	110	100

The source of funds for payment, if any, of these persons was revealed by 98 of the 110 organisations concerned. In 63 per cent of cases the persons receive no payment and in 15 per cent of cases the funds come from the Health Board/State. In two per cent of cases board and/or lodging is provided in lieu of wages. In two cases wages are funded jointly by the Health Board and a fee for service. Both FAS and the recipients of the service are the source of funds in three per cent of cases. The organisation itself is the source of funds in six per cent of cases. Other answers were given in five per cent of cases (see Table A 3.10).

The distribution of voluntary and other staff by health board is shown in Table 3.10. In six health board areas the proportion of organisations with more than ten volunteers is between 60 per cent and 68 per cent. A higher proportion of organisations in the Eastern Health Board area reported having more than ten volunteers, 78 per cent, a smaller proportion of those in the North Western Health Board area report having more than ten volunteers, 45 per cent. Approximately a quarter of organisations in the Eastern and South Eastern Health Board areas report having at least one paid full-time staff member. The smallest proportion of organisations with paid full-time staff members are in the North Western, Midlands and North Eastern Health Board areas. A higher proportion of organisations employ part-time staff, at least a

TABLE 3.10: Distribution of volunteers and staff by health board area* (Q.2, Q.13(a), Q.14, Q.I6, Q.I8.Q.19)

Health Board	Per cent more than 10 volunteers		Per cent Full-Time staff		Per cent Part-Time staff		Per cent FAS		Per cent Other Employment	
	Per cent	N	Per cent	N	Per cent	N	Per cent	N	Per cent	N
Eastern	78	142	23	181	27	166	11	159	21	161
Southern	66	98	15	132	25	125	17	122	14	125
South Eastern	67	85	26	113	25	104	17	100	24	96
Mid-Western	66	61	12	85	10	77	10	73	11	73
North Eastern	68	56	9	75	15	61	8	63	11	64
Western	60	52	17	70	29	62	18	65	10	62
Midland	66	35	8	49	14	42	7	42	14	42
North Western	45	44	6	64	10	57	7	56	15	59

*Because of non-response regional comparisons must be treated with caution

quarter of those in the Eastern, Southern, South Eastern and Western Health Board areas report doing so.

Organisations in all health board areas employ people engaged with FAS, at least 17 per cent in the Southern, South Eastern and Western Health Board areas. Other persons, who work for the organisations, but who are neither volunteers nor employed by the organisations themselves are reported by organisations in all health board areas.

It can be seen in Table 3.11 that organisations with more than 20 volunteers are more likely than others to have paid full-time or part-time staff, or staff engaged with FAS or to have others working for the organisations who are neither volunteers nor employed by them.

TABLE 3.11: Number of volunteers by other staff (Q.13(a), Q. 14, Q.16, Q. 18, Q.19)

	Less than 21 volunteers		21 or more volunteers	
	Per cent	N	Per cent	N
Full-time Staff	13	(409)	28	(153)
Part-time Staff	18	(372)	31	(147)
FAS Employees	10	(366)	21	(141)
Other Employees	17	(370)	19	(145)

Sixty one per cent of respondents, 462 of the 761 who replied to question 21 indicated they have offices. Their nature of tenure is presented in Table 3.12. Of those who have offices only a minority of organisations, 20 per cent, own their offices. Twenty six per cent rent offices or have them "on loan". The highest proportion, 37 per cent, are in the "used occasionally" category.

TABLE 3.12: Offices of voluntary organisations — nature of tenure (Q.22)

Nature of Tenure	Number	Per cent
Owned	93	20
Rented	57	12
On loan	63	14
Used occasionally	171	37
Other	52	11
Combination	26	6
Total	462	100

The distribution of organisations reporting they have offices by health board area is shown in Table 3.13. Overall, the proportions are similar: in six health boards the percentage reporting they have offices is between

55 and 65. The highest percentage reporting they have offices is in the North Eastern Health Board, 74; the lowest percentage, 35, is in the North Western Health Board.

TABLE 3.13: Organisations with offices by health board area* (Q.2, Q.21)

Health Board	Per cent	n*»
Eastern	63	175
Southern	65	131
South Eastern	55	106
Mid-Western	58	82
North Eastern	74	69
Western	59	66
Midland	63	49
North Western	35	62

'Because of non-response regional comparisons must be treated with caution.
"Number of organisations that replied to the question.

One hundred and ninety respondents revealed the source of office funding. These are presented below in Table 3.14.

TABLE 3.14: Source off office funding (Q.23)

Source	Number	Per cent
Organisation staff	23	12
Health Board	13	7
Other state agency	6	3
Parent organisation	4	2
Fund raising/donation	90	47
Combination of above	28	15
Parish/religious org.	11	6
Other	15	8
Total	190	100

Although the response to this question is low it indicates that most organisations fundraise for their office expenses and few receive assistance from the health boards or other statutory agencies to meet these expenses.

The majority, 76 per cent, of the 415 respondents who replied to question 24 stated that their offices are adequate for their needs. The improvements required by the 24 per cent who did not consider their offices adequate are presented in Table 3.15 below.

TABLE 3.15: Improvements in offices required (Q.25)

Improvements	First Improvement		Second Improvement	
	Number	Per cent	Number	Per cent
More space	41	43	3	3
More/betterequipment	17	17	8	8
Want own house	20	20	1	1
Renovations	10	10	4	4
Other	10	10	6	6
No answer	—	—	76	78
Total	98	100	98	100

One hundred and sixty two organisations, 33 per cent of the 488 who replied to question 26, share offices with another organisation. Sixty eight of those sharing, 42 per cent, indicate there are conditions attached to such sharing. These conditions are presented in Table 3.16 below.

TABLE 3.16: Conditions of sharing offices with other organisations (Q.27(b))

Conditions	Condition 1		Condition 2	
	Number	Per cent	Number	Per cent
Share costs	6	9	—	—
Contribute to heating	8	12	2	3
Use certain times	29	43	3	4
Other	20	29	2	3
No answer	5	7	61	90
Total	68	100	68	100

Two hundred and fifty two organisations, 39 per cent of the 650 who replied to question 28(a), have other premises at their disposal. These premises are listed in Table 3.17. In addition, details of the usage are supplied, whether the premises are owned, used on a part-time basis or rented.

TABLE 3.17: Other premises at disposal of voluntary organisations (Q28(b))

Premises	Nature of Entitlement				
	Owned	Part-time Basis	Rented	Combination	No Elaboration
Community centre	4	28	12	—	1
School	—	9	3	—	
Parish hall	4	46	12	1	
Other	65	58	25	5	3

The total number of entries in Table 3.17 is 280, some organisations have more than one "other" facility.

Section 4: Management Structures of Voluntary Organisations

The majority of organisations, 639, 90 per cent of the 706 who replied to question 48, have a committee structure. The categories of persons represented on the committees were described by 601 of these and are presented in Table 3.18. Eighty seven organisations, 13 per cent of 652 replies, in reply to a separate question (Q.50) reported that a health board was represented on their committee, this is inconsistent with the replies presented in table 3.18. However, because Question 50 was more specific, "is the Health Board represented on your committee?", responses to it are considered more valid.

TABLE 3.18: Categories off persons represented on committees of voluntary organisations (Q.49(a))

Categories	Number	Percentage
Volunteers only	436	73
Staff and volunteers	56	9
Staff, volunteers and Health Board*	13	2
Staff, volunteers and community	16	3
Members of community	13	2
Trustees, directors	12	2
All members	10	2
Other	45	7
Total	601	100

•Inconsistent with above estimate of health board involvement.

Three hundred and four organisations, 49 per cent of replies, have committee meetings on a monthly basis. Sixteen per cent have them on a weekly basis, eight per cent have them on a quarterly basis and one per cent have them on an annual basis. Twenty six per cent have them on an irregular or other basis (see Table A 3.11).

Thirty nine organisations, 27 per cent of the 144 who replied to the question, have guidelines for planning within the organisation.

Summary

Nearly a quarter of the organisations responding have an address in the Eastern Health Board area. The Southern and South Eastern Health Board areas together account for nearly one-third of the total. The distribution of respondent organisations by health board area is very similar to the distribution of the national elderly population.

Twenty one per cent of respondents are registered with their own constitutions while 12 per cent are incorporated as charitable trusts; in addition 24 per cent report they are both of these. More than one-third of the organisations are care of the aged committees or associations of elderly people, 11 per cent are social service councils and four per cent are voluntary housing agencies. Forty eight per cent of organisations are members of larger organisations, have affiliations with other organisations or both.

Three organisational objectives were each given by more than ten per cent of respondents; namely, help/care for elderly, help poor/needy and enjoyment for elderly. More than half of the respondents identified their primary objective as being focused on the elderly.

The majority of organisations, 72 per cent, have less than 21 volunteers providing services, 33 per cent have less than 10 and only 12 per cent have 50 or more. In 66 per cent of organisations volunteers typically contribute less than five hours weekly. The primary tasks in which volunteers are engaged are day-to-day all tasks, home and hospital visits, entertainment and catering/helping. Full-time and part-time staff are employed by 16 per cent and 21 per cent of voluntary organisations respectively.

More than half of the organisations have offices and the majority of those who have them consider them suitable. Ninety per cent of organisations have committees and 65 per cent of these have meetings monthly or more frequently.

References

[1] There are 868 organisations represented in the analysis of census forms under phase II of the study. See "response to the survey"in the Introduction.

[2] See discussion of response rate in Chapter One.

[3] Ruddle. H.. *Charitable Giving and Volunteering in the Republic of Ireland,* forthcoming publication.

[4] Derived from *1991 Census of Population,* Vol II. Table 1A.

CHAPTER 4

Services for the Elderly Provided by Voluntary Organisations

Introduction

Chapter Four describes what voluntary organisations do; how many clients they cater for, what services they provide, how many clients are served by each of the services provided and the frequency of service provision. Clearly information of this kind is essential in forming an assessment of the contribution voluntary organisations are currently making to the care of the elderly and in providing a perspective on their capacity for partnership arrangements with statutory bodies. Chapter Four is divided into the following sections: number of clients served, services provided, frequency of service provision, service duplication, number of services provided by health board area and number of clients, and relationship between level of service provision and personnel resources. A summary is provided at the end of the chapter.

Section 1: Number of Clients Served by Organisations

The number of clients served by the organisations was given by 685 respondents. Of these: 15 per cent, have between 1 and 20 clients; 33 per cent, have between 21 and 50 clients; 27 per cent, have between 51 and 100 clients; 22 per cent, have more than 100 clients; 3 per cent, indicated that the number of clients served by them varies (see Table A 4.1).

On average each voluntary organisation providing services for the elderly serves 79 clients. The procedure employed in computing the average is the same as that used for estimating the average number of volunteers (see Chapter Three). Given that the average number of volunteers is 25 the ratio of volunteers to clients is 1 : 3.16.

Multiplying the average number of clients by the total number of respondent organisations (868) results in a total of 68,572. *When account is taken of the estimated number of non-respondents*[1] *this increases to 93,800*

rounded to the nearest 100. This number is equivalent to 24 per cent of the number of persons aged 65 and over in 1991 throughout the State.

Neither the average nor the total number includes all those for whom social events are provided. Most organisations do not identify those for whom social events only are provided as their clients. In general social events which consist of annual parties or other seasonal events only are perceived by voluntary organisations to be marginal to their main activities.

The number of clients catered for by organisations is quite similar in all health board areas (see Table 4.1). In seven health boards the number of organisations with less than 50 clients is in the range 46 per cent - 51 per cent; organisations in the North Western Health Board area are the exception, 59 per cent of their organisations have less than 50 clients. The percentages of organisations serving between 51 and 100 clients and more than 100 are in the range 22 per cent - 35 per cent and 13 per cent - 26 per cent respectively.

TABLE 4.1: Health board area by number of clients catered for* (Q.2, Q.8)

	<50	51-100	>100	Varies	n
	Percentage				
Eastern	46	26	26	2	162
Southern	46	24	24	6	113
South Eastern	50	22	25	3	108
Mid-Western	48	26	23	3	77
North Eastern	47	35	15	3	62
Western	46	33	14	7	57
Midland	51	31	13	5	45
North Western	59	22	14	5	59

*Because of non-response regional comparisons must be treated with caution.

Section 2: Services Provided

The services provided by the organisations are listed in Table 4.2. Services of a social contact nature are provided by the largest proportions of organisations. Three services of this nature are each provided by at least half of the respondents; they are social events (outings/parties), visiting the elderly at home and visiting the elderly in hospital. The other service of a primarily social nature, day centre — social and recreational facilities, is provided by 21 per cent of respondents; in addition, day centre based personal and social services are provided by 13 per cent of respondents. General supportive services are provided by substantial proportions of respondents; advice/information, material aid, transport and financial support are provided by 41, 36, 33 and 24 per cent of

respondents respectively. Laundry and surveillance services are provided by 26 and 17 per cent of respondents respectively. Most of the other services are focused on specific practical needs of the elderly. Meals-on-wheels are delivered to the clients' homes by 28 per cent of respondents and provided in day care centres by 17 per cent of respondents. Home helps are provided by 18 per cent of organisations. Housing repairs/improvements/adaptations are provided by 24 per cent of respondents while the building and provision of special sheltered housing is undertaken by 11 per cent of respondents. Warden and supervisory services for sheltered housing are provided by five per cent of respondents. Physical aids/alarms are provided by 14 per cent of respondents. With the exception of chiropody the proportion of respondents providing nursing and paramedical services generally is low. Twenty six per cent of respondents provide a chiropody service; the proportions providing occupational therapy, physiotherapy and home nursing, are nine, five and six per cent respectively. Two services are provided for carers of the elderly; a carer support group and a respite service are each provided by six per cent of respondents.

TABLE 4.2: Services provided by organisations (Q.9)

Service	Number	Per cent*
Social event (outings/parties)	670	77
Visiting elderly at home	504	58
Visiting elderly in hospital	437	50
Advice/information	354	41
Material aid (e.g., ciothes/fuel)	312	36
Transport	287	33
Meals-on-wheels (delivered to person)	240	28
Laundry service	229	26
Chiropody	222	26
Financial support	212	24
Housing repairs/improvements/adaptations	204	24
Day centre providing social/recreational facilities	182	21
Home helps	158	18
Surveillance (e.g., community alert)	151	17
Meals-on-wheels (in day centre)	147	17
Provision of physical aids/alarms	122	14
Day care centre providing personal and social services	109	13
Building and provision of special/sheltered housing	98	11
Occupational therapy	77	9
Carer support group service	55	6
Service for carers, eg respite care	52	6
Home nursing service	52	6
Warden and supervisory services for sheltered housing	42	5
Physiotherapy	40	5

*Of 868

With two exceptions there are no data available to compare with these estimates of the number of voluntary organisations providing services.

One of these exceptions relates to meals-on-wheels provision. In a recent study of charitable giving and volunteering, based on a representative sample of the national adult population, respondents were asked whether they were engaged in providing meals-on-wheels on a voluntary basis.[2] A small number, 0.4 per cent, indicated they were engaged in such activities. Applying this proportion to the 1991 adult population of approximately 2,360,000[3] indicates that approximately 9,440 persons were engaged in the provision of meals-on-wheels on a voluntary basis throughout the State.

It is reported here that meals-on-wheels are delivered to the homes of recipients by 240 of the respondent organisations and that they are also provided in day centres by 147 organisations. However, 97 of those organisations delivering meals-on-wheels to recipients' homes also provide them in day centres so that only 50 organisations provide them in day centres exclusively. Accordingly, 290 of the respondents provide meals-on wheels. Allowing for non-respondents[4] results in an estimate of 397 organisations providing a meals-on-wheels service. Multiplying the number of organisations by 25, the estimated average number of volunteers per organisation, results in an estimate of 9,925 volunteers engaged in the provision of meals-on-wheels nationally. This estimate of 9,925 is in good agreement with that yielded by the sample survey referred to above, 9,440. (The number of persons benefitting from the meals-on-wheels service is considered later).

The second exception relates to day care centres. It is reported here that 182 of the respondents provide day centres with social and recreational facilities. In addition, 109 respondents report the provision of day centres with personal and social services. However, most (90) of the organisations providing personal and social services in day centres also provide the social and recreational facilities. Therefore, 201 of the respondents provide some kind of day centre facilities. Allowing for the estimated number of non-respondents[5] results in an estimate of 275 voluntary organisations providing some kind of day care services throughout the State. This estimate exceeds an estimate made recently by the Department of Health.[6] It estimates that 224 day centres operate throughout the country. If the provision of meals in a day centre was taken as a measure of high level day centre provision then the estimate of day centres provided by respondents would be closer to the estimate made by the Department of Health. Allowing for non-respondents the 147 organisations

providing meals in day centres would be grossed up to 201. In part the variation in these estimates reflects the considerable difficulty in estimating the number of day centres because of the absence of an agreed operational definition.[7]

Provision of Services by Health Board Area

The proportion of voluntary organisations in each health board area providing each of the services listed in Table 4.2 is shown in Table 4.3. Overall, the proportions supplying the services in each of the health board areas are similar; only 34 of the 192 percentages presented in Table 4.3 are 10 percentage points more or less than the average percentage providing the service. There is little variation in the proportion of respondents providing occupational therapy, home nursing, physiotherapy, warden and supervisory services for sheltered housing, carer support group service and services for carers; overall, such services are provided by very few organisations (no more than 13 per cent provide any of them).

The range in the level of provision is greater in respect of providing personal and social services, day centre providing social and recreational activities, provision of physical aids/alarms, building and provision of special sheltered housing, advice/information, financial support, transport, surveillance and social events. The services in this group with the greatest range in level of provision are day centres providing social and recreational activities and advice/information. The proportion of respondents reporting the provision of day centre/social and recreational activities ranges from 7 per cent in the Midlands Health Board area to 32 per cent in the Eastern Health Board area. The proportion of respondents reporting the provision of advice/information ranges from 30 per cent in the North Eastern Health Board area to 55 per cent in the North Western Health Board area.

The range in the level of provision is greatest in respect of the nine remaining services; laundry, housing repairs, chiropody, home-help, visiting elderly at home, visiting elderly in hospital, meals-on-wheels provided in day centres, meals-on-wheels delivered to person's home and material aid. Of this group the service with the narrowest range in level of provision is meals-on-wheels provided in day centres, five per cent of respondents in the Midlands Health Board compared with 32 per cent of respondents in the Eastern Health Board area report the provision of this service. The service with the widest range in level of provision is home helps, more than half of the respondents in the North Western Health Board area report the provision of this service while

only seven per cent of ihose in the North Eastern Health Board area do so.

Organisations in the North Western Health Board area account for much of the width of these ranges; a considerably higher proportion of them provide services in the four following categories: laundry services (16 percentage points more than the next highest proportion), housing repairs (18 percentage points more than the next highest proportion), home helps (28 percentage points more than the next highest proportion), meals-on-wheels delivered to person's home (10 percentage points more than the next highest proportion) and material aid (14 percentage points more than the next highest proportion).

TABLE 4.3: Proportion of voluntary organisations in each health board area providing services (Q.2, Q.9)

Services	Health Board — Percentage•							
	E	S	S E	M-W	N E	W	M	N W
Day centre/pers & soc		14	11	10	11	21	5	16
Day centre/soc & rec	14	20	20	18	19	25	7	15
Laundry	32	34	26	13	11	38	38	54
Phys.aids/alarms	20	14	18	7	11	17	23	16
Occup.therapy	13	5	12	7	8	9	7	7
Home nursing	13	11	2	1	4	7	7	13
Physiotherapy	6	3	8	1	0	3	4	6
Sheltered housing	9	17	13	6	6	12	4	19
Warden service	11	7	5	3	5	1	4	1
House reps	7	40	21	18	5	28	23	58
Chiropody	7	32	21	34	21	20	48	26
Home helps	21	26	12	17	7	13	11	54
Visitelderly/home	15	71	54	58	50	58	77	83
Visitelderly/hosp	45	64	42	53	36	54	68	67
Meals/centre	43	19	11	6	10	26	5	9
Meals/home	32	32	21	15	26	32	16	45
Advice/info	35	42	39	40	30	50	48	55
Financial support	39	26	24	26	16	36	29	38
Material aid	17	43	33	37	30	42	36	57
Transport	28	37	33	38	36	36	25	33
Surveillance	31	24	24	27	6	20	20	20
Carer support	8	7	8	5	1	8	4	6
Services for carers	8	6	5	3	4	5	4	10
Social events	9	76	70	83	84	84	73	91
Number	78	145	133	99	81	78	58	69

200

•Because of non-response regional comparisons must be treated with caution

KEY TO TABLE 4.3

E	Eastern Health Board	N E	North Eastern Health Board
S	Southern Health Board	W	Western Health Board
S E	South Eastern Health Board	M	Midland Health Board
M-W	Mid-Western Health Board	N W	North Western Health Board

TABLE 4.4: Number of clients catered for by services (Q.10)

Service	Number of Clients						
	1-10	11-20	21-50	51-100	100 +	Not Fixed	*
Social event (337)	16	34	94	110	79	4	50
Visiting elderly at home/hopital (282)	112	58	53	24	19	16	53**
Advice/information (135)	45	23	28	11	12	16	38
Material aid (124)	70	20	17	8	1	8	40
Transport (136)	51	32	26	10	6	11	47
Laundry service (171)	81	42	29	9	8	2	75
Meals-on-wheels (home delivery) (192)	76	36	51	21	6	2	80
Chiropody (137)	29	41	48	7	7	5	62
Housing repairs (126)	92	14	9	3	2	6	62
Financial support (102)	65	11	11	3	3	9	48
Day care centre (146)	12	35	62	21	15	1	73***
Home helps (95)	50	18	8	4	14	1	60
Surveillance (47)	13	11	9	7	4	3	31
Meals-on-wheels in day centre (110)	27	25	43	6	8	1	75
Physical aids/alarms (67)	32	13	10	8	4	—	55
Sheltered housing (58)	24	12	14	4	3	1	59
Occupational therapy (52)	13	14	17	5	2	1	68
Carer support group service (18)	8	3	4	1	2	—	33
Service for carers (15)	11	1	—	1	1	1	29
Home nursing (29)	11	4	7	2	4	1	56
Physiotherapy (23)	9	6	5	1	2	2	58
Warden Services (22)	3	5	11	2	1	—	52

Note: the total number of organisations providing information on the number of clients served by each service listed above is shown by brackets after the service name.

*Total number of organisations providing an estimate of the number of clients as a percentage of the number reporting the provision of the service (see Table 4.2 for the latter).

•"Total number providing an estimate of the number of clients as a percentage of the number reporting visiting elderly at home.

•••Total number providing an estimate of clients as a percentage of the number of voluntary organisations with day centres (201).

Estimated Number of Clients Provided with Services by Voluntary Organisations

We noted already that social contact type activities are provided by most organisations. In addition, however, such activities affect the largest numbers of elderly people. We will see below that some services provided by voluntary organisations are available to small numbers of elderly people only. Estimates (to the nearest 100) of the total number of clients served by each of the services provided by voluntary organisations are presented in Table 4.5. The procedure involved in making them is described at the end of this chapter.[8]

Occasional services such as social events, a substantial proportion which consist of annual events only, are provided for 76,900 elderly people. Services which may not require significant amounts of time, and which do not require significant financial resources, are made available to substantial numbers. These include: visiting the elderly at home or in hospital, 26,700, and surveillance, 21,200. It is unlikely this latter figure refers to elderly persons only as in some cases the organisations concerned refer to entire areas rather than to elderly residents only-
Services of this kind are also provided by persons who are not members of voluntary organisations engaged specifically in the provision of services for the elderly or any organisation. It is estimated that 9.6 per cent of the adult population, 227,000 approximately, visit elderly persons who are not members of their own family.[9] All neighbourhood watch schemes, being area based include elderly residents. Many voluntary organisations, especially those focused on health issues rather than on any age group, include elderly persons if relevant.

Voluntary sector services which have a significant part to play in assisting the elderly to live in the community are available to small numbers only. Day centres cater for 13,900 clients, equivalent to ten per cent of the 75+ population. Meals-on-wheels, whether delivered to the home or provided in day centres, are provided for 15.900 persons, equivalent to 11 per cent of the 75+ population. Transport, critical if the frail elderly are to avail of day centres, is available to 11,000 persons, equivalent to eight per cent of the 75+ population. Home helps are provided for 8,000 elderly persons, equivalent to six per cent of the 75+ population. A laundry service is available to 7,400 persons, equivalent to five per cent of the 75+ population.

Chiropody, home nursing and other paramedical services are provided to very small numbers of elderly persons by voluntary organisations; it should be noted that statutory bodies are the main providers of such services. A chiropody service is available to 9,300 persons, equivalent

to six per cent of the 75+ population. Home nursing is available to 4,700 persons, equivalent to three percent of the 75+ population, occupational therapy is provided for 3,300 persons equivalent to two per cent of the 75+ population. Physiotherapy, so important for maintaining mobility, is provided for 2,100 persons only, equivalent to one per cent of the 75+ population.

Appropriate housing, and a supportive housing environment, can also be of great assistance in maintaining independent living and in providing a decent quality of life. As yet only a small number of the elderly are assisted by voluntary organisations in these respects. Voluntary organisations report the building or provision of special or sheltered housing for 3,700 elderly persons, equivalent to three per cent of the 75+ population. A smaller number of elderly persons, 1,900, equivalent to one per cent of the 75+ population, benefit from warden and supervisory services for sheltered housing. Miscellaneous physical aids and alarms are made available to 5,000 elderly persons, equivalent to three per cent of the 75+ population. Housing repairs and improvements are made available to 4,700 elderly persons, equivalent to three per cent of the 75+ population.

Direct material or financial aid is made available to a small number of elderly persons by voluntary organisations. Material aid. e.g., fuel or Christmas hampers etc., is provided to 7,700 elderly persons, equivalent to five per cent of the 75+ population. Financial aid is provided to 7,100 persons, equivalent to five per cent of the 75+ population.

It is clear that voluntary organisations have not yet become engaged in the provision of services for carers of the elderly to a significant degree. A carer support group service is provided for 2,500 persons, equivalent to two per cent of the 75+ population. Services for carers, for example, respite care, are provided for 1.500 only, equivalent to one per cent of the 75+ population.

Some information is available for comparison with the estimates of the number of clients served by some of the services listed in Table 4.5.

(i) According to the Department of Health 12.074 elderly persons were beneficiaries of the home help service in 1990. This estimate includes such services provided directly by health boards or through or in conjunction with voluntary organisations in receipt of funds from health boards to provide such a service. The number of those benefitting from the home help service provided by voluntary organisations only should therefore be less than 12,074 as is the above estimate of 8.000.

(ii) It was estimated (see page 101) that 201 of the 868 respondent

TABLE 4.5: Estimated numbers off clients availing of services (Q.9, Q.10)

	Number	Number as a Percentage of Over 75 Population*
Social events	76,900	54
Visiting elderly at home/hospital	26,700	18
Advice/information	27,300	19
Material aid	7,700	5
Transport	11,100	8
Meals-on-wheels (delivered to home)	8,900	6
Laundry service	7,400	5
Chiropody	9,300	6
Financial aid	7,100	5
Housing repairs/improvements	4,700	3
Day care centre	13,900	10
Home helps	8,000	6
Surveillance	21,200	15
Meals-on-wheels (day centre)	7,000	5
Provision of physical aids/alarms	5,000	3
Build/provide special shelter/ housing	3,700	3
Occupational therapy	3,300	2
Carer support group service	2,500	2
Service for carers (e.g., respite care)	1,500	1
Home nursing	4,700	3
Warden & supervision services for sheltered homes	1,900	1
Physiotherapy	2,100	1

*1986 population (1991 data not available). Estimates of the equivalent percentage of the over 75 population are provided to place the estimated number of clients in perspective; there are no norms implied.

organisations provide some kind of day centre service (assuming they are referring to different centres and not different services only). Taking account of non-respondents results in an estimate of 275 day centres.[10]

It has been estimated that the average attendance at day centres is 25 persons and that individuals may attend from one day a week to five day." If on average each person attends for 2.5 days and assuming centres are open for five days weekly the average number of users per centre would be 50. Multiplying this latter number by 275 would result in an estimate of 13,750 clients which is in good agreement with that obtained here, 13,900.

(iii) It is estimated here that the meals-on-wheels service is available to 8,900 persons (home delivery) and is provided in day centres for an additional 7,000 persons. Assuming there is no overlap a

total of 15,900 persons avail of this service. The Department of Health's 1990 estimate is less than this. 11,182. This latter estimate does not include the South Eastern Health Board area. Assuming that 800 persons avail of the service these results in a total of approximately 12,000. This is in reasonable agreement with the estimate of 15.900 made here. See also the note above on the estimate of volunteers engaged in the provision of the meals-on-wheels service.

Health board personnel take the view that the services best provided by voluntary organisations are those which involve social contact with the elderly because the most significant problems facing elderly people are loneliness and isolation. They suggested that the services currently being provided most satisfactorily by the voluntary sector include the following:

- day care facilities
- meals-on-wheels
- home helps
- social visiting
- transport
- chiropody
- Christmas parties
- laundry service
- sheltered housing

Health board representatives reported that following the recommendations made in *The Years Ahead* there has been an increase in the number of day care centres being run voluntarily with financial assistance from the health boards. Health boards take an active role in the referral of elderly people by public health nurses to them as day centres are "providing extensive surveillance and care services for the more frail elderly during the day".

Section 3: Frequency of Service Provision

Most of the services listed in Table 4.5 fit into three frequency categories. The first of these categories is one where the services are provided mainly on either a daily or at least weekly basis. This includes those services which have a very substantial role to play in maintaining the independence of the elderly. Many of these services require substantial resources, commitment, and a high degree of organisation. They include

TABLE 4.7: Number of services provided by voluntary organisations (Q.9)

Number of Services	Number	Per cent
Less than 5	389	46
5-8	256	29.5
9-12	145	16.7
13-16	52	6.0
17-20	15	1.7
21-24	1	0.1

The number of services provided by organisations in each of the health board areas is presented in Table 4.8. Organisations in Eastern Health Board areas are more likely than others to provide less than five services. Those in the North Western and Mid-Western Health Board areas are more likely than others to provide more than eight services.

TABLE 4.8: Health board area* by number of services provided (Q.2, Q.9)

	Less than 5	5-8	More than 8
	Percentages		
Eastern	52	25	23
Southern	38	30	32
South Eastern	49	30	21
Mid-Western	25	29	46
North Eastern	64	20	16
Western	44	30	26
Midland	34	52	14
North Western	25	29	46

n = 868.
'Because of non-response regional comparisons must be treated with caution.

Organisations serving less than 50 clients are more likely than others to offer less than five services and are considerably less likely than those serving more than 100 clients to offer more than eight services, 20 per cent compared with 40 per cent do so respectively. (See Table 4.9).

TABLE 4.9: Number of clients by number of services (Q.8, Q.9)

Clients	Services			
	Less than 5	5-8	More than 8	n
	Percentages			
Less than 50	49	31	20	330
51 — 100	43	34	23	183
More than 100	30	30	40	148

Section 6: Relationships Between Level of Service Provision and Personnel Resources

The number of volunteers in voluntary organisations is only broadly related to the number of clients served by them. As can be seen in Table 4.10, 33 per cent of organisations serving more than 100 clients have more than 20 volunteers whereas only 24 per cent of organisations serving less than 50 clients have more than 20 volunteers. However, virtually the same proportions of organisations have between 10 and 20 volunteers whether between 51 and 100 clients or more than 100 clients are catered for, 48 per cent and 46 per cent respectively.

TABLE 4.10: Number off clients by number off volunteers (Q.8, Q.13(a)

Clients	Volunteers			
	Less than 10	10-20	More than 20	n
	Percentages			
Less than 50	40	37	24	38
51-100	27	48	25	124
More than 100	21	46	33	114

It can be seen in Table 4.11, that organisations serving more clients are more likely to have full-time or part-time staff, FAS personnel or services provided by others who are neither volunteers nor paid employees.

TABLE 4.11: Number off clients by staff (Q.8, Q.14, Q.16, Q.18, Q.19)

	Number of Clients		
	Less than 50	51-100	More than 100
Full-time Staff	10* (311)"	17(173)	29 (140)
Part-time Staff	17 (281)	19(156)	30(132)
FAS	9 (274)	14(152)	16(128)
Other Employees	13 (278)	19(155)	21 (126)

•Percentage
"Number replying to both questions

Likewise it can be seen in table 4.12, that organisations which provide more services are more likely to have full-time or part-time staff, FAS personnel or services provided by others who are neither volunteers nor paid employees.

TABLE 4.12: Number of services by staff (Q.9. Q.14, Q.16. Q.18, a i 9)

	Services		
	Less than 5	5-8	More than 8
Full-time Staff	9* (318)**	12(246)	32 (210)
Part-time Staff	11 (283)	17(217)	40(201)
FAS	3 (277)	12(214)	27 (194)
Other Employees	9 (274)	14 (222)	28(191)

'Percentage
••Number replying to the question

Summary

The number of clients served by organisations is as follows: 15 per cent have less than 21 clients, 33 per cent have between 21 and 50, 27 per cent have between 51 and 100, and 22 per cent have more than 100 clients. On average each organisation serves 79 clients. The number of clients served by organisations in all health board areas is quite similar. Three services of a social nature arc each provided by at least half of the respondents, these are social events (outings/parties), visiting the elderly at home or visiting them in hospital. A day centre — social and recreational facilities is provided by 21 per cent of respondents. Advice/information and day care centre — personal and social events are provided by 41 per cent and 13 per cent of respondents respectively. Meals-on-wheels are delivered to the clients' homes by 28 per cent of respondents and are provided in day care centres by 17 per cent of respondents.

Overall the percentage of organisations providing each of the services investigated is uniform throughout all the health board areas. In terms of the number of clients served, social events, visiting the elderly, either at home or in hospital, and day care centre organisations are the most important services of a social nature provided. Meals-on-wheels, whether delivered to the home or provided in a day centre is the practical service provided by most organisations.

Forty Six per cent of organisations provide less than five services, 29.5 per cent provide between 5 and 8 and 24.5 per cent provide more than eight services. In general organisations with more clients offer more services and have more volunteers. Organisations that serve more clients or provide most services are more likely to employ staff, full-time or part-time.

It is estimated that nationally social events are provided for 76,900 persons, that 26,700 elderly persons are visited by members of voluntary

organisations and that 13,900 elderly persons avail of day centres operated by these organisations. Meals-on-wheels are provided for 15,900 persons, 8,900 in their homes and the remainder in day centres, in all equivalent to 11 per cent of the 75+ population. Two other services are each availed of by more than 20,000 clients, advice/information and surveillance. With the exception of transport (11,100) all other voluntary services are available to less than 10,000 persons throughout the State. Paramedical services in particular are in short supply; for example, it is estimated that physiotherapy is available to one per cent only of the population aged 75 and over through voluntary organisations. Some of the services which are available to small numbers are provided with a high degree of frequency. In general those provided with a high degree of frequency are those which have a very substantial role to play in maintaining the independence of the elderly. They include day centre services, meals-on-wheels, home helps, home nursing, laundry, occupational therapy, physiotherapy, sheltered housing and warden services.

References

[1] See discussion of response rate. Chapter One.

[2] Ruddle. H. *Charitable Giving and Volunteering in the Republic of Ireland.* Forthcoming publication.

[3] Derived from *1991 Census of population.* Vol II. Table 1A: Dublin: Stationery Office. 1992.

[4] See discussion of response rate. Chapter One.

[5] *ibid*

[6] Department of Health, personal communication.

[7] Convery. J. *Choices in Community Care: Dav centres for the elderlx in the Eastern Health Board.* Dublin: National Councillor the Aged. 1987. p.29.

[8] Estimates of the numbers of clients catered for by each of the services provided by voluntary organisations were calculated as follows:

(i) mid points of the closed numerical categories: 1-10. 11-20. 21-50 and 51-100 in table 4.3 were calculated. There are 5.5. 15.5. 35.5 and 75.5 respectively.

(ii) The average for those organisations serving more than 100 clients was calculated in respect of each service listed in Table 4.3.

(iii) These values were then multiplied by the number observed within each category and the products were added together.

(iv) Those organisations which indicated that the number of clients varied, or those organisations which indicated the service was provided but gave no estimate of the number of clients served were assumed to serve on average the same number of clients as those who provided numerical estimates.

(v) The estimated number of clients availing of each of the services was then grossed up to take account of the estimated proportion of relevant non-respondents. The total numbers derived after the completion of (iv) above was adjusted to take account of the non-respondents. (See discussion of response rate in Chapter One).

[9] Ruddle H.. *op cit.*

[10] See discussion of response rate. Chapter One.

[11] Convery *I. op cit.*

CHAPTER 5

A Typology of Voluntary Organisations

Introduction

In Chapter Three some characteristics of voluntary organisations engaged in the provision of services for the elderly were described. Characteristics described included the nature of the organisations, their personnel and other resources, their funding and management structures. In Chapter Four the services provided by these organisations, the number of clients served, and the frequency of service provision were described. In this chapter this information will be brought together in a systematic way and characteristics of organisations will be related to the services they provide. To the degree that this is successful it will result in a typology or categorisation of voluntary organisations engaged in the provision of services for the elderly.

Typologies of voluntary organisations were referred to in Chapter Two; however, these classifications refer to all voluntary organisations. The typology presented here refers to voluntary organisations engaged in the provision of services for the elderly only. It will be functionally based, related to what services the organisations provide — not to their name or self description. Because of the wide variety of voluntary bodies any attempt to classify them bears the risk of over-simplification.

In Section One the factor analysis, the procedure used to discover patterns in service provision, will be described. In Section Two organisations will be clustered or grouped together on the basis of these patterns in service provision. In Section Three comparisions will be made of the characteristics of the different groups of organisations. In Section Four summary descriptions of the main organisational types resulting from these procedures will be presented. Finally, in Section Five, the distribution of the main organisational types by health board area will be described.

respective factors. Their omission helps to reduce overlap between the groups. The number of services in each of the four adjusted factors provided by organisations is shown in Table 5.1

TABLE 5.1: Number of services provided by organisations in respect of each factor (Q.9(derived))

Number of Services	Number of Organisations			
	Factor 1	Factor 2	Factor 3	Factor 4
0	256	598	761	557
1	93	135	74	224
2	134	45	33	87
3	112	50	—	—
4	110	20	—	—
5	92	20	—	—
6	71	—	—	—
Total	868	868	868	868

The proportions of organisations providing at least one service in Factors 1, 2, 3 and 4 is 71 per cent, 31 per cent, 12 per cent and 36 per cent respectively. More than half, 55 per cent, of the organisations that provide at least one service in Factor 1 provide at least three Factor 1 services. Half of those providing at least one Factor 2 service provide one Factor 2 service only. More than half of those providing any of the services in either Factor 3 or Factor 4 provide one such service only, 69 per cent and 72 per cent respectively. All services investigated (see question 9) are not included in the four Factors. Accordingly some organisations do not provide any of the services identified with the factors but they do provide other services.

The great majority of organisations provide services under more than one Factor heading and only a minority, 17 per cent, provide no service in any of the four Factors. Organisations are clustered vertically and horizontally. Most (612) organisations provide at least one Factor 1 service. Most of these in addition provide at least one service in one or more of the other three factors; 362 organisations provide services in Factor 1 and (Factor 2 or Factor 3 or Factor 4). Of the 612 organisations providing services in Factor 1 212 also provide Factor 2 services, 89 also provide Factor 3 services and 256 also provide Factor 4 services. The numbers providing services in any one factor only are relatively small; these are: Factor 1, 250; Factor 2, 39; Factor 3, 14; Factor 4, 38. Of the 270 organisations providing Factor 2 services 49 also provide Factor 3 services and 149 also provide Factor 4 services. Of the 107 organisations providing Factor 3 services 54 also provide Factor 4 services. Three

hundred and fifty eight organisations provide Factor 1 or Factor 2 services only. 294 provide Factor 1 or Factor 3 services only and 394 provide Factor 1 or Factor 4 services only.

Practical considerations were used to determine the classification of organisations; it was considered that the classification should achieve the following:

(i) group those organisations together which supply no services under any of the four Factors.

(ii) group those organisations together which supply intermediate support services only, i.e.. Factor 1 services only.

(iii) group those organisations together which supply services listed under at least one of the other Factors in addition to intermediate support services.

(iv) form groups of those organisations which are relatively specialized, i.e., those which supply services in one only of the three factors — Factor 2, Factor 3 or Factor 4. The majority of these organisations also supply Factor 1 services and they are accordingly largely sub-categories of (iii) above.

(v) The number of organisations in any of the classes employed should exceed five per cent of the total number of organisations.

On the basis of these considerations the organisations were categorised as follows:

Type 1: those which provide no services in any of the four factors. There are 146 Type 1 organisations.

Type 2: those which provide Factor 1 services only i.e., intermediate support services only. There are 250 Type 2 organisations.

Type 3: those which provide intermediate support services and which in addition supply at least one service listed under one of the other three factors, i.e., day centre services, housing services or domiciliary services. There are 362 Type 3 organisations.

Type 4: those which provide Factor 2 services (day centre services) only or both day centre services and intermediate services only. There are 108 Type 4 organisations; 39 of them supply day centre services only.

Type 5: those which provide Factor 3 (housing services) only or both housing services and intermediate services only. There are 44 Type 5 organisations, 14 of them provide housing services only.

Type 6: those which provide Factor 4 (domiciliary services) only or both domiciliary services and intermediate services only. There are 144 Type 6 organisations, 38 of them provide domiciliary services only.

The first three types listed above are mutually exclusive; together they account for 758 organisations (87 per cent of all respondent organisations engaged in the provision of services). Types 4, 5, and 6 exclude one another but they are largely sub-categories of Type 3. There are 91 organisations in Types 4, 5 and 6 excluded from the first three types above; these supply services listed under one only of Factor 2, Factor 3 or Factor 4. Each of these factors respectively accounts for 39, 14 and 38 of the total of 91. A total of 849 organisations, 98 per cent of all respondent organisations are therefore included in at least one type. Nineteen organisations, those which provided services listed under at least two of the three factors, Factor 2, Factor 3 and Factor 4 — but not those listed under Factor 1 — are not included in these types.

Services Provided by Organisations in the Different Categories.

With the exception of social events only very small proportions, if any, of Type 1 organisations provide services. Eight per cent provide chiropody services and six per cent each provide surveillance and carer support group services. Five per cent or less provide services in the following categories: laundry, physical aids, home nursing, transport or services for carers. (Table 5.2 shows the proportion of each type of organisation providing services).

Type 2 organisations, those providing intermediate services, naturally focus mainly on these services. Thus the six services of which the factor is comprised are well represented. The percentages providing the six services: visiting elderly at home, visiting elderly in hospital, advice/information, material aid, financial support and housing repairs are 83, 69, 49, 42, 32 and 23 respectively. Other services provided by more than ten per cent of Type 2 organisations include physical aids/alarms, chiropody, transport, surveillance and social events. Ten per cent or less of Type 2 organisations provide the following services: laundry, home nursing, carer support group service or services for carers.

Type 3 is the category with the greatest number of organisations. Consisting as it does of organisations providing intermediate support services and at least one service in one of the other three factors, members of this group provide most services. All services are provided by organisations in this group.

TABLE 5.2: Proportion of organisation*t in each' category providing services. (Q.9(derived))

Service	Organisational Category Percentages					
	Type 1	Type 2	Type 3	Type4	Type 5	Type 6
Day centre/per & soc	—	—	27	11*	—	—
Day centre/soc & rec	5	—	41	73*	—	—
Laundry	1	10	50	28	32	34
Phys. aids/alarms	—	11	24	13	34	12
Occup. therapy	1	—	19	30»	—	—
Home nursing	—	2	12	4	5	6
Physiotherapy	—	—	10	9»	—	—
Shelt. housing	—	—	23	—	86*	—
Warden service	—	—	10	—	32*	—
House reps.	8	23*	40	12	36	35
Chiropody	—	18	40	41	11	23
Home helps	—	—	42	—	—	47»
Visit elderly/home	—	83*	82	44	48	65
Visit elderly/hosp.	—	69»	73	44	41	54
Meals/centre	—	—	33	32*	—	—
Meals/home	—	—	52	—	—	76»
Advice/info	—	49*	64	40	36	41
Financial support	—	32*	37	14	34	26
Material aid	—	42*	57	25	43	40
Transport	3	30	53	51	25	27
Surveillance	6	22	23	9	9	23
Carer support	6	4	12	8	5	6
Services for carers	1	4	11	4	2	8
Social events	82	71	88	86	52	67
Number	146	250	362	108	44	144

* Denotes services which provide the basis for typology.

Type 4 organisations, those providing day centre services or both intermediate support and day centre type services but not housing or domiciliary services, provide a wide range of services. The percentages of organisations providing day centre services: day centre providing personal and social services, day centre providing social and recreational services, occupational therapy, physiotherapy and meals-on-wheels provided in day centre are 11, 73, 30, 9 and 32 respectively. Six other services are provided by 40 per cent or more of Type 4 organisations; these are chiropody, visiting elderly at home, visiting elderly in hospital, advice/information, transport and social events. Less than 40 per cent provide services in the following categories: laundry, physical aids/alarms, home nursing, housing repairs, financial support, material aid, surveillance, carer support group service and services for carers.

Type 5 organisations, those providing housing services only or both intermediate support and housing services but no day centre or domi-

ciliary services, also provide a wide range of services. The percentages of organisations providing the housing services: building/provision of special sheltered housing and warden/supervisory services for sheltered housing are 86 and 32 respectively. More than 30 per cent of Type 5 organisations also provide services in each of the following categories: laundry, physical aids/alarms, housing repairs, visiting elderly at home, visiting elderly in hospital, advice/information, financial support, material aid and social events. Less than 30 per cent of Type 5 organisations provide the following services: home nursing, chiropody, transport, surveillance, carer support group service and services for carers.

Like Type 4 and Type 5 organisations those categorised as Type 6 also provide a wide range of services. Type 6 organisations are those providing domiciliary services or both intermediate support and domiciliary services but no day centre or housing services. The percentages of Type 6 organisations providing domiciliary services: home helps and meals-on-wheels delivered to the home are 47 and 76 respectively. Seven other categories of services are provided by more than 30 per cent of Type 6 organisations; these are laundry, house repairs, chiropody, visiting elderly at home, visiting elderly in hospital, advice/information, material aid and social events. An additional eight categories of services are provided by less than 30 per cent of Type 6 organisations; these are physical aids, home nursing, chiropody, financial support, transport, surveillance, carer support group service and services for carers.

Apart from the services which define the Factors on which they are based, with just a few exceptions, the services provided by Type 4, Type 5 and Type 6 organisations are not substantially different. Similar proportions of these groups provide laundry services, home nursing, visiting the elderly at home or in hospital, advice/information, carer support group service or service for carers. Type 4 organisations are considerably more likely to provide chiropody, or transport but are less likely to provide financial support or material aid then either Type 5 or Type 6. Type 5 organisations are more likely to provide physical aids/alarms but are less likely to provide social events than Type 4 or Type 6. Type 6 organisations are more likely to provide surveillance than either Type 4 or Type 5.

The different emphasis in the service provision of these groups of organisations probably reflects the opportunities arising from their core services. Type 4 organisations because of their involvement in day centre services have a greater opportunity to provide chiropody services and perhaps a greater need to make transport available to enable clients to avail of day centre services. Type 5 organisations because of their involvement in housing have a clear connection with physical aids/alarms.

Type 6 organisations have a greater opportunity for surveillance because of their contact with the homes of clients through the delivery of meals-on-wheels or home help provision.

To assist in their identification the six different organisation types will be labelled from here on as follows:

Type	Label
Type 1	Social Event Service Organisations
Type 2	Intermediate Support Service Organisations
Type 3	General Support Service Organisations
Type 4	Day Centre Service Organisations
Type 5	Housing Service Organisations
Type 6	Domiciliary Service Organisations

Section 3: Characteristics of Groups of Organisations

So far the typology of organisations has been based exclusively on the services provided by them. It is necessary to relate other organisational characteristics to these to develop a more comprehensive and practical typology. The following characteristics will be explored here: organisational nature, personnel resources, funding, relationship to statutory agencies and involvement in policy and planning. The emphasis will be placed on establishing differences between the organisational types.

The relationship between organisational nature and organisational type is shown in Table 5.3.

TABLE 5.3: Relationship between organisational nature and organisational type. (Q.5(a), Q6(a), Q6(b), Q.9(derived), Q48)

Characteristics	Organisational Type Percentages					
	Soc Event	Inter. Support	Gen. Support	Day Centre	Housing	Domiciliary
Branch/affiliated	43	79	57	39	45	66
Committee structure	51	72	85	81	68	76
Vol. hous. agency	2	1	5	—	32	1
Soc. Serv. Co.	4	8	14	8	5	17
Care of aged	16	20	31	22	20	29
Association	24	5	5	26	2	3
Local committee	22	21	12	12	2	21
Registered/ incorporated	27	41	61	45	68	40
Number	146	250	362	108	44	144

Social event service organisations are least likely to have committee structures or to be either social service councils, care of the aged committees or to be registered or incorporated. Nearly half of them are either associations of older people or local committees. Intermediate support service organisations are most likely to be branches or affiliated, nearly half of them are either care of the aged committees or local committees and are either registered or incorporated. More than half of general support service organisations are branches or affiliates, almost one half identify themselves as social service councils or care of the aged committees and more than half of them are registered or incorporated. Less than half of day centre service organisations are branches or affiliates, just under one half are either care of the aged committees or associations of older people, and more than half are registered or incorporated. Nearly one half of housing service organisations are branches or affiliates, one half are voluntary housing agencies or care of the aged committees and two thirds are registered or incorporated. Two thirds of domiciliary service organisations are branches or affiliates, just under one half are social service councils or care of the aged committees and less than half are registered or incorporated.

The relationship between personnel resources and organisational type is shown in Table 5.4.

TABLE 5.4: Relationship between personnel resources and organisational type. (Q.9(derived), Q.14, Q.16, Q.18, Q.19)

Personnel Resources	Organisational Type Percentages					
	Soc Event	Inter. Support	Gen. Support	Day Centre	Housing	Domiciliary
More than 20 volunteers	6	8	26	19	2	31
Employs full-time staff	5	4	26	19	23	8
Employs part-time staff	5	2	31	25	39	13
Others work for organisation	5	7	19	20	16	13
Number	146	250	362	108	44	144

Social event and intermediate support service organisations are considerably less likely than general support service, day centre service or domiciliary service organisations to have more than 20 volunteers providing services. They are also less likely than any of the other categories to employ staff whether full-time or part-time, or to have others working for their organisations. Housing service organisations,

perhaps reflecting the kind of services they provide, are considerably less likely to have more than twenty volunteers providing services; they are. however, more likely that the others to employ staff. Type 6 organisations, perhaps reflecting the high labour content of home-delivered meals-on-wheels, are most likely to have more than 20 volunteers providing services.

The relationship between funding and organisational type is shown in Table 5.5

TABLE 5.5: Funding and organisational type. (Q.9(derived), Q.38, Q.29)

Funding Source	Organisational Type Percentages					
	Soc Event	Inter. Support	Gen. Support	Day Centre	Housing	Domiciliary
Budget	10	17	27	27	20	20
Housing Authority	1	1	8	1	23	5
Statutory Grants	21	26	66	58	52	65
Charges	18	9	44	50	34	36
National Lottery	2	2	9	7	5	2
Legacies/Donations	14	30	41	33	48	37
Fund-raising	51	67	80	75	48	69
Number	146	250	362	108	44	144

Social event service organisations are considerably less likely than others to have annual budgets or to obtain funding through legacies or donations. Both social event service and intermediate support service organisations are much less likely than others to benefit from statutory funding or to levy charges on the recipients of their services. Substantial proportions of general support service, day centre service, housing service or domiciliary service organisations achieve funding through statutory grants, charges to clients, legacies/donations and fund-raising. With the exception of housing service organisations more than half of all organisations engage in fund-raising. Housing authority grants are more likely to be received by housing service organisations.

The relationship between statutory agencies and organisational type is shown in Table 5.6

General support service, day centre service, housing service and domiciliary service organisations are more likely than social event service or intermediate support service organisations to report the receipt of assistance, other than funding, from health boards and statutory authorities, to have health board representation on their committees (H B rep), to report that the health board has decision-making power in the running of their organisations (H B has power), and to be satisfied with the input made by statutory bodies into the running of the organisations

TABLE 5.6: Relationship between statutory agencies and organisational type. (Q.9(derived), Q.46, Q.47(b), a50, Q.53, Q.54(b),Q.56, Q.58(a), a61)

Nature of Contact	Percentages					
	Soc Event	Inter. Support	Gen. Support	Day Centre	Housing	Domiciliary
Other assistance	4	5	22	20	11	15
Satis, with input	3	9	18	15	5	17
Health Board rep.	3	3	18	15	11	12
Required to report	10	27	53	32	30	50
Adequate support	11	20	41	24	23	41
Health Board has power	3	6	23	19	16	25
Should H. B. have input	8	11	22	21	14	14
Input from other	2	6	6	9	5	1
Satis, with stat. input	10	11	21	17	16	25
Number	146	250	362	108	44	144

(satis, with stat. input). Social event service organisations are less likely than all others to have a requirement to report to a statutory body (required to report) or to receive adequate support from statutory agencies in the day-to-day administration of the organisation (adequate support). There are few substantial differences between general support service, day centre service, housing service or domiciliary service organisations. The most notable are that more general support service and domiciliary service organisations are required to report to a statutory body and more of them report the receipt of adequate support from statutory agencies in the day-to-day administration of their organisations.

The relationship between involvement in policy and planning and organisational type is shown in Table 5.7.

TABLE 5.7: Involvement in policy and planning and organisational type. (Q.9(derived), Q.63, Q.65, Q.67

Activity	Percentages					
	Soc Event	Inter. Support	Gen. Support	Day Centre	Housing	Domiciliary
Government body	0	6	14	6	18	11
Interest Groups	8	20	31	25	20	18
Planning Services	1	4	17	14	14	9
Number	146	250	362	108	44	144

Social event service and intermediate support service organisations are in general less likely than others to be involved with any government

body in planning services for elderly people (government body) or to have any say in planning services for elderly people. There is one exception to this pattern, the same proportion of intermediate support service organisations and day centre service organisations (6 per cent) report involvement with some government body in planning services. Social event service organisations have less involvement with interest groups who work for the elderly.

Section 4: Organisational Types

Relating organisations, grouped according to the services they provide, with the other characteristics investigated here: personnel resources, organisational nature, funding, relationship to statutory agencies and involvement in policy and planning, provides a more extensive basis for a typology. The most significant differences to emerge distinguish most clearly between social event service, intermediate support service and general support service organisations, the mutually exclusive categories. As already discussed day centre service, housing service or domiciliary service organisations are largely sub-categories of general support service organisations; they share many characteristics while each has a particular emphasis on certain services. This arises from the fact that few of the organisations labelled day centre service, housing service or domiciliary service are exclusively based on the factors (2,3 and 4) which distinguish them. Substantial proportions of each of them also provide intermediate support services. As noted earlier only 39, 14 and 38 organisations respectively provide day centre services, housing services or domiciliary services only; the other organisations in these groups, 69, 30 and 106 respectively, also provide intermediate support services.

Social Event Service Organisations

Services: Few of the 146 organisations in this category, 17 per cent of the 868 respondents, provide any services other than social events. Four-fifths of them provide social events; minorities provide other services including chiropody, surveillance, carer support group service and laundry. However, the highest proportion of social event service organisations providing any of these is 8 per cent.

Organisational nature: These organisations are least likely to have a committee structure (though half of them have one) or to be registered or incorporated. They are most likely to view themselves as being either associations of older people (such as old folks or senior citizens groups and activity centred associations of the retired) or local committees.

They are least likely to view themselves as social service councils or care of the aged committees, though 16 per cent describe themselves as the latter.

Personnel resources: These organisations have limited personnel resources, only very small proportions have more than 20 volunteers or any paid staff or other full-time personnel. The highest proportion of social event service organisations having any one of these resources is 6 per cent.

Funding: These organisations are least likely to have annual budgets or obtain funding from statutory agencies, through legacies/donations or through fund-raising. However, one half of them engage in fund-raising.

Relationship with statutory agencies: **Only very small proportions of** social event service organisations receive assistance other than funding from statutory agencies, have health board representation on their committees or are required to report to statutory agencies. They are least likely to receive assistance from statutory agencies in day-to-day administration or to be satisfied with the input by statutory bodies generally into the running of their organisation.

Involvement in policy and planning: These organisations are least likely to be involved in policy and planning. Eight per cent report having inputs into interest groups working for the elderly.

Intermediate Support Service Organisations

Services: There are 250 organisations in this category, 29 per cent of the 868 respondents. The services provided by this group are of an intermediate supportive nature. The services which distinguish this group are visiting the elderly (whether at home or in hospital), advice-information, material and financial aid and housing repairs. Other services include physical aids/alarms, chiropody, transport, surveillance and social events.

Organisational nature: Most intermediate support service organisations are branches or affiliates of (in many cases of national/transnational voluntary organisations), a higher proportion than any other type. Nearly half of them are either local committees (unspecified) or care of the aged committees. Less than half of them are registered or incorporated though most have a committee structure.

Personnel resources: Intermediate support service organisations have, like social event service organisations, limited personnel resources. They are less likely to have more than 20 volunteers than day centre service,

housing service or domiciliary service organisations. They are least likely to employ staff, only four per cent employ full-time staff.

Funding: These organisations are least likely to charge clients for services and excepting social event service organisations are least likely to benefit from statutory grants. However, most of them engage in fund-raising and one-third benefit from legacies/donations.

Relationship with statutory agencies: **The proportion of intermediate** service organisations in receipt of assistance other than funding from statutory agencies or with health board representation on their committees is like that of social event service organisations, very small. They are, however, more likely to be required to report to statutory agencies and to receive adequate support from statutory agencies in day-to-day administration than social event service organisations. Only a very small proportion, similar to that of social event service organisations, is satisfied with the input made by statutory agencies. Overall the relationships between intermediate support service organisations and statutory agencies are less developed than those of general support service, day centre service, housing service or domiciliary service organisations.

Involvement in policy and planning: Intermediate support service organisations are more likely to be involved in policy and planning than social event service organisations, especially with respect to having an input into interest groups who work for the elderly (20 per cent). However, very small proportions are involved with government bodies in planning services or doing so otherwise.

General Support Service Organisations

Services: There are 362 organisations in this category, 42 per cent of the 868 respondents. All of the services are provided by some proportion of the organisations in the group, the key service providers for the elderly. This group comprises those organisations which provide intermediate support services and which in addition provide more specialised maintenance services: day centre services; housing services or domiciliary services. Some of these organisations provide some services in all three of these categories in addition to intermediate support services. Half or more of these organisations provide the following services; laundry, visiting the elderly (whether at home or in hospital), meals-on-wheels delivered to the home, advice/information, material aid, transport, and social events.

Organisational nature: Most general support service organisations have a committee structure (85 per cent) and more than half are registered

or incorporated. Their organisational nature is more formal in character than social event service or intermediate support service organisations. More than half of them are branches or affiliates. Nearly half of them are either social service councils or care of the aged committees. (45 per cent are either compared with 20 per cent and 28 per cent of social event service or intermediate support service organisations respectively).

Personnel resources: General support service organisations have considerably more personnel than either social event service or intermediate support service organisations. More than a quarter of them have more than 20 volunteers or employ full-time or part-time staff.

Funding: These organisations are most likely to benefit from statutory grants (66 per cent), charges to clients (44 per cent), fund-raising (80 per cent) and, with the exception of housing service organisations, legacies/donations (41 per cent). They are more likely than social event service or intermediate support service organisations to have budgets.

Relationship with statutory agencies: Reflecting their statutory funding and the services they provide general support service organisations have more developed relationships with statutory agencies than social event service or intermediate support service organisations. About one-fifth of general support service organisations receive assistance other than funding from statutory agencies, have health board representation on their committees or report that the health board has decision-making power in their organisations. More than one half of them are required to report to a statutory body. While the proportion of these organisations reporting satisfaction with aspects of their relationship with statutory bodies is greater than that of either social event service or intermediate service organisations it is small. Only one-fifth are satisfied with the input they have in determining the level of funding received from statutory bodies or with the input generally made by statutory bodies. Two-fifths report that statutory agencies provide adequate support for day-to-day administration.

Involvement in policy and planning: These organisations have more involvement in policy and planning than social event service or intermediate service organisations. One-third have inputs into interest groups working for the elderly and one-sixth each report involvement with a government body or otherwise in planning services for the elderly.

Sub-Categories of General Support Service Organisations

As day centre service, housing service and domiciliary service organisations are largely sub-categories of general support service each of

them will not be described in detail. Instead attention will be given to the characteristics which distinguish them from one another.

Services: The services provided by day centre service organisations only are essentially day centre based personal and social services or recreational activities. These include occupational therapy, physiotherapy and meals-on-wheels delivered to centre. Those provided by housing service and domicilary service organisations only are building and provision of sheltered housing and warden services, and home helps and meals-on-wheels (home delivery) respectively. Day centre service organisations, in addition, are more likely to provide chiropody and transport. Housing service organisations are more likely to provide physical aids/alarms while domiciliary service organisations are more likely to engage in surveillance.

Organisational nature: Nearly half of day centre service organisations are either care of the aged committees or associations of older people. A similar proportion of housing service organisations are either voluntary housing agencies or care of the aged committees. A similar proportion of domicilary service organisations are either social service councils or care of the aged committees.

Personnel resources: Domiciliary service organisations are less likely to employ staff than either day centre service or housing service organisations. However, they are much more likely than them to have more than 20 volunteers. Only a very small proportion (2 per cent) of housing service organisations have more than 20 volunteers.

Funding: The sources of funding for these organisational types are broadly similar. Domiciliary service organisations are most likely to benefit from statutory grants while day centre service organisations are most likely to levy charges on clients or engage in fund-raising. Housing service organisations are most likely to avail of legacies/ donations.

Relationship with statutory agencies: There are few substantial differences in the relationships these three types have with statutory agencies. Domiciliary service organisations are most likely to be required to report to a statutory agency and to receive adequate support in day-to-day administration. Housing service organisations are least likely to report satisfaction with the input made by them in determining the level of statutory funding received.

Involvement in policy and planning: Overall these organisations have similar (low) levels of involvement in policy and planning. Day centre service organisations are least likely to be involved with a government body in planning services while domiciliary service organisations are least likely to be otherwise engaged in planning services.

Section 5: Distribution of Organisation Types by Health Board Area

There is overall a considerable degree of uniformity in the regional distribution of organisation types as indicated in Table 5.8. Social event service organisations are under-represented in the Southern, Midland and especially in the North Western Health Board areas. Intermediate support service organisations are under-represented in the Eastern Health Board area and are substantially over-represented in the Midland Health Board area. Compensating for these divergences general support service organisations are substantially over-represented in the North Western Health Board area and under-represented in the Midland Health Board area. Day centre service organisations are under-represented in the Midland and especially in the North Western Health Board area. Apart from their absence in the Midland Health Board area housing service organisations are fairly uniformly distributed. Domiciliary service organisations are substantially over-represented in the North Western Health Board area.

TABLE 5.8: Organisational types by health board area* (Q.2, Q.9(derived)

Health Board	Type (Percentage)**						
	Soc Event	Inter. Support	Gen Support	Day Centre	Housing	Domiciliary	N
Eastern	17	17	41	18	6	13	200
Southern	10	30	52	9	6	17	145
South Eastern	23	29	32	14	6	14	133
Mid-Western	24	33	33	15	3	15	99
North Eastern	22	31	33	15	2	17	81
Western	18	28	46	13	5	12	78
Midland	10	57	31	7	—	19	58
North Western	4	26	68	—	4	38	69
	17	29	42	13	5	17	863

* Because of non-response regional comparisons must be treated with caution.
** The percentages in rows add to more than 100 per cent as organisations can be in more than one category.

Summary

In this chapter a typology of voluntary organisations engaged in the provision of services for the elderly was presented. This typology is functionally based; it is based on services that tend to be provided together. Four factors or groups of services were identified. The main services constituting these four factors or groups of services were: (i) housing repairs, visiting the elderly (at home or in hospital), advice/

information, financial support and material aid; (ii) day centre providing personal social services/social and recreational services, occupational therapy, physiotherapy and meals-on-wheels provided in day centres; (iii) building/provision of special sheltered housing, warden and supervisory services for same; (iv) home helps and meals-on-wheels delivered to home. These four factors or groups of services were identified as general support services, day centre services, housing services and domiciliary services respectively.

On the basis of these factors or groups of services respondent organisations were divided into six types, the first three of which are mutually exclusive. The first three types are: organisations which provide none of the services identified in any of the four factors, social event service organisations; organisations which provide intermediate support services only, intermediate support service organisations; organisations which provide intermediate support services and services listed under one or more of the other three factors, general support service organisations. The other three types, which are largely sub-types of the general support service category are day centre service, housing service and domiciliary service organisations. Day centre service organisations are those which provide day centre services only or both intermediate support services and day centre services only. Housing service organisations are those which provide housing services only or both intermediate support services and housing services only. Similarly domiciliary service organisations are those which provide domiciliary services only or both intermediate support services and domiciliary service only.

These types were then related to other characteristics of the organisations to establish a more comprehensive typology. This supported the distinctiveness of the first three types and notwithstanding the particular specializations of day centre service, housing service and domiciliary service organisations it revealed the characteristics they had in common with each other and with general support service organisations. Arising from this the following more comprehensive typology was developed.

Few social event service organisations provide services for the elderly other than social events. They are most likely to describe themselves as either associations of older people or simply as local committees. They have limited personnel resources, very few have more than 20 volunteers or any paid staff. Few have annual budgets or obtain funding from statutory agencies or through legacies/donations; however, half of them engage in fund-raising. Relationships between these organisations and statutory organisations are very limited and they are least likely to be engaged in policy or planning.

The services provided by intermediate support service organisations consist mainly either of social support activities or material aid. These organisations are most likely to describe themselves as care of the aged committees or local committees. They are more likely than any other type to be affiliated to or members of larger organisations. Like social event service organisations they have limited personnel resources. They are least likely to employ staff, only four per cent employ part-time staff. These organisations are more likely to benefit from statutory funding than social event service organisations but less likely than others to do so; however, one third benefit from legacies/donations and most engage in fund-raising. Relationships between these organisations and statutory agencies are more developed than those of social event service but they are less developed than those of the other types. These organisations are more involved in policy and planning than social event service organisations but not to the same degree as the other types.

General support service organisations comprise the key providers of services for the elderly. They provide services of an intermediate supportive nature and in addition provide more specialised maintenance services. These specialised services may be in one or more of the three categories: day centre services, housing services or domiciliary services. The organisational nature of a substantial proportion of these organisations is more formal in character; nearly all have a committee structure and most are registered or incorporated. Nearly half of them are either social service councils or care of the aged committees. They have greater personnel resources than social event service or intermediate support service organisations; a quarter have more than 20 volunteers or employ staff. Most of these organisations benefit from statutory grants and engage in fund-raising, half of them levy charges on services. The relationship with statutory bodies is more developed than in the case of social event service and intermediate support organisations. One-fifth receive assistance other than funding from statutory agencies, have health board representation on their committees or report that a health board has decision making power in their organisation. Though, they are more satisfied than others with the inputs made by statutory agencies, only a minority are satisfied. Furthermore, they are more involved in planning and policy making than others, but again only a minority report this.

As day centre service, housing service and domiciliary service organisations are largely sub-categories of general support service organisations their very distinctive aspects only will be summarised here. The services which distinguish these types have been referred to above. While day centre service organisations are more likely to be care of

the aged committees or associations of older people housing service organisations are more likely to be voluntary housing associations or care of the aged committees. Domiciliary service organisations are more likely to be either social service councils or care of the aged committees. Though funding sources for these three types are similar day centre service, housing service and domiciliary service organisations are respectively more likely to benefit from charging clients and fund-raising, avail of legacies/donations, and benefit from statutory grants. Domiciliary service organisations are most likely to be required to report to a statutory agency and to report the receipt of adequate support in day-to-day administration. Day centre service organisations are least likely to be involved with a government body in planning services while domiciliary service organisations are least likely to be otherwise engaged in planning services.

CHAPTER 6

The Funding of Voluntary Organisations

Introduction

Information on the level of funding of voluntary organisations is important for assessing their capacity to engage in partnership arrangements with statutory authorities. Moreover, current funding arrangements with statutory authorities is a significant indicator of the nature and extent of partnership arrangements already in existence. In the first Section of Chapter Six, sources of funding of voluntary organisations, the following matters are described: the sources of funding of voluntary organisations and the proportion of total funding received from the various sources. In Section Two, reported funding from statutory bodies, the following matters are discussed: the proportion of organisations in receipt of funding from all statutory sources, the conditions attached to funding, some characteristics of voluntary organisations in receipt of funding, targets of new applications for funding and the purposes for which these are made. In the third Section, funding of voluntary organisations by selected statutory authorities, the level of funding given in 1990 to voluntary organisations providing services for the elderly by health boards and the Departments of Environment and Social Welfare is described. In Section Four, in order to make an assessment of the reliability of the financial data provided by voluntary organisations, in particular the level of statutory funding reported by them, a comparison is made of the Southern Health Board's list of grants paid in 1990 and reported funding, in particular section 65 grants, by voluntary organisations in the Southern Health Board area. In Section Five, fund-raising and budgeting matters are discussed. A summary is provided at the end of the chapter.

Section 1: Sources of Funding of Voluntary Organisations

The source of funding of voluntary organisations are presented in Table 6.1.

TABLE 6.1: Sources of funding of voluntary organisation*. (Q.29)

Source	Used		Not Used		No Answer	
	Number*	Per cent	Number	Per cent	Number	Per cent
Statutory Grants	408	(47)	329	(38)	131	(15)
Charges to recipients	272	(31)	447	(52)	145	(17)
National Lottery[1]	43	(5)	674	(78)	151	(17)
Legacies/donations	285	(33)	436	(50)	147	(17)
Fund-raising	588	(68)	149	(17)	131	(15)
Other	104	(12)	601	(69)	163	(19)

'Numbers and percentages add up to 868 and 100 per cent in respect of each source.

More organisations, 68 per cent, employ fund-raising than any other source. Statutory grants, used by 47 per cent of organisations, are the second most used source of funds. Legacies/donations and charges to recipients are used by almost the same proportions of organisations, 33 per cent and 31 per cent respectively. Other sources are used by 12 per cent of organisations. The National Lottery is used least, by five per cent only.[2] The percentage of total funding received from each of the above sources is presented in table 6.2. This information, together with the information in Table 6.1 indicates the overall importance of each source.

Section 2: Funding from Statutory Sources

As reported in Table 6.1, 47 per cent of all organisations, 55 per cent of respondents, indicated that statutory grants were a source of funding for them.

One hundred and forty nine organisations, 26 per cent of 569 replies to question 41, stated they had received once-off payments (including block-grants, covenants, bequests, etc.).

The number of organisations who received, or did not receive, funding from health boards is presented in Table 6.3 below. In terms of the number of grants, the 1953 Act is the most important for voluntary organisations. Two hundred and fifty organisations, 29 per cent, report the receipt of at least one of these grants. The failure of so many respondents to reply to this question may be due to their lack of knowledge of the precise section of legislation under which grants from health boards were made. See Section Four of this chapter for a discussion of the reliability of financial information, in particular the reporting of statutory funding, received from respondents.

TABLE 6.2: Percentage of voluntary organisations' funding received from various sources. (Q.30)

	Percentages						
Source of Funding	Less than 21%	21%-40%	41%-60%	61%-80%	more than 80%	no answer	number
Statutory grants	13	14	11	11	6	45	408
Charges to recipients	29	13	9	4	3	42	272
National Lottery	33	12	5	2	2	46	43
Legacies/donations	40	13	8	2	4	33	285
Fund-raising	15	10	9	7	19	40	588
Other	35	12	6	1	17	29	104

TABLE 6.3: Receipt of grants from health board* by voluntary organisations. (Q.42(a), Q.42(b), Q.42(c»

Act	Number		
	Yes	No	No Answer
Section 65, 1953 Health Act	189	293	386
Section 61, 1970 Health Act	47	355	466
Section 26, 1970 Health Act	62	374	432

Whether organisations have budgets, or are in receipt of statutory or health board grants, categorised by health board area is indicated in Table 6.4. The percentage of organisations who reported statutory grants as a source of funding is in the range of 38-65. The highest proportion of organisations reporting this is in the Eastern Health Board area, the lowest is in the North Eastern. The variation in the proportion of organisations reporting the receipt of health board grants is more considerable, it ranges from 17 per cent in the North Eastern to 51 per cent in the North Western Health Board area.

TABLE 6.4: Health board* by budget, statutory funding and health board grants. (Q.2, Q.38, Q.29, Q-42(a),(b),(c))

	Has Budget		Statutory Grant		Health Board Grant	
	Per cent	Number"	Per cent	Number"	Per cent	Number***
Eastern	36	127	65	170	18	200
Southern	22	106	60	126	41	145
South Eastern	34	87	53	108	29	133
Mid-Western	25	63	46	76	18	99
North Eastern	24	50	38	73	17	81
Western	44	55	62	68	41	78
Midland	38	39	60	50	29	58
North Western	9	57	49	63	51	69

*Because of non-response regional comparisons must be treated with caution.
••Number of those replying to the question.
•••Total number of respondent organisations.

Thirty seven organisations, six per cent of replies, stated they had received funding from a housing authority.

One hundred and sixteen organisations stated they are aware of conditions attached to statutory funding; 106 stated they were not aware of such conditions. The conditions of which they are aware are presented in Table 6.5.

TABLE 6.5: Conditions attached to statutory funding stated by voluntary organisations. (Q45(b))

Conditions	First Condition Number	Second Condition Number
Details on expenditure	44	3
Provision of service	20	
Demonstration of need	5	1
Raise % of cost locally	8	
Only service for elderly	9	1
Other	21	
None stated	9	5
Total	116	10

Many organisations that receive grants do so on a quarterly basis, 40 per cent of the 308 who replied. Twelve per cent receive them monthly and 33 per cent receive them annually. Fifteen per cent receive them on some other basis. The majority of organisations receive their grants on time: 169 do compared with 135 who state they do not.

Organisations with more than one hundred clients are more likely than others to report the receipt of statutory funding or health board grants. However, those with less than 50 clients are slightly more likely to do so than those with between 51 and 100 clients. (See Table 6.6).

TABLE 6.6: Number of clients by statutory funding and health board grant. (Q8, Q29, Q.42(a),(b),(c))

	Number of Clients		
	Less than 50	51-100	More than 100
Statutory Funding	55* (159)**	53(160)	64(138)
Health Board Grants	34 (246)	31 (183)	45 (148)

•Percentage
**Number replying to the question

Organisations providing more services are more likely to report the receipt of statutory and health board funding, 74 per cent and 56 per cent in respect of those who provide more than eight services. Of those who provide less than five services 43 per cent report the receipt of statutory funding while 13 per cent report the receipt of health board funding (see Table 6.7).

TABLE **6.7: Number of services by statutory funding and health board grant. (Q.9, Q.29.Q.42(a),(b),(c))**

	Number of Services		
	Less than 5	5-8	More than 8
Statutory Funding	43» (299)"	54 (235)	74 (203)
Health Board Grants	13 (399)	30(256)	56(213)

'Percentage
"Number replying to the question

Organisations with more than 20 volunteers are more likely than others to report the receipt of statutory or health board funding. However, as can be seen in Table 6.8 those with less than ten volunteers are more likely than those with between 10 and 20 to report the receipt of either.

TABLE 6.8: Number of volunteers by statutory funding and health board grant. (Q.13(a), Q.29, Q.42(a),(b).(c))

	Number of Volunteers		
	Less than 10	10-20	More than 20
Statutory Funding	54* (173)**	51 (209)	76(150)
Health Board Grants	32 (189)	28 (227)	40(155)

•Percentage
**Number replying to the question

As noted in Chapter Five those organisations which provide day centre services, housing services or domiciliary services are considerably more likely than others to benefit from statutory grants and to a lesser degree from legacies/donations. They are also much more likely than others to levy charges on recipients of their services.

One hundred and seventeen organisations, 21 per cent of 551 replies to question 46, receive assistance other than funding from statutory agencies. One hundred and six organisations are satisfied with the level of input they have in determining the level of funding required; 138 are not (question 47b).

Fifty three organisations, 13 per cent of the 399 who replied to question 35(f), consider that their levels of fund-raising affect the help they receive from statutory bodies. The majority who replied, 346, 87 per cent, were not of this opinion.

Two hundred and fifteen organisations, 30 per cent of the 717 who replied to question 32, made new applications for funding in the year previous to the survey. The targets of these applications are presented in Table 6.9.

TABLE 6.9: Targets of new applications for funding by voluntary organisations. (Q.32(a))

Target	Number	Per cent
Department of Health/Health Board	60	28
Department of Social Welfare	31	14
National Lottery	69	32
Combination	17	8
County Council/Corporation	11	5
Department of Environment	7	3
Other	20	10
Total	215	100

The purposes of these new applications for funding are presented in Table 6.10.

TABLE 6.10: Purposes of new applications for funding. (Q.32(b))

Reasons	Number	Percentage
Buy equipment	41	19
Build housing/premises	64	30
Cover expenses	70	32
Travel costs	6	3
Courses/classes/training	8	4
Other	21	10
No response	5	2
Total	215	100

Two hundred and five organisations, 95 per cent of those who applied, stated the outcome of their application. In 41 per cent of cases the application was accepted and in 23 per cent of cases it was rejected. In 31 per cent of cases the application was still in process and in five per cent of cases it was either conditionally passed or it was passed but not yet acted upon (see Table A 6.1).

Section 3: Funding of Voluntary Organisations by Selected Statutory Authorities

The Health Act, 1953 (Section 65) is the major enabling legislation under which health boards provide assistance to voluntary organisations. A health authority may give assistance to any body which provides or proposes to provide a service similar to or ancillary to a service which the health authority may provide. The ways in which such aid might be given is as follows:

(a) by contributing to the expenses incurred by the body,

(b) by supplying to the body, fuel, light, food, water or other commodity,

(c) by permitting the use by the body of the premises maintained by the health authority and, where requisite, executing alterations and repairs to and supplying furniture and fittings for such premises,

(d) by providing premises (with all the requisite furniture and fittings) for use by the body.

The 1992 Housing Act and the Plan for Social Housing are viewed as major breakthroughs for voluntary organisations concerned with the provision of housing for the elderly. The provision of sheltered housing by local authorities is now more responsive to and dependent on the initiative of voluntary organisations. The Department of Social Welfare provides financial assistance under the Community Development Scheme for the staffing of local resource centres which provides a focal point for community activities, among which are included activities specifically provided for the elderly. Also, under the Department's Voluntary Grants Scheme, funds are made available to organisations in the social services area to undertake suitable projects. Grants are generally made for capital projects which are likely to be completed within the year of the award of the grant. Total budget allocation under this scheme amounted to £750,000 in 1991.

TABLE 6.11: Funding of voluntary organisations providing services for the elderly in 1990

Health Board	Department of the Environment[3]	Department of Social Welfare[4]	Health Boards[5]
Eastern	2,290.000	49,850	3,005,765
Midland	303,420	4,750	281,779
Mid-Western	20,000	20,200	300,169
North Eastern	13,000	9,450	N/A
North Western	110,000	39,900	411,985
South Eastern	581,854	21,000	N/A
Southern	802,000	39,000	205,651
Western	129,000	21,000	591,940
Total	4,250,074	205,150	4,797,289

The amounts shown in Table 6.11 were paid to voluntary organisations engaged in the provision of services for the elderly in 1990. It should be noted that the amounts paid by the health boards to voluntary organisations represent a proportion only of their expenditure on services

running of the organisation, 32 per cent (n=290) compared with seven per cent (n=338) respectively.

(iv) be satisfied with the input made by statutory bodies, 66 per cent (n=126) compared with 48 per cent (n=95) respectively.

(v) consider the health board should have input into the running of the organisation, 30 per cent (n=197) compared with 23 per cent (n=270) respectively.

The majority of those who are required to report to a statutory authority, 56 per cent (n=307), reported funding from a health board. Twenty seven per cent (n=233) of those who receive funding from a health board, reported no such requirement.

The form of reporting required is indicated in Table 7.1. The most typical forms of reporting required are the production of an annual report, annual accounts or audits.

TABLE 7.1: Form of reporting to statutory bodies by voluntary organisations. (Q.53(b))

Form	Number Yes
Annual Report	248
Audits	151
Statistical analysis	33
Progress report	51
Annual accounts	192
Other	15

Relationship with Statutory Bodies

It was reported in Chapter Three that the majority, 90 per cent, of voluntary organisations have a committee structure. Eighty seven organisations, 13 per cent of replies, indicated that the health board is represented on their committee; 62 of these reported being in receipt of health board funding.

Most replies, 54 per cent (n=451), state that those responsible for the day-to-day running of voluntary organisations receive adequate support from statutory agencies, however, 45 per cent state that they do not. Those in receipt of health board funding are more likely than those who are not to feel that adequate support is received. 64 per cent (n=195) compared with 47 per cent (n=259) respectively. One hundred and one respondents suggested at least one change that would improve matters. These proposals are presented in Table 7.2.

TABLE 7.2: Change required to support those responsible for day-to-day running of voluntary organisations. (Q.54(c))

Changes	Number	
	First Proposal	Second Proposal
More input	19	1
More funds/facilities	42	3
More staff	9	3
Pay grants in time	6	2
Other	25	19
Total	101	28

Twenty one per cent (n=551) of respondents reported that their organisations receive assistance, other than funding, from statutory agencies like health boards and local authorities. Forty three per cent (n=244) were satisfied with the level of input they themselves had in determining the level of funding received by them.

The distribution of respondents by health board area reporting that assistance other than funding is received from statutory agencies and satisfaction with the level of input in determining the level of funding received is shown in Table 7.3. It can be seen that the proportion reporting the availability of assistance other than funding is in the range 13 per cent, (Mid-Western and North Eastern health board areas) to 32 per cent (Midland). There is a more substantial variation in the proportion reporting satisfaction with the level of input they had in determining the level of funding received: it ranges from 14 per cent. Western Health Board area, to 64 per cent, Midland Health Board area.

TABLE 7.3: Assistance received from statutory agencies and satisfaction with organisation's input in determining level of funding received. (Q.2, Q.46. Q.47(b))

Health Board*	Assistance other than funding		Satisfaction with Input	
	Per cent	N	Per cent	N
Eastern	21	127	37	56
Southern	29	97	51	47
South Eastern	20	84	35	34
Mid-Western	13	55	35	20
North Eastern	13	46	44	16
Western	16	56	14	21
Midland	32	34	64	22
North Western	24	50	62	29

•Because of non-response comparisons must be treated with caution.

One hundred and twenty four respondents. 18 per cent of replies, stated that a health board has decision-making power in the running of the organisation: 68 per cent of these reported they receive health board funding. The majority of these. 69 per cent, consider that this involvement of the health board is of value in the management of the organisation. Only six per cent consider it not to be valuable. The remainder stated no opinion, were unsure, or gave qualified support. Seventy per cent of those who considered the health board input valuable reported the receipt of health board funding. A majority of those. 64 per cent (n=223). who report they receive health board funding reported the health board has no decision-making power in the running of the organisation.

Seventy four per cent (n=493) of respondents who reported the health board has no decision-making power in their organisation do not think it should have an input into their organisations while 26 per cent do. Only 36 per cent (n = 129) of those who think the health board should have an input report the receipt of funding from it. A majority of those who receive health board funding. 69 per cent (n=140). do not think it should have any other input; this is slightly less than the proportion of those who do not receive health board funding and do not think it should have any other input. 76 per cent (n=345). Of those who favour an input from the health board 142 state what the nature of the input should be. Of these. 42 per cent want funding for facilities. 31 per cent want to benefit from the knowledge or other support of health board personnel. 15 per cent favour professional support and various other requirements are stated by the remaining 12 per cent.

Forty four respondents stated there are statutory agencies other than health boards with inputs into the running of their organisations. These are listed in Table 7.4. Only 14 of these report funding from a health board.

TABLE 7.4: Statutory agencies other than health boards with inputs into the running of voluntary organisations. (Q.59)

Agency	Number with Input
Local authority	19
Department of Environment	3
Department of Social Welfare	6
FÁS	3
Other statutory support	24

The volume of input of these agencies is limited and half of those described concern funding and grants only. 24 of 51. Two hundred and thirty five respondents stated an opinion (question 61) on the sufficiency of the input by statutory bodies into the running of their organisations. Of these. 60 per cent consider the input to be sufficient. 40 per cent do not consider it to be sufficient. Organisations who reported the receipt of funding from health boards are more satisfied than those **who** are not **with** the **input** by statutory bodies into the running of their organisations. 65 per cent (n= 108) compared with 55 per cent respectively (n = 127).

As can be seen in Table 7.5 the variation in the proportions of organisations who consider the health board has decision-making power is considerable, from 3 per cent in the North Eastern to 42 per cent in the North Western Health Board area respectively. The proportions of organisations who consider the health boards should have input vary considerably also, from 20 per cent in the Eastern and South Eastern to 51 per cent in the North Western health board areas respectively. High proportions of the respondents (from 52 per cent to 92 per cent) report satisfaction with inputs made by statutory bodies into the running of their organisation.

TABLE 7.5: Whether health board has decision making power in organisation, whether health board should have an input and satisfaction with inputs by statutory bodies. (Q.2, Q.56. Q.58(a), Q.61)

Health Board*	Health Board has Power		Health Board Should have Input		Satisfaction with Inputs by Statutory Bodies	
	Per cent	N	Per cent	N	Per cent	N
Eastern	14	159	20	116	55	51
Southern	23	120	25	92	92	12
South Eastern	13	95	20	76	54	35
Mid-Western	15	72	26	49	57	30
North Eastern	3	64	27	52	57	14
Western	24	62	34	44	52	25
Midland	22	40	28	29	92	12
North Western	42	57	51	35	63	27

*Because of non-response comparisons should be treated with caution.

Organisations satisfied with the input made by statutory bodies into the running of their organisation are more likely than those who are not to:

(i) report that those responsible for day-to-day administration receive adequate support from statutory agencies in their tasks, 74 per cent (n=114) compared with 30 per cent (n=77) respectively.

(ii) report that the health board has decision-making power in the running of their organisations, 28 per cent (n=131) compared with 26 per cent (n=93) respectively.

(iii) consider that the decision-making power of the health board is valuable, 93 per cent (n=31) compared with 70 per cent (n=20) respectively.

The data reported here do not provide evidence which supports the view that dependency on funding from the statutory sector has reinforced feelings of helplessness on the part of the voluntary sector in relation to future development of their own service delivery. Whether the voluntary sector feels helpless or competent in that regard is not clear from these data; however, it is clear there is strong demand for more statutory support. Support for the other positions; that the lack of a coherent funding framework has resulted in uncertainty and inhibits good working relationships, and that voluntary organisations have difficulty in accepting accountability is mixed and inconclusive.

The majority of respondents state that those responsible for the day-to-day running of voluntary organisations receive adequate support from statutory agencies. However, an examination of the changes proposed to improve matters suggests that what respondents have in mind are primarily funds or other resources. A substantial minority, 21 per cent, report that assistance other than funding is received from statutory agencies and a substantial proportion, 43 per cent, were satisfied with the level of input they themselves had in determining the level of funding received by them.

One of the ways in which some health boards ensure accountability is by requiring their representation on the committee of voluntary organisations or through obtaining some other form of decision-making power. A considerable minority of respondents, 18 per cent, report that a health board has decision-making power in the running of their organisation. It is quite significant that the majority of these consider that such involvement by the health board is of value in the management of their organisations and that only a very small minority, 6 per cent, considered it not to be valuable. This would appear to question the view that voluntary organisations have a difficultly in accepting this form of accountability. However, a majority, 69 per cent, of those who report the receipt of health board funding do not think it should have any other input. Again, nearly half, 42 per cent, of those who favour more input from the health board specify that more funding is desired. More positively from a partnership perspective perhaps is that a higher proportion, 46 per cent, of these would like to benefit from the expertise or professional support of health boards. Where health boards are

reported to have decision-making power it is in most cases considered valuable, where they do not have it it is in most cases unwelcome. It may be the case that this particular form of accountability has to be experienced in order to be appreciated and the regional variation in its acceptability suggests that much may depend on an organisation's perception of the health board with which it has to work.

It was noted in Chapter Five that Type 3,4, 5 and Type 6 organisations, those which provide services for the elderly of a general supportive nature and which in addition provide more specialised maintenance services, are more likely than others to receive funding and other assistance from statutory authorities. They are also more likely to have health board representation on their committees, to report that the health board has decision-making power in the running of their organisations, and to be more satisfied with the input made by statutory bodies into the running of their organisations.

Section 3: Involvement of Voluntary Organisations in Policy and Planning

Eleven per cent of voluntary organisations are involved with some government body in planning services for elderly people. Thirty per cent have inputs into interest groups who work for the elderly. Apart from government and interest groups 14 per cent have some influence on the planning of services for elderly people (see Table 7.6).

Involvement with government bodies in planning services for the elderly

TABLE 7.6: Health board by involvement with government body in planning, input into interest groups or say in planning services for elderly. (Q.2, Q.63, Q.65, Q.67)

Health Board*	Involved with Government: Body		Input into Interest Groups		Say in Planning	
	Per cent	N	Per cent	N	Per cent	N
Eastern	5	150	31	139	11	139
Southern	17	116	40	110	21	107
South Eastern	10	95	27	86	11	87
Mid-Western	10	72	24	59	15	56
North Eastern	10	69	21	57	7	57
Western	8	59	30	53	18	50
Midland	5	40	32	37	12	34
North Western	21	57	33	54	14	50
Total	11	658	30	595	14	580

*Because of non-response regional comparisons should be treated with caution.

is low in most health board areas (see table 7.6). It is reported by five per cent only of respondents in the Eastern and Midland health board areas, the highest proportion is reported by respondents in the North Western, 21 per cent. Higher proportions of respondents report having some input into interest groups engaged in working for the elderly, they range from 21 per cent in the North Eastern to 40 per cent in the Southern Health Board area respectively. The proportions reporting a say in planning services for the elderly otherwise ranges from seven per cent in the North Eastern to 21 per cent in the Southern Health Board area.

It was noted in the Introduction that partnership implies a co-operative and consultative relationship with the parties concerned working towards common and agreed objectives, and that furthermore it suggests the involvement of voluntary organisations or their representatives in the planning and policy-making process. At first glance the data reported here suggest that at least a small proportion of voluntary organisations do have an input into the planning and policy making process. However, an examination of the nature of such involvement suggests a less optimistic interpretation. The nature of the involvement voluntary organisations have with government bodies in planning services for elderly people is summarised in Table 7.7.

TABLE 7.7: Nature of involvement with government body in planning services for elderly people (Q. 64)

Activity	Number
Planning with health board/personnel	18
Information/research/publications	9
Planning of housing budgets	8
Planning with Garda authority at national level	5
Parent organisation involved at national/county level	4
Planning community alert with Gardai	4
Planning with county council/local authority	4
Other	9
Involvement not specified	9
Not involved	588
No answer	210
Total	868

Only 18 respondents report they engage in planning activities with health boards, eight are involved in planning housing or housing budgets while four plan with some other local authority. Five respondents engage in planning with the garda authorities at national level while four plan for community alert systems at local level. Nine report involvement with government bodies in research activities and another nine report various

other activities. The degree of involvement by voluntary organisations in planning operations with government bodies, whether central or local, as indicated by the above is clearly negligible. This suggests that partnership arrangements between voluntary organisations and government bodies hardly exist. Account is not taken here of representation by health boards on the committees of voluntary organisations or other informal and formal communication between voluntary organisations and statutory bodies. As indicated in Chapter One however, partnership may be operationally defined as the set of arrangements made to enable practical involvement by the voluntary sector in both policy development and planning as well as the actual operation of services. The activities summarised in Table 7.7 indicate that such arrangements hardly exist.

The extent to which voluntary organisations have an input into interest groups again indicates that availability of structures required for partnership and perhaps also the degree to which voluntary organisations are prepared for such a relationship. The nature of such input is summarised in Table 7.8

TABLE 7.8: Input into interest groups who work for the elderly (Q. 66)

Input	First Mention Number	Second Mention Number
Talking/passing on information	46	4
Representation on/liaison with county/regional/national group	42	7
Joint provision of services	36	
Representation on/liaison with local committee (social services etc.)	30	2
Co-ordinating body	6	
Other	6	2
Input not specified	14	
No input	415	580
No answer	273	273
Total	868	868

About a quarter of respondents who report having an input into interest groups indicate it is limited to exchange of information. However, similar proportions indicate they engage in the joint provision of services or representation on or liaison with local committees. Most importantly only a quarter of those reporting any input into such interest groups have either representation on or liaison with county, regional or national groups. This low level of representation indicates an absence of a sound organisational framework for engagement in planning and policy making at regional and national level.

The extent to which voluntary organisations have a say in planning services for elderly people apart from government and interest groups also indicates their involvement at policy level. The extent to which they have such a say is summarised in Table 7.9.

TABLE 7.9: Organisations with an influence on the planning of services for elderly people (apart from government and interest groups) (Q. 68)

Influence	First Mention Number	Second Mention Number
Consulted by agency (hospital/corporation)	10	
Representation on local committee	4	
Influence with own services/organisation	40	2
Research on needs	3	
Representation on regional/national group	4	
Planning local initiative	4	3
Other	8	2
Influence not specified	8	
No influence	499	573
No answer	286	286
Total	868	868

The majority of those who report having any influence on the planning of services for elderly people have it within the confines of their own services or organisation. Eight have representation on local committees or participate in planning local initiatives and ten others are consulted by some local agency. Only four report representation on regional or national groups. This again indicates either virtually no participation in the structures required for partnership or their absence.

One of the positive features to emerge from the typology of organisations in Chapter Five is that those organisations which provide essential maintenance services for the elderly are more likely than others to be involved with a government body in planning services for elderly people or to have a say in planning services for elderly people otherwise. However, the highest proportion of any type reporting involvement with a government body in planning services for the elderly is 18 per cent (housing services) and the highest proportion of any type reporting an input into interest groups who work for the elderly is 31 per cent (general support services). Moreover, the examination of the nature of such activities, as indicated above, suggests that little reassurance can be derived from these patterns.

Some Characteristics of Organisations Engaged in Policy and Planning

To provide an overview of the characteristics of organisations engaged

in policy and planning the following matters are examined here: statutory funding status, branch or affiliation status, number of clients served, number of services provided, and number of volunteers; the objective of the examination is to discover how variations in these characteristics are related to the likelihood of being engaged in policy and planning.

Organisations in receipt of statutory funding are more likely than those who are not to:

(i) be involved with a Government body in planning services for elderly people, 13 per cent (n=347) compared with eight per cent (n=268) respectively.

(ii) have inputs into interest groups who work for the elderly. 34 per cent (n=321) compared with 27 per cent (n=245) respectively.

(iii) otherwise have a say in planning services for the elderly, 18 per cent (n=324) compared with nine per cent (n=236) respectively.

Organisations who are branches of larger organisations or affiliated to an organisation are more likely than those who are not to:

(i) be involved with a government body in planning services for elderly people, 13 per cent (n=333) compared with eight per cent (n=330) respectively.

(ii) have inputs into interest groups who work for the elderly, 35 per cent (n=306) compared with 26 per cent (n=291) respectively.

(iii) otherwise have a say in planning services for the elderly. 15 per cent (n=302) compared with 12 per cent (n=291) respectively.

Organisations with more than 100 clients are more likely than others to be involved with a government body in planning services for elderly people, to have an input into interest groups who work for the elderly or to have a say otherwise in planning services for elderly people (see Table 7.10). Organisations with between 51 and 100 clients are however less likely than those with less than 51 clients to be engaged in such activities.

TABLE 7.10: Number off clients by involvement with government body in planning, input into interest groups or say in planning services for elderly. (Q.8, Q.63. Q.65, Q.67)

	Number of Clients		
	Less than 51	51 — 100	More than 100
Involvement with Government Body	9* (267)**	7(145)	15(130)
Input into Interest Groups	31 (244)	23(135)	37(118)
Say in Planning Services	13 (241)	12(133)	17(119)

* Percentage.

**Numbers replying to the question.

Organisations providing more than eight services are more likely than others to be involved with a government body in planning services for elderly people or to have an input into interest groups who work for the elderly (see Table 7.11). Those organisations providing five to eight services are more likely to be engaged in such activities than those providing less than five.

TABLE 7.11: Number of services by involvement with government body in planning or input into interest groups or say in planning services for the elderly. (Q.9, Q.63, Q.65)

	Number of Services		
	Less than 5	5 — 8	More than 8
Involvement with Government Body	4* (259)**	12(218)	18(186)
Input into Interest Groups	18 (233)	35(191)	42 (173)

'Percentage.
••Numbers replying to the question.

The number of volunteers available to organisations is unrelated to the likelihood they will be involved with a government body in planning services for elderly people or have a say otherwise in planning services for the elderly (see Table 7.12). Those with more than 20 volunteers are more likely than others to have an input into interest groups who work for the elderly; likewise, those with between 10 and 20 volunteers are more likely to have such an input than those with less than 10 volunteers.

TABLE 7.12: Number of volunteers by involvement with government body in planning, input into interest groups or say in planning services for elderly. (GL13(a), Q.63, Q.65, Q.67)

	Number of Volunteers		
	Less than 10	10 — 20	More than 20
Involvement with Government Body	12* (155)**	11 (197)	11 (136)
Input into Interest Groups	30 (137)	32 (185)	36 (128)
Say in Planning Services	16 (136)	13(181)	16(131)

•Percentage.
••Numbers replying to the question.

Summary

In the course of the series of in-depth interviews with representatives of statutory bodies it was made clear that many kinds of assistance in addition to financial assistance are made available to and are availed of

by voluntary organisations. Close liaison with voluntary organisations was reported; moreover, some of those interviewed considered that health boards should actively promote the development of voluntary organisations. Despite this commitment to the support of voluntary activity the personnel interviewed were reluctant to impinge on the independence of voluntary organisations. Where organisations are in receipt of substantial funding this can result in a dilemma for health boards, as a conflict between accountability, including contractual arrangements, and freedom can ensue. Resolution of this impasse is urgent as the provision of funding on a short-term basis only, which is the general rule, is perceived as an obstacle to the planned development of voluntary organisations. Overall, statutory authorities have an approach somewhere between the *enhanced monopolist* and the *responsive pluralist,* the discretionary nature of health board funding is a major reason why the approach of statutory authorities cannot be characterised as *responsive pluralist.* Notwithstanding the absence of appropriate funding mechanisms some health board personnel at least aspire towards *developmental pluralism.*

More than half of respondents report the receipt of statutory' funding. It is clear that notwithstanding the problems raised in the literature concerning the funding of voluntary organisations by statutory bodies such organisations in Ireland are keen to benefit from such funding. The majority of respondents reported that those responsible for day-to-day organisational administration receive adequate support from statutory bodies. Forty three per cent of respondents were satisfied with the level of input they themselves make in determining the level of funding received by them. However, only a minority of respondents reported that assistance other than funding is received from statutory agencies.

Organisations in receipt of statutory funding are more likely than those who are not: to receive other assistance from statutory sources, to have health board representation on their committee, to be required to report to a statutory body, to feel that those responsible for day-to-day administration receive adequate support from statutory agencies, to report that the health board has decision-making power in the running of the organisation, and to be satisfied with the input made by statutory bodies into the running of their organisation.

A minority of respondents reported that the health board is represented on their committee. Eighteen per cent of respondents stated that a health board has decision-making power in the running of their organisations. The majority of these, 69 per cent, consider this involvement to be valuable in the running of the organisation. Only six per cent consider it not to be valuable. The positive view of this form of engagement by

The majority of voluntary organisations providing services for the elderly have a recognisable structure.

The majority, 57 per cent, have their own constitutions or they are incorporated or both.

A substantial proportion of voluntary organisations have supportive relationships with other voluntary organisations.

One half of the respondent organisations are branches of organisations or are affiliated to them. There is a considerable variation in respect of the proportion of respondents in different health board areas reporting such membership or affiliation, ranging from one-third to three-quarters.

A substantial proportion of voluntary organisations providing services for the elderly define the elderly as their primary clients.

The first objective of more than half of the organisations studied, 54 per cent, is clearly focused on the elderly. One half of them are care of the aged committees, associations of older people, or social service councils.

Section 2: The Resources of Voluntary Organisations

In this Section of the study the staffing and resources of the organisations, the numbers of volunteers and their tasks, the number of staff employed and the sources of payments for staff are described. The conclusions arising are as follows:

The personnel resources of voluntary organisations are in overall limited.

It is estimated that throughout the State 27,700 volunteers are engaged in the provision of services for the elderly. The average number of volunteers per organisation engaged in service provision is 25. One-third of voluntary organisations providing voluntary services for the elderly have less than ten volunteers, and 73 per cent have less than 21. However, 12 per cent have more than 50 volunteers.

The time given by volunteers is on average limited.

Two-thirds of respondents report that on average volunteers give less than five hours weekly.

The tasks in which volunteers engage are of a general nature.

In 90 per cent of cases the primary tasks of volunteers include day-to-day/all tasks, home and hospitals visits, entertainment and catering/helping.

Only a minority of voluntary organisations employ staff.

Full-time or part-time staff are employed by 16 per cent and 21 per cent of voluntary organisations respectively. Thirteen per cent of organisations employ staff associated with FAS. A minority of organisations have people working for them who are neither employed by them nor acting in a voluntary capacity, presumably they are on "loan" from elsewhere. In the majority of cases voluntary organisations pay the wages of employed staff themselves, in a small proportion of cases wages are paid by health boards or other statutory bodies.

Few voluntary organisations own their offices.

While a majority (51 per cent) of respondents have offices only 20 per cent of these own them, a substantial proportion, 37 per cent, have the use of their offices on an occasional or sessional basis only. Nonetheless, the majority, 76 per cent, feel that their offices are adequate for their needs.

Section 3: The Services Provided by Voluntary Organisations

This part of the study describes what voluntary organisations do, how many clients they cater for, what services they provide, how many clients are served by each of the services provided and the frequency of service provision. The conclusions arising are as follows:

A substantial proportion of the elderly are served by voluntary organisations.

It is estimated that 93,800 persons, equivalent to a quarter of the number of persons throughout the State aged 65 and over in 1991, are counted as clients by voluntary organisations. This estimate does not include all of those for whom social events are provided. Many voluntary organisations regard social events which occur annually or occasionally only as marginal to their main activities. Other organisations, those labelled here as social event service organisations, regard them as their primary activities.

Overall the average number of clients served by voluntary organisations is small.

On average each voluntary organisation providing services for the elderly serves 79 clients. Nearly one half have less than 50 clients and less than a quarter serve more than 100 clients. It should be noted that these estimates include all clients served by the respondent organisations, some of which provide services for groups other than the elderly.

Overall the number of services provided by voluntary organisations is small.

Approximately one-fifth of respondents provide one service only and one half of them provide less than five services. Only one in six provide more than eight services.

Voluntary organisations primarily focus on those activities which health board personnel consider they do best, the provision of services which involve social contact to counter loneliness and social isolation.

The provision of social events (outings/parties), visiting the elderly at home and visiting the elderly in hospital are reported by 77 per cent, 58 per cent and 50 per cent of respondents respectively. It should however be noted that the provision of social events is infrequent and seasonal in nature. More than one-third of those reporting the provision of social activities do so annually only and less than one-sixth do so weekly or more frequently.

What might be considered to constitute essential maintenance services, day centres, meals-on-wheels, home helps, laundry service or the building and provision of sheltered housing are all provided by minorities of voluntary organisations only.

Day centres providing social/recreational facilities or personal and sociai services are provided by 21 per cent and 13 per cent of respondents respectively. Meals-on-wheels delivered to the person and meals-on-wheels provided in a day centre are reported by 28 per cent and 17 per cent of respondents respectively. Underlying the significance of these services is the frequency with which they are provided, over 70 per cent of the organisations reporting the frequency of these services provide them on a weekly or more frequent basis.

Paramedical/nursing services are provided by a minority of voluntary organisations only.

While chiropody is provided by 26 per cent of respondents, occupational therapy, physiotherapy and home nursing are each made available by less than ten per cent of respondents. However, those who provide them do so frequently, 70 per cent of those reporting the frequency of their provision do so weekly or more often.

Voluntary organisations are engaged in a wide range of housing activities.

A quarter of respondents report involvement in housing repairs/improvements/adaptions, 11 per cent are engaged in the provision of special sheltered housing while five per cent provide warden and supervisory services for sheltered housing.

Carers of the elderly are relatively neglected by voluntary organisations.

A carer support service and other services for carers, for example, respite care, are each reported by six per cent of respondents only. It is estimated that 2,500 persons avail of carer support group services and that 1,500 benefit from services provided for carers by voluntary organisations.

With the exception of social events and visiting, the number of clients provided with any of the services specified is low.

It is estimated that social events are provided for 76,900 persons and that 26,700 elderly persons receive social visits from volunteers. More practical maintenance services are less widely available; for example it is estimated that the number benefitting from meals-on-wheels, day centres and home helps are 15,900, 13,900 and 8,000 respectively. Paramedical services in particular are in short supply; for example it is estimated that physiotherapy is made available to 2,100 persons, a number equivalent to less than one per cent of the population aged 65 and over.

There is a positive relationship between the number of clients served and the number of services provided.

Two-fifths of those providing more than eight services have more than 100 clients while half of those providing less than five services have less than 50 clients.

The number of clients served is only broadly related to the number of volunteers.

One-third of organisations with more than 100 clients have more than 20 volunteers as have one-fifth of those with less than ten, however one-quarter of organisations with less than 50 clients have more than 20 volunteers while two-fifths have less than ten.

Organisations with paid staff members have more clients and provide more services.

More than a quarter of organisations with more than 100 clients compared with one-tenth of those with less than 50 clients have full-time staff. One-third of organisations providing more than eight services compared with one-tenth of those providing less than five services have full-time staff.

Section 4: Typology of Voluntary Organisations

Overall voluntary organisations engaged in the provision of services for the elderly can be placed in one of three mutually exclusive categories.

The first category consists of those which provide few services for the elderly other than social events. These social event service organisations have limited personnel or funding resources. Relationships between these organisations and statutory bodies are limited and they are least likely to be engaged in policy or planning. The second category includes those organisations which provide services of an intermediate supportive nature only, consisting mainly of either social activities or general material aid. They do not provide practical maintenance services like meals-on-wheels, home helps, day centres or special housing. Like those in the first category, these organisations have limited personnel resources but they are more likely to benefit from statutory funding. Relationships between these intermediate support service organisations and statutory bodies are more developed and they are more likely to be engaged in policy and planning activities. The third category of organisations are the key providers of services for the elderly. In addition to the intermediate supportive services provided by those in the second category they provide more practical maintenance services, for example, meals-on-wheels, home helps, day centres or special housing. These general support service organisations are more formal in character, they have greater personnel and other resources, most benefit from statutory grants and engage in fund-raising, and half

of them levy charges on their services. Their relationships with statutory agencies are more developed and they are more involved in planning and policy-making than others.

Many of the organisations in the third category of voluntary organisations described above, the key service providers, can be subdivided into three functionally based sub-categories.

Organisations in the first of these (day centre service organisations) are engaged in the provision of day centre based personal and social services or recreational activities. These include occupational therapy, physiotherapy and meals-on-wheels in the centre. Organisations in the second sub-category (housing service organisations) are engaged in the provision of sheltered housing and warden services. Organisations in the third sub-category (domiciliary service organisations) focus more on domiciliary services including meals-on-wheels and home helps.

Section 5: The Funding of Voluntary Organisations

This part of the study describes the sources of funding of voluntary organisations and the proportion of total funding received from each source. It also describes the proportion of voluntary organisations in receipt of statutory funding and the conditions attached to it. The level of funding provided by selected statutory authorities for 1990 is detailed. The results of a comparative study of funding provided by a statutory authority and the reporting of such funding are given. Finally, fund-raising activities and budgeting matters are discussed. The conclusions arising are as follows:

Fund-raising and statutory grants are the most importance sources of funding for voluntary organisations; however, legacies! donations and charges to recipients are also important.

The proportions of organisations that reported such sources of funding are 68 per cent, 47 per cent, 33 per cent and 31 per cent respectively; the proportions that reported these sources account for more than 40 per cent of their funding are 35 per cent, 28 per cent, 14 per cent and 16 per cent respectively.

Statutory bodies provide substantial funding to voluntary organisations.

In 1990, nearly £4.8 million was provided to them by six of the eight health boards. In excess of £4.25 million was provided by the

Department of the Environment. In excess of £200 thousand was provided by the Department of Social Welfare.

Voluntary organisations in receipt of statutory funding are more likely than those who are not to report that they have more clients, provide more services or have more volunteers. A substantial proportion of those organisations which provide practical supportive services for the elderly receive statutory funding.

The amount of money generated by voluntary organisations in fund-raising is in general not substantial.

During 1990 half of them reported raising £1,000 or less, two-thirds raised less than £2,000 and a quarter raised between £2,001 and £9,000. However, the remainder, nine per cent, reported raising in excess of £9,000.

Church (gate) collections are the most popular form of fund-raising employed by voluntary organisations.

Two-fifths of respondents reported this as their principal means of fund-raising. More than one-tenth of organisations each employed entertainments, activity days or bingo as their principal form of fund-raising. Only one-fifth of those who engage in fund-raising or seek sponsorship for fund-raising activities.

Only a minority of voluntary organisations report having annual budgets.

Thirty percent of respondents indicated they have an annual budget. In most cases, 74 per cent, the responsibility for determining this belongs to the committee; however, in nine per cent of cases the health board was reported to be responsible.

Voluntary organisations have limited spending power.

Only 15 per cent of organisations stated the size of their budget for 1990. One-third of these had a value of less than £500, another third had a value between £501 and £2,000. Approximately one-quarter had budgets in the range £2,001-£9,000; however, the remainder, one in seven, had budgets valued in excess of £9,000.

Section 6: Relations Between Voluntary and Statutory Organisations

This part of the study examines current partnership arrangements

between voluntary organisations and statutory authorities. Views of statutory authorities on the voluntary-statutory relationship are presented. Characteristics of grant recipients, whether they have broader and more integrated relationships with statutory authorities than others, are examined. The support received from statutory authorities, other than financial support, and the influence statutory authorities have on voluntary organisations are described. It also examines voluntary organisations' perceptions of the adequacy of statutory support received by those responsible for the day-to-day running of the organisation from statutory authorities, whether assistance other than funding from such authorities is received and whether voluntary organisations are generally satisfied with the inputs made by statutory authorities into their organisations. Finally, it examines the involvement of voluntary organisations in policy and planning. The conclusions arising are as follows:

Senior staff members of health boards reported that, in addition to financial assistance, other forms of assistance are available to and availed of by voluntary organisations. In addition close liaison with voluntary organisations is reported, indeed some feel strongly that health boards should actively promote the development of voluntary organisations. In spite of this commitment they are concerned about infringing on the private affairs of voluntary organisations.

The views presented by health board representatives suggest their approach to voluntary organisations is somewhere between the *enhanced monopolist* and the *responsive pluralist.* In keeping with the *responsive pluralist* approach they welcome voluntary action; however, consistent with the *enhanced monopolist* approach any substantial funding is given within a tightly controlled statutory framework. In so far as some health board personnel believe they should actively promote the development of appropriate voluntary organisations, they at least aspire towards *developmental pluralism.*

There is much in the information provided by voluntary organisations to suggest that considerable progress has been made and is being made in the relations between statutory and voluntary organisations.

As already indicated statutory grants are one of the two most important sources of funding for voluntary organisations; moreover, two-fifths of respondents reported satisfaction with the input they have in determining the level of funding made available to them. One-fifth of respondents reported the receipt of assistance other than funding from statutory authorities and more than half of respondents, 54 per cent, reported that those responsible for the day-to-day running/administration of their organisations receive adequate support from statutory agencies.

If the variations in statutory-voluntary relations reported by voluntary organisations in the different health boards are representative of all voluntary organisations they indicate that even within existing structures considerable improvements in voluntary-statutory relationships could be achieved.

For example, while on average two-fifths of respondents reported satisfaction with their input in determining the level funding received by them, in one health board area 64 per cent reported this. Whereas on average one-fifth of respondents reported the receipt of assistance other than funding from statutory authorities, in one health board area 32 per cent reported this.

Some forms of accountability appear to be quite acceptable to some voluntary organisations, for example, the majority of respondents who report that health boards have decision-making power in the running of their organisations welcome such involvement.

In a small proportion of cases (13 per cent) health boards have representation on the committees of voluntary organisations. Eighteen per cent of respondent reported them to have decision-making power in the running of their organisations, 42 per cent reported this in one health board area. Three-quarters of those reporting such power considered it to be valuable for their organisation, only six per cent considered it not to be valuable; in one health board area 92 per cent of respondents considered such an input valuable.

Where health boards do not have decision-making power a majority of respondents would not welcome an input from the health board into the running of the organisation.

Three-quarters of those respondents in organisations where health boards do not have decision-making power do not think it should have such an input. However, one quarter think it should, in one health board area 51 per cent were of this opinion. More than half of those who favour such an input do so because of their perception of the desirability of such advice or assistance other than finance that health boards can provide, two-fifths were motivated by a desire for more funding.

Organisations in receipt of statutory funding are more likely than those who are not to report satisfaction with statutory authorities.

They are more likely to report:

—receiving other assistance from statutory authorities.

—that those responsible for day-to-day administration receive adequate support from statutory agenices.
—satisfaction with the input made by statutory bodies into the running of their organisations.

Organisations in receipt of statutory funding are more likely than those who are not to report involvement with statutory authorities.

They are more likely to report:
—health board representation on their committees.
—a requirement to report to a statutory body.
—that the health board has decision-making power in the running of their organisations.
—involvement with a government body in planning services for elderly people.
—having inputs into interest groups who work for the elderly.
—otherwise having a say in planning services for the elderly.

That group of organisations, identified as the key providers of practical services for the elderly, those which operate day centres, provide special housing or meals-on-wheels and home helps, have, overall, more developed relationships with statutory bodies.

These key organisations are more likely than others to receive funding and other assistance from statutory authorities, to have health board representation on their committees, to report that the health board has decision-making power in the running of their organisations, and to be more satisfied with the input made by statutory bodies into the running of their organisations.

The extent of involvement of voluntary organisations, especially with government bodies, in policy and planning is limited.

Only 11 per cent of respondents reported involvement with some government body in planning services for elderly people. Thirty per cent of respondents reported having inputs into interest groups who work for the elderly. Fourteen per cent reported influence otherwise on the planning of services for elderly people. There is considerable variation by health board area in the proportions of respondents reporting involvement in such activities. The proportion that reported involvement in some government body ranged from five per cent to 21 per cent. The proportion that reported being involved

with interest groups working for the elderly ranged from 21 per cent to 40 per cent while the proportion reporting having a say otherwise in planning services ranged from seven per cent to 21 per cent. A greater involvement in policy and planning activities is reported by organisations which are members of larger organisations or affiliated to other organisations. Those organisations which provide more services or that have more than 100 clients are more likely than others to engage in policy and planning activities.

An examination of the nature or quality of involvement by voluntary organisations in policy and planning, whether with governmental agencies, interest groups or otherwise, reveals that significant activity of this kind is rare. This suggests that in general consultation systems are either unused or unavailable. As such systems are essential for the development of good partnership practice suitable systems will have to be created together with incentives for using them.

Summary

Voluntary organisations providing services for the elderly are heterogeneous in nature. Some define the elderly as their primary clients, many do not. They range considerably in respect of size in terms of the number of volunteers they have, the number of clients they serve, the number of services they provide and the level of funds they have.

There is considerable reliance on funding from statutory authorities and the amounts of money generated through fund-raising activities are in general quite limited. Few have paid staff or own their offices. The future development of voluntary organisations must be considered with these realities in mind and implies the requirement for considerable assistance for them.

Only a minority of voluntary organisations providing services for the elderly make essential maintenance services such as home-helps, meals-on-wheels, sheltered housing or day centres available. The facilitation of such necessary services requires careful consideration of funding mechanisms and other administrative structures.

A substantial proportion of voluntary organisations have a positive opinion of the financial and other assistance made available to them by statutory bodies. The very high levels of satisfaction in this regard reported by voluntary organisations in some health board areas indicates that even within existing structures more could be done. However,

the relationship that many voluntary organisations have with statutory organisations, if any, is limited to funding.

Few voluntary organisations engage with statutory bodies in planning and policy-making activities. Organisational structures are required to redress this situation. The policy issues arising from these conclusions are presented in the next chapter.

half of the voluntary organisations are in the third category, general support service organisations, those which in addition to providing intermediate supportive services provide essential maintenance services, for example, meals-on-wheels and home helps, day centres or housing services. These organisations are the key voluntary providers of services to the elderly.

Scale and Resources

The scale and resources of organisations vary considerably as do the nature and number of services provided. Some are small locally based groups working in an *ad hoc* way, without offices, with few resources or services and with limited if any contact with other organisations, whether voluntary or statutory. Some are large, with substantial resources, provide a wide range of services and have well developed relationships with other voluntary and statutory organisations.

It was established in Chapter Three that there are approximately 28,000 volunteers providing services for the elderly throughout the State. Though this is a substantial number it is spread over many organisations and the average number of volunteers in organisations providing services for the elderly is 25. One-third of voluntary organisations providing services for the elderly have less than ten volunteers and three quarters have less than 21, about one in ten have more than 50. These volunteers on average give a small amount of time, two-thirds of respondents report that on average volunteers gave less than five hours weekly, and the tasks in which they engage are general in nature. Moreover, only a small proportion of organisations employ staff. Those which do provide more services to more clients.

The main sources of funding used by voluntary organisations are fund-raising, statutory grants, legacies/donations and charges to recipients. The percentages of organisations that reported such sources of funding are 68, 47, 33 and 31 respectively; the percentages that reported these sources account for more than two-fifths of their funding are 35, 28, 14 and 16 respectively. The two most important sources of funding are fund-raising and statutory grants. Church (gate) collections are reported as the principal form of fund-raising by two-fifths of respondents. Two-thirds of respondents reported that less than £2,000 was raised by them in 1990. In 1990, nearly £4.8 million was granted to voluntary organisations engaged in providing services for the elderly by six of the eight health boards, in excess of £4.25 million was provided by the Department of the Environment and in excess of £200,000 was provided by the Department of Social Welfare. Many voluntary organisations are

relatively unsophisticated in respect of financial matters; for example, many voluntary organisations do not have annual budgets indicating an absence of financial planning. This has implications for the funding and efficiency of voluntary organisations. Moreover, in the course of this study it became apparent that the knowledge voluntary organisations have of statutory and other funding sources varies considerably. This is one of a number of areas where voluntary organisations would benefit from appropriate training and educational programmes.

The Services Provided

More than three-quarters of voluntary organisations providing services for the elderly have less than 100 clients, on average each voluntary organisation serves 79 clients. Five in six provide eight services or less for the elderly and one in five provides one service only. This small scale has advantages in so far as it may increase the likelihood that the services which are provided are more personal in nature. However, it can result in diseconomies of scale in the provision of those services which are costly in nature and can make it difficult to establish or maintain high professional standards.

It is estimated that 93.800 persons, equivalent to a quarter of the number of elderly persons throughout the State aged 65 and over in 1991. are counted as clients by voluntary organisations. This estimate does not include all those for whom social events are provided as many organisations regard events which occur annually or occasionally only as marginal to their main activities. The provision of social activities (outings/parties), visiting the elderly at home and visiting the elderly in hospital are the activities engaged in by the highest proportions of voluntary organisations. 77 per cent, 58 per cent and 50 per cent respectively. Approximately one-fifth of the organisations providing services for the elderly, social event service organisations, provide little more than social events. These organisations are less likely than others to be registered or incorporated and they have very limited resources in respect of personnel or funding. They are least likely to obtain funding or other assistance from statutory bodies.

Approximately one quarter of voluntary organisations are categorised here as intermediate support service organisations. The services which distinguish this group are of an intermediate supportive nature. They primarily include visiting the elderly, advice/information, material and financial aid and housing repairs. The majority of these organisations are branches of or affiliates of larger organisations. Like social event service organisations they have limited resources in respect of personnel

or funding. They are more likely to be involved in policy and planning than social event service organisations but only very small proportions are involved.

Less than one half of all respondent organisations provide at least one service in the categories, day centre services, domiciliary services or housing services in addition to intermediate supportive services. These organisations are more formal in nature than those providing social event services or intermediate support services only. Most of them have a committee structure and more than half of them are branches or affiliates. They have considerably more personnel resources than either of the other two categories and they are more likely to benefit from statutory funding, two-thirds of them report that they so. Approximately one-fifth of these organisations report receiving assistance other than funding from statutory authorities, having health board representation on their committees, or that the health board has decision-making power in their organisations. Though the proportion of these organisations reporting satisfaction with aspects of their relationship with statutory bodies is greater than that of the other categories, nevertheless it is small. Only one-fifth are satisfied with the input they have in determining the level of funding received from statutory bodies or with the input generally made by statutory bodies.

Given that the immediate concern with the development of partnership between voluntary and statutory bodies arises from the need to provide community based supportive services for the elderly it is of considerable significance that only minorities of voluntary organisations provide the services that distinguish this group of organisations. Such essential support services as day centres, meals-on-wheels, home helps and special housing are provided by a minority of respondents only. It was estimated in Chapter Four that only small numbers of elderly people benefit from the provision of such services by voluntary organisations. It was estimated that 13,900 persons are served by day centres and 15,900 and 8,000 avail of meals-on-wheels and home 'ielp services respectively; approximately 3,700 persons benefit from special housing. The numbers of the elderly benefitting from day centres, meals-on-wheels, home-helps and special housing provided by voluntary organisations are estimated to be equivalent to ten, eleven, six and three per cent respectively of the 1991 over 75 population.

Paramedical services such as occupational therapy and physiotherapy, both of which have considerable relevance for the mobility and independence of the elderly, are provided by very few voluntary organisations, nine per cent and five per cent respectively. Perhaps the most practical role for voluntary organisations to play in the provision of

paramedical services is to act as facilitators only; for example, the provision of space in a day centre for health board personnel to deliver the services and the encouragement of the elderly to avail of the services.

Carers of the elderly are relatively neglected by voluntary organisations providing services for the elderly. Only a minority of voluntary organisations provide services for carers. While voluntary organisations make a considerable contribution to the welfare of the elderly many individuals have primary responsibility for the day-to-day care of one or more elderly persons. The primary needs of carers, needs which are largely unmet, revolve around: practical help in care-giving, relief or respite care, financial support and psychosocial support. These needs vary according to the different stages of the caring process: making the decision to become a carer, day-to-day working out of the caring role, reviewing of the caring process and termination of the caring role. Supportive services for carers can help to reduce their burden.

The Relationships between Voluntary Organisations and Statutory Bodies

Some voluntary organisations have acknowledged their accountability to health boards by sharing decision-making power with them in the running of their organisations. A majority of respondents who reported such involvement by health boards considered it valuable for their organisations. Some of those organisations that have not yet developed such an arrangement would welcome it; however, a majority would not favour it. Sound contractual arrangements between voluntary and statutory organisations may render such arrangements unnecessary; however, they may be desirable in some cases. There is no evidence arising from this study that voluntary organisations have difficulties with the forms of accountability currently in practice apart from the occasional inconvenience that may arise.

Voluntary organisations, partly arising from the implementation of the recommendations in *The Years Ahead*, are becoming more involved in the provision and operation of day centres. Also, as a result of housing legislation they are becoming more involved in the provision of special housing for the elderly. Such involvement, in consideration of the capital investment required, raises questions about ownership and the possibility of joint ownership arrangements between statutory and voluntary bodies. Related to this is the issue of the long-term maintenance and operation of the buildings. The development of voluntary organisations in these directions suggests that appropriate training and development programmes could make a valuable contribution.

While funding is of central importance it is only one aspect of the development of partnership between voluntary and statutory organisations. The development of partnership presupposes consultation on policy, planning, implementation and evaluation. While there are indications that progress has been made much more can be done. A significant proportion of voluntary organisations reported satisfaction with the level of input they have in determining the funding made available to them and a majority reported that those responsible for the day-to-day administration of their organisations receive adequate assistance from statutory agencies. In addition, a significant proportion reported the receipt of assistance other than funding from statutory authorities. The high proportions of respondents in a number of health board areas reporting satisfaction with some of these matters suggests that even within existing structures more can be done. However, the majority of respondents did not report the receipt of assistance other than funding from statutory authorities.

Few voluntary organisations are engaged in policy and planning activities, an essential part of any mature partnership arrangement. The Southern Health Board's *A Framework for Partnership*[2] seeks to address the need to develop stronger relationships between itself and voluntary organisations. The framework emphasises the desirability of the increased involvement of voluntary organisations in planning and accepts a developmental role for itself in assuming responsibility for the creation of new voluntary organisations at local level. The framework has two dimensions — consultative and contractual. It proposes the establishment of joint consultative committees or standing conferences comprising of representatives of the relevant voluntary organisations and the health board to evaluate and help integrate services. A substantial role is envisaged for community workers to co-ordinate voluntary organisations and district care teams. The proposals recognise that for consultation to succeed better co-ordinated structures within the voluntary sector itself will be required. The allocation of a specific budget for promoting new voluntary organisations and activities by the Southern Health Board is particularly welcome. However, while this framework is a welcome initiative, any judgement regarding its adequacy must take into account the issues addressed and the recommendations made here.

Recent proposals for the reorganisation of the health services may have implications for the provision of community based services. The Report of the Commission on Health Funding (1989)[3] suggested a single executive and policy making authority at national level together with several regional managers who would have autonomy in the allocation of resources. Implementation of this would seem to facilitate the determination of national standards for the provision of community based

services. Moreover, it would facilitate integrated planning at regional level and clarify the weight given to community based services and preventative measures generally. The Report of the Dublin Hospitals Initiative Group (1990)[4] proposed a regional authority with a number of area authorities. This would have several implications including the discontinuation of community care programmes in their present form. Such a reorganisation would appear to have the potential to devolve decision-making to a lower level which would have some positive implications for the provision of community based services.

Issues and Recommendations

It is argued here that because only small proportions of the elderly are benefitting from personal social services provided by voluntary organisations more support is required for them. Given the expected increase in the number of elderly people over the next decades such support will become increasingly urgent. The requirement for more support of the voluntary sector is underlined when account is taken of the significant role they play in the provision of personal social services. Allied to this is the considerable variation in the provision of such services in different health board areas. This reflects the absence of a clear policy for the provision of essential community based services for the elderly despite the acknowledged importance of such services in major published reports on the elderly. To redress this situation clear criteria for service provision and eligibility must be agreed at national level by the principal parties concerned. This must be supported by the provision of ear marked funding. Policy developments and changes in legislation suggest that Section 65 funding is no longer adequate for funding voluntary organisations providing these important services. The proposed legislative changes will in themselves not guarantee adequate partnership arrangements between the voluntary and statutory sectors but they provide a necessary condition for them. Without such a platform statutory bodies are less dependent on the cooperation of the voluntary sector and the voluntary sector is in turn in a weaker position to seek support. To develop partnership statutory bodies, health boards in particular, must adopt a developmental role in respect of the voluntary sector. They have the resources and organisational capacity. Both sides must together develop the required organisational structures at local, regional and national level.

The Availability of Services

The small number of voluntary organisations engaged in the provision of personal social services and the relatively small numbers of elderly

people estimated to be in receipt of them indicates a need to provide more support for these services. The urgency of this is underlined when the critical role of voluntary organisations in the provision of such services is taken into account. This role was stated clearly in *The Years Ahead*—

> As much as half of the home help service, almost all the meals-on-wheels and laundry service and a sizeable proportion of day care centres for the elderly are run by voluntary organisations.[5]

When account is taken of the expected increase in the number of elderly persons living alone over the next decades and the possible reduction in the numbers of volunteers available the need to support and resource the contribution of the voluntary sector becomes more urgent. In addition there are other problems arising from both the uneven geographical distribution of voluntary organisations and the different policies of health boards. These include the variations in the proportions of services provided by voluntary organisations in different health board areas and different priorities in the provision of services from one health board to another.[6]

Criteria for Service Provision

In *The Years Ahead* awareness of the need to establish national standards in the provision of some services resulted in the establishment of norms for such community services as public health nurses, home helps and day centres.[7] The lack of national criteria for personal social service provision by health boards results in a policy vacuum which is inhibiting the development of voluntary organisations and the provision of services for the elderly. The absence of criteria for services which are acknowledged to provide a better and cheaper alternative to institutional care contrasts sharply with the provision by the Department of Environment of criteria for housing related services.

The essential personal social services or "core" services require definition by an appropriate body. An appropriate body would consist of the Department of Health together with the health boards who administer Section 65.

Criteria for the definition of core services might include

> "that they play a role in preventing unnecessary institutional care"
>
> "that they are necessary to ensure a minimum acceptable quality of life"

The services so defined might vary over time and would be subject to periodic review.

The objective of developing these criteria is to provide a legal basis for the provision of core personal social services. Such an approach was recommended in *The Years Ahead:*

> health boards should be legally obliged to provide or make arrangements to provide services to maintain persons at home who would otherwise require care in another setting.[8]

Funding

The development of criteria for core service provision would require adequate earmarked funding for the implementation of the new policy. Up to now personal social services funded by health boards have been funded on a discretionary basis, discretionary funding of discretionary services. The nature of this funding has been criticised and identified as an obstacle to the development of the contribution made by the voluntary sector. The unsatisfactory nature of such funding was recognised in *The Years Ahead* by the recommendation for multi-annual contracts between voluntary organisations and health boards and local authorities.[9] Moreover, since the introduction of the 1953 Act the role of community based personal social services and the contribution made by voluntary organisations has changed substantially. The view taken by the *Care of the Aged* Committee of the importance of community based services (as above) has not yet been adequately reflected in funding arrangements. Neither has account been taken of the transformation in the provision of community based services subsequent to the creation of the health boards in 1970. The Health Act of 1970 extended the powers of health boards to provide services for elderly people. Section 61 empowered, though did not oblige, health boards to provide a home help and other home support services with or without charge. Moreover, Section 26 empowered health boards to make arrangements with voluntary bodies and others to provide services under the Health Act for eligible persons.[10]

Education and Training

Attention has been drawn here to the lack of sophistication displayed by a proportion of voluntary organisations in respect to financial planning and knowledge of funding sources. Suitable education and training programmes clearly have a role to play here. The new directions being taken by many voluntary organisations, their growing involvement in the operation and management of day centres, their increasing responsi-

bility in the provision and management of housing, their operation of such services as meals-on-wheels and home help would likewise benefit from appropriate training programmes. The development of partnership structures will also require education and training for both the statutory and voluntary sector. Both the voluntary and statutory sectors should be involved in planning all educational and training programmes and should participate in them together.

Equality of Service Provision

In discussing partnership arrangements between the voluntary and statutory sector it is essential that the consumers, the elderly, are not lost in the debate. Criteria for service provision should incorporate a principle of equality of service provision. The core services available to the elderly should as far as possible be independent of the priorities of particular health boards or voluntary organisations. They should be addressed to the needs of the elderly. Such an arrangement would greatly reduce the uncertainty and anxiety faced by the elderly in their efforts to maintain independent and decent lives. Those speaking out on behalf of the elderly, whether the elderly themselves, voluntary organisations or statutory bodies would be supported by the availability of clear criteria for provision and eligibility.

Conditions for Partnership

Without a firm and clear commitment at national level to the provision of community based personal social services satisfactory partnership arrangements between voluntary and statutory organisations are unlikely to develop. It is not surprising that given the policy vacuum currently existing in respect of these services that voluntary organisations are engaged to such a small degree in planning and consultation at any level. Given the absence of a clear national policy there is limited pressure on statutory bodies to engage and develop the voluntary organisations in their respective areas. Despite the recommendation in *The Years Ahead* that, health boards and local authorities should encourage by all possible means the involvement of voluntary organisations in caring for the elderly [u] There is little evidence that this has occurred. Because of the discretionary nature of the personal social services they provide the power of voluntary organisations to influence the situation is limited.

While the establishment of criteria for service provision and the provision of an adequate funding mechanism will provide a firm basis for the establishment of partnership; in themselves they will not be sufficient. Neither is consultation an adequate formula for partnership. Partnership

requires a recognition that, without detracting from the special authority and responsibility of statutory authorities, both statutory authorities, health boards in particular, and voluntary organisations have a joint responsibility for and commitment to the elderly. This requires that voluntary organisations are meaningfully engaged in the planning and policy making for services at national/regional and local level.

In the development of partnership and indeed in the development of the voluntary sector a strong developmental role is required of statutory organisations and health boards in particular. Health boards are permanent bodies with full-time professional and expert staff and considerable organisational resources. Many voluntary organisations are small in scale, have limited resources and only a minority have paid staff, whether full-time or part-time. Most volunteers have limited time to devote to their voluntary activities and the tenure of many of their key committee members is short term.

The development of partnership will require adjustment by statutory and voluntary organisations. To play a full role voluntary organisations will require suitable representational structures while the relevant statutory authorities will have to be more open to the influence of the voluntary sector. There are no simple formulas available for mapping out the structures which will cause partnership or any co-ordination systems to thrive. A long-term developmental process will be required before good systems are developed. This will not be easy; it has been noted by Browne that the pilot projects for co-ordinating services for the elderly:

> highlighted an absence of an ethos of co-ordination throughout the Irish administrative system which has obvious implications for service co-ordination for the elderly at local level.[12]

The contribution of the voluntary sector to the welfare of the elderly is so valuable and urgent that institutional "inertia" cannot be permitted to put it at risk.

Conclusion

This study was the first substantial attempt to establish a profile of the voluntary organisations engaged in the provision of services for the elderly at community level in the Republic of Ireland, to make an estimate of the contribution they make and to examine their current partnership arrangements with the statutory sector. About half of the 868 organisations who provided information engage in the provision of at least one kind of maintenance service, whether day centre based, domiciliary, or housing, in addition to intermediate supportive services,

those which are social supportive in nature or consist of material aid. While the number of elderly persons in receipt of these services is substantial, it represents a small proportion only of the elderly population. Given the limited resources of voluntary organisations, the pivotal role they play in the provision of these services, and the expected increase in the number of persons who will require these services, increased support for the voluntary sector is required.

Despite the substantial contribution being made by voluntary organisations there is little evidence that other than a minority of them are engaged in the planning of services with the statutory authorities or are otherwise engaged in significant relationships with them, moreover, recommendations have been made in *The Years Ahead* for their engagement in such activities and for their unequivocal support by statutory authorities. It is a matter for concern that more considerable progress in these respects cannot be reported.

It is argued here that before partnership arrangements can be expected to develop some more fundamental steps have to be taken. Provision of the services with which this study is primarily concerned, the services which are designed to maintain the independence of the elderly and provide a decent alternative to institutional care are provided in a policy vacuum. Though some significant steps were undertaken in *The Years Ahead* to redress this situation the work has not been completed. Despite the acknowledged important role of these services — the community based supportive services have not been adequately defined or agreed at national level. Services of this kind are still provided on a discretionary basis and their provision is supported by discretionary funding. Whether an elderly person in need of such services receives them is dependent on the goodwill of local voluntary organisations or on the priorities of the local statutory authorities or on both.

Until these maintenance services are provided on a clear legally defined basis with supportive budgets significant partnership arrangements between the voluntary and statutory sector will not develop. There is little reason to engage in planning and partnership when everything is discretionary. Statutory organisations are not as dependent on the co-operation of voluntary organisations while these services are discretionary and the voluntary organisations do not have the support of established criteria for service provision and funding.

To address adequately the current policy vacuum the Department of Health, health boards and the other relevant statutory bodies may require to reassess their belief in the need for and value of community based services for the elderly. Despite the considerable amount of money provided to voluntary organisations by statutory bodies practice to date

suggests that their conviction regarding the need for and value of such services is limited. This raises a suspicion that the emphasis given to community care of the elderly is a kind of opting out, an excuse for not providing alternative care. This may be based on the unspoken belief that responsibility for the care of the elderly lies elsewhere, perhaps together with the untested assumption that the necessary care is being provided by others. In order to undertake their reassessment it may be necessary for the authorities concerned to make a formal study of the needs of the elderly.

Having made their reassessment, and if they find that community based services have a worthwhile role the authorities responsible must decide what services should be accorded priority and what standards, including criteria for eligibility, they should conform to. Furthermore, they must then decide what role is required of voluntary organisations in the provision of such services. This role will indicate the nature of the partnership and funding arrangements required. The considerations guiding these deliberations must be support for and welfare of the elderly and the contribution of either the statutory or voluntary sector must be addressed with that objective in mind.

The eradication of this policy vacuum will provide a necessary condition though not a sufficient condition for the development of partnership. The development of partnership will require a long learning process and significant changes in both the administrative system and the voluntary sector; the difficulties arising from the lack of a participatory ethos in the Irish administrative system have been noted above. The statutory sector and health boards in particular will have to adopt a developmental role consistent with the developmental pluralism model within the context of welfare pluralism. The voluntary sector will have to co-operate in the development of the necessary representational structures. Organisational adaptation will be required to integrate the voluntary and statutory contribution at district, regional and national level.

References

[1] *The Care of the Aged* — report of an Inter Departmental Committee. Stationery Office. Dublin. 1968. p. 13

[2] Southern Health Board. *A Framework For Caring: A Review of Voluntary Organisations in the Southern Health Board Region.* Southern Health Board. 1992.

[3] *Report of the Commission on Health Funding.* Department of Health. Dublin. 1989.

[4] Dublin Hospitals Initiative Group. *Second Report.* Dublin. 1990.

[5] *The Years Ahead — A Policy for the Elderly.* Report of the working party on services for the elderly.. Stationary Office. Dublin. 1988. p. 25

[6] *The Years Ahead, op. cit.* p. 169 — 170.

[7] *The Years Ahead, op. cit.* p. 222
[8] *The Years Ahead, op. cit.* p.5
[9] *The Years Ahead, op. cit.* p. 171
[10] *The Years Ahead, op. cit.* p. 25-26
[11] *The Years Ahead, op. cit.* p. 11
[12] Browne, M., *Co-ordinating Services for the Elderly at Local Level*: *Swimming Against the Tide,* National Council for the Elderly, Dublin, 1992. p. 189

APPENDIX ONE

Outline of Questionnaire Design

1. Organisational details.
2. Organisational Objectives.
3. Nature of organisation.
4. Clients served.
5. Services provided.
6. Extent of service provision.
7. Frequency of service provision.
8. Number of volunteers.
9. Tasks of volunteers.
10. Full-time staff.
11. Part-time staff.
12. People on FAS courses.
13. Other staff.
14. Availability of offices.
15. Nature of tenure.
16. Adequacy of offices.
17. Other premises available.
18. Funding sources.
19. Distribution of funding.
20. New applications for funding.
21. Use of funding.
22. Fund-raising.
23. Sponsorship.
24. Outstanding loans.
25. Budgeting.
26. Responsibility for budget.
27. Size of budget.
28. Health board funding.
29. Housing authority funding.
30. Conditions attached to statutory funding.
31. Payment of grants.
32. Other assistance from statutory agencies.
33. Committee structure.
34. Health board representation on committee.

had been detected as a result of ongoing enquiries so that altogether a further 1,182 questionnaires were dispatched. On this occasion 255 organisations returned questionnaires and a further 301 were discovered to be not applicable or duplications; 12 refusals were encountered. After the questionnaires were dispatched all of the organisations were contacted personally. Reminder letters were also sent on this occasion and duplicate questionnaires were sent to about 100 organisations. The response rate to this stage of the survey was 29 per cent:

(i) Questionnaires dispatched	1,182
(ii) Less duplications/not applicable	301
(iii) (i)-(ii) = valid population	881
(iv) Refusals	12
(v) Questionnaires Returned	255
(vi) Response Rate (v/iii) = 255/881 =	28.9%

Overall Response Rate

This second stage of the survey resulted in a substantial improvement in the overall response rate increasing it to 59 per cent:

(i) Organisations to whom questionnaires were sent		2,442
(ii) Less duplications/not applicable	*Stage 1*	563
	Stage 2	301
		864
(iii) (i)-(ii) = valid population		1,578
(iv) Refusals	*Stage 1*	15
	Stage 2	12
(v) Questionnaires returned	*Stage 1*	682
	Stage 2	255
		937
(vi) Response rate — (v/iii) = 937/1,578 =		59.4%

Completed questionnaires were not received from 614 organisations despite extensive personal contact. In the course of enquiries it emerged that many organisations who had in their opinion a marginal involvement with the elderly only expressed a disinclination to complete the questionnaire. Questions about finances generated deep concern in others

despite numerous efforts to reassure then regarding the confidentiality of the study. In some cases uncertainty about what members of the organisations should complete the questionnaire or rapid turnover of committee members may have prevented a positive result. It should be noted that the number of duplications detected or organisations discovered to be not applicable, 864, was almost as great as the total number of responses (937) and refusals received (27). If the proportion of duplications/not applicable was similar among the 614 organisations outstanding the response rate would be substantially more, 290 or 47 per cent of them would be invalid. This would result in a response rate of 73.0 per cent as follows:

(i)	Total questionnaires distributed	2,442
(ii)	Less duplications/not applicable (864+290)	1,154
(iii)	(i)-(ii) = valid population	1,288
(iv)	Questionnaires returned	937
(v)	Response rate = (iv/iii) = 937/1,283 =	73%

APPENDIX THREE

Note on Factor Analysis

The factor analysis was focused on the 24 services listed in Question 9 (see questionnaire). The principal components analysis extracted six factors. The six factors, together with their eigenvalues and percentage of variance accounted for were as follows:

Factor	Eigenvalue	Percentage of variance	Cumulative percentage
1	5.970	24.9	24.9
2	2.659	11.1	36.0
3	1.632	6.8	42.8
4	1.506	6.3	49.0
5	1.272	5.3	54.3
6	1.088	4.5	58.9

The rotated factor matrix was as follows:

Rotated Factor Matrix

	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6
DP	.103	.743	.026	.235	.127	.023
OS	.069	.765	.018	.193	.048	.027
LS	.191	.356	.309	.499	.004	.180
PA	.201	.229	.523	.124	.108	.348
OT	.025	.781	.136	.100	.150	.087
HN	.066	.163	.346	.339	.334	.372
PH	.043	.638	.255	.095	.184	.159
BS	.214	.058	.768	.148	.054.	108
WS	.000	.072	.775	.073	.098	.009
HR	.614	.120	.287	.236	.057	.175
CH	.089	.545	.030	.255	.083	.397
HH	.238	.053	.097	.615	.239	.409
VE	.727	.031	.059	.095	.048	.317
VL	.669	.090	.061	.106	.004	.304
MC	.104	.616	.039	.436	.039	.197
MH	.150	.160	.023	.734	.036	.139
AI	.638	.214	.084	.034	.265	.063
FS	.762	.024	.110	.089	.016	.146
MA	.776	.100	.161	.136	.052	.000
TR	.504	.447	.015	.009	.090	.181
SU	.269	.004	.006	.057	.093	.628
CS	.175	.179	.052	.021	.791	.035
SC	.120	.124	.104	.175	.773	.120
SE	.196	.263	.084	.109	-.370	.333

Key to Table

DP	**Day care centre providing personal & social services**
DS	**Day centre providing social & recreational activities**
LS	**Laundry service**
PA	**Provision of physical aids/alarms**
OT	**Occupational Therapy**
HN	**Home Nursing Service**
PH	**Physiotherapy**
BS	**Building and provision of special sheltered housing**
WS	**Warden and supervisory service for sheltered housing**
HR	**Housing repairs/improvements/adaptions**
CH	**Chiropody**
HH	**Home Helps**
VE	**Visiting elderly at home**
VL	**Visiting elderly in hospital**
MC	**Meals-on-Wheels provided by day centre**
MH	**Meals-on-Wheels delivered to person's home**
AI	**Advice/information**
FS	**Financial support**
MA	**Material aid (e.g., clothes, fuel)**
TR	**Transport**
SU	**Surveillance (e.g.. Community Alter, Neighbourhood Watch)**
CS	**Carer support group service**
SC	**Services for carers e.g., sitting at home, respite care**
SE	**Social events (e.g., outings, parties)**

Each of the following factor groupings (scales) were tested for mobility:

Group 1

Housing repairs/improvements
Visiting at home
Visiting in hospital
Advice/information
Financial support
Material aid
Transport

Group 2

Day care centre — personal and social services
Day centre — social and recreational services
Occupational therapy
Physiotherapy
Chiropody
Day care centre — meals-on-wheels

Group 3

Physical aids/alarms
Building and housing provision
Warden and supervisory service

Group 4

Laundry service
Home helps
Home: meals-on-wheels

Group 5

Carer support group
Services for carers

Group 6

Home nursing service
Surveillance

The reliability (alpha) scores for the above scales were as follows:—

1	0.813
2	0.784
3	0.564
4	0.551
5	-0.053
6	0.114

APPENDIX FOUR

A Comparison of The Southern Health Board's List of Grants and Reported Funding

After stage one of the survey a comparison was made of the organisations in receipt of grants from the Southern Health Board and the organisations in the Southern Health Board area reporting the receipt of grants in the survey.

At that time 108 organisations in the Southern Health Board area had responded to the survey; subsequently 37 more did. However the exercise reported here is limited to the 108 organisations from whom replies had been received at that stage. The purpose of this exercise was to check the comprehensiveness and accuracy of financial information supplied by the voluntary organisations. Doubts about the comprehensiveness of the financial information supplied had arisen because of a reluctance expressed by some organisations to provide what they considered was very confidential information and because, though in many cases receipt of grants was acknowledged, there was some confusion in identifying the legislative mechanism for such grant provision as required by some of the questions in the questionnaire.

One hundred and twenty grant recipients are included in the SHB list. Fifty two of the organisations in the Southern Health Board area that returned questionnaires are included in the SHB list; grant related information on these 52 questionnaires is compared with the information contained in the SHB list.

The first and most comprehensive question in the questionnaire dealing with funding was Question 29, "For the last complete year: please list the sources of funding which are used to finance the organisation". In 1990, 49 of the 52 organisations received grants under Section 65 of the 1953 Health Act according to the SHB list. Forty three of the 49 listed indicated that statutory grants are sources of funding for their organisation in reply to Question 29; the other six did not answer the relevant part of Question 29.

According to the SHB list, four of the 52 organisations received National Lottery grants in 1990; three of these, according to the SHB list, received no grant under Section 65 of the 1953 Health Act. These three did not answer the relevant part of Question 29, thus giving no indication that lottery grants are sources of funding for their organisations. However, apparently in error, one of the three indicated that statutory grants are sources of funding for their organisation. The organisation listed as having received Section 65 and National Lottery grants in 1990 indicated that both statutory and National Lottery grants are sources of funding.

One of the more detailed questions on sources of statutory funding was Question 42(a) "Does your organisation — receive funding from the health board under Section 65 of the 1953 Health Act?" Thirty organisations indicated they receive such funding, 18 supplied no answers and one indicated that such grants are not received. As noted above, according to the SHB list, 49 organisations receive such funding.

One organisation, listed by the SHB as receiving National Lottery grants only, indicated that Section 65 funding is received.

An examination of a sample of questionnaires (18) returned by organisations not included in the SHB list revealed the following: in response to Question 29, two indicated that (for the last complete year) statutory grants are sources of funding, 15 supplied no answer and one stated no. In response to Question 42 (a) two indicated that Section 65 grants are received, nine indicated they are not and seven gave no reply.

Twenty five of the 52 organisations that returned questionnaires and are included in the SHB list provided information on the amount of money received from the SHB either in the questionnaire, in an attached balance sheet, or on both. In 15 cases the amount listed by the SHB as a Section 65 grant was identical to the amount stated in the questionnaire. In three cases, the amount stated in the questionnaire was less than listed by the SHB; the differences were small; £353 V £400, £525 V £700 and £675 V £700. Moreover, the years identified in the balance sheets were not identical with the financial year or the calender year of 1990. In the remaining seven cases the amounts stated in the questionnaires were greater than those recorded in the SHB list, in four cases substantially greater, at least double the amount stated in the list. A total of £22,129 is stated in respect of these four organisations in the questionnaires, compared with £3,300 in the SHB list. The payment of money on some basis other than Section 65 may account for this discrepancy.

Taking into account that "the last complete year", referred to in Question 29, is defined by the respondent and so may not coincide with the

year as defined by the SHB, the level of agreement, 88 per cent, between the SHB list of Section 65 grant recipients and the replies to Question 29 regarding statutory grants being used must be viewed favourably. The underestimation of organisations availing of statutory grants is more than balanced by organisations claiming statutory grants are used for funding that do not appear on the SHB list, two of 18, 11 per cent.

The larger discrepancy between the numbers acknowledging receipt of Section 65 grants and the SHB list of recipients may arise for a number of reasons including:—

(i) Respondents, though aware of contributions from the health board may not know what act authorises such funding. It should be noted that those persons completing the questionnaires may not have been those most familiar with financial matters.

(ii) Some confusion may have arisen due to the inadvertent inclusion of the words "if yes" between Questions 41 and 42 (a) in the questionnaire and may have reduced the number of responses to this question.

APPENDIX FIVE

TABLE A 1.:1 Ago composition of population by county

Health Board	County	Age Group				
		0-24 %	25-44 %	45-54 %	55-64 %	65 + %
National average		44.4	26.9	9.7	7.8	11.2
Eastern	Dublin	44.4	28.6	9.9	7.7	9.4
	Kildare	48.0	30.3	9.1	5.5	7.1
	Wicklow	44.9	28.1	10.0	7.1	9.9
Southern	Cork	44.0	26.8	9.8	8.0	11.4
	Kerry	41.5	25.6	9.9	8.5	14.5
South Eastern	Carlow	46.2	26.4	9.2	7.8	10.4
	Kilkenny	44.0	26.8	9.6	7.9	11.7
	Tipp.S/R	43.5	26.2	9.4	8.5	12.4
	Waterford	44.6	26.3	10.0	8.1	11.0
	Wexford	44.7	26.0	9.9	8.0	11.4
Mid-Western	Clare	43.1	26.5	10.0	8.1	12.3
	Limerick	45.1	26.7	9.7	7.8	10.7
	Tipp.N/R	43.5	25.1	9.8	8.8	12.8
North Eastern	Louth	45.7	26.7	9.8	7.4	10.4
	Meath	46.5	27.8	9.5	6.9	9.3
	Cavan	42.5	25.0	9.0	9.0	14.5
	Monaghan	44.5	25.5	9.1	8.3	12.6
Western	Galway	44.9	25.7	9.4	7.6	12.4
	Mayo	41.8	24.0	9.4	8.6	16.2
	Roscommon	40.5	23.8	9.6	9.7	16.4
Midland	Laois	45.0	26.1	9.1	8.1	11.7
	Longford	43.7	24.8	9.2	8.6	13.7
	Offaly	45.8	25.4	9.3	8.0	11.5
	Westmeath	45.2	26.1	9.3	8.1	11.3
North Western	Donegal	45.1	24.2	9.4	7.8	13.5
	Leitrim	38.6	23.7	9.8	9.6	18.3
	Sligo	42.0	25.8	9.4	8.5	14.3

TABLE A 3.1 Year organisation established (Q.4)

Year	Number	Per cent
1900 or earlier	27	3
1901-1967	144	17
1968-1990	540	62
In last year	18	2
No answer	140	16
Total	868	100

TABLE A 3.2 **Status of organisation (Q.5)**

Status	Number	Per cent
Registered and incorporated	166	19
Registered	149	17
Incorporated	84	10
Neither of these	299	34
No answer	170	20
Total	868	100

TABLE A 3.3 **Affiliation of organisation (Q.6(b»**

Status	Number	Per cent
Branch	286	40 (n=713)
Affiliate	211	35 (n=607)
Branch or affiliate or both	410	48 (n=863)
Neither of these	453	52 (n=863)

TABLE A 3.4 Time given by volunteers (Q.13(b))

Time	Number	Per cent
Less than 5 hours weekly	343	40
5-10 hours weekly	42	5
10-19 hours weekly	12	1
20 or more hours weekly	11	1
When needed	9	1
Annually	3	—
Varies	32	4
Other	71	8
No answer	345	40
Total	868	100

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2. *Retirement: A General Review,* December 1982
3. *First Annual Report,* December 1982
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