

Research Article

Older People's Understandings and Experiences of Using Health and Social Care Services under COVID-19 Lockdown Restrictions in Aotearoa, New Zealand

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Internationally, the COVID-19 pandemic resulted in changes to services as governments funneled health-related funding and resources into stopping the spread of COVID-19. At the same time, older people were singled out as an “at-risk” group, which prompted caution from both older people and governments to limit their exposure to COVID-19. It remains unclear what the impact this has had on older people’s routine health and social care access, and how older people themselves viewed these changes. This analysis investigates older people’s understanding and experiences of using health and social care services under the COVID-19 lockdown restrictions in 2020. This analysis draws from a wider, letter-writing study that received 748 letters from 854 participants aged 70 years and older who were living in New Zealand during the COVID-19 lockdowns. Just over half of letter writers described access to health and social care services. Informed by Penchansky and Thomas’ 5 A’s of the access framework, we conducted a thematic analysis of this subsample of letters ($n = 404$). This analysis identified four broad categories relating to access to health and social care services under COVID-19 lockdown restrictions: (a) the system-wide strangeness of physically accessing services, (b) accommodation of services, (c) availability of resources and personnel, and (d) enhanced quality of those included by services. Rather than passively accepting changes, older people adapted to restrictions by drawing on their available materials and social resources. We conclude this analysis with suggestions for improving future interventions and policies to better older people’s access to health and social care during times of crisis.

1. Introduction

Internationally, the COVID-19 pandemic resulted in changes to services as governments funneled health-related funding and resources into stopping the spread of COVID-19 [1]. From the beginning, older people were singled out as an “at-risk” group, which prompted caution from both older people and governments to limit their exposure to COVID-19 [2]. While in theory, this could have increased older people’s access to resources, there is early evidence that older people experienced discrimination and

disadvantage when accessing health and social care during this period. For example, in the United Kingdom (UK) and South Africa, the high demand for respiratory support systems during the pandemic disadvantaged older people who disproportionately required respiratory support [3], while Italy had age-based cut-offs for ICU admissions [4]. Some scholars in the UK also felt the mass labelling of older people as “frail” and “at risk” masked the work that they did during the pandemic as volunteers and healthcare professionals, rendering their significant efforts invisible [5]. There is also evidence that the differential access came from

older people's reluctance to engage with services during this period, for various reasons. A quantitative study from central and eastern Europe showed that older people with comorbidities were fearful and avoidant of accessing healthcare services during the pandemic possibly due to early evidence of their higher risk of mortality and morbidity if they contracted the virus [6].

Other qualitative research considered how older people may have been resistant to Telehealth measures aimed at improving their access to services [7–9].

Access to services under COVID-19 restrictions matters because older people worldwide tend to have *disadvantaged* access to health and social care services even prior to the pandemic [10]. Disadvantage relates to the ways that health and social care services operate in a way that privileges younger populations, for example, by focusing on curative, rather than recovery and long-term, care [11].

Older people also tend to have complex health and social needs that do not neatly align with one system due to various challenges. Evidence has indicated that older people tend to utilize a patchwork of services to meet their health needs including, nongovernment organizations (NGOs), retirement villages [12], and churches as well as more standard forms of care such as general practices and social services. In the COVID-19 context, these community groups and organizations were often the first to close [13]. However, it is important to note that disadvantaged access does not affect older people equally as chronological age alone does not determine health and functionality, but rather it involves a complex interplay with other identity characteristics (ethnicity, gender, ability, etc.), which mediate access to health-promoting resources and lifestyles [14]. What someone may need/expect from services, others may not. Creating policies while assuming a direct relationship between the age and functionality may only cause greater disparities in health outcomes. For example, in the NZ context, research has found that Māori and Pacific under 70 had a greater likelihood of COVID-19 hospitalization and death due to the virus than white NZers over 70, although this was often overlooked given the focus on older age and risk [15]. Given that equity has become a central aspect of the COVID-19 response [16], it is fundamental to understand how a diverse range of older people's access changed during the COVID-19 pandemic.

This paper adds to the pool of literature, which explores the experiences of older people in accessing health and social care services under the COVID-19 lockdown restrictions while delving into the specific barriers to their access and how they coped. We also problematize the understanding of "access" from understandings offered by older people.

1.1. Context. This paper looks specifically at older New Zealander's access to health and social care services during the COVID-19 lockdowns. New Zealand (NZ) is an interesting case study as the country, similar to other countries, has an aging population and is estimated to have approximately one million people aged 65 years and above by 2028 [17]. NZ currently has a broadly socialized medical

system that offers a range of state and privately provided health and social care [18]. The nation's COVID-19 public health response saw a massive adjustment of its health and social care system to pre-emptively stop the wider health system from being overwhelmed [13, 19]. The NZ lockdown period used a four-level alert system guided by an age-based approach (see Figure 1) [13]. This included restrictions on the number of visitors in hospitals, minimizing everyday movement and contact, and halting the operation of non-essential services [13]. A handful of studies have discussed older people's experiences dealing with a lag time in accessing healthcare [20] and problems with waiting in long queues [21]. Common disadvantages older people experience include having coexisting health problems, having low social support, and low or lack of sufficient income [22]. However, these are not solely caused by old age; confounding factors and systematic issues contribute to these.

NZ had relatively low numbers of cases of COVID-19 compared to other countries, which meant that the healthcare system was under less catastrophic circumstances than other nations. Nevertheless, NZ was in a crisis mode, preparing and dealing with the pressure of controlling the spread of COVID-19. There is evidence that these restrictions reduced access to services in the general population. NZ general practitioners reported reduced rapport and engagement from patients [23], especially when using Telehealth, which complicated diagnosis and treatment [24]. Concerns were also raised about the impact on non-COVID-19 health and social care services. Evidence from NZ-based primary healthcare professionals suggests that publicizing how COVID-19 disproportionately affected older people had the unintended effect of discouraging them from accessing healthcare services [24]. Social activities were also restricted, and people were advised against going to community centres, including places of worship [13]. Little is known about the impact of these restrictions on older people's service use, especially during the COVID-19 lockdown period, and is something this study hopes to add to the literature.

1.2. Aim. To explore the understanding and experiences of older people using health and social care services under the COVID-19 lockdown restrictions in Aotearoa, NZ.

2. Materials and Methods

2.1. Theoretical Framework. This study uses Penchansky and Thomas' framework to understand older people's access to health and social care services in general in NZ. Penchansky and Thomas 5 A's of service access suggest that access is about the fit between what a client needs or expects, and how a service can provide this [25]. They elaborate on previous researcher's thinking, where access was merely about providing healthcare services for people [25]. They grouped a more elaborate set of characteristics into 5 A's—accessibility, accommodation, availability, affordability, and acceptability. Accessibility is about physically being able to go to health and social care services. Accommodation

- Maintain a 1-metre distance from others
- Stay at home in your bubble
- Travel only for necessities or for safe, recreational activities. Border measures are in place and travel can only be permitted in special cases
- Work and learn at home
- No gatherings. All public and education facilities close
- Bubbles can only extend if you are an Alert Level 4 business or service and have no childcare options. A carer may join your bubble
- Only essential businesses (e.g. supermarkets, pharmacies, petrol stations, lifeline utilities) can open
- Wear a face mask whenever you leave the house
- Rationing supplied, requisitioning of facilities and reprioritising health care services is possible
- Household members or those in the same bubble can view/accompany the deceased in a funeral home, cemetery or faith-based institution subject to strict conditions.

FIGURE 1: Alert level 4/lockdown restrictions adapted from the New Zealand COVID-19 website.

is how the operation of health and social care services meets clients' preferences and needs. Availability is about services having enough resources and personnel to meet the demands and needs of clients. Affordability is about how the price of services relates to what people are willing to and can afford to pay. Acceptability is about the client's attitudes towards the service's personal characteristics. This includes the characteristics of a clinician such as gender, age, and ethnicity, as well as the neighbourhood of the service's location. The clinician's attitudes towards a client's personal characteristics are also considered [25]. Altogether, these five pillars are essential for successfully using health and social care services. Multiple studies have applied this framework to specific health issues during the COVID-19 pandemic, such as access to vaccines [26, 27], Telehealth [28], and COVID-19 treatment [27, 29, 30]. Less research has been conducted holistically on older people's views of their general access to health and social care during the pandemic.

2.2. Qualitative Approach: Letter Writing Method. This study is based on a wider research project, "Have Our Say," which elicited letters from people 70 and over about their experiences of the COVID-19 pandemic and resulting lockdowns in NZ. The University of Auckland's School of Nursing Te Ārai Palliative Care and End of Life research group conducted this qualitative study. Ethical approval was granted through the University of Auckland Human Participants Ethics Committee (Reference No. 024568). Collecting letters via e-mail or post is advantageous as it gives people a choice on how to express their experiences [31]. Letter writing is a suitable method for working with older people because it is a familiar method of communication [32]. Letter writing allows researchers to access people across a wide geographical location and those who may be hard to reach [33]. The anonymity that letter writing provides also enables participants to reveal thoughts and feelings that they may not easily express in face-to-face interviews [32]. To support high-quality qualitative research, this study follows SRQR guidelines [34].

2.3. Sampling Strategy. We selected a convenience sampling strategy. Eligible older adults included those who were aged 70 and over and willing to write us a letter. Although the researchers acknowledge that age is a social construct, this was chosen to reflect the group that many governments deemed as "at risk" and "vulnerable" during the COVID-19 pandemic, resulting in this group experiencing similar restrictions [35]. While aging is a biological process, the terms "old" and "young" are created by society and can change depending on culture or community [36]. Such terms say little about one's physical abilities or functionality [37]. Recruitment was supported by media outlets such as social media, Radio NZ, newsletter agencies, and community radio, which helped distribute the study advertisement. The University of the Third Age (U3A) groups, The Auckland War Memorial Museum, and word-of-mouth also assisted with advertising. This helped ensure that we represented a wide variety of older people in NZ—such as those living rurally and in urban areas.

2.4. Data Collection and Instruments. Participants were invited to write letters about their COVID-19 experience using mail, e-mail, or a Qualtrics online survey using a free-text dialogue box with prompts. They were asked to express their personal experiences of the COVID-19 pandemic and lockdowns in an open-ended letter format (see prompts in Appendix A). Qualtrics also had a direct question regarding health services. Those who provided their contact details were sent a thank-you letter for their participation. Data collection commenced on June 1, 2020, and lasted until June 8, 2021. Most letters were received in the first three months of the data collection phase, with many being written about the lockdown in March-May. The whole of NZ had another lockdown on August 12, 2020, lasting until September 23, 2020, which did not directly affect data collection but resulted in some participants expressing their experiences of lockdown based on this time as well.

Overall, 854 participants aged 70 years and over were included and produced 748 letters. The average age of participants was 77 years and ranged from 70 to 94 years. 67% of participants were female, 29% were male, and 3% did not disclose their gender. 51% of participants identified as NZ European, 45% did not disclose their ethnicity, and 8 people identified as Māori, 4 as Asian, 1 as Pacific, and 3% as Other. A third of the letters were received from Auckland.

2.5. Data Processing. To begin, letters were imported to the data management software NVivo12. A sample of 50 articles was randomly selected by the research team to create a provisional indexing framework of broad categories such as health and social support. Two analysts initially read and coded every letter based on the indexing framework created in NVivo. Letters mentioning health and social care services, and other synonyms relating to these, were further sorted into the categories: health systems, NGOs, and retirement villages. As we hand-searched each letter rather than using search terms, we were able to capture synonyms, for example, where specific organizations were named. To support the trustworthiness of the analysis, a third analyst then read through the categories for quality assurance. This analysis combines all excerpts that mention health and social systems, NGOs, and retirement villages into this analysis as the literature suggests that older people have complex health and social needs which include a range of different organizations [38].

2.6. Data Analysis. A thematic analysis was applied to a subsection of 404 letter, which mentioned health and/or social care services. A thematic analysis was selected as it is a flexible, inductive research approach aiming to identify themes, conceptualized as “patterns of shared meaning, cohering around a central concept” [39] (p. 4). Themes were identified through a process of data familiarization, coding, category development and clustering, and revision (McDermid et al., 2020). A thematic analysis required a critical reflection from analysts on their position in producing knowledge (McDermid et al., 2020). To support the trustworthiness of the analysis, the lead analyst reflected on her position as a young and healthy nursing student who has had minimal interaction with health and social care services from a consumer’s point of view. Rigour and reflexivity were further ensured by multiple analysts refining each other’s interpretations through frequent analysis meetings. Any tensions were resolved through wider team discussions. Through this process, we identified three main themes: (a) barriers to health and social care service use, (b) improved quality and/or quantity of care received, and (c) adapting to COVID-19 lockdown restrictions. To illustrate themes and give context, participants’ quotes are presented with age, gender, and ethnicity of the writer (if available). Participants’ names are also excluded for anonymity.

3. Results

Of the 748 letters received, 404 (54%) mentioned “health and social care services.” We identified a variety of experiences

relating to older people’s access to services. We identified that for some participants, access to services became more difficult, but they could still engage with services. Others experienced a completely diminished access to services, and some found the changes strange, but their access to services was not necessarily impeded. Barriers to access included (a) the system-wide strangeness of physical accessibility, (b) accommodation of services, and (c) availability of resources and personnel. Those who were able to overcome service barriers felt that they received (d) an enhanced quality and/or quantity of care.

3.1. System-Wide Strangeness of Physical Accessibility. Many letter writers discussed the strangeness of physical accessibility, the uncanny experiences they had and the observations they made when accessing services. Even if this did not prevent access, it did impact their perceptions and experiences of health and social care. *“I caught a train and bus last week, as I was due for a routine blood test, and found the signs telling me where to sit or not sit totally fascinating”* (E0110, 78, NZ/European, Female).

Social distancing rules meant that it took extra time and effort for people to engage with services due to the physical restrictions people had to adhere to. Thus, initially getting to and using services was made harder: *“Blood tests were required, which meant standing outside 2 metres apart. As there were many people ahead of her this took a long time. . . In normal times, these things could have been completed quickly. . . These were not normal times”* (E0025, Early 70s, Male).

The difficulty in accessing pharmacies was a fragment topic in the data, suggesting that this is one of the healthcare services that most impacted older people under restrictions: *“It took the poor assistant ages to find my prescription. . . Their normal efficient service could simply not cope with the volume of customers. . .”* (E0015, 80, Female).

Many letters also discussed the flu vaccine. This was advertised by the government as particularly beneficial for older people during the pandemic. Older people found that physically getting it required taking unusual steps: *“I had my name down at the chemist and the doctors. . . We stood at an outside door while it was administered and we sat outside in the carpark on chairs while we waited for the required 10 minutes, all set out at 2 metres”* (E0055, 71, Female).

Rest home residents tended to only mention accessing services inside their village. When they did leave their villages, letter writers described the additional hygiene procedures put in place, which did not necessarily affect the service’s accessibility, but added another layer to access: *“I went for a regular treatment to the hospital. The manager took me in the back of the 10 seat van-he was masked and gloved as was I. When I got home 4 hrs later I was in full isolation for 2 weeks. I didn’t get to talk to anyone. . .”* (Q0218, 72, NZ/European, Female).

Unfortunately, people already affiliated with in-home support services pre-lockdown could not access the same quality of care they used to receive before the COVID-19 restrictions: *“My home help provider made no contact at all*

though they did deliver a 'hygiene' package when we came down to level 2" (E0178, 80, Female). This led to worry and distress: "Mainly because [provider]... treated me and, as I later discovered, many other clients with complete disregard and heartlessness. That has been distressing" (E0022, 73, NZ/European, Female). In the worst cases, the lack of support, particularly for those with existing health conditions, hindered their physical recovery and contributed to stress and distress: "My husband was admitted to [provider] Hospital two days after it commenced. . . I was not allowed to visit and, due to his ill health, he was unable to talk on the phone or read the emails I sent. His mental health deteriorated so much that, at the time he was transferred to Hospice [name], I had never seen him in such a state both emotionally, mentally and physically. It was agreed, by the professionals that, if he had been allowed to experience the ongoing love and support I could have given, he would have had contentment in his life while coping with his illnesses" (E0269, Female).

3.2. Accommodating Changes to Care. Overall, participants felt services were not as accommodating as they hoped but that this was understandable given the circumstances. Perhaps in order to cope, older people themselves were accommodating and adjusted their needs. One participant who described the process of getting the flu vaccine also alluded to the issues with requiring technology to access health and social care services, highlighting how not all approaches by the government were accommodating for people without the means or resources: "I had been informed that I should park outside and phone to let the nurses know I was there, then wait in my car. I wondered what anyone without a phone would do?" (E0285, 90, Female). The inability to do effective physical assessments over Telehealth also meant that services could not accommodate everyone's diagnostic needs "Some things require hands-on attention, a phone call won't do it!" (Q0195, 72, NZ/European, Female).

Some discussed the unconventional process of receiving medical attention when appointments were not face-to-face, often making such interactions uncomfortable: ". . . here I am taking a photo of this foot to send to my doctor. . . He was in full PPE gear and my foot was stuck out the car door. A unique way to have a doctors appointment. . ." (E0290, 79, Female). This participant also highlighted how services adapted as best they could, and healthcare professionals also had to work in unaccommodating environments themselves.

Where services could not accommodate the needs of letter writers, participants themselves commented on how they played a role in ensuring a smooth operation. One participant explained how people in retirement villages took it upon themselves to take extra safety measures: "From then on we worked within the rules of the Village, which were stricter than the government. We met with family at the gate, keeping our distance" (Q0037, 74, NZ/European, Female). The strict rules also meant that some people decreased their own needs to accommodate for the restrictions: "We felt pressured both by other residents' relations and by management not to go outside after a while" (E0046, 72, NZ/European, Female).

Often, participants identified problems with the changes and what did not work for them and then followed this with ways they had sought to solve or redress them, usually with support from family and friends: "My wife had to visit the doctor on my behalf and later go to the pharmacist to collect a prescription. . ." (E0171, 72 & <70, Male & Female). Some participants shared that they took on the responsibility of supporting the needs of their spouses or friends, adding to the narrative of older people helping each other: "If I was not around he would be in hospital-level care" (E0125, 72, Female).

Some letter writers minimized the severity of the situation, as one participant wrote "It wasn't nearly as bad as the media portrayed" (Q0304, 73, NZ/European, Female), while another compared their health issues with others: "Mine have proved relatively easy to cope with" (Q0243, 79, NZ/European, Male).

3.3. Availability of Resources and Personnel. Many people discussed the lack of personnel and resources for nonurgent or non-COVID-19-related issues. The redistributing of personnel and resources meant that many hospital wards were converted and reserved for COVID-19 patients. A participant noted the realistic consequence of not receiving treatment when needed: "I feel that it was a shame that the hospitals sat empty for a month or more waiting for the influx of Corona virus patients when there were people waiting for critical surgery that may have in some instances resulted in their bereavement. . ." (E0253, 74, Male).

Some participants were also puzzled at the lack of staff available, making it hard to receive care: "The Hospitals and Doctors were virtually inaccessible and pharmacies an unusual experience. . ." (Q0194, 72, NZ/European, Female).

Despite being advised by the government to receive the flu vaccine, letter writers found few available. One participant described: "We tried to get flu jabs from the [local] Medical Centre. . . but were told there were no more slots available. . . When we phoned again a couple of days ago, we were told they have now run out of vaccine. . ." (E0068, 70, Female). The same was found with PPE gear, which made it hard to access services in a safe-manner: "Level 4 meant I still had my 2 carers—using hand sanitizer/gloves provided by HealthcareNZ. Masks were not provided until much later—and sanitizer was rationed. PPE was not available. . ." (E0123, 71, NZ/European, Female). This was a big issue for healthcare workers in the community as the funding and reserved stocks for PPE were for hospital use only.

3.4. Improved Quality and/or Quantity of Care Received. Even so, some letter writers also claimed that they were given an improved quality of care and kindness above that typically provided by health and social care providers they were able to see. For example, ". . . the Doctors at the Hospice made the decisions regarding [partner] drug regime and then contact us back and at one time the [local] Pharmacist delivered the required drugs to our home. . . This was service above and beyond and truly kind" (Q0381, 76, NZ/European, Female).

The extra restrictions placed by retirement villages were generally viewed with appreciation.

Many were grateful that villages took extra measures to keep residents safe and expressed feelings of security: "... living in a retirement village and the operator was quick to provide a high degree of isolation... The up-side of that arrangement is that we did not feel threatened by virus" (Q0097, NZ/European, Male).

Participants affiliated with churches, NGOs, and retirement villages discussed their communities rallying together. Thus, the improved quality and quantity of care stemmed from community support. For example, "... our Church (Henderson Methodist) kept in touch each week and although we did not require additional support the offer was always there should the need have arisen" (E0222, 82 & 77, Male & Female). NGOs offered support even when they were not actively sought out: "There were many phone calls to us from entities and organisations wishing us well and offering assistance. We are fortunate... we did not need additional assistance..." (Q0053, NZ/European, Female). Participants from retirement villages shared how they even received extra supplies: "We were well cared for by the retirement village... they gave us all 'goodie bags' of all sorts of useful food" (E0046, 72, NZ/European, Female).

However, some were concerned about NZ's age-based approach, which assumed that an increase in the age required increased care. It created questions of deservingness. One individual claimed that age should not be an accurate marker of how health and social care services are distributed: "... I do feel that many in my age group are fitter and more active than the same age group even five or ten years ago, and the perception that we are all frail oldies is a bit unfair..." (E0220, 70 & 72, Female & Male). It led to internalized feelings of fear about their health: "I received a text from my GP today inviting 'people at risk' and ones in the older age bracket to come in for a flu jab. I have never had one... But now my head is taking me from one thought to another regarding this..." (E0068, 70, Female).

4. Discussion

Drawing on Penchansky and Thomas's 5 A's of access approach, this paper offers a conceptually useful framework for thinking about older people's access to health and social care services during the COVID-19 pandemic. While the current literature has discussed service access issues during the pandemic, it has done so in disparate ways that make it hard to understand the underlying mechanisms contributing to it and to compare it across health and social care systems. Through applying this framework, we determined that older NZers experienced service access differently, and this hinged around concerns of access, availability, and accommodation of services. We contend that by better understanding access, we can better target the causes of inequitable access during the current and future pandemics. In doing so, this analysis provides a more nuanced account of how ageism and vulnerability intersected during the pandemic than in other accounts in the literature, which tend to stress the adverse impacts [40, 41]. On one hand, ageism led older people to

internalize stigma and potentially self-restrict their access. Conversely, some experienced improved access as health and community providers responded to public health messaging.

We found that the system-wide strangeness of physically accessing services contributed to challenges in getting to services, disrupting timely and efficient care. Consistent with the literature [42], queuing for long periods was discouraging for older people, threatening their adherence to therapies. Given that older people have different functionalities/mobility, physical accessibility is important to consider when creating interventions that enhance older people's access to services. The physical accessibility of services is rarely established in the literature, apart from in the context of rural NZ [43, 44]. It would be beneficial for more research to explain the degree of difficulty older people face in physically accessing services to help health and policymakers distinguish which groups struggled the most and tailor interventions accordingly. Older people with limited mobility or who have minimal support from their family and community may require more help than those who are fully mobile and can reach out for support to access health and social services.

Consistent with the literature [4], people were concerned about staff and resource availability, leading to reduced or disrupted access to services. Many letter writers discussed issues with the availability of flu vaccines and PPE gear, both of which were advised by the government to receive and use, respectively. The Auditor-General's report on the Ministry of Health's management of PPE confirmed that there was an inadequate stock of PPE held by the district health boards [45]. This was due to using outdated population figures and basing the need for PPE on modelling that only considered hospitals and not the whole health sector [45]. This appeared to be a general concern during the pandemic, with people in the USA also struggling with shortages [46].

Older people questioning their deservingness and minimizing their needs/situation were also identified in our data. This was consistent with other research, which found that older people were reluctant to seek help for various medical conditions due to the shame of being labelled "vulnerable," and wanting independence/control [47]. This emphasizes not just how access is about the physical engagement with services but also how people are made to feel about utilizing health and social care services. This stigma is not acknowledged in Penchansky and Thomas' framework but is addressed in reconceptualizations of it. Fortney et al. [48] added a "cultural" component to their framework that addresses the provider and consumer's stigma [48]. Our analysis similarly highlights the need for greater consideration of the role of stigma, including self-stigma, in deepening our understanding of healthcare access.

We identified that participants felt a change in the quality of the in-home support services they received, emphasizing how the visibility of older people in the community and services seems to be a key mediating factor in their access. One Australian study that conducted interviews of older people and carers found that those receiving in-home help often flew under the radar of healthcare services [49]. In-

home services were also one of the groups that the government did not consider when calculating the distribution of PPE [45]. Thus, it is unsurprising that these services could not deliver the same amount of care to older people.

NZ saw relatively low numbers of COVID-19 cases during the early years of the pandemic due to the closing of the borders and the national lockdowns [50]. In contrast, countries with minimal restrictions or implemented them later on had a higher number of COVID-19 cases, which overwhelmed their healthcare system [51]. Unique findings in our study include how older people were provided with an improved quality and/or quantity of care from service providers once they gained access to services. NZ's early elimination strategy may have contributed to this [50]. This was incongruent with the literature, where some countries implementing the age-based approach found it resulted in discriminatory practices [4]. Interestingly, both our findings and the literature appeared to result from ageism. Higgs and Gilleard [37] shared the consequences of perceiving old age as a burden to the health and social care system, while our analysis exhibited that the sometimes positive consequences of assuming older people were "vulnerable." Our findings may be explained by a shift in people's attitudes towards older people during the pandemic. A NZ-based report on the impacts of COVID-19 found that media discourse heightened people's awareness of older people [52]. People became more concerned about older people's health, potentially prompting them to go out of their way to help this age group. The advantage our research offers is that it considers older people's complex feelings towards an age-based approach, which can urge future health and policymakers to create interventions that maintain older people's dignity.

Older people's adaptability and accommodation of new restrictions was another unique finding. Social cohesion was one-way communities accommodated older people and helped them adapt to restrictions. This may have been prompted by the NZ government encouraging NZers to support each other, frequently referring to the "team of five million" [53]. Political scientists Mazey and Richardson suggest that this framing exemplifies how authoritative figures can encourage people to unite [19]. Our findings were also not surprising, given how current studies show a positive correlation between age and prosociality [54, 55]. Moreover, because these government messages were for all NZers, similar adaptability and accommodation styles may have been present in younger age groups. Some older adults have also experienced historical, adverse events such as war and famine [56], and indeed, our letter writers also mentioned such a historical context as a way to make sense of their lockdown experiences, making the COVID-19 pandemic situation not too unusual for them. Our letter writers frequently identified that family and friends were their main sources of support for participants and many were older people themselves. This was incongruent with media coverage that portrayed older people as passive members of society [41], exemplifying how structural barriers have contributed to older people's vulnerability. Our study highlights how older people want to be portrayed, as helpful, contributing members of society.

This study finds that access is complex and by drawing on the 5A's of access as a conceptual framework, we identify which domains require the most attention to aid future interventions [25]. We identified that affordability and acceptability were not discussed in our research, which may be attributed to NZ's healthcare system, the diversity of the population, and the freedom to choose what services they wish to access. Treatments such as the flu vaccine are free for those aged 65 and over, and those who have long-term conditions [57]. The well-supported health and social care system, therefore, financially helped people to access services during the COVID-19 lockdown [58]. Acceptability may not have been discussed in our research potentially because we did not have sufficient diversity. Both affordability and acceptability would be useful areas to explore in future research.

4.1. Implications for Healthcare Professionals/Public Health Policies. Findings from this study inform several improvements both during the pandemic and beyond. Firstly, health and policymakers should consider older people's physical access and how they feel about engaging with services. For example, older people have different mobility abilities and may need support in physically accessing services [43, 59]. Ensuring that essential services like COVID-19 testing stations or pharmacies are in practical areas can also alleviate barriers [59], especially if restrictions—like social distancing—will increase wait times.

It is also important to distinguish which services are essential for older people's health to fund and plan accordingly [12]. This includes acknowledging the needs of in-home support services and community healthcare workers when creating interventions. The government should also have adequate supplies and resources, which align with its public health approach. It is imperative that the government and researchers use data that better reflect the current population and situation to predict equipment needs. This was echoed in an article regarding the COVID-19 vaccine rollout, which emphasized the need for health facilities to have adequate outreach services to reach equitable outcomes [60]. The lack of personnel highlighted the importance of providing sufficient staff in times of crisis rather than relying on a priority system that disadvantages certain groups.

Issues with accommodation may be mitigated differently and give an opportunity for the healthcare system to adapt to older people's needs rather than having older people rely solely on their resilience and accommodation. Other alternative methods of accessing health and social care services without utilizing technology should be explored. It is also important for health and policymakers to be mindful of how they promote services and older people's health. Portraying them as "frail" and "vulnerable" may prevent engagement with services. Therefore, a key driver that can help older people access health and social care services is if health and policymakers aim to improve their visibility and promote older people's health in a way that is not based on assumptions. For example, this may look like portraying older people as capable, creative, and diverse, in health

promotions and media relating to COVID-19. It would include avoiding labelling older people as “frail” and “vulnerable” where possible, by focusing on the contextual factors that place people at risk (including reduced healthcare access). Promoting intergenerational solidarity by recognizing mutual vulnerability would also help reinforce a context where everyone has the right to seek and receive health care [61].

4.2. Strengths and Limitations. A strength of our research is that it provides insight into the experiences of participants. We were able to delve into issues that people struggle with in reality, which are often hard to gauge in a typical quantitative analysis. We also had a large sample, and a large proportion of them discussed their experiences and understanding of accessing health and social care services during the COVID-19 lockdown. This helped us gain a wide range of insights and strengthened our results. We also analysed data from multiple services that provide for older people’s holistic well-being. Churches, NGOs, and retirement villages are only a few of the many services that older people access. Analysing these services together with health systems helped emphasize the complexity of older people’s health needs and the importance of an integrated approach when designing future interventions.

A limitation of our research is that it used open-ended questions, which may have resulted in participants under-reporting their access to health and social care services. Although our letter writers acknowledge some positive changes in their use of health and social care services during the lockdown, research also shows it is much easier to focus on negatives, which may have contributed to people reporting about barriers [62]. We did not use specific questions tailored to the topic of access. Thus, our analysis depended on those who reported this by chance. While many participants were already accessing health and social care services pre-lockdown, there were also some who were not, resulting in differing accounts and experiences—or lack of—to health and social care access. We also did not map the changes over time or have a clear baseline of participants’ use of health and social care services. Our analysis relies on the chance that participants discussed changes. Although our research aimed to cover a broad range of older adults, those who responded were predominantly NZ European. Thus, we could not account for other issues with access for minority groups who usually struggle with other barriers such as discrimination and racism.

5. Conclusions

Overall, this paper provides a nuanced account of older people’s multifaceted experiences of access during the COVID-19 pandemic. Barriers to health and social care service access primarily consisted of issues with accessibility, availability, and accommodation. However, older people who successfully made it into services reported improved quality and/or quantity from these services. This analysis provides lessons for improving older people’s access to services during future public health crises.

Appendix

A. Instructions to Letter Writers for the Qualtrics Online Survey

Your letter

Please tell us what it has been like for you to be in lockdown during the COVID-19 pandemic. Below are some questions to give you ideas about what to write about, though you are free to write about anything you choose.

- (i) How have you found the experience of lockdown? Was it different for you at the different alert levels?
- (ii) Did the lockdown remind you of any other significant events in your life?
- (iii) How did you stay socially connected with family/whānau/friends who were not in your bubble?
- (iv) What helped you the most get through the lockdown period, especially at Level 4?
- (v) How did you help others during the lockdown?
- (vi) What did you learn during lockdown that is of value to you?
- (vii) Do you have any thoughts or comments about the ways that various media talked about people over 70 in relationship to the pandemic?
- (viii) Is there anything you would like to tell the Prime Minister about what people in your age group needed during the lockdown or more generally about the pandemic?

Data Availability

Data are not publicly available to protect the confidentiality of the letter writers.

Conflicts of Interest

The authors declare that there are no conflicts of interest.

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