



Rural Seniors Research Pilot Survey – North West Tasmania Phase II Report

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Background and Methodology

Introduction

This two-stage study was designed as a pilot for a considerably larger study into the situation and service needs of rural and regional older people in Tasmania. These studies arise out of the recognition that complex social and demographic changes demand a better evidence base to inform aged care policy development and service planning: ‘At the moment neither the Government nor the aged care industry have adequate strategic planning and decision support tools for forecasting future demand for aged care services.’ⁱ If we are to meet long-term national objectives around successful and healthy ageing, we need a much better understanding of the situations, aspirations and expectations of older Australians. As Kaneⁱⁱ argues, while geriatric health service research is badly needed, and has much to contribute to successful ageing, it has been ‘ignored in practice to date’ (p. 460).

Australia’s ageing demographicⁱⁱⁱ means government is becoming increasingly concerned with the issue of meeting the needs of older people and ensuring that they remain relatively healthy, active and independent for as long as possible, in order to minimise their call on services and maximise their contribution to the community and the country.^{iv} Maintaining our ageing individuals as community assets, not liabilities, requires evidence-based long-term approaches to developing policy and models for delivery of healthy ageing and frailty services.

In the past, policy development and service planning have been largely based on broad demographic data and historical trends in service demand and utilisation. Even if this has previously proven adequate – a point open to dispute – it is unlikely to be so in the future as the ‘baby-boomer bulge’ moves towards retirement. Apart from their sheer numbers, this group is likely to be more demanding and more geographically mobile than preceding generations. While these changes are happening nation-wide, they have particular implications for regional and rural areas, where changing health services and changes in the traditional social support bases of rural communities worsen already substantial inequalities within rural/regional aged care.

Research Aim

This research report comprises the second phase of a two-part study of older people (aged 65 years and over) living in North West Tasmania. The report profiles their current state and perceived future needs and expectations in relation to community, social and health services support. The study was designed both as a pilot for a planned larger Tasmania-wide study and as a stand-alone study which will look at how this group deals with the changes and challenges they experience as they age. Phase I baseline data from this study was reported in November 2005 and a copy of that

report is available at <http://fcms.its.utas.edu.au/healthsci/ruralhealth/project.asp?lProjectId=1844>. The Phase II data, collected in July 2006, focuses primarily on exploring changes that have occurred in the lives of our participants over the 18 months since the original data collection in late 2005.

The Research Team

The initial study design was undertaken by a large team consisting of researchers from five different departments within the University of Tasmania: the Rural Clinical School, University Department of Rural Health, Nursing, Pathology, Geography and Environmental Studies and Economics. The completion of the second phase of the study was undertaken by a smaller team from the Rural Clinical School and University Department of Rural Health. The actual data collection in both phases was undertaken by a commercial social research firm, Myriad Consultancy.

Methodology

1. The Phase II questionnaire (Appendix 1) was based on the Phase I survey design framework, modified to better capture change processes and to address some issues with the original questionnaire.
2. The Phase II instrument was further tested and refined prior to roll-out using a focus group consisting of a representative sample of nine Phase I participants.
3. Data collection was undertaken by a team recruited and trained by Myriad between 29th June and 14th July 2007.
4. Phase I participants were recruited from among people 65+ living independently in the North West region of Tasmania via snowball sampling using 'warm' contacts. Phase II recruitment involved re-contacting by phone all Phase I participants who, at the Phase I interview, had indicated their willingness to participate in the second phase. The study sought to remain in touch with participants in the interim via a Christmas greeting and summary report mail-out. Those who were contactable and willing to participate took part in an in-home structured interview lasting on average 36 minutes.
5. Data analysis and reporting was undertaken in Excel and SPSS by Dr Peter Orpin on behalf of the team.

6. Both phases of the study were approved by the Tasmanian Health and Medical Human Research Ethics Committee.

The Sample

Phase I of the study interviewed a total of 193 people aged 65 years and over in the Cradle-Coast area of North West Tasmania. Sample distribution was designed to ensure that the survey sample was representative of the target population across the seven Local Government Areas (LGAs) in terms of total numbers of persons aged 65 plus, age group and gender (*Australian Bureau of Statistics Community Profiles – Census 2001*).

The second phase of the study was able to re-interview 154 of the original sample approximately 18 months after the original interview. Twenty of the original sample had indicated at the conclusion of Phase I that they did not wish to be re-interviewed, four had died, one had a partner who had recently died, one had left the area, five were too unwell to be interviewed and eight could not be contacted. The attrition sample does not appear to show any obvious pattern or bias in age or geographic location which might substantially threaten the representativeness of the remaining sample.

Results and Discussion

The following relates only to the Phase II findings of the study and is designed to be read in conjunction with the Phase I report: Rural Seniors Research – Pilot Survey North West Tasmania <http://fcms.its.utas.edu.au/healthsci/ruralhealth/project.asp?lProjectId=1844>. A future report will consider issues across both phases of the data collection.

Age

The median age of the remaining Phase II sample is 75.9 years with a range of 66-96 and an even spread across age groups.

Changed Living Arrangements

A major factor in planning for rural ageing in place is the provision of suitable accommodation to cater for changing needs. Despite a sample which includes 78 (50.7%) individuals over the age of 75 and 36 (23.4%) over 80, only six (3.9%) report moving home in the previous 18 months (Table 1). This accords with research showing the effectiveness of the shift in policies and services towards maintaining older people in their own homes. There is no apparent correlation between age and moving, even into a nursing home, with none of the sample over 80 reporting such a move (those who did were 74, 75 and 79 years of age).

Table 1: If moved, change in residence type?

Q 1b Resident moved from (coded choices)		Q1c Resident moved to (coded choices)				Total
		Family Home	Ind. living unit in aged care complex	Nursing Home	Other	
Family Home	Count	1	1	1	1*	4
	Percentage	25.0%	25.0%	25.0%	25.0%	100.0%
Private Flat/Unit	Count	0	0	1	0	1
	Percentage	.0%	.0%	100.0%	.0%	100.0%
Indiv. living unit in aged care complex	Count	0	1	0	0	1
	Percentage	.0%	100.0%	.0%	.0%	100.0%
Total	Count	1	2	2	1	6
	Percentage	16.7%	33.3%	33.3%	16.7%	100.0%

*In hospital awaiting nursing home placement.

The very small sample, for those who have moved, rules out further statistical analysis. However, the qualitative responses to questions about the move (Table 2) reveal both the important role the spousal relationship plays in decisions about living arrangements and a certain stoic acceptance of losses forced by realities of ageing.

Table 2: How has the move worked out?

Moved From	Moved To	Aspects worked out well	Regrets
Family Home	Family Home	It is closer to respite care for my wife who has memory loss	Having no friends. It is very lonely.
Unit in Aged Care Complex	Unit in Aged Care Complex	Smaller unit. Closer to bus stop. Level walking area.	
Private Unit	Nursing Home	Full time care. Assistance of medical care.	My wife had a stroke and is unable to care for me..
Family Home	Nursing Home	Health deteriorated. I had no options.	Not having my wife care for me.
Family Home	Unit in Aged Care Complex	Closer to my husband in hostel accommodation. Closer to medical help. Less stress in running home.	Miss my old home.
Family Home	Nursing Home	Feel safer. Have had double amputation since last interview. Have assistance on hand to toilet or shower.	Miss own home and beautiful view, but realised I had to make the move.

The Household

Table 3: Number sharing household

Number sharing	Frequency	Percent
0	60	39.0
1	85	55.2
2	4	2.6
3	2	1.3
Not Applicable	3	1.9
Total	154	100.0

Four out of every 10 people in the sample live alone (Table 3). Of those who reported a shared house (a total of 91) the vast majority (85) report that they do so with a spouse. Given that 89 (57.8%) participants also reported having a spouse or partner, this suggests that four couples are living apart, most likely with one in dependent care. Twelve (13.2%) share with a son or daughter and two (2.2%) with grandchildren. Only eight (5.2%) individuals reported a change in their household composition over the previous 18 months; most commonly children or grandchildren moving in temporarily. Three people report a change in their partnering status since the last interview, two through death of a spouse and one unexplained.

Twenty (13%) individuals reported being the primary carer for a person who suffers a significant disability; most (80%) caring for a spouse/partner, with two caring for a sibling and two for a son or daughter. This figure is lower than might be expected for the age group, but may be related to issues of defining the point at which growing dependence (unilateral or mutual) within the marriage/intimate partner relationship becomes a carer relationship. This has more than theoretical importance since it may have implications for help-seeking and service access.

Pets

The Phase II instrument included an expanded section on pets in acknowledgement of the important role pets can play in providing support and companionship in later age. Pet ownership appeared quite low with almost two thirds reporting having no pets. Almost half of the 55 (36.9%) who owned a pet had only one – although one person reports 53 and another 200, presumably flock animals.

Fifteen individuals reported that they had lost pets since the Phase I interviews and 12 had gained a new pet (Table 4). Participants were given the opportunity to comment on the effect of these losses and gains on their lives. These comments reveal the important place pets hold in the lives of some.

Table 4: Effect of loss or gain of pets

Pets Lost	New Pets	Effect on life
Yes	Yes	No but they (chickens) died because I was given the wrong grain (I think). They all died at the same time. Upset that that happened.
Yes	Yes	Lost 2 cats and 2 dogs, gained 2 cats.
Yes	Yes	Terrible.
Yes	Yes	Great loss for both husband and I. I cried for days. However, now have a new much loved dog.
Yes	Yes	One rabbit. Miss seeing of a morning.
Yes	No	Lost a cat. Upset me at the time. I think the man over the road caught her in a trap. Missed her for a while of course. Still have my dog. Would really miss her if something happened.
Yes	No	He was a wanderer. Doesn't worry me that he's gone.
Yes	No	
Yes	No	One of our dogs was attacked by a white staffy pitbull and died from its injuries. We still have one dog but we have been very traumatised by the loss and are only just returning to normality after 6 months.
Yes	No	Yes, traumatised. Deep sense of loss for 16 years.
Yes	No	Canaries in aviary out back. More for husband than myself.
Yes	Missing Data	To a certain extent, miss it being around.
Yes	Missing Data	Lost dog. Yes I miss her company.
Yes	Missing Data	Sad but coped well.
Yes	Missing Data	Missed them for a while but have got used to it.
No	Yes	Don't really want dog but as it's my brother in law's I feel I must. Inherited it from brother in law who is not able to look after dog now.

Table 5: Reliance on pets

How much rely on pets for companionship	Frequency	Percent
A lot	15	33.3
To some extent	14	31.1
A little or not at all	16	35.6
Total	45*	100.0
How much owning pet increases physical activity		
A lot	11	25.6
To some extent	15	34.9
A little or not at all	17	39.5
Total	43*	100.0

Pet owners were asked specifically about how reliant they were on their pets for companionship and as an incentive to exercise (Table 5). The responses indicate that for those who owned pets they played an important role in warding off loneliness and keeping them moving.

*Two responses from people who do not currently own pets but have in the past

Social Support – Friend and Family

Most respondents (147, 95.5%) could identify someone close by who they call on for support in an emergency. Though the number who could not was small, that there are any at all is a concern. Such support is overwhelmingly provided by family and friends and neighbours (Table 6).

Table 6: Who can be relied on for help in an emergency

	Primary Person			Second Person Identified		Third Person Identified	
	Frequency	Percent	Valid Percent	Frequency	Valid Percent	Frequency	Valid Percent
Family member	89	57.8	60.5	0	0	0	0
Friend or neighbour	54	35.1	36.7	26	78.8	0	0
Professional Service Provider	4	2.6	2.7	7	21.2	6	100
Total Valid	147	95.5	100.0	33	100.0	6	100.0
Not Applicable	7	4.5					
Total	154	100.0					

Such contacts are clearly important, with almost half the sample reporting needing to call on these informal supports at some time in the past, almost a quarter of these were within the preceding 12 months (Table 7).

The listed emergencies (Table 8) included 15 instances that appear to have been very serious medical emergencies (strokes, heart attacks and haemorrhages) and eight falls (with a further two likely consequences of falls). Household emergencies varied from being locked out to having a snake in the backyard, but there were only two mentions of what might be termed household maintenance emergencies (flooded bathroom and burst hot water cylinder). One instance related to a matter of personal safety (home invasion). The list is notable for the absence of any instances that could be considered trivial.

Table 7: Last time needed to call on someone

	Frequency	Percent
Never	83	56.8
Within last 6 months	22	15.1
Within last 12 months	12	8.2
Within last 2 years	8	5.5
More than 2 years	19	13.0
Cannot recall	2	1.4
Total	146	100.0

Table 8: Nature of the emergency for help in an emergency

	Frequency	Percent	Percent
Accident	11	7.1	19.3
Medical Emergency	35	22.7	61.4
Household emergency	11	7.1	19.3
Total	57	37.0	100.0
Missing	97	63.0	
	154	100.0	

The vast majority (94.8%) have at least close family and/or close friends living nearby who contacted and supported them on a regular basis. Most of these were able to name two or three such people with 88.4% reporting that that contact occurs at least weekly (Table 9)

Table 9: Regular, close-by support from family and friends

Number of Contacts Named	0	1	2	3	4	5	6	Missing/Not Stated	Total
Frequency	8	29	54	34	19	6	3	1	154
Percentage	5.2	18.9	35.1	22.1	12.4	3.9	1.9	0.6	100

Sons and/or daughters were clearly the major source of contact and support for our participants; they were most likely to be first named and generally provided daily or at least weekly contact (Table 10). Friends are more likely to be named second contact and also likely to provide weekly contact.

Table 10: Frequency of contact by identity by order named (1st – 3rd Named)

Who Provides Contact/Support	Frequency of Contact – First Named				Frequency of Contact – Second Named				Frequency of Contact – Third Named			
	Virtually every day	Not daily but at least weekly	Not weekly but at least monthly	Less than monthly	Virtually every day	Not daily but at least weekly	Not weekly but at least monthly	Less than monthly	Virtually every day	Not daily but at least weekly	Not weekly but at least monthly	Less than monthly
Son/Daughter	35	61	7	2	2	18	8	0	2	4	4	1
Sibling	2	4	1	0	0	10	1	3	0	2	2	2
Grandchild	1	1	0	1	5	7	3	3	0	8	2	2
Other Family	2	9	2	1	2	6	3	2	1	3	1	0
Friend	3	10	1	1	8	22	6	0	4	20	2	0
Carer	0	1	1	0	3	2	2	0	0	1	0	0
Spouse	0	0	0	0	0	0	0	0	1	0	0	0
Total	43	86	12	5	20	65	23	8	8	38	11	5

Table 11: Reason for loss of contact

	Frequency	Percent
I moved	3	10.7
They moved	5	17.9
Their failing health/capacity	2	7.1
Their death	18	64.3
Total	28	100.0

Twenty-four participants (15.6%) reported losing at least one key contact in the preceding 18 months. While losses covered the full range: siblings, children, and grandchildren, by far the largest number of losses were among friends (9 out of 28) and the most common cause was death (64.3%) (Table 11).

A quarter of the participants (24.7%, 38) reported having made at least one new friend or acquaintance in the previous 18 months who now provide them with support (three people cited two new friends). Interestingly, a third (12) of the new friends/acquaintances identified were (professional) carers. The nature of the question does not allow us to determine with any certainty

whether these individuals are seen as friends or simply support providers, but comments elsewhere suggest the former. A third of new acquaintances were the result of either party moving into a new living arrangement with most of the remainder made through community involvements and activities.

Mobility – Getting Around

The question on transport from the Phase I survey was extensively re-vamped in Phase II in order to capture more detail on how our participants moved about within their communities. For the overwhelming majority of our participants, the private car was the principal means of transport in going about their daily lives (Table 12). Surprisingly, given the age range and the historically lower rate of licence-holding among older females, almost all drove themselves, although there is substantial reliance on private cars belonging to others - presumably spouses, friends and neighbours.

The most notable feature of the data is the small numbers who report using publicly provided modes of transport, even for accessing services. The data highlight the importance for this group in having access to a car and someone with a licence. Small numbers continue to walk despite their age; however, the predominance of the car suggests that many facilities are not within walking distance.

Table 12: Means of mobility

		Shopping	Accessing services	Meeting with friends and family	Community and recreational activities
Walk	Mostly	11	8	8	13
	Sometimes	17	1	8	4
	Only occasionally	0	0	1	0
Private car – self-drive	Mostly	110	109	110	99
	Sometimes	5	3	5	4
	Only occasionally	0	0	0	1
Private car - household	Mostly	12	12	12	10
	Sometimes	10	11	12	7
	Only occasionally	3	1	1	1
Private car – outside household	Mostly	13	13	19	8
	Sometimes	9	13	18	14
	Only occasionally	5	10	7	7
Community Transport	Mostly	0	4	0	3
	Sometimes	1	5	0	3
	Only occasionally	1	4	2	3
Public transport	Mostly	1	2	1	2
	Sometimes	6	4	3	6
	Only occasionally	4	2	4	2
Taxi	Mostly	2	3	0	0
	Sometimes	4	3	1	3
	Only occasionally	2	3	0	0
Other (Specify)	Mostly	1	0	1	2
	Sometimes	3 cases miscoded	2	5 cases miscoded	1
	Only occasionally		3 cases coded 4		16

Of the 42 (27.3%) participants who reported a change in 'their ability to get around' over the preceding 18 months, almost all report a deterioration which most relate to increasing physical disability – musculo-skeletal, balance, confidence and general health issues. There is only one mention of the loss of licence or car. This appears at odds with the heavy reliance on the car but may be a reflection of participants interpreting the question in the narrow sense of personal physical mobility.

An invitation to provide open comment on how these changes affected the individual's quality of life produced 38 responses. Taken together they present a picture of loss, restriction and increasing physical disability met largely with acceptance, adaptation and coping. There are many 'can't . . . anymore' quotes: cant 'go for long walks'; 'mow the lawns like I used to'; 'play bowls'; 'go to lodge'; 'handle stairs'; 'answer the phone and the door'. Most, however, cope with a combination of outside help: 'can only cope with help from daughter and home help'; 'now always shop with a friend'; 'Coped fairly well with good family support'; hard work and medical treatment: 'By keeping on moving and visiting health professionals'; aids and devices: 'Enjoy golf so have had to invest in a golf buggy'; 'Have more help and using walking stick'; 'Slowed me up, use walking sticks and have some help'; and simply putting up with it: 'Just put up with it'; 'Just had to get on with it'; 'Have reluctantly adapted to change'; 'Perseverance'.

For a minority, the story is more gloomy: 'Not coping well with major adjustments'; 'Haven't the energy for everyday activities'; 'Not coping'; but the overall tenor of the comments is up-beat: 'Can't do some things on my own, toilet, getting in and out of the shower. Doing my best. Coping quite well with [the] overall situation. Still manage a lot of things myself and keep my sense of humour.'

Work and Finance

Only seven of the participants were currently in any form of paid employment. The two who were full-time workers were aged 69 and 75 years. Of the two part-time workers, one 80 year old still works 17 hours per week on average and one 83 year old works 25 hours per week on average. Three reported they performed five to six hours casual work per week. There are a large number of missing data around the number of years retired, but of the 42 who answered the questions the time varied from 1 – 30 years with a mean of 14.6 years.

Sixty-three participants (40.9%) report that they regularly do volunteer work in their communities. The 59 volunteers (four missing/not stated) who provided data volunteered a median of 3 hours per week (average of 5.4 hours) with a range of 1 to 35 hours (Figure 1).

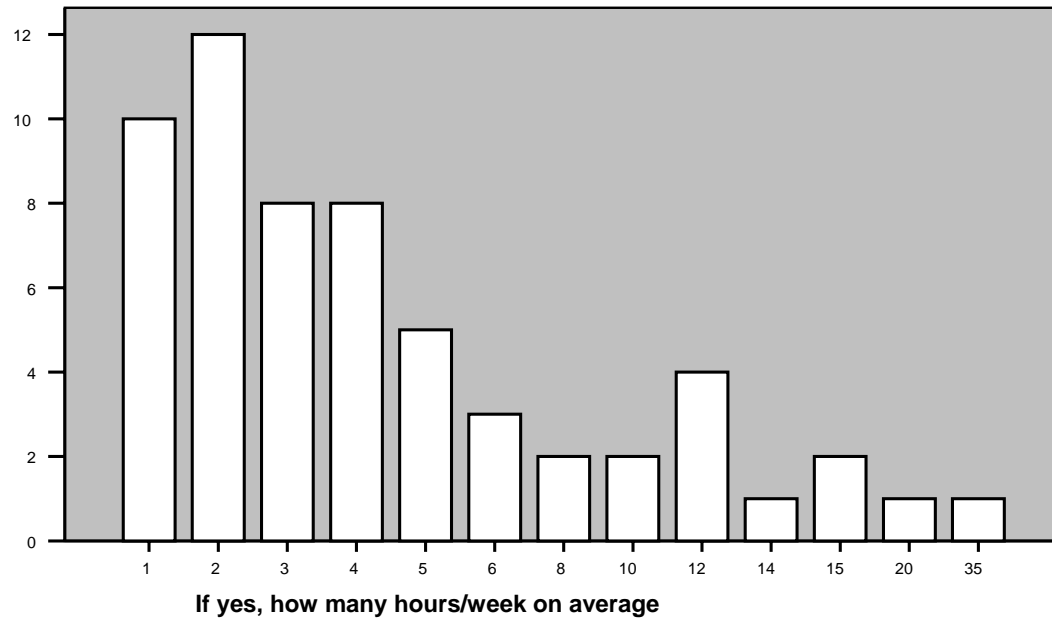


Figure 1: Spread of Volunteer Hours

The broad range in the types of voluntary work undertaken paints a picture of very wide involvement in the life of the community:

- Church work
- Fund raising and charity collections
- Meals on wheels
- Work at aged care facilities
- Sporting clubs
- Other clubs and societies
- Community work
- Work with the 'needy'
- Environmental work
- Charity craft production
- Assisting neighbours
- Baby-sitting
- Service clubs
- Home visiting
- Cooking

It should be noted that, apart perhaps from baby-sitting, the list does not include contributions to family. It is likely, however, that family support is not seen as ‘volunteering’, since we know from other sources that older people do make significant unpaid contributions as family carers.^v

A third of the participants (33.8%) had private health insurance. Over half (51.3%) were Healthcare card holders and 16 (10.4%) had a Veterans’ Affairs Gold Card. Ten people in all had a combination of two or more forms of health cover. One participant raised the specifically rural issue of the effect of farm ownership on government entitlements: “[I have] a Pension Card. These need looking into. If you own a farm, you are asset rich but money poor. Had to hand over farm to family to get pension. Farms don’t put money on the table.”

The large majority (121, 78.6%) reported owning their own homes with only 21 (13.6%) renting and two holding a current mortgage. Two reported living with family. One person reported owning a second home (with mortgage), three were in ‘owner donor’ units (revert to facility ownership on death) attached to an aged care facility and a further two were living in units owned by their children.

Only a small number of participants (13, 8.4%) described their current financial situation as at all ‘difficult’ and 39% (60) saw themselves as ‘comfortable’ (Table 13). Even with the large majority reporting that they were at least financially ‘OK’, a substantial number still reported their financial situation as having a (negative) effect on their quality of life with 35 (22.7%) reporting at least some effect and 9 (5.8%) of those, affecting it ‘a lot’ (Table 14).

Table 13: Financial situation

	Frequency	Percent	Cumulative Percent
Very comfortable	23	14.9	14.9
Reasonably comfortable	37	24.0	39.0
OK	81	52.6	91.6
A little difficult	7	4.5	96.1
Difficult	6	3.9	100.0
Total	154	100.0	

Table 14: Effect of Financial Situation on Quality of Life

	Frequency	Percent
No, not really	119	77.3
Yes, to some extent	26	16.9
Yes, a lot	9	5.8
Total	154	100.0

The vast majority of participants (85.1%) reported no significant change in their financial situation since the Phase I interviews. Of the remainder, nine (5.8%) report an improvement and 14 (9.1%) a deterioration, with four people in a ‘much worse’ situation. More importantly, 92.8% of the sample report that they would be able to access \$1,000 to meet a health or life emergency without major difficulty.

Community Engagement

There are two quite distinct groupings in terms of involvement in organised community activities. While well over half the participants (57.1%) report engaging in such activities at least once a week, another quarter (24.7%) 'hardly ever' engage. The latter suggests that a substantial proportion of older participants are isolated from their wider community.

Participants were somewhat more likely to get together with friends and neighbours in a less organised setting with 68.2% (105) doing so at least weekly and only 14 (9.1%) reporting that they 'hardly ever' socialise with friends and neighbours.

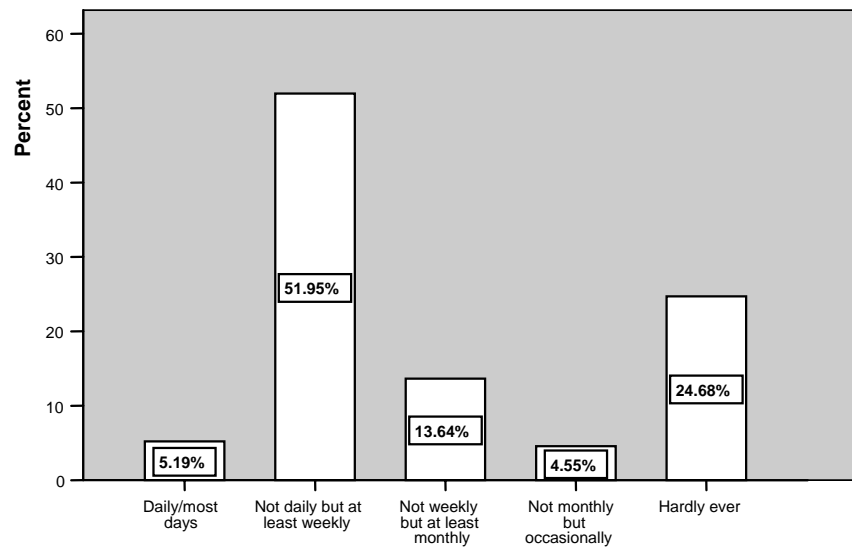


Figure 2: How frequently engage in organised activity

Very few participants could not name at least one hobby or sporting activity that they regularly took part in with a median number of 3 activities/sports reported per participant. Nine people were able to name 6 activities and 2 people, 7. The majority of these activities were enjoyed on a daily or weekly basis.

The list of hobbies and activities runs to 502 covering a very wide range from the highly active and creative to the passive. The following categories dominate: arts and crafts (90 named ranging from knitting to movies); sport (89 named covering at least 17 different sports although some 'followed' their sport rather than actively participated); gardening (85); walking (56); reading (59) and social and family outings (32). Of the remaining a number are notable: seven participants reported computing as a hobby, nine farming and two household duties.

Table 15: Frequency of hobby/activity

	Hobby 1		Hobby 2		Hobby 3		Hobby 4		Hobby 5		Hobby 6		Hobby 7	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Daily/most days	68	45.9	72	51.4	59	53.2	24	36.9	9	34.6	3	33.3	0	0
Not daily but at least weekly	61	41.2	41	29.3	31	27.9	28	43.1	10	38.5	3	33.3	0	0
Not weekly but at least monthly	15	10.1	20	14.3	9	8.1	6	9.2	4	15.4	1	11.1	2	100.0
Not monthly but occasionally	4	2.7	6	4.3	10	9.0	6	9.2	2	7.7	2	22.2	0	0
Hardly ever	0	0.0	1	.7	2	1.8	1	1.5	1*	3.8*	0	0	0	0
Total	148	100.0	140	100.0	111	100.0	65	100.0	26	100.0	9	100.0	2	100.0

The activities were re-coded on a five point scale in terms of their physicality and intellectuality. While a substantial group of the activities are low in physicality, e.g. watching TV, knitting, and reading, in general activities tend towards the more physical rather than the cognitive. Of greater concern perhaps, given the known correlation between social engagement and healthy ageing, is the solitary nature of many of the activities.

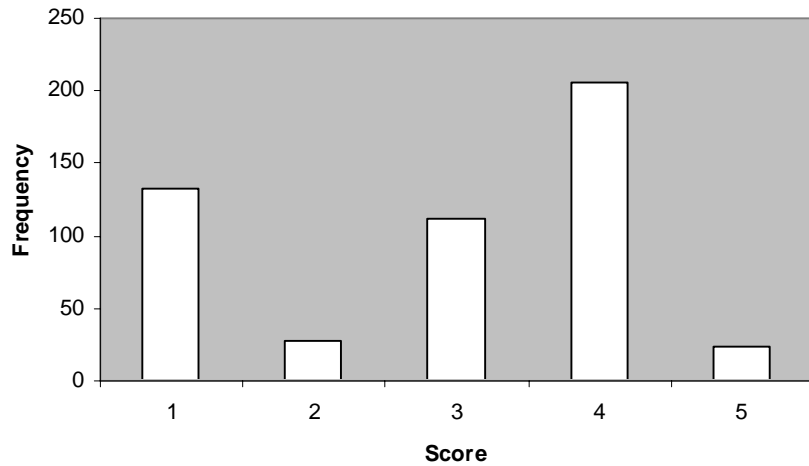


Figure 3: Physicality of Hobbies

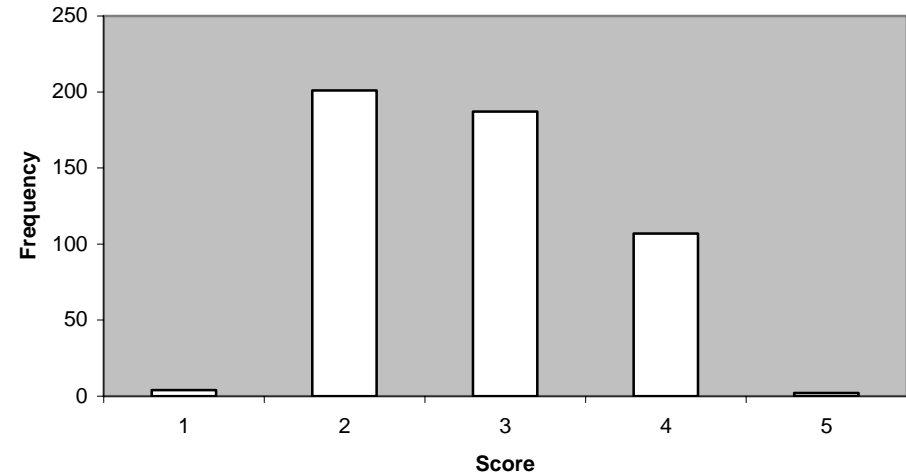


Figure 4: Cognitive Content of Hobbies

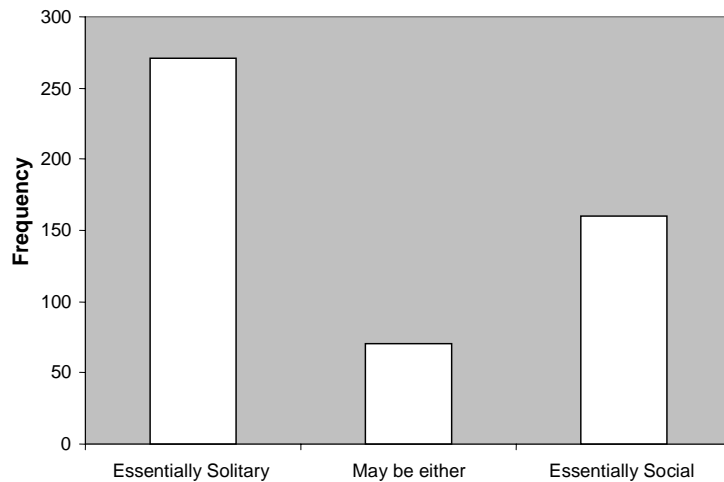


Figure 5: Social nature of activities

Participants were asked whether there had been any changes since the last interview in the activities, hobbies, or sports that they regularly take part in. Thirty reported a change; the majority (19, 19.5%) reporting a drop in activities due to failing health and physical capacity, such as loss of mobility, flexibility and cardiovascular capacity: *'Not able to play golf as much. Getting too bloody old. Cataract surgery prevents as much golf as before.'* Three report that a problem with deterioration in their partners' health had limited their activities.

Not everybody reported deterioration. Two actually reported a health improvement that allowed them to do more: *'Managing better getting around. Electric heating put in so not as much work (compared to wood heater) and feel more energetic for other interests.'* One lifted their activity levels on retirement and another increased their workload because a volunteer work partner resigned.

Two participants took the opportunity to report that they were lonely. One had just moved into the area and the other (aged 78) said: *'I'm terribly lonely, don't know how I'm going to cope when my daughter goes to the mainland (daughter lives up the road, but never contacts - there if I needed her - she works, busy). Wish I had someone to call on just to go out for a meal. Don't want anyone around all the time, just when I'm feeling lonely.'*

Quality of Life and Health

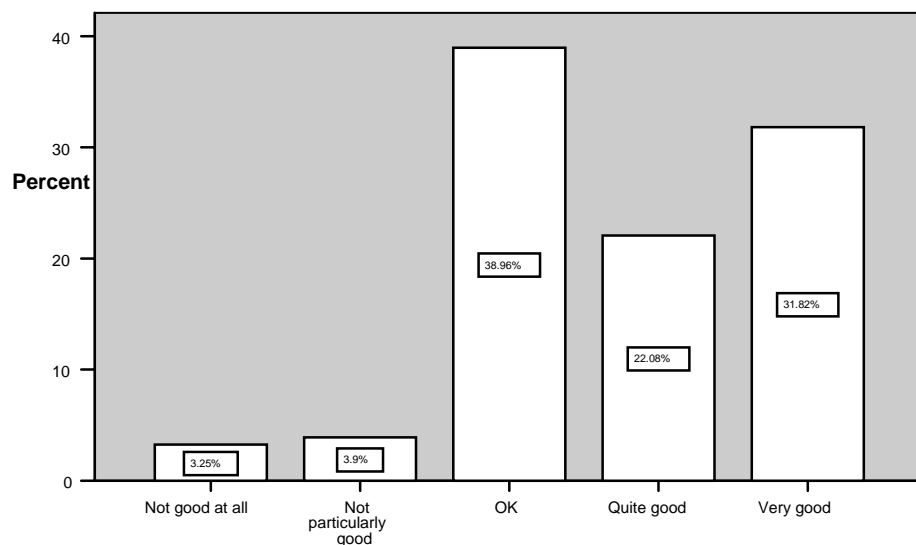


Figure 6: Overall quality of life/lifestyle

Overall, however, participants report a high quality of life (Figure 6) despite the inevitable problems with health and capacity associated with ageing. Over half rate quality of life and lifestyle 'quite good' or better and 92.9% rate it as at least 'OK'.

They also rate both their own and their partner's health quite highly with over one third reporting both 'quite good' or better (Tables 16 & 17).

Table 16: Overall state of own health

	Frequency	Percent	Cumulative Percent
Excellent	32	20.8	20.8
Quite good	24	15.6	36.4
Average	77	50.0	86.4
Somewhat poor	11	7.1	93.5
Poor	10	6.5	100.0
Total	154	100.0	

Table 17: Overall state of partner's health

	Frequency	Percent	Valid Percent	Cumulative Percent
Excellent	18	11.7	20.2	20.2
Quite good	15	9.7	16.9	37.1
Average	38	24.7	42.7	79.8
Somewhat poor	9	5.8	10.1	89.9
Poor	9	5.8	10.1	100.0
Total	89	57.8	100.0	
Not Applicable	65	42.2		
Total	154	100.0		

For most, neither their own or their partner's health was seen as a major limitation on their day-to-day activities (Tables 18 & 19). Interestingly, a partner's health was more likely to be seen as imposing some limitation but less likely to be seen as a major limitation.

Table 18: Own health limit activities

	Frequency	Percent	Cumulative Percent
Not at all	51	33.1	33.1
A little	71	46.1	79.2
A lot	32	20.8	100.0
Total	154	100.0	

Table 19: Partner's health limit activities

	Frequency	Percent	Valid Percent	Cumulative Percent
Not at all	51	33.1	57.3	57.3
A little	26	16.9	29.2	86.5
A lot	12	7.8	13.5	100.0
Total	89	57.8	100.0	
Not Applicable	65	42.2		
Total	154	100.0		

A question about factors that significantly impact on participants' general quality of life drew 99 responses in which health issues dominated. Among these, the major concerns, by far, were about those conditions that placed restriction on their mobility both in the sense of moving around house and home and taking part in social activities out in the wider community. A number of participants mentioned the importance of having a car and licence in allowing them to still get around despite problems with personal mobility:

'Arthritis stops [me] getting around.'

'Feel restricted as to areas to go fishing in case of having a fall or becoming unwell.'

'Incontinence stops me going out at night.'

'Sore back sometimes. Some chairs are uncomfortable (plastic meeting chairs) so take [my] own pillow to sit on.'

'Mobility restricted. Less walking.'

'Since [my] accident (broken bones), still not able to walk around much. Luckily I still drive a car.'

Being unable to get around restricted social life: *'Tendonitis has greatly affected my life. Loss of social contact as well as playing sport.'*

Failing health and declining capacity impacted quality of life in other ways; weaker eyesight and arthritis restricted even relatively passive home based interests such as reading and sewing. A number of participants mentioned the restrictions and stresses of the carer role, not just for partners but also siblings and even children: *'Caring for [my] brother. Activities limited due to getting very tired.'*

A number simply cited the general loss of capacity and energy that comes with age but show a general acceptance and adaptation:

'I haven't got as much energy as I used to. Take my time to do things but I am still totally independent.'

'Have had to slow down in general.'

'Can't work like I used to, don't want to either.'

While for some there was sadness and loneliness: *'My wife has memory loss which takes up a lot of my time and is very stressful. Also [I am] very sad.'*, *'Death of spouse six weeks earlier. Married for 54 years. Carer of spouse for 30 years. Never had a social life.'* The tone of the comments

was, by and large, one of acceptance and adaptation, even at times cheerful optimism: *‘Not [impacting] significantly. Still do things, just slower.’*; *‘Not at 72 years of age!’*

Not surprisingly, given their age, the majority reported at least one major diagnosed illness, with the largest number (80, 51.8%) reporting two or more co-morbid conditions (Figure 7). While variations in the way conditions are named causes some difficulties in categorisation, the most frequently reported conditions, in order, include the range of cardio-vascular diseases (including hypertension), arthritis, other musculo-skeletal conditions, diabetes and sight and eye conditions. Only four people report a diagnosis of cancer, three people report having had a stroke and three a psychological condition.

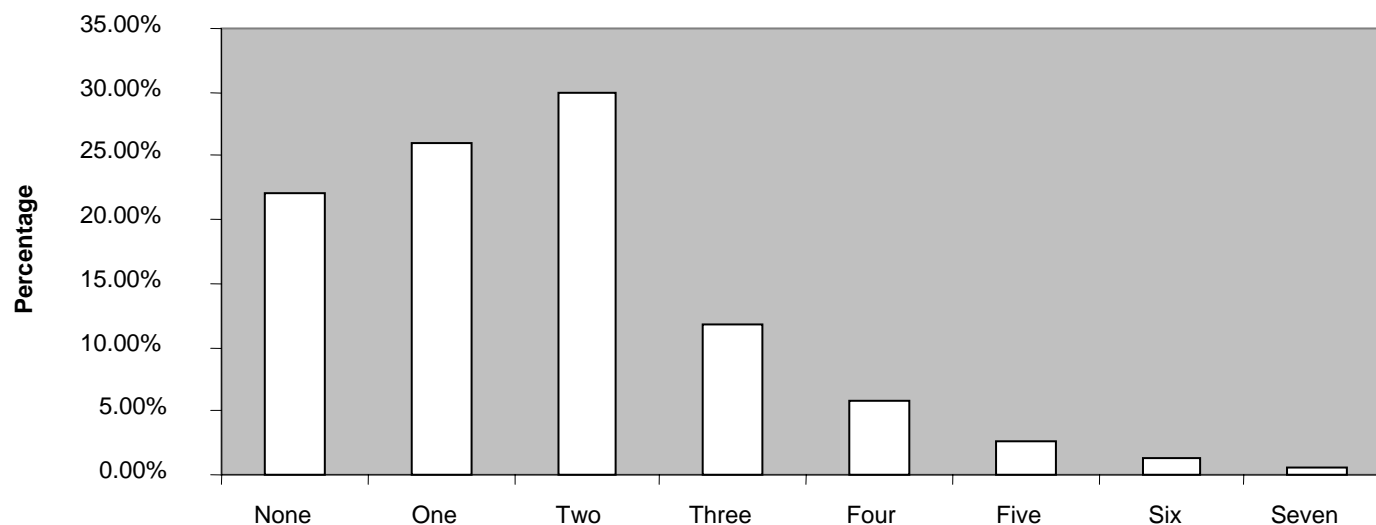


Figure 7: Number of diagnosed conditions

Participants were asked to rate conditions on a scale of 1-3 in terms of their effects on their life. As shown in Table 20 and Figure 8, many of the less commonly reported conditions have the greatest effect on quality of life: depression, dementia, cancer, musculo-skeletal, other than arthritis and blood disorders, whereas the frequently reported cardiovascular diseases have very low impact.

Table 20: Conditions by Effect on Quality of Life

Condition	Occurrence Ranking	Mean Impact Score	Condition	Occurrence Ranking	Mean Impact Score
Psychological Condition (depression, dementia)	13	3	Gastrointestinal Condition	10	2.3
Cancer	12	2.75	Osteoporosis	7	2.3
Musculoskeletal Other	6	2.7	Circulatory Other	12	2.25
Blood Disorder	11	2.6	Skin condition	11	2.2
Stroke	11	2.6	Auto-immune Condition	14	2
Other	7	2.5	Eye Condition	5	2
Prostate Problem	14	2.5	Diabetes	4	1.9
Renal Disease	12	2.5	High Cholesterol	12	1.5
Neurological Condition	9	2.3	Hypertension	2	1.5
Asthma/Pulmonary Disease	8	2.3	Thyroid Disease	14	1.5
Arthritis	1	2.3	Cardiovascular Disease	3	1.4

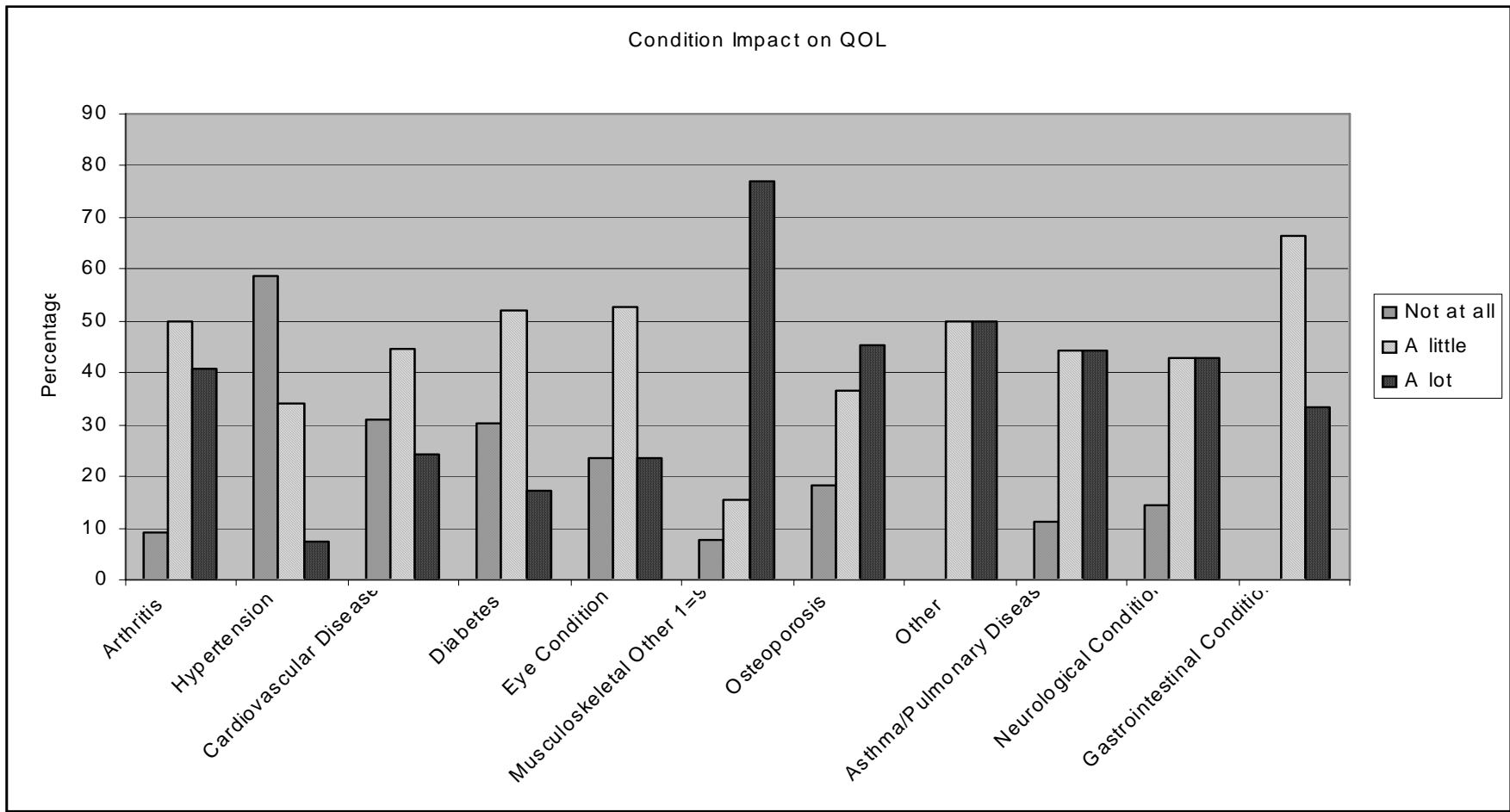


Figure 8: Impact of Conditions on Quality of Life (Most frequent conditions)

Use of Health Services

The services used most by the participants in the previous 12 months were the GP, followed by the chemist and medical specialists, although the chemist was the most frequently visited service. Many other services are notable for how infrequently they are used (Table 21).

Table 21: Health service use in previous 12 months

Health Service		Not at all	At least weekly	Not weekly but at least monthly	Less than monthly	Total
Community Nurse	Frequency	133	7	5	9	154
	Percent	86.4	4.5	3.2	5.8	100.0
General Practitioner	Frequency	5	2	62	85	154
	Percent	3.2	1.3	40.3	55.2	100.0
Medical Specialist	Frequency	85	1	9	59	154
	Percent	55.2	.6	5.8	38.3	100.0
Chemist	Frequency*	15	13	96	29	153*
	Percent	9.7	8.4	62.3	18.8	99.4
Community Health Centre	Frequency	139	1	0	14	154
	Percent	90.3	.6	0	9.1	100.0
Hospital Outpatients	Frequency	125	1	0	28	154
	Percent	81.2	.6	0	18.2	100.0
Hospital Inpatients	Frequency	126	1	0	27	154
	Percent	81.8	.6	0	17.5	100.0
Dentist	Frequency	122	0	0	32	154
	Percent	79.2	0	0	20.8	100.0
Other Health Professionals#	Frequency	93	2	19	40	154
	Percent	60.4	1.3	12.3	26.0	100.0
Patient Transport	Frequency	133	2	2	17	154
	Percent	86.4	1.3	1.3	11.0	100.0
Home Help	Frequency	114	17	22	1	154
	Percent	74.0	11.0	14.3	.6	100.0

Health Service		Not at all	At least weekly	Not weekly but at least monthly	Less than monthly	Total
Other Home Support	Frequency	137	8	8	1	154
	Percent	89.0	5.2	5.2	.6	100.0
Meals on Wheels	Frequency	140	12	1	1	154
	Percent	90.9	7.8	.6	.6	100.0
Other Social Eating	Frequency	151	0	1	2	154
	Percent	98.1	0	.6	1.3	100.0
Day Centre	Frequency	152	2	0	0	154
	Percent	98.7	1.3	0	0	100.0
Other Services (Specified) §	Frequency	138*	1	3	12	154
	Percent	89.6	.6	1.9	7.8	100.0

*Missing Values

Other Health Professionals: Physiotherapist (4) Podiatrist (6) Eye Specialist (1)

§ Other Services (Specified): Community Care, Mowing lawns and heavy garden maintenance and 'daughter'

Fifteen participants (9.7%) reported problems with accessing services in the previous 12 months. Services mentioned include the dentist (4), medical specialists (3) and the general practitioner and podiatrist (2 each).

Very few participants (13, 8.4%) registered any concern with the quality of the services they had received in the previous 12 months. Of the 13 concerns, three related to waiting times (specialist, surgery and dentist) and seven to the quality of care and professional interaction, generally in respect to one encounter and/or an individual practitioner rather than a service as a whole. Of the remaining comments, there was one concern about pharmacists offering generic drug equivalents, one about the quality of Meals on Wheels and one about inadequate disabled parking. Overall, the concerns are quite diverse and do not appear to point to any significant major systemic problems in health delivery in the area.

Assistance with Activities of Daily Living

Table 22 reveals that the vast majority of participants could manage most activities of daily living related to personal care without help and that those who did require assistance, with rare exception, were receiving the help they needed. The areas in which participants required most help were those relating to maintaining the household; that is, housework and house maintenance. Even here, most were receiving adequate help. Table 23 reveals how much of the day-to-day help is provided by families and, in the case of household maintenance, by private commercial providers.

Table 22: Assistance with Activities of Daily Living

Activity		Can Manage	Receive Help	Meets Needs?				
				Not Really	A Little	Partly	Largely	Totally
Bathing and Showering	Frequency	145	9			2	1	6
	Percentage	94.2	5.8			1.3	.6	3.9
Dressing	Frequency	147	7	1		2		4
	Percentage	95.5	4.5	14.3		28.6		57.1
Eating	Frequency	153	1					1
	Percentage	99.4	.6					.6
Getting in and out of bed or chair	Frequency	149	5			2	3	
	Percentage	96.8	3.2			40.0	60.0	
Walking	Frequency	143	11	1	1	5		4
	Percentage	92.9	7.1	9.1	9.1	45.5		36.4
Getting outside	Frequency	150	4			1		3
	Percentage	97.4	2.6			25.0		75.0
Using the toilet	Frequency	152	2		1			1
	Percentage	98.7	1.3		50.0			50.0
Preparing meals	Frequency	143	11		1	1	1	8
	Percentage	92.9	7.1		9.1	9.1	9.1	72.7
Shopping	Frequency	141	13		1	1	1	10
	Percentage	91.6	8.4		7.7	7.7	7.7	76.9
Managing money	Frequency	151	3					3
	Percentage	98.1	1.9					1.9
Using the telephone	Frequency	150	4			1		3
	Percentage	97.4	2.6			25.0		75.0
Doing heavy housework	Frequency	106	48	1		2	3	42
	Percentage	68.8	31.2	2.1		4.2	6.3	87.5
Doing light housework	Frequency	144	10				1	9
	Percentage	93.5	6.5				10.0	90.0

Activity		Can Manage	Receive Help	Meets Needs?				
				Not Really	A Little	Partly	Largely	Totally
Doing small maintenance jobs	Frequency	93	61			6.6	1.6	91.8
	Percentage	60.4	39.6			6.6	8.2	100.0
Doing large/heavy maintenance jobs	Frequency	58	96	3		5	3	85
	Percentage	37.7	62.3	3.1		5.2	3.1	88.5
Other activities Not Specified	Frequency	152	2			1		1
	Percentage	98.7	1.3			50.0		50.0

Table 23: Who Helps with Activities of Daily Living?

Activity		Family	Professional Providers	Private Services	Mechanical Aids	Missing Data
Bathing and Showering	Percentage	42.9	57.2			
Dressing	Percentage	71.4	28.6			
Eating	Percentage		100			
Getting in and out of bed or chair	Percentage		66.6		33.3	
Walking	Percentage	12.6	6.3		75	6.3
Getting outside	Percentage	16.6	33.3		33.3	16.7
Using the toilet	Percentage		100			
Preparing meals	Percentage	27.3	63.6			
Shopping	Percentage	84.7	15.4			
Managing money	Percentage	66.6	33.3			
Using the telephone	Percentage		50		50	
Doing heavy housework	Percentage	20	64	14		2
Doing light housework	Percentage	10	80	10		
Doing small maintenance jobs	Percentage	58.1	9.7	30.7		1.6
Doing large/heavy maintenance jobs	Percentage	43.7	9.8	39.8		6.8
Other	Percentage	66.6	33.3			

Changing Living Arrangements

Participants were asked a series of questions around their thoughts about their future living arrangements. Thirty-six participants (23.4%) reported that they had at least considered the need to change their living arrangement in the 18 month period since the first round of interviews, although only 13 of those actually eventually decided to make the change and three of those eventually rescinded their decision. Twenty-nine (80.5%) of the 36 who considered moving were doing so because their advancing age and declining capacity made it difficult to manage and maintain, their present living arrangements (Table 24).

Table 24: Why did you consider changing your living arrangements?

	Frequency	Valid Percent	Cumulative Percent
House & garden too much	13	36.1	36.1
Health compromising ability to live independently	10	27.8	63.9
Mobility/access issues	3	8.3	72.2
Financial Issues	3	8.3	80.5
Move closer to family	3	8.3	88.8
Move closer to services	1	2.8	91.6
Other	3	8.3	100
Total	36	100.0	

Given that a concern driving this research was the possibility that rural older people may be forced out of their homes and communities in order to access services, it is notable that only one participant cited a need to move closer to services as a reason for considering changing their living arrangements. All but four of those who had considered moving had discussed the issue with family but no-one reported having discussed it with health and community service professionals. One participant *‘Made up my own mind then discussed idea [with niece].’*

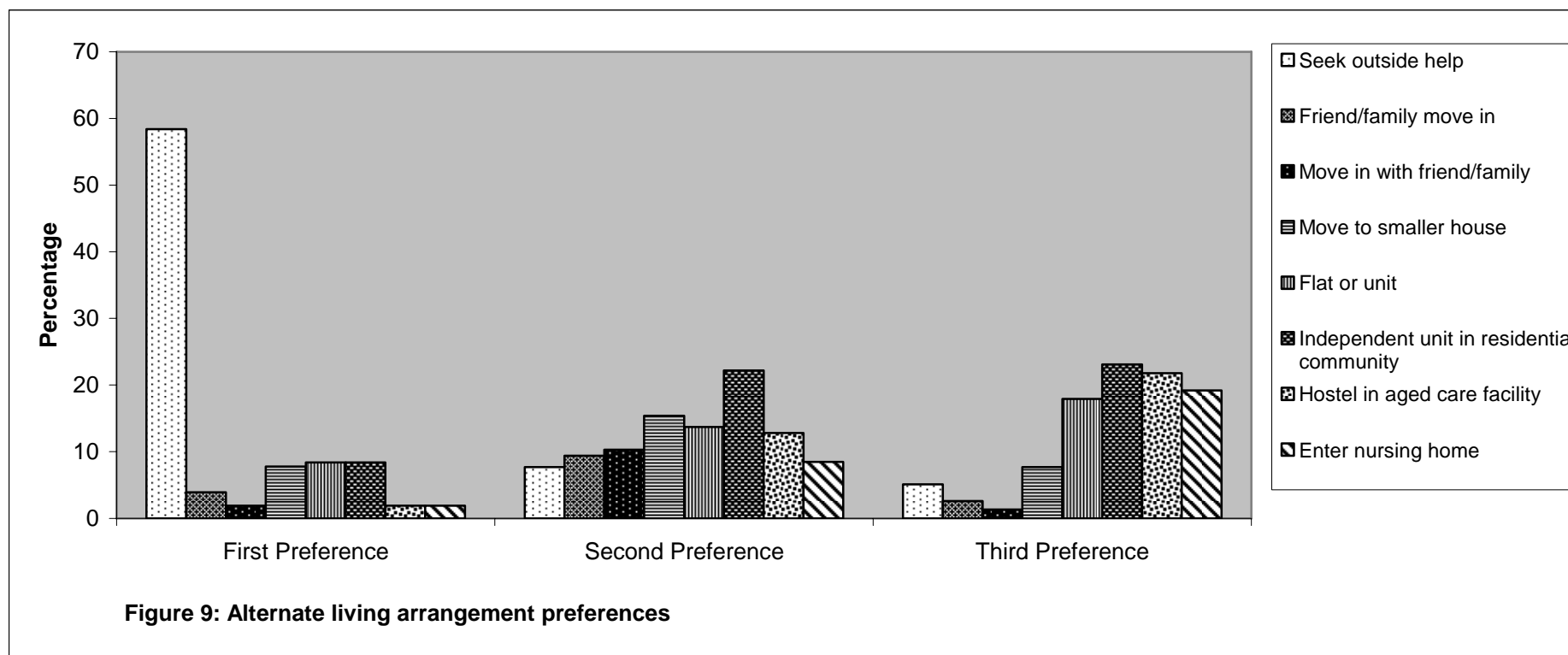
The options considered revealed a strong preference for maintaining independent living as much, and as long, as possible through a strategy of graduated downsizing, with moving to a smaller house nominated by 11 participants, a flat or unit by eight, and an independent living unit within a residential community by six. Only two respondents nominated moving in with a friend or family and two moving to a nursing home. The graduated strategy is clearly preferred where people provided ranked choice. Two people provided ranked choices. One indicated a hostel unit as first choice with nursing home bed as second choice. The other nominated a smaller house as first choice with a flat or unit second. One participant provided three ranked choices: moving in with family or a friend, then a flat or unit in the community, with an independent living unit in an aged care facility as last choice.

The reasons behind the decision to move all reflect difficulties in managing in the face of decreasing physical capacity, although these fall into two groups; those who are unable to care for themselves or their partners (hostels and nursing homes) and those who could no longer care for house and garden (unit).

The comments of those who decided against moving reveal the difficulty in relinquishing home and garden: *‘Not ready, I love the garden and love*

growing [my] own vegetables.’; and the determination to manage for as long as possible: ‘Been living here for fifty seven years so hard to move. Indecisive, decision too complicated, will cope as long as able.’

All participants were also asked to consider their options at some hypothetical future point when they are no longer able to cope in their present living arrangements. As with those who actually considered a move, the strong preference is to remain living independently, preferably within the community. The overwhelming first preference was to seek outside assistance (such as home help) to allow them to remain in their present home, followed by flats and independent living units with hostels and nursing homes a last resort.



If they were forced to change their living arrangements, most (127, 82.5%) expected to stay within their rural communities. The small number who expected to move community were much more likely to report doing so in order to be closer to services (87%) than being closer to family (43.5%) or friends (21.7%). However, when the larger group, who have no expectation of moving community, were asked to consider what might prompt them to change their mind, being closer to family (48%) was seen to be almost as important as being closer to services (51.2%). This is difficult to explain but possibly reflects the different health states of the two groups with those considering changing communities more cognizant of their dependence on health services.

Only 13 participants (8.4%) reported obligations or ties that restrict their choices in changing living arrangement. Of these, the majority (46.2%) relate to a partner and the remainder are evenly spread between siblings, children and, even, a parent.

Possible Future research phases

While no plans are in place for future phases of the study, 136 (88.3%) of the Phase II participants expressed a willingness to take part in a further interview.

Conclusions

This study is part of a longer term research plan to build a better evidence base for service planning for rural ageing. As a pilot study, this has provided both an opportunity to refine the methodology for a larger study and to build a useful picture of the current and likely future service needs of a small group of older rural people. The design, with 2 data collection rounds 18 months apart, was primarily aimed at providing a measure of change across time with the additional benefit of a second opportunity to refine the methodology. This two-phase approach has allowed more sophisticated probing on some issues inadequately explored in Phase I.

The Phase I data provided a quite detailed picture of a group of older people who remained highly functioning and engaged members of their communities despite evidence of problems with their health and declining capacity. In fact, there seemed to be little concession to age in either activity or future planning. The major question for the researchers in Phase II related to how much impact a further 18 months of age related decline had had on this situation. While a fuller picture of change awaits a detailed comparative analysis of the Phase I and II data (presently underway), the Phase II instrument contains sufficient (retrospective) change measures to draw at least interim conclusions.

The overall picture in Phase II does not differ dramatically from Phase I. Participants on the whole remained well supported, engaged, optimistic, generally satisfied with their finances, quality of life and access to quality health services and generally 'doing very well'. The numbers reporting major change events in their lives are quite small although at the personal level many of these changes such as the loss of significant others or being forced by declining health into a more dependent living arrangement, would have been dramatic in the effect on individual lives. More widely, the picture is more one of incremental loss; a gradual shrinking of independence and choice though a progressive loss of physical capacity, generally met with acceptance and stoic adaptation. Apart perhaps from the (more dramatic) penultimate decline into frailty and dependence, it is a process easily missed by communities and services providers alike as older people become incrementally marginalised and disconnected from the life of their communities with a likely attendant acceleration in decline. The challenge is to develop policies and services that address this process from the earliest stages; to delay the onset of disconnection, dependence and frailty by supporting people, and communities, to maintain their active engagement in the life of their families and communities in the face of inevitable declining capacity.

The Phase II data provides a clearer picture of a number of issues only touched upon in Phase I. It reveals that older people play a carer role not just for dependent spouses but at times for siblings, children and grandchildren. It highlights the role that pets play in older people's lives both as companions and as incentives to exercise. The older people in this sample are extremely well supported but much of that support comes from family and neighbours. This may work well in many rural communities at present but will likely be an issue for service providers in the future as increasing numbers of older 'sea' and 'tree'-changers move into rural and regional areas leaving behind the support of family or established friendship networks. When examined more closely, the relatively high level of involvement in hobbies found in Phase I has to be qualified by the number of these that are essentially solitary and provide less exercise for the mind than for the body, leading to potentially greater social isolation.

Finally, Phase II data on actual and hypothetical future changes in living arrangements reveal an overwhelming preference for living arrangements that preserve, for as long as possible, both independence and community connection. In terms of services, this requires an approach that includes, but goes beyond, supporting people to stay in their own homes as they age. It means policies and infrastructure that provide a series of graduated support and accommodation options that at each stage are designed to minimise tendencies towards disconnection and marginalisation from the community. For example, the sample overwhelmingly relies on private cars in moving about their communities. Losing access to a car or licence means much greater difficulty in keeping appointments with health providers; it also means being unable to continue working with the football club, or the church or meeting friends for afternoon tea. In the end, loss of social contact may be more significant for healthy ageing than restricted access to health services.

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