

Rural Seniors Research – Pilot Survey North West Tasmania

Rural Ageing Research Consortium

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October 2005

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Executive Summary

This study was prompted by concerns about the paucity of evidence available for rural aged care service planning and policy development. It was conducted by a consortium of researchers drawn from five departments within the University of Tasmania (Rural Clinical School, University Department of Rural Health, Nursing, Pathology, Geography and Environmental Studies and Economics) with the data collection undertaken by a local commercial social research company.

The study involved interviewing 193 people, aged 65 years and over, across seven local government areas in the Cradle-Coast region of North-West Tasmania. The interview was designed to explore their present situation, also present and projected future service needs. It was designed both as a pilot for a planned larger Tasmanian-wide rural ageing study and as the first phase of a stand-alone 18 month two-part study looking into how a group of older rural Tasmanians deal with the changes and challenges of ageing.

The study found that:

- This is a homogeneous and stable group with over three quarters born in Tasmania (with only one in ten born overseas) and an average of 41 years residence in the area.
- Although 39.4% live alone, as a group they enjoy a high level of social support with 38.9% having at least daily face-to-face or phone contact with someone who provides support and 93.3% reporting at least one such contact a month.
- The group are quite mobile with 46.1% walking at least weekly and 99% having access to a car which they use at least weekly. They are low users of public transport and taxis.
- Although they report very modest incomes, 82.9% own their own homes and 90.2% rate their financial situation as 'OK' or better.
- 96.4% rate their quality of life and lifestyle as 'OK' or better with over two thirds rating it 'good' or better.
- The groups is very active and involved in their community with:
 - 43% involved in volunteer activities
 - 62.7% involved in some form of organised social groups
 - 73.6% 'getting together' at least weekly with friends or neighbours
 - 94.3% reporting having an least one hobby with an average of 3.3 hobbies listed per person
- While 73% of respondents report at least one significant health condition, 86% judge their own health, and 82% their partners health to be 'average' or better, and most report that their own health or their partner's health (81.2% and 88.5% respectively) limit their activities only 'a little' or not at all.
- Respondents use a very wide range of health services and express a generally high level of satisfaction with those services with an average satisfaction score of 4.6 out of a possible 5 (1=very dissatisfied – 5= very satisfied) and a range of only 4.3-4.8. There were a small number of disparate concerns expressed about services with length of waiting lists, restrictions on services, inconvenience of access and lack of personal touch most prominent.

- Sixty four people identified ‘missing’ or inadequate services. This list covers a wide range of services but is topped by transport and dental services.
- The interviews included a set of questions designed to measure respondents’ dependence on help with routine activities of daily living. This revealed that the vast majority of the respondents were capable of living very independent lives.
- When questioned about their intentions should changing circumstances force them to reconsider their living arrangements, there was a very strong preference for minimising change with 88.5% indicating they had no contingency plans, and approximately 80% intending to remain within their communities, regardless. When asked about influences on this decision 70.6% nominated immediate family and 26.7% indicated that the decision would be largely their own. The major factors in that decision were access to health (64.8%) and community (36.8%) services. Over ninety percent of the respondents indicated their willingness to participate in the 18 months second stage of the study.

Full Report

Introduction

This 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 recognition that complex social and demographic changes mean that we need 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.’ [1 p.1] 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. Kane [2] argues that while geriatric health service research is badly needed, and has a lot to contribute to successful ageing, it has been ‘ignored in practice to date’ (p. 460).

Australia’s ageing demographic[3] 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 [4]. Maintaining our ageing individuals as community assets, not liabilities, will require evidence-based long-term approaches to developing policy and models for delivery of healthy ageing and frailty services [3].

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 proven adequate in the past – a point open to dispute – it is unlikely to do so in the future as the ‘baby-boomers bulge’ moves towards retirement ages. Apart from their sheer numbers, they are 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 [5].

Research Aim

This research comprises the first phase of a two-part study of senior citizens (aged 65 years and over) living in North West Tasmania to profile their current state and perceived future needs and expectations in relation to community, social and health services support. This study was designed both as a pilot for a planned larger Tasmanian-wide study and as a stand-alone study which will look at how this group deals with the changes and challenges they experience over an 18 month period.

The Research Team

The team consisted 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 actual data collection was undertaken by a commercial social research firm, Myriad Consultancy.

Methodology

1. The survey design was developed by the Project Team in early 2005. The design incorporated a draft survey questionnaire with showcard, an information sheet to be sent to respondents prior to interview and a consent form for sign-off by respondent and interviewer.
2. The survey instruments and methodology received the necessary approval from the *Tasmanian Health and Medical Human Research Ethics Committee*.
3. In order to refine the survey methodology and instruments, two focus groups were conducted by Myriad in early May 2005 with participants from the target demographic – males and females aged 65 plus, resident in the Northwest region
4. Data collection by a team recruited and trained by Myriad commenced over the weekend 25/26 June and was concluded by the 14th July, 2005.
5. Potential survey participants were sourced from existing contacts and referrals – people aged 65 plus living in the Northwest region, and not residents of aged care homes (unless separate independent living arrangement). This ‘warm’ contact approach was agreed as an alternative to randomised ‘cold calling’ in order to maximise participation and minimise apprehension. This decision has some implications for the research which are discussed below. The survey then utilised a two stage approach:
 - a. **telephone contact** to explain the purpose of the survey and to obtain consent for an in-home interview. At this stage the information letter was sent to the respondent.
 - b. **an in-home interview** conducted by the Myriad researcher with the formal fully informed consent of the respondent Respondents were able to opt out of the survey process at any stage. There were minimal opt outs during the telephone contacts and just one at the in-home interview stage.
6. Interviews duration ranged from 20 – 60 minutes, with an average length of 35 minutes. Respondents were given a small ‘thankyou’ from our client in appreciation of their time – University carry bag and Rural Clinical School pen.
7. The initial data collation, analysis and reporting (using Microsoft Excel) was undertaken by Myriad, with further analysis and reporting (using Excel and SPSS) done by Dr Peter Orpin on behalf of the team.
8. Survey participants responded positively to the chosen approach with over 90% of respondents indicating that they would be willing to participate in a follow-up interview in twelve months time.

The Sample

A total of 193 people aged 65 years and over were interviewed. 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 final survey sample of 193 respondents is summarised in Table 1.

Table 1: Sample Distribution (Frequencies)

	Male	Female	65 - 69	70 - 74	75 - 79	80+	Not recorded	Total
Burnie	15	19	6	12	8	8		34
Central Coast	23	22	15	7	14	9		45
Circular Head	6	6	5	3	2	1	1	12
Devonport	22	26	11	14	12	11		48
Kentish	5	5	2	1	4	3		10
Latrobe	7	12	6	5	4	4		19
Waratah Wynyard	12	13	7	6	6	6		25
Overall	90	103	52	48	50	42	1	193

Given the ‘networking’ method of recruiting participants, there is likely to be a *skew* towards those more socially connected residents and away from those less socially connected. The *very frail elderly* were less likely to be included in the survey sample for two reasons – the survey demands for participants, and the exclusion of those in nursing home dependent care from the target population.

The sample is more regional than rural – 70.4% of the sample (138/193 with 3 missing values) is drawn from the rural population centres and 28.1% (55) from rural locations outside of those centres. According to the 2001 census, overall, 43.1% of the population in these LGAs live outside of the major population centres but this varies between <1% and 82% across the 7 LGAs.

Results

Demographics

This is a homogeneous group with three quarters (144, 74.6%) born in Tasmania and only 21 (10.9%) overseas born. The latter came principally from Europe with the UK and Holland the most prominent countries of origin, and all but 4 are residents of many year's standing.

It is also a very stable population living in the area for an average of 41 years and only 36/193 (31.1%) for 10 years or less.

Table 2: Years Lived in Area

	Frequency	Percent
0-5 Years	24	12.4
6-10 Years	12	6.2
11-20 Years	22	11.4
21-30 Years	17	8.8
31-40 Years	25	13.0
40+ Years	93	48.2
Total	193	100.0

Of the 24 people (12.4%) who had lived in the area for five years or less, almost half had moved to the area from interstate - generally for a mixture of lifestyle and family reasons - and the remainder from elsewhere in Tasmania, or overseas.

Table 3: Those living in the area <= 5years – where moved from?

Moved from?	Elsewhere North West	Elsewhere within Tasmania	Interstate	Overseas	Total
Frequency	7	5	11	1	24
Percentage	29.2%	20.8%	45.8%	4.2%	100.0%

Given the study's interest in mobility, some comparisons were undertaken between this group and the longer term residents. This yielded some noticeable differences – as a group they are much less likely to live alone, to have support living close, to have daily or weekly support visits and to be involved in volunteer work; although no less likely to be involved in organised activities - however, the nature and size of the sample precludes reliable statistical testing of these differences.

Support

People in the sample appear to have good access to social and emotional support.

Households

Almost 2 in every 5 (76, 39.4%) of the sample live alone whereas about half (107, 55.4%) share their house with only one other, the vast majority (113, 96.6%) with a partner or spouse – 6 of these also have a son or daughter at home and one a parent. Almost two thirds (116, 61.4%) report that they currently have a spouse or partner, with a further 58 (30.7%) widowed.

Table 4: Numbers Sharing Household

Number sharing Household	Frequency	Percent
0	76	39.4
1	107	55.4
2	8	4.1
3	2	1.0
Total	193	100.0

Table 5: Relationship of person sharing house

	Frequency	Percent
Partner/Spouse	113	96.6
Son/Daughter	3	2.6
Other	1	.9
Total	117	100.0

Pets

Seventy respondents (36.3%) reported keeping at least one pet. Of those who detailed their pets the vast majority reported one or two pets although one person reported 16 animals sharing their house and a small number 4 or 5. Dogs (41) and cats (24) predominated but the remainder covered a very wide spectrum: caged and exotic birds, rabbits and goldfish. Surprisingly for a regional rural area only 6 people reported keeping what could be called ‘farm’ animals.

Personal Contact and Support

The group appears to enjoy an extremely high level of personal contact and support. The vast majority (180, 93.3%) report at least one other family member or close friend living nearby who ‘supported them on a regular basis’.

The pattern of support is complex with most reporting more than one source and mode of support and varying frequencies of contact (See Tables 7 and 8 for details). Overall, more than three quarters of the total sample have at least weekly supportive contact with a friend or family. Family are providing more of the overall support and 3-6 times more of the phone support. Support is most often face-to-face rather than by phone, especially if it is daily support.

Table 6: Combined table –frequency of visit/phone contact family and friends - cumulative

	Freq.	% total respondents
Everyday	75	38.9
At least weekly	150	77.7
At least monthly	180	93.3
No close support	13	6.7
Total	193	100

Table 7: Frequency of face-to-face contact for those reporting at least one friend or family member providing support

<i>Frequency of Visit</i>	Family		Other		Total†	
	Freq.	%	Freq.	%	Freq.	%
everyday	36	20.0	25	13.9	54*	30.0
at least weekly (but not daily)	108	60.0	60	33.3	132*	73.3
at least once a month (but not daily or weekly)	16	8.9	5	2.8	19*	10.6

Table 8: Frequency of phone contact for those reporting at least one friend or family member providing support

<i>Frequency of phone contact</i>	Family		Other		Total†	
	Freq.	%	Freq.	%	Freq.	%
everyday	22	12.2	7	3.9	24*	13.3
at least weekly (but not daily)	100	55.6	16	8.9	109*	60.6
at least once a month (but not daily or weekly)	20	11.1	3	1.7	23*	12.8

**Totals include multiple responses*

† Tallies are mutually exclusive not cumulative. That is, totals are those getting at least a daily/weekly/monthly visit or phone contact – be it from a family member or friend or both

Mobility

This is a very mobile group. One third get around daily by walking and almost half are sufficiently mobile to walk at least occasionally. Almost all the sample (99%) have access to a car which they use at least weekly, three quarters of those, a household car. There is very low usage of public transport and taxis probably reflecting availability as much as anything. A quarter use community transport, mostly on an irregular basis.

Table 9: Transport use

	Daily		At least weekly		Less than weekly		Total	
	Freq	%	Freq	%	Freq	%	Freq	%
Walking	62	32.1	27	14	6	3.1	95	49.2
Household Car	81	42.0	68	35.2	0	0	148	77.2
Other Private Car	7	3.6	19	9.8	16	8.3	42	21.8
Public Transport	0	0	6	3.1	21	10.9	27	14.0
Taxi	2	1.0	5	2.6	14	7.3	21	10.9
Community Transport	1	0.5	6	3.1	20	10.4	27	14.0
Other	0	0	2	1.0	1	0.5	3	1.6

Education and Employment

The group reports somewhat lower than national levels of educational achievement for their age group (ABS 2001 Census) with almost two thirds (126, 65.3%) not staying beyond 'School Certificate' level and only 20 (10.4%) with a university degree.

Table 10: Highest Level of Education Completed

	Frequency	Percent
Left school before completion	69	35.8
School certificate or similar	57	29.5
Matriculation or similar	8	4.1
Technical or trade qualification	23	11.9
Graduate certificate or diploma	15	7.8
Undergraduate degree	9	4.7
Post-graduate degree	11	5.7
Missing	1	.5

179 (92.7%) of the sample are retired with only 7 (3.6%) reporting that they were in fulltime work. Prior to retirement, the respondents worked in a wide range of industries and occupations with a predominance of lower level white, pink and blue collar jobs.

Table 11: Employment by Industry*

Industry	Frequency	Percent
Primary	25	13.0
Manufacturing	19	9.8
Utilities	5	2.6
Building and Construction	14	7.3
Wholesale/Retail	12	6.2

Hospitality	13	6.7
Transport	4	2.1
Communication	2	1.0
Finance & Insurance	5	2.6
Property & business	1	.5
Government & Defence	5	2.6
Education	11	5.7
Health & Community Services	22	11.4
Cultural & recreational	7	3.6
Other	3	1.6
Missing/Not Stated	45	23.3
Total	193	100.0

Table 12: Employment by occupational group*

	Frequency	Percent
Managers and administrators	17	8.8
Professionals	23	11.9
Associate Professionals	8	4.1
Tradespersons and related workers	37	19.2
Advanced clerical and service workers	9	4.7
Intermediate clerical, sales and service workers	10	5.2
Intermediate production and transport workers	6	3.1
Elementary clerical sales and service workers	25	13.0
Labourers and related workers	23	11.9
Missing/Not shown	35	18.2
Total	193	100.0

***Respondents were asked to state their occupation and the categorisations in these table have been derived analytically from those responses. This does raise the possibility of some level of interpretive error.**

Financial Status

The mean monthly household income of the 106 (54.9%) who provided a figure was \$1690 with a range of \$800-\$8,000. Of these, only 6 (11.3%) reported a monthly income above \$2000. A further 27 (14%) stated their income as 'pension'. Further analysis reveals that 90.2% of the respondents rely on some form of pension for at least part of their income.

Seventy one people (36.8%) report holding private health insurance. Problems with the design of this question mean that there are no reliable data on the numbers holding health care cards.

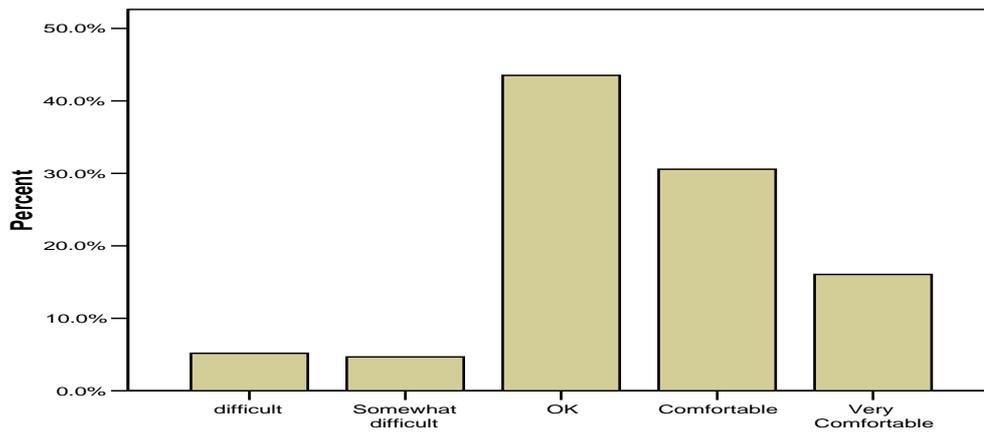
There is a high level of home ownership among the sample at 85% (164) reporting living in their own homes with all but 4 of those reporting that they fully own that home.

Table 13: Home Ownership

	Frequency	Percent
Fully Owned	160	82.9
Paying off mortgage	4	2.1
Renting	27	14.0
Living with family	1	.5
Other	1	.5
Total	193	100.0

Most tellingly, while the reported incomes are not high by current standards, as a group the sample are generally quite comfortable with their financial situation with 90 (46.6%) reporting that they are at least 'comfortable' and 174 (90.2%) 'OK' or better.

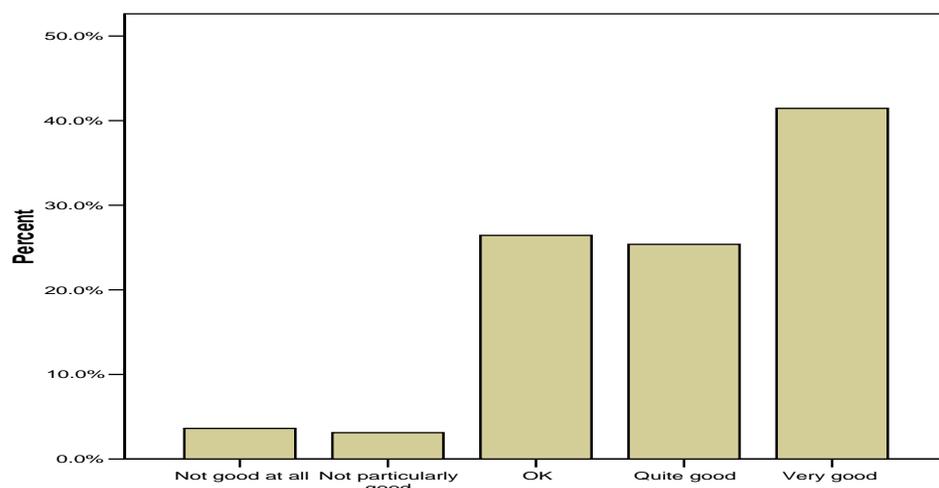
Chart 1: Satisfaction with financial situation



Quality of Life and Activities

As with income, people in the sample are generally very happy with their overall quality of life and lifestyle with over two thirds (129, 66.8%) reporting it as 'quite good' or 'very good' and 96.4% (180) as 'OK' or better.

Chart 2: Satisfaction with Quality of life and Lifestyle



As a group, these people are quite active in their communities.

Volunteering

Forty three percent (83) report being involved in volunteer activities putting in an average of 6.5 hours per week with a range of from 'twice yearly' to 60 hours per week (involved in State Emergency Service and road rescue). These cover a large range of one-on-one and group activities with a particular emphasis on assistance to the less privileged. They encompass church-based activities, sport, general community welfare and support including home support and Meals on Wheels, entertaining, work with service clubs and production of handicrafts for charities.

Socialising

The group is also very socially active and connected with almost two thirds (121, 62.7%) involved at least weekly in some form of organised social group and almost three quarters (142, 73.6%) 'getting together' at least weekly with friends and/or neighbours.

Table 14: Getting together with others

	Getting together in organised groups			Getting together with friends and neighbours		
	Freq	Percent	Cumulative Percent	Freq	Percent	Cumulative Percent
Daily	7	3.6	3.6	39	20.2	20.2
At least weekly	114	59.1	62.7	103	53.4	73.6
At least monthly	20	10.4	73.1	23	11.9	85.5
Less than monthly	45	23.3	96.4	27	14.0	99.5
Missing	7	3.6	100.0	1	.5	100.0
Total	193	100.0		193	100.0	

Hobbies

Almost all the sample have at least one hobby and in total 193 subjects produced a list of 597 activities with most people reporting multiple hobbies (mean number reported 3.3) and some reporting as many as 6 or 7.

Table 15: Numbers of activities/hobbies listed

	1	2	3	4	5	6	7	8	Total	Missing
Freq	26	38	49	33	16	12	8	1	183	10
Percent	13.5	19.7	25.4	17.1	8.3	6.2	4.1	.5	94.3	5.2

Gardening is by far the most often mentioned hobby. The majority of the activities have a strong social dimension and there is wide involvement in range of quite physical activities and sports: bowls, badminton, dancing, fishing, golf, shooting/hunting, tai chi and other exercise classes. There is however, also a strong representation from quite solitary and sedentary pursuits such as handcraft (especially knitting), reading (very commonly) and watching TV (especially sports). Overall the activities are more social and physical than intellectual with apart from reading only crosswords and computers (small numbers) appear to be predominantly intellectual in nature.

Table 16: Listed hobbies

Antique tractors	Crafts / craft group (5)	Photography
Badminton (2)	Crochet (2)	Pigeon racing
Bible study	Crosswords (2)	Potter
Bingo (6)	Dancing (4)	Probus/Lions Club
Birds	Elderly citizens	Reading (8)
Bowls (9)	Fishing (8)	Rotary
Breeding budgies	Football club (local) (6)	RSL meetings
Bus trips	Gardening (23)	Senior citizens (5)
Cake decorating	Golf (7)	SES
Camera club	Gymnasium	Spectator at family sports
Camping	Hobby farming	Spinning
Cards (4)	Horses	Swimming (3)
Chat'n'choose	Indoor bowls (5)	Tai chi
Choir (3)	Knitting (12)	Tennis (3)
Church (8)	Meals on Wheels	Walking (21)
Computer class (3)	Music (2)	Weight lifting
Cooking and catering	Needlecraft (4)	

Health

Despite their age, 86% (166) judge their own health and 82% (91/111) their partner's health to be 'average' or better.

Chart 3: Perceptions of own health status

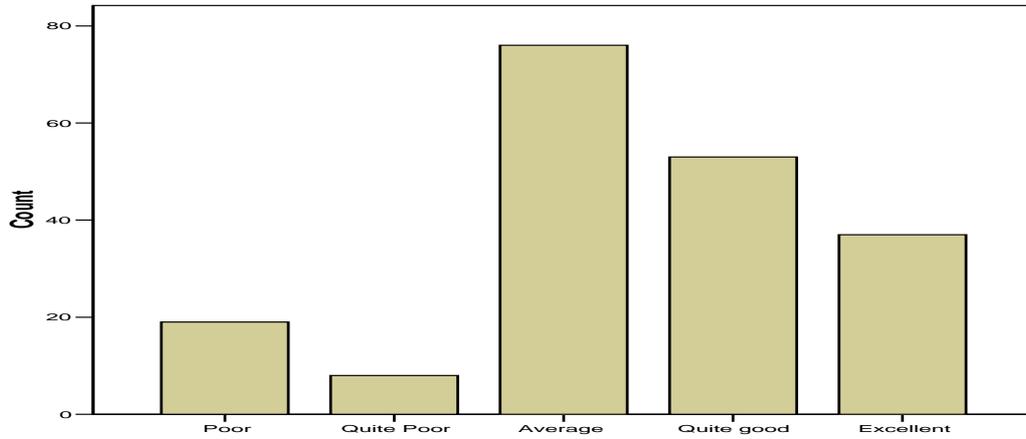
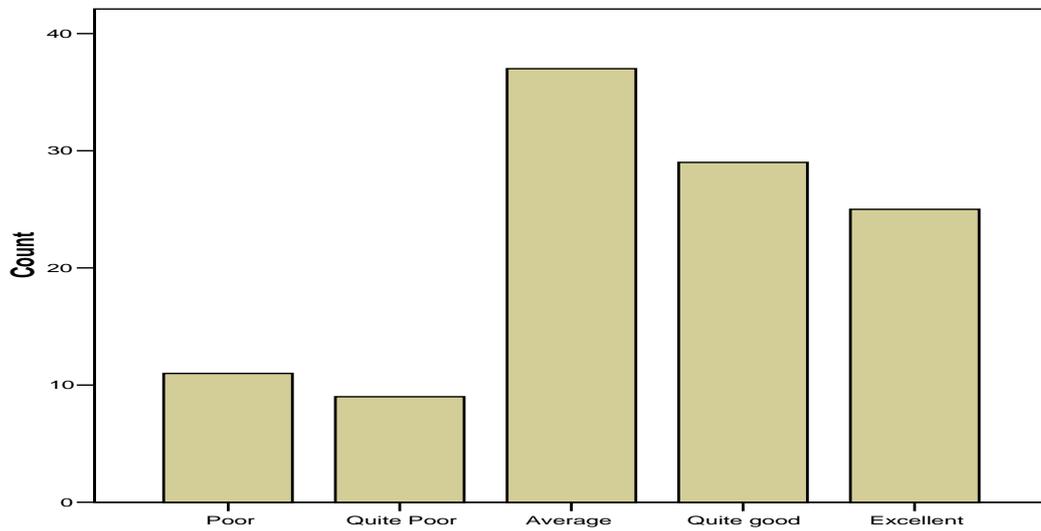


Chart 4: Perceptions of partner's health status



Neither the respondents' own health, nor that of their partners appears to be seen as significantly limiting their activities with only 18.8% (own health) and 11.5% (partner's health) reporting that health problems limit their activities 'a lot'.

Chart5: Perceptions of how much own health limits activities

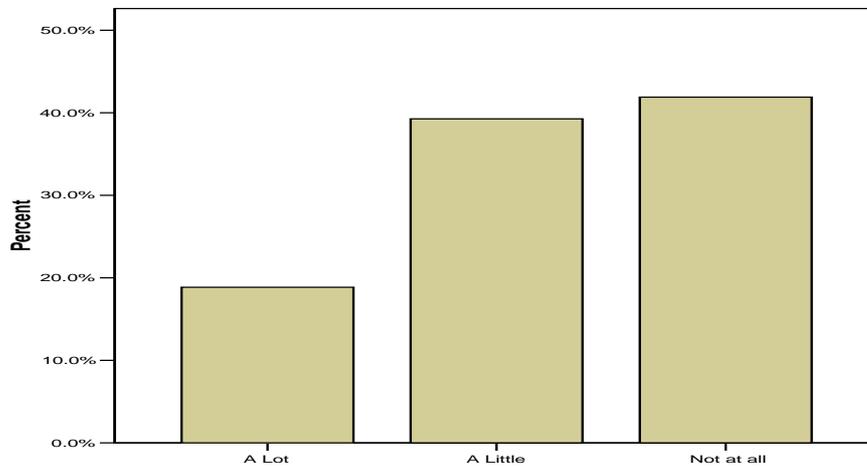
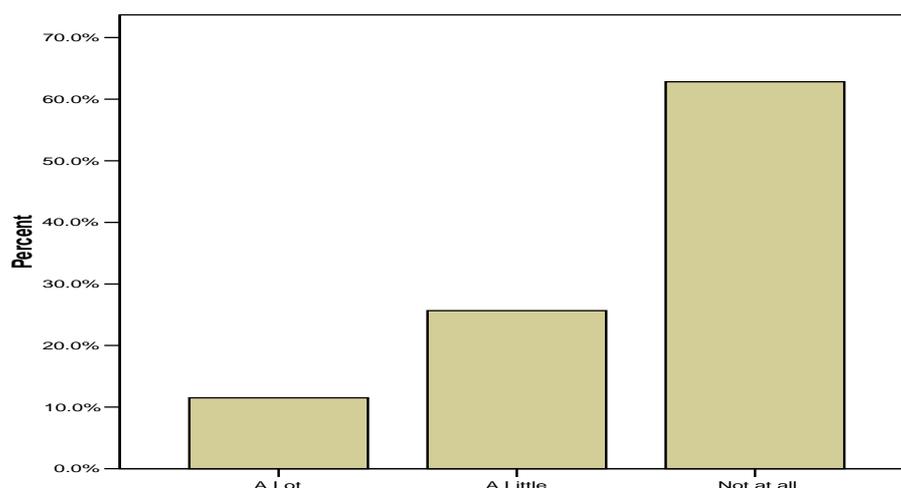


Chart 6: Perceptions of how much partner's health limits activities



Three quarters of respondents (141, 73%) reported at least one health condition with an average of 1.6, and a median 1 condition per person. These cover the expected range of mainly chronic conditions associated with ageing with arthritis (and other musculoskeletal diseases), cardiovascular disease and diabetes being the most prominent. There is perhaps a lower than expected incidence of cancer and chronic pulmonary disease.

Table 17: Range of conditions listed

	Freq.	%		Freq.	%
Blood pressure/hypertension	39	20.2	Blood disorder	5	2.6
Arthritis/osteoarthritis	46	23.8	Prostrate	5	2.6
Heart	39	20.2	Hip replacement	5	2.6
Diabetes	33	17.1	Thyroid	5	2.6
Back/neck	19	9.8	Epilepsy	4	2.1
Eye/cataracts	15	7.8	Bowel	4	2.1
Asthma/emphysema	12	6.2	Stroke	4	2.1
Osteoporosis	8	4.1	Knee	4	2.1
Cancer	7	3.6	Hearing	2	1.0
Cholesterol	7	3.6			

Health Services Usage

The list of services used in the previous 12 months was dominated by general practitioner and pharmacy services but covered a very wide range. Only 20 (10.4%) report using Meals on Wheels and 4.7% (9) patient transport services. There is a uniformly high level of satisfaction with services with even the lowest scoring service scoring above satisfied.

Table 18: Health service usage and satisfaction

Service Used	Freq	%	Daily (%)	At least weekly (%)	At Least monthly (%)	Less often than monthly (%)	Mean Satisfaction Score*
General Practitioner	190	98.4	0	7.4	41.1	51.6	4.6
Chemist	176	91.2	0	13.7	68.0	18.3	4.8
Medical Specialist	89	46.1	0	2.2	13.5	84.3	4.6
Other Health Professionals	75	38.9	1.3	9.3	17.3	72.0	4.5
Dentist	51	26.4	0	1.9	0	98.1	4.5
Home Help	45	23.3	8.9	42.2	42.2	6.7	4.8
Hospital Outpatient	38	19.7	0	2.6	13.2	84.2	4.5
Hospital Inpatient	30	15.5	0	0	0	100.0	4.3
Other Home Support	29	15.0	17.2	24.1	37.9	20.7	4.8
Community Health Centre	28	14.5	3.6	14.3	17.9	64.3	4.5
Community Nurse	24	12.4	4.2	29.2	41.7	25.0	4.7
Meals on Wheels	20	10.4	75.0	20.0	0	5.0	4.4
Patient Transport	9	4.7	0	0	22.2	77.8	4.6
Day Centre	4	2.1	0	75.0	0	25.0	4.7

* Scored on Likert scale: 1=very dissatisfied to 5=Very satisfied.

While the overall satisfaction level was high, a number of individuals did raise issues about particular services. The list is reasonably disparate although a number of issues do recur: the length of waiting lists, restrictions on services and a lack of a personal touch in some services.

Moving outside the area for services

Medical specialists top the list of services accessed outside of the region with 17 people reporting travelling to Launceston (northern centre), 8 to Hobart (southern centre) and one to Melbourne for this purpose. Seven people reported travelling to Launceston for hospital inpatient or outpatient services.

Services lacking in District or difficult to access

Almost half the sample (93, 48.1%) of people responded to this question although 29 of those replied 'none'. The following issues and services stood out (numbers raising issue in brackets):

- 1. Transport (16):** By far the most often cited with people concerned both about having to travel to access services and the difficulties of travel with the lack of public transport and demand on community transport;
- 2. Dental Services (11):** Mostly this referred to lack of access but also the range of treatments available;

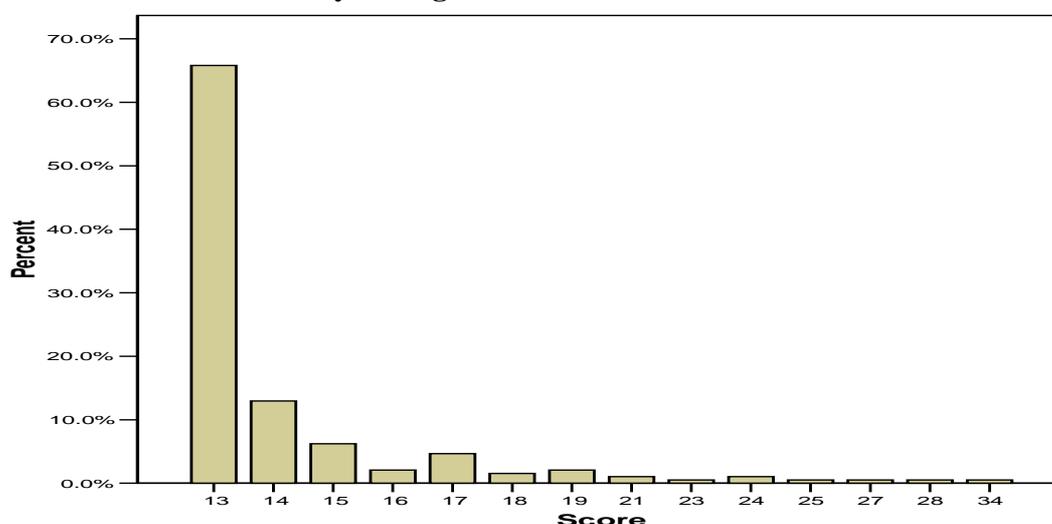
3. **Public Services and Facilities – Non health and para-health (13):** This covers a range; police presence, mail and phone services, pedestrian access but most prominent is lack of access to Medicare offices;
4. **Hospitals and Health Centres (8):** Most prominent was the general issue of hospital waiting lists but also two respondents criticised the placement of a new health centre and a small number would like closer hospital or health centres or more beds;
5. **Medical Specialists (8):** People were concerned not only with the need to travel to access specialists – mostly to Launceston – but also the long waiting times;
6. **Home Maintenance (6):** People were looking for an increase in the available help with chores around the home – lawn mowing, gardening, minor maintenance;
7. **General Practitioner Services (5):** These people were concerned about the difficulty of getting appointments and the need to travel to access GP services.

A further, quite long, list of issues was raised by just one or two people: allied health services, aged care, nursing, ambulance, exercise classes, cancer, diagnostic and disability services. In many cases the issue was inconvenience and difficult access rather than no access.

Activities of Daily Living (ADL)

This series of questions was designed to measure levels of dependence/independence among the sample. Interviewees were provided with a list of thirteen common activities of daily living and asked to indicate the degree of help they needed to perform these activities where 1=No Help; 2=Some help; 3=Total help. This provided for a maximum score of 39 (totally dependent for all activities) and a minimum of 13 (fully independent). The sample yielded a mean score of 14.2 (range 13-34) suggesting a very independent group of people - 65.8% (127) of the sample scored at the lowest level (13), and 85% (164) scored 15 or less. There was a scattering of higher scores each generally representing one or two individuals.

Chart 7: Activities of Daily Living scores



The pattern of responses reveals that where assistance was required it was generally with activities related to the maintenance of the household - preparing meals, shopping and housework - rather than the person.

Table 19: Activities of Daily Living – Assistance Required (Percentages)

	No Help (%)	Some Help (%)	Total Help (%)
Bathing	96.9	2.1	1.0
Dressing	96.9	2.6	.5
Eating	0	0	100
Getting in and out of bed or chair	97.4	2.1	.5
Walking	92.7	4.7	2.6
Getting outside	97.4	1.6	1.0
Using toilet	99.0	.5	.5
Preparing Meals	87.6	8.8	3.6
Shopping	85.5	7.3	7.3
Managing Money	98.4	.5	1.0
Using telephone	99.0	1.0	
Heavy Housework	72.0	13.0	15.0
Light Housework	89.1	4.7	6.2

Where assistance was required the source of that assistance depended on the nature of the task. Assistance with personal care was predominantly provided by partners, shopping by friends and housework and meals by service providers and outside carers.

Table 20: Activities of Daily Living – Source of assistance when required (Frequencies)

	Partner	Family/Friends	Physical Aids	Outside/Carer
Bathing	1		1	3
Dressing	3			2
Eating				
Getting in and out of bed or chair	2		2	1
Walking	2	3	7	1
Getting outside	2	0	2	1
Using toilet			2	
Preparing Meals	5			1 (17 Meals on wheels)
Shopping	6	13	0	5
Managing Money	1			1
Using telephone				
Heavy Housework	5	1		40
Light Housework	4			13

Only a small number (19, 9.8%) identified specific areas in which they needed help and were not getting it. These primarily related to home maintenance tasks – garden maintenance, lawn mowing and heavy cleaning and housework.

Staying and Moving

The final section of the survey was concerned with moving house in the later stages of life: how long people expected to stay in their present living arrangement, where they planned to move, if and when they did, and what factors would influence that decision.

Stay or Move?

Over half of the sample (103, 53.4%) answered ‘don’t know’ when asked how long they expected to stay where they were, 26 (13.5%) planned to stay ‘as long as possible’ and a further 41 (21.2%) stated quite categorically that they had no intention whatever of moving – at least while they were alive. This means that 88.5% (170/193) of the respondents have no contingency plans for what they would do, should at some time in the future, it become untenable to remain where and as they are.

Table 21: How long do you expect to stay in your current housing arrangement?

	Frequency	Percent	Cumulative Percent
Don't Know	103	53.4	53.6
Indefinite/As long as possible	26	13.5	67.2
Till Death/Forever	41	21.2	88.5
Less than a year	4	2.1	90.6
1-5 years	9	4.7	95.3
6-10 years	2	1.0	96.4
More than 10 years	5	2.6	99.0
Total	190	98.5	
Missing	3	1.5	

Where?

Data on where people might move was compromised by problems with the design of the relevant question. However, a clear majority of the sample (between 126, 77.8% and 151, 85.8%) appear intent on remaining within their community even if forced to move from their present homes. Regardless of whether they intend staying within the area or moving elsewhere, there is a preference for a retirement home over a nursing home and a significant number who hope simply to move to a smaller, more easily managed house.

Table 22: If you move from you present home where are you likely to move?

Elsewhere in present Community			Outside of present Community		
	Frequency	Percent		Frequency	Percent
Stay where are	151†	85.8†	Move Elsewhere	36†	22.2†
Not Stay	23†	13.1†	Not move elsewhere	126†	77.8†
Don't Know	2	1.1	Don't Know	0	0
Total	176	100.0	Total	162	100.0

Missing	17		Missing	31	
Total	193		Total	193	
If move, where to?			If move, where to?		
Retirement Home	63	41.7	Retirement Home	14	38.9
Nursing Home	51	33.8	Nursing Home	8	22.2
Move in with family	8	5.3	Move in with family	2	5.6
Other*	27	17.9	Other*	12	33.3
Total	151	100.0	Total	36	100.0
Missing	43		Missing	157	
Total	193		Total	193	

†Discrepancies reveal a problem with the question design and interpretation.

*The 'Other' response is almost uniformly unit/smaller home.

Among those who indicated they would likely move elsewhere, and nominated an area, there was a reasonably even split between staying within the North West community, moving elsewhere in Tasmania and moving interstate.

Table 23: If Moving Elsewhere – where would you move to?

	Frequency	Percent
North West Community	9	37.5
Elsewhere in Tasmania	8	33.3
Interstate	7	29.2
Total	24	100.0
Missing	12	
Total	36	

Influences on Decisions about Moving

When questioned about who would influence their decision when deciding whether and where to move, the largest number by far (132, 70.6%) nominated immediate family. The other substantive category (50, 26.7%) was 'other' which most often was expanded as 'self', a clear statement of independence.

Table 24: Who is likely influence your decision on moving?

	Primary Influence (Freq)	Primary Influence (Percent)	Second Influence (Freq)	All Influences (Freq)	All Influences (Percent)
Immediate family	131	74.9	1	132	70.6
Friends	2	1.1	3	5	2.7
Other	42	24.0	8	50	26.7
Total	175	100.0	12	187	100
Missing	18				
Total	193				

In terms of what, rather than who, would be likely to influence this decision, the availability of health and welfare services are by far the most common responses with two thirds mentioning the former and one third the latter. The ‘other’ grouping most commonly mentioned family but also included: own health, cost, professional advice, home upkeep, general coping, ‘not thinking about it at present’, transport, weather and church.

Table 25: What is likely influence your decision on moving?

	Frequency	Percent*
Health services in area	125	64.8
Community services in area	71	36.8
Other services	5	2.6
Other	20	10.4
None	9	4.7
Missing/Did not know	24	12.4

* Multiple responses possible.

Participation in Second Phase of Study

Almost all the subjects 178/193 (92.2%) agreed to be reinterviewed in 18 months for the second phase of the study.

Discussion

The pilot study reveals a group of older people who are managing a high quality of life as active, involved and committed members of their communities despite some clear issues around health and capacity.

This is a homogeneous and stable group with low levels of geographical mobility. Although not unexpected, this does restrict the study’s ability to address questions around the different needs of in-comer and longer term residents. The literature suggests that the former have more financial resources and use less services and the latter more social resources [6] however this will need to wait until the full study to be addressed.

While the group report modest incomes, significant health issues and less than the state average with private health insurance coverage (36.8% versus 42.1% [7]) they appear reasonably comfortable and satisfied with their financial situation and their overall quality of life.

While over a third of the sample report living alone, virtually all the group enjoy a very high level of social contact and support. Most are highly independent apart from small numbers reporting difficulties with shopping, meals and household maintenance. They are also very mobile with at least half walking regularly and high levels of access to, and frequent use of, private cars. This is crucial in a region with a high level of geographic dispersal, the concentration of many services in regional centres and an under-developed public transport system.

They are deeply involved and active in their communities with almost all reporting at least one hobby, almost half undertaking volunteer work in the community involving an average of six and a half hours per week, two thirds taking part in at least weekly organised group activities and almost three quarters getting together with friends at least once a week. Neither their own, nor their partner's health appears to significantly limit these activities.

Not surprisingly, given their age and medical conditions, they are heavy users of a range of health services but appear to be accessing most services within their local areas and express high levels of satisfaction with those services. When asked to list services deficiencies within the area, only a third of the sample listed a service and these related mainly to sub-optimal levels of access – the need to travel, poor public transport, long waiting times for appointments - rather than a complete lack of access, although public dental services are a possible exception to this.

A crucial factor in planning services for increasingly mobile older cohorts is building an understanding of the process by which mobility decisions are made. The pilot included a number of questions exploring the likely decision process if people found themselves unable to sustain their current living arrangements. The responses reflect the independent approach seen elsewhere in the data. More than half appear not to have considered the possibility of moving and many of the remainder would move only with the greatest of reluctance, staying put 'until death'. If required to move, most would stay within the area and although they would generally take into account the wishes of immediate family, there is a strong sense that for many the final decision would be their own. This has major ramifications for service planning.

Taken overall, the picture is one of strength and independence. However, there are pointers to the underlying potential vulnerability of the group. This independence is founded on deep and active embedment in community, high levels of social support and substantial mobility. A loss of mobility through the loss of access to a private car and/or the decreased capacity for walking and any deterioration in their own or their partners' health that impacts on their capacity to maintain their family home, is likely, given the geographic dispersal of services and the lack of public transport to rapidly shrink their social world and eventually force them into higher dependency care. This suggests the need for continuing focus on the provision of transport and support with household maintenance if this group are to remain as the high functioning contributors they are at present.

It suggests that without planning for services to maintain or compensate for the loss of these capacities, both individual and their communities would be in considerable danger of losing much of the richness of their present lives. These services include traditional health services, but, importantly for policy and planning within this area, they also include broader community services such as transport, house and garden maintenance and social and recreational activities.

The degree to which this group is representative of the wider population in the region remains an open question given the 'warm' recruitment method which may have skewed the sample away from the more isolated members of the community. This, and a number of other design issues, will need to be addressed in the planned larger study for which this was a pilot.

These data, however, while providing an informative snapshot of a group of rural/regional older people, will not realise their full value until matched with data collected in the second phase of the study in 18 months time. It is likely that in that period, many of the sample will have faced quite significant changes in their own and their partner's health and challenges to their present way of life. The two data sets should allow some insights into the role health services make to life outcomes for these people.

The pilot, as expected, has thrown up a number of issues that will need addressing in the design of a larger scale study.

While a 'warm' recruitment process has major advantages for older rural people, it introduces unacceptable biasing risks and the larger study will need to develop a random sampling approach which still takes into account rural aged sensibilities.

There will also need to be a review and reshaping of some questions in the instrument which did not yield the hoped for depth or range of data, especially around issues of mobility, support, health cover, health service usage and future intentions.

Conclusion

The pilot study satisfactorily fulfilled its two principal aims. Firstly, it has provided a detailed and very informative snap-shot of a substantial sample of people 65 years and older living in the Cradle Coast region. When combined with the 18 month data it should shed considerable light on whether, and how, this very 'sprightly' group is able to maintain its independence and connectedness as their circumstances change, and provide important clues for planning support services in the area.

Secondly, the lessons learnt in respect of recruitment, sampling and the refinement of the instrument will strengthen the planned larger study, particularly in addressing questions around the impact of geographical mobility on service planning and delivery.

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