ARC Linkage

Community Engagement for Productive Ageing:
Models to support rural healthy ageing through the
maintenance of community involvement and contribution

Phase 1 Report

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University of Tasmania
Rural Clinical School & University Department of Rural Health
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of Main Findings</td>
<td>1</td>
</tr>
<tr>
<td>Summary Insight</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Genesis of Study</td>
<td>5</td>
</tr>
<tr>
<td>Industry Partners</td>
<td>5</td>
</tr>
<tr>
<td>The Research Team</td>
<td>6</td>
</tr>
<tr>
<td>Governance</td>
<td>6</td>
</tr>
<tr>
<td>Purpose of the Report</td>
<td>6</td>
</tr>
<tr>
<td>Study Background</td>
<td>7</td>
</tr>
<tr>
<td>The Challenge</td>
<td>7</td>
</tr>
<tr>
<td>Limitations of Present Approaches</td>
<td>7</td>
</tr>
<tr>
<td>Social Engagement and Ageing</td>
<td>8</td>
</tr>
<tr>
<td>Supporting Social Engagement/Ameliorating Disengagement</td>
<td>8</td>
</tr>
<tr>
<td>Study Sites</td>
<td>9</td>
</tr>
<tr>
<td>Site Profiles</td>
<td>11</td>
</tr>
<tr>
<td>Central Highlands LGA (Bothwell and Ouse)</td>
<td>11</td>
</tr>
<tr>
<td>Circular Head LGA (Smidtton and Stanley)</td>
<td>13</td>
</tr>
<tr>
<td>West Coast LGA (Queenstown and Strahan)</td>
<td>14</td>
</tr>
<tr>
<td>Methodology</td>
<td>16</td>
</tr>
<tr>
<td>Sampling</td>
<td>16</td>
</tr>
<tr>
<td>Data Collection</td>
<td>17</td>
</tr>
<tr>
<td>Interviews with Older Rural People Aged 65+Years</td>
<td>17</td>
</tr>
<tr>
<td>Focus Groups and Telephone Interviews with Rural Aged Care</td>
<td></td>
</tr>
<tr>
<td>Service Providers</td>
<td>17</td>
</tr>
<tr>
<td>Interviews with Key Policy Developers and State Level Service Managers</td>
<td>17</td>
</tr>
</tbody>
</table>
Data Analysis ................................................................. 18
Limitations of this Report ........................................... 18

Findings ......................................................................... 18
Research Aim ................................................................. 18
Introductory Comments .................................................. 20
  Maintaining Social Engagement .................................... 20
  Cohort Issues ............................................................... 20
  Ageing as Pathology ..................................................... 21
Older Rural Participants .................................................. 22

Factors Shaping the Ageing Experience: Interviews with Older Rural Participants ............................................. 23
  Changes in Personal Health and Capacity ......................... 23
    Defining Capacity ....................................................... 23
  Health ........................................................................ 24
  Psycho-social and Emotional Responses to Ageing ............... 29
    Resilience and Adaptive Capacity .................................. 29
  Sociability .................................................................... 31
  Social Connection and Engagement ................................. 33
    Consolidation of Personal Networks ............................... 33
    Intimate Partners ....................................................... 35
    Family .................................................................... 37
    Key Friends .............................................................. 43
  Connection to Place and Community ............................... 44
    Belonging ................................................................. 44
    Community and Support ............................................. 46
    Changing Community Involvement ................................. 47
Factors Restricting Opportunity ....................................... 50
  Organisational and Community Decline ............................ 50
  Role linked Socialisation ............................................... 51
Rural Aged Care Service Providers’ Perspectives on Factors Affecting Older Rural People’s Ability to Maintain Social Engagement

**Ageing**

**Access and Mobility**

**Psychological Resources and Personal Styles**

**Deteriorating Health and Capacity**

**Changing Social Relationships**

**Residential Issues**

**Services**

**Adequacy of Services**

**Transport**

**Help-seeking**

**Fitting Services to the Rural Context**

**A Triangulated View of the Ageing Experience**

**Informing Phases 2 and 3**

**References**
List of Tables and Figures

Table 1: Selected population, household and residential statistics for the three study sites, Tasmania and Australia ........................................ 11

Table 2: Selected population and in-migration statistics for the three study sites .... 11

Table 3: Older Rural Participants by Gender ........................................ 22

Table 4: Older Rural Participants by Age in 5 Year Categories .................... 22

Table 5: Older Rural Participants by Community ................................... 23

Table 6: Self-assessed Health Status .................................................. 25

Table 7: Older Participants’ Rating of their Experience of Ageing ................. 29

Table 8: Partner Status ........................................................................ 35

Table 9: Family Living Locally .............................................................. 37

Table 10: Residential Status - Family living locally Cross-tabulation (Frequencies) ..... 37

Table 11: Rating of Financial Situation ............................................... 52

Table 12: Driver Status ........................................................................ 58

Table 13: Older Participants Missing Social Occasions because of Transport .... 58

Figure 1: Location of the study sites ..................................................... 10

Figure 2: Older Rural Participants by Age in 5 Year Categories .................. 22
SUMMARY OF MAIN FINDINGS

The primary aim of Phase 1 of this three-phase study, was to explore the mechanisms behind age-related changes in social networks and their impact on patterns of social engagement in order to design service models that can assist older rural people to stay socially engaged despite the changes and challenges posed by increasing age. The rich data gathered in this research provide a broad insight into the experience of ageing in a changing rural environment. However, for the purposes of this report we focus primarily on those findings that are likely to be directly relevance to informing future policy and service design.

- The well established correlation between social engagement and ageing well is unlikely to be a simple causal relationship but rather a complex product of a constellation of personal and social traits operating over a lifetime. This correlation precludes a simplistic approach to improving the ageing experience where ‘increased engagement = ageing well’.

- The ageing experiences of older rural participants (hence referred to as older participants) are very much a product of the place and time in which they have lived their lives. Policies and service models cannot be static but continually need to evolve to reflect changing times and changing cohorts.

- Ageing brings with it inevitable deterioration in health and loss of capacity; however the rate of loss and the impact of that loss on quality of life varies widely with different individuals and different contexts.

- A major determinant of quality of life in ageing is personal psycho-social capacity and style. The most likely marker of successful ageing is the ability to be resilient in the face of change, or to accept what cannot be changed and then to be able to use compensation and optimisation to adapt. The majority of older participants in the study met the changes and challenges of ageing with a stoic and self-reliant, ‘making the best of what they had’ approach, underpinned by a wry, sometimes self-deprecating humour.

- Ageing also appears to bring with it a consolidation of networks with a loss or shedding of wider networks of weaker ties in favour of investments in a smaller circle of emotionally close and supportive ties. It is the quality, not quantity of ties that is important and the match between social network as experienced and expectations/aspirations.
The most important ties in the ageing experience for older participants appear firstly to be spouse and close kin (especially adult children and grandchildren) and secondly a small number of close and supportive friends and confidants.

Attachment to place and connection to community are powerful influences in the ageing experience and an important resource for older participants. It is not at all clear to what extent this observation holds for those who move into rural communities late in life.

Community support manifests more in terms of ‘being there if and when needed’ rather than as day-to-day intense relationships or interactions.

Community involvement and engagement decreases with declining health and capacity, for almost all older participants. This pattern comes from a combination of volitional withdrawal to conserve diminished energy, and declining opportunity:

- Many traditional and formerly cherished organisations and activities are declining as older members withdraw or relinquish leadership positions and others are not stepping in to replace or succeed them. While to some extent this is counterbalanced by the growth of new organisations and activities, these tend to cater more for changing demographics than for long term local older participants.
- Loss of social role through retirement from paid work and from community leadership positions generally leads to a loss of networks.
- Financial constraints can limit socialisation for some, although for many older participants, used to managing with little, these constraints are not seen as serious.
- Declining mobility, in terms of walking and driving, can have catastrophic effects on social engagement and quality of life in rural communities where the problems of dispersed infrastructure and service are compounded by very poor or non-existent public transport.

There are widespread concerns in the data, reflected in comments from older participants and rural aged care service provider participants (hence referred to as service provider participants), about the costs, strains and inconvenience of having to travel long distances to access many health services and treatments. Nevertheless there are few instances of people feeling that they were missing out completely on necessary services or treatments.
One of the most traumatic change pressures faced by older participants is the necessity to move to a large population centre in order to gain access to needed services and supports. A very strong attachment to place and severe potential financial repercussions from such moves or relocations may make this a major life disruption, at least for long-term resident older participants. For most, this decision never ultimately needs to be taken but many still live constantly with fear that it may be necessary. Older participants who have recently moved into the area appear to have a weaker place attachment and more incentive capacity to move closer to services if necessary.

Older participants and service provider participants identify many of the same issues related to ageing: declining health and capacity; social loss and isolation; and distance and travel issues in relation to service access. However, service provider participants are much more likely to identify these issues as problems requiring a service response. Older participants tend to see the provision of health services as a government responsibility but beyond that place heavy emphasis on personal responsibility.

Service provider participants recognise the need to adopt a very flexible, adaptive approach to service delivery, one that is based on individualised responses grounded in personal relationships. They feel that the regulations, protocols and fragmented, programme-based funding that mark present service models hamper the delivery of such an approach and they appear willing to ‘work outside the box’ where it is considered in the clients’ interests.

**Male, older participant:** As people get older they’ve got to have assistance you know. They need somebody to go to, to ... organise their life a little bit, ... make appointments for them, medical or whatever. You become, your mind is ... older people are not up to making medical appointments, ... you know making phone calls.

**SUMMARY INSIGHT**

Despite the inevitable losses that accompany ageing, it is both wrong and unhelpful to view ageing as pathological and a constellation of problems to be ‘fixed’. Rather it is a natural process which can be a relatively positive or negative experience depending on a complex, often fine, balance of factors within the individual and their environment. The most that service providers can hope to do is to attempt to help structure that environment to maximise
the positive aspects of the journey and minimise the negative. In practical terms, wherever possible, the aim must be to adapt and manage the environment and conditions in order to make it both possible and easier for each individual to choose to engage as fully as they desire in life rather than withdrawing into isolation and a socially and emotionally poorer and possibly impoverished existence. The forms of service required mandate a subtle and individualised approach based on a good understanding of each client, grounded in a personal relationship to facilitate a tailored and targeted response to personal circumstances. The kernel of such a model already operates, albeit in a de facto manner, in at least some of the study sites.

**Researcher:** So when you say that everyone is an individual, do you think it’s important to respond to that fact, that you are not exactly the same as the next person?

**Male older, rural participant:** That’s right. And you’ve got to be treated that way too. You can try and persuade them to think differently. But lots of them have had this sitting in their mind for 80 years and don’t want to change. They can change but you can’t bully them. Got to gently do it.
INTRODUCTION

Genesis of Study

This study has its genesis in a two-stage study, conducted between 2004 and 2007 by the rural health team, as a pilot for a larger study into the situation and service needs of older people in rural and regional in Tasmania. These studies arose from the recognition that complex social and demographic changes in rural areas could provide a strong evidence base to inform aged care policy development and service planning. The study used in-depth, structured, face-to-face interviews with an initial sample of 193 older people living in the Cradle Coast area of north-west Tasmania and explored their experience of ageing in a rural area and their service and support needs. Eighteen months later a second round of interviews was conducted with 154 of the original participants to examine how their situations and needs had changed over time (Walker, Behrens, Boyer, Bull, Felmingham, Orpin, Robinson, Stratford & Vickers, 2005; Walker, Orpin, Boyer & Behrens, 2007). Phase 1 and 2 reports from this study are available at


A major finding of that earlier study was that, although participants faced considerable age-related challenges to their health and capacity, almost universally they remained very actively engaged in their communities and generally upbeat about their lives. It was also very apparent that this engagement was a fragile accomplishment, under constant threat from deteriorating health and waning physical and cognitive capacity, and from a rapidly changing social environment. Placing these findings in the context of reports in the literature, and in the context of a robust correlation between social engagement and successful ageing raises important research questions about how to protect social engagement in the face of ageing and the changing rural social landscape which, in turn, requires an understanding of the mechanisms underlying these changes and challenges.

Industry Partners

This initial research led to a successful funding application to the Australian Research Council (ARC) Linkage Grant Scheme with industry partners, the Department of Health and Human Services Tasmania (DHHS) (Home and Community Care) and the Tasmanian Council of Social Service (TasCOSS), and the project commenced in early 2008.
The Research Team

**Team Leader:** Professor Judi H Walker, Professor of Rural Health and CEO of the Rural Clinical School

Assoc. Prof. Elaine E Stratford, Head, School of Geography and Environmental Studies

Professor Andrew L Robinson, Professor of Aged Care Nursing, School of Nursing and Midwifery

Dr Peter Orpin, Senior Research Fellow, University Department of Rural Health

Ms Kim Boyer, Senior Research Fellow, University Department of Rural Health/Rural Clinical School

Dr Hazel Baynes, Post-doctoral Research Fellow, Rural Clinical School

Ms Janet Carty, Department of Health and Human Services

Dr Carol Patterson, Tasmanian Council of Social Service

Ms Nadia Mahjouri, Linkage Industry Fellow seconded from the Department of Health and Human Services

Initial field data collection was undertaken by Dr Ros Foskey and additional data collection, analysis and the major report writing were undertaken by Dr Peter Orpin and Dr Hazel Baynes.

Governance

The study was overseen by a Reference Group meeting twice yearly, chaired by Prof. Walker, and consisting of senior management representatives from the principal stakeholder and industry partners groups, the ‘hands-on’ research team, relevant University of Tasmania Theme Area Coordinators, and two older rural community representatives with high level community organisational and local government experience (Mr Barclay Walker and Mrs Mary Binks).

An informal Policy Group, consisting of higher level policy representatives from government and the hands-on research team, met regularly to discuss issues related to the nexus between the on-the-ground research and the changing health policy environment.

Purpose of the Report

This report represents a broad, first-line analysis of the data collected in Phase 1 of a three-phase study funded under an ARC Linkage grant. It is designed as a primary resource
document for Phases 2 and 3 of the study, which will culminate in the development of a policy and services framework to support the maintenance of community engagement among older rural people.

**STUDY BACKGROUND**

This study explores the mechanisms behind age-related changes in social networks and their impact on patterns of social engagement in order to design service models that can assist older rural people to stay socially engaged despite the changes and challenges posed by increasing age.

Australians, like many in the developed world, are grappling with the social, economic and political implications of population ageing (Australian Government Productivity Commission, 2005; Australian Government, 2007). Over the next 40-50 years there will be a steady increase in the proportion of the Australian population that is old, with a projection that by 2050 over a quarter of the Australian population - approximately 7.2 million people - will be 65 years or older (Jackson, 2004). These trends will be most keenly felt in rural and regional areas where the outward migration of younger people and inward migration of later life ‘sea/tree changers’ (Burnley & Murphy, 2004) is contributing to ageing among an already older population profile (National Rural Health Alliance & Aged and Community Services Australia, 2005).

**The Challenge**

Population ageing presents major social and economic challenges on two fronts. Firstly, the needs of an older population will increase the national health bill especially if, as projected, the proportion of old-old (85+ years), presently the largest users of medical services, rises from 1.4% of the population in 2000-1 to 8% by 2044-5 (Australian Government Productivity Commission, 2005). Secondly, population ageing will mean an increase in the number and proportion of citizens who are net social and economic dependants (Australian Government Productivity Commission, 2005). These challenges have prompted Australian governments to move to put in place policy settings and service models designed to extend the independence, health and productivity of older citizens, and a related surge in research activity exploring relationships among age, health, productivity and dependence.

**Limitations of Present Approaches**

The literature on healthy and productive ageing and government policy and service structures are largely focused on the twin strategies of delaying retirement from the paid workforce and preventing and managing a growing chronic disease burden as a means to delay the age-related development of dependency, losses in productivity, and an escalation in national medical costs (Australian Health Priority Action Council, 2005). Important
though these initiatives are, they are limited by their long time-frames (at least generations for full effect, missing a large part of the ‘baby boomer bulge’) and their inability to do more than time-shift the inevitable onset of disability. **There is room for a third approach which has shorter time-frames and seeks to prolong independent productive social engagement in older people, despite, and in the face of, inevitable age-related declines in health and physical and cognitive capacity.**

**Social Engagement and Ageing**

There is strong and growing evidence of a link between the maintenance of social connection or social engagement in ageing and improvements in age-related morbidity and mortality (House, Landis & Umberson, 1988; Valliant, Meyer, Mukamal & Soldz, 1998; Giles, 2004). Despite deteriorating health and capacity, this link raises the possibility that supports and services which enable older people to protect their social connections and engagement could deliver significant and immediate returns in terms of improved health and social productivity among older people - given that both health and engagement are necessary if not sufficient preconditions for the maintenance of socially productive roles.

Just prior to the time this study commenced less than 8% Australians aged 65 years and over were in dependent care (Australian Institute of Health & Welfare, 2002) although this sector consumes approximately 77% of the Australian Government aged care budget (Australian Government Productivity Commission, 2005). The vast majority of older people - the healthy aged - are neither particularly frail nor dependent. Properly supported and until quite late in their lifespan, these individuals are likely to remain substantial contributors to their families and communities through a wide range of socially productive roles. A pilot study of 193 individuals aged 65+ years conducted by the team in the rural north-west of Tasmania in 2004-7 (Walker, et al., 2005; Walker, et al., 2007) revealed that the vast majority, regardless of age, remained highly active and engaged within their communities although this was a fragile accomplishment, highly dependent on continuing formal and informal supports and services. This picture may also apply to urban settings, but it does accord well with understandings in rural health, where complex webs of mutual support and dependence in communities in some measure compensate for lower levels of formal services and supports. There is justification for a shift in attention and resources to models of service delivery that protect the community resource represented by the relatively healthy non-frail aged, particularly within rural and regional areas where service capacity and options are limited.

**Supporting Social Engagement/Ameliorating Disengagement**

A major impediment to developing approaches that support healthy and productive ageing by protecting social engagement is the lack of a detailed understanding of the disengagement process and a dearth of available service models designed to circumvent or slow the process. There is mounting evidence about the correlates of disconnection or disengagement - for
example, *rurality* (Savikko, Routasalo, Tilvis, Strandberg & Pitkala, 2005), driving cessation (Marottoli, Mendes de Leon, Glass, Williams, Cooney & Berkman, 2000), living alone (Savikko, et al., 2005), loss of partner though death (McInnis & White, 2001), carer burden (Levine, 1999) and disability (Savikko, et al., 2005) - however, many if not most of these are simply inevitable and unmodifiable consequences of growing old. Supports and services are therefore required that focus on addressing the avoidable sequela or consequences that follow ‘disengagement triggering’ events or processes. The immediate consequences of these triggering events - for example, the loss of a partner or a decline in mobility due to hip fracture - are already generally well-recognised and understood within aged services and most jurisdictions have service models to deal with them. Such services focus on coping or crisis, particularly in terms of supporting continued independent living. Disengagement processes on the other hand, are likely to be drawn out, progressive and largely invisible to service providers until the individual has become frail and requires traditional services.

In light of this, the study aims were to develop models that not only intervene at the point of crisis, but also put in place long term supports and services to address the threat that social disengagement represents not only to individual health and wellbeing, and also, in aggregate, to the community and the nation. For older people, remaining socially engaged and contributing as community members is known to be strongly correlated with improved health and longevity. As ageing of the Australian population continues, it becomes increasingly important to find ways to maintain older peoples’ social contributions. The specific aim of Phase 1 was to explore the process of age-related social network change in rural communities by identifying disengagement triggers and the mechanisms though which they might function in order, in Phases 2 and 3, to design service frameworks and models that allow interventions before older people become isolated and dependent, and to support them to remain active contributors to social life.

**STUDY SITES**

The initial study proposal methodology entailed collecting interview data from 20 older rural people in each of three rural communities of Remote, Rural and Metropolitan Areas Classification (RRMA) 5 or above. It was agreed at an early stage to broaden this requirement to three rural local government areas (LGAs) each encompassing a number of RRMA 5-7 communities. The selection of study sites was informed by discussion in the research literature and took account of rurality and geographical, demographic, socio-economic and logistical factors. Eight possible locations were considered and following site visits and extended discussion the following communities were selected:

- Bothwell/Ouse (Central Highlands LGA)
- Queenstown/Strahan (West Coast LGA)
- Smithton/Stanley (Circular Head LGA).

Figure 1 shows the location of the six communities.
The sites encompass a range of communities that were static, transforming or declining. They reflected a range of migration, mobility and occupational patterns and economic characteristics and presented a broad sample to facilitate generalisation to other sites/communities within Australia. Tables 1 and 2 below present a summary of the statistics included in the study site profiles. This summary highlights some of the characteristics of particular sites and the differences among the sites to be discussed below.
Table 1: Selected population, household and residential statistics for the study sites, Tasmania and Australia

<table>
<thead>
<tr>
<th>Place</th>
<th>Pop. (2006)</th>
<th>Median age</th>
<th>% of Pop. 65+years</th>
<th>% of single person h'holds</th>
<th>% in same home as 2001</th>
<th>% moved locally in last 5 years</th>
<th>% owning own home</th>
<th>% purchasing own home</th>
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<tr>
<td>Central Highlands</td>
<td>2242</td>
<td>43</td>
<td>14.5</td>
<td>26.7</td>
<td>59.3</td>
<td>0.82</td>
<td>45.1</td>
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<td>Bothwell</td>
<td>556</td>
<td>41</td>
<td>16.4</td>
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<td>64.2</td>
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<td>47.2</td>
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<td>53.8</td>
<td>27.0</td>
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<td>4203</td>
<td>37</td>
<td>14.3</td>
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<td>30.7</td>
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<td>17.4</td>
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<td>16.9</td>
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Table 2: Selected population and in-migration statistics for the study sites.

<table>
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<tr>
<th>Place</th>
<th>Pop. (2006)</th>
<th>% who were in-migrants 2001-2006</th>
<th>% of in-migrants from elsewhere in Tasmania</th>
<th>% of in-migrants from interstate</th>
<th>% of in-migrants from overseas</th>
<th>% of in-migrants aged over 55 years</th>
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<tr>
<td>Central Highlands</td>
<td>2242</td>
<td>26.7</td>
<td>61.2</td>
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<td>40.9</td>
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<td>Strahan</td>
<td>638</td>
<td>22.1</td>
<td>74.1</td>
<td>23.0</td>
<td>3.0</td>
<td>11.6</td>
</tr>
</tbody>
</table>


Site Profiles

Central Highlands LGA (Bothwell and Ouse)

The Central Highlands LGA in the midlands of Tasmania has an area of 8010 square kilometres (Central Highlands Council, 2010). Council chambers are located in Hamilton. At the 2006 Census, the population of 2242 was located mainly in three small townships with the remainder in ten hamlets and dispersed localities and 43% of the LGA population
was over 65 years of age (Australian Bureau of Statistics, 2007) (Table 1), the highest percentage of the three study areas. The area also had, at 43 years, by far the oldest median age of the three study sites, older than either the Tasmanian or Australian averages (Table 1). It also had the most residentially settled population with less than 1% having moved locally in the previous five years. Of all the study sites, it had the highest inward migration between 2001 and 2006 and the highest number of those in-migrants who were aged over 55 years (Table 2). Agriculture and tourism are of economic importance. The municipality has large scale livestock, crop and dairy farms, and on a smaller scale, vineyards, cherry farms and cattle, sheep and horse studs (Central Highlands Council, 2010).

The interviews were conducted in Bothwell and Ouse.

**Bothwell**

Bothwell, the largest township in the municipality, is an inland agricultural community located 76 kilometres or about one hour’s drive from Hobart. At the time of the 2006 Census it had 556 residents, the median age was 41 and 16.4% of the population was aged 65 years or older (Australian Bureau of Statistics, 2007) (Table 1). The median age and proportion over 65 years are above the comparable figures for Tasmania and Australia (Table 1). The community has basic retail outlets and a limited range of services and facilities, and of organisations and activities providing socialisation opportunities. Most health services are delivered out of Ouse. The Bothwell community is experiencing social, economic and environment stress. It is in an area which has been affected by an extended drought which is having a direct impact on the ongoing viability of the local community.

**Ouse**

Ouse is an inland agricultural community, one of the smaller townships in the Central Highlands LGA. At the 2006 Census, the population of 137 (Australian Bureau of Statistics, 2007) had a median age 51 and 22.6 % was over 65 years of age (Table 1), well above the other sites and both Tasmanian and Australian figures (Table 1) This population profile was by far the oldest of the six communities (Table 1). The population is reasonably residentially stable with 62.4% of residents at the same address in 2006 as in 2001 (Table 1). However, about one in five of residents had moved to Ouse in those same five years; most were from elsewhere in Tasmania and 26.6% of these were over 55 years old (Table 2).

The large land holdings in the surrounding area are used for sheep, cattle, crop and dairy farming. Ouse is about 90 kilometres or an hour’s travel from Hobart en-route to the west coast. It is the service centre for a widely dispersed population extending from Ellendale to Derwent Bridge and the base for medical services for the whole region. The area has undergone a period of considerable community unrest over the past two years following the conversion of the hospital – with acute and aged care beds staffed 24 hours a day, seven days a week – to a business hours only, community health centre.
Circular Head LGA (Smithton and Stanley)

The Circular Head LGA covers an area of 4917 square kilometres of the far north-west coast of Tasmania (Circular Head Council, 2010). The council chambers are located in Smithton. At the time of the 2006 census, Circular Head had a population of 7952 (Australian Bureau of Statistics, 2007) (Table 1). This population is dispersed but less so than the Central Highlands with 53% concentrated in Smithton. The economy is diversified across a range of primary and secondary industries including dairy and prime beef production, commercial fishing and aquaculture, agriculture, forestry and timber production, iron ore pelletising, vegetable processing, manufacturing and tourism. More than 30% of Tasmania's dairy farms are in the Circular Head LGA (Circular Head Council, 2010). The area had fewer people aged 65+ years than the Tasmanian and Australian average (Table 1) and between 2001-2006, showed lower in-migration rates than the other study sites, although the overall measure masks marked differences between the two study communities (Table 2). The area is experiencing less drought stress than most other Tasmanian agricultural communities.

Interviews were mainly conducted in two townships, Smithton and Stanley.

Smithton

Smithton, the major township in the Circular Head LGA, is a primary industry administrative and service town with a population of 4203 at the 2006 Census (Australian Bureau of Statistics, 2007) (Table 1). The median age in 2006 was 37 years (younger than all but one of the study sites) and 14.3% of the population was aged 65 years or over (Table 1). Smithton is 415 kilometres or 4-5 hour’s travel from the capital city Hobart, about two and a half hour’s travel from Launceston, the next largest city, and one and a half hour’s travel, from the nearest large regional centre, Burnie.

Smithton’s health services include a district hospital with 16 inpatient beds, an accident and emergency unit, an oncology day ward, obstetrics services and a wide range of visiting services, four general practitioners and one registrar, a 66-bed residential aged care facility and a large centre, Wyndarra, housing a wide range of community services. The community has a comprehensive retail shopping centre and a large range of community organisations and activities among which sporting, services clubs and religious organisations are prominent.

The population in Smithton is the least residentially settled of all the communities. Although in 2006 53.6% of people were residing in the same home as in 2001, another 30.7% had moved within the local area (Table 1). This represents the highest level of within-SLA movement of all six communities (Table 1). Around one in ten residents had moved into the area from elsewhere and of these, 50.2% were from elsewhere in Tasmania and 38.5% from other states (Table 2). Almost 14% of the in-migrants were aged 55 or older and most came from other parts of Tasmania (Table 2).
Stanley

Stanley is a small township with a population of 458 at the 2006 Census (Australian Bureau of Statistics, 2007), a median age of 42 and with 16.4% of the population aged 65 years or older (Table 1). Like Bothwell and Ouse these figures are above those for Tasmania and Australia (Table 1). Stanley is located on the coast at the eastern end of the Circular Head LGA, about 20 kilometres or half an hour’s drive from Smithton and about 75 kilometres or one and a half hour’s drive from Burnie. It is the main tourism township in the municipality.

There are no medical services in Stanley; residents use the services in Smithton. The community has a limited range of facilities, organisations and activities providing socialisation opportunities. Stanley’s population is relatively residentially settled with about half the population in the same residence from 2001 to 2006 (Table 1). About 15% of the population had moved to Stanley in that period (Table 2), somewhat lower than most of the study sites. This belies Stanley’s status as a transforming community. The once busy port that served the whole north-west coast now has a booming tourist industry, an influx of ‘sea-change’ in-migrants who are well-educated and have high socio-economic status, and a considerable part of the town’s housing stock has been converted to tourist or holiday accommodation.

West Coast LGA (Queenstown and Strahan)

The West Coast LGA covers an area of 9575 square kilometres (West Coast Council, 2010) and is distinguished by a particularly rugged topography. The council chambers are located in Queenstown. The area had a population of 5006 at the 2006 census (Australian Bureau of Statistics, 2007) of which 11.2% was aged over 65 years - less than in all the other sites and for Tasmania and Australia as a whole (Table 1). The population is concentrated primarily within the towns of Rosebery, Strahan, Queenstown, and Zeehan.

Tourism, mining and fishing form the basis of the economy. The area has a long history of boom and bust mining and Queenstown has endured considerable decline and uncertainty in recent years linked to the fluctuating fortunes of the large mine on which the town was founded. The West Coast is classified as RRMA 5 and, despite improvements in road access to Burnie and Hobart, it is still perceived by both residents and other Tasmanians as being very isolated.

The interviews were conducted in the formerly principal town of Queenstown and the booming tourism centre of Strahan.

Queenstown

Queenstown, the largest of four inland townships in the municipality, is a remote mining township, first established in the late nineteenth century. More recently, with significant
downgrading of the mining workforce, tourism has become increasingly important for the local economy. At the time of the 2006 Census the population was 2117, the median age was 37 and 12.8% was aged 65 years old or older (Australian Bureau of Statistics, 2007) (Table 1). It is notable among the study communities for having more males than females in the resident population and for having the highest proportion of single-person households (Table 1). Queenstown is located 260 kilometres or three hours and 40 minutes’ drive from Hobart and 150 kilometres or two hours and 25 minutes’ drive from Burnie.

Medical services for the area are largely centred in Queenstown and include a newly-opened district hospital with 10 acute and 16 nursing home beds. Most necessary retail and professional services are available locally although choice is often very limited. A similar situation prevails for the infrastructure, organisations and activities providing opportunities for social engagement.

Queenstown has the lowest number of people aged 65+ years of any of the study communities (Table 1). The population is relatively settled with three-quarters either living in the same home, or having moved only within the local area in the five years between 2001 and 2006 (Table 1). In the same period 19.2% of residents had moved into the area and of these 47.8% were from elsewhere in Tasmania, 40.9% were from interstate, and 11.3% were from overseas (Table 2). People aged 55 years and over comprised 13.6% of in-migrants (Table 2), broadly similar to all other study sites, apart from those in the Central Highlands.

Over several decades changes to the nature of mining have substantially affected the social fabric of the town. An increasingly proportion of those employed in mining in the area work on a fly-in and fly-out basis rather than bringing their families with them to the town. The impression gained during the scoping visit was that some original residents are beginning to return as retirees, seeking not only the financial benefits of cheaper housing but also the social support they perceive to be more available in this mining community.

**Strahan**

Strahan is the largest coastal township in the municipality with a population of 638 at the time of the 2006 Census (Australian Bureau of Statistics, 2007) (Table 1). The median age was 41 years and 15.4% was over 65 years old – older than the Tasmanian and Australian averages and markedly older than nearby Queenstown (Table 1). There is a large floating population of younger workers who move into the community for the tourist season, and many local homes have been converted into tourist or holiday accommodation placing upward pressure on prices to the likely disadvantage of those seeking to move into the community to live fulltime.

Strahan is located 298 kilometres or almost five hour’s drive from Hobart and 41 kilometres or almost an hour’s drive from Queenstown. Tourism, fishing, and forestry are economically important to the township. The port is home to cruise boats travelling into the Gordon River World Heritage Area and crayfish and abalone fishing fleets.
Strahan has a medical centre which is the base for community nursing and general practitioner services (four days a week). Other health services are supplied by visiting providers. Strahan has a limited range of retail services and recreational and socialisation opportunities apart from those specifically geared for the tourists.

METHODOLOGY

Phase 1 of the study was concerned with the development of an in-depth understanding of the triggers and processes of disengagement. We sought to understand the experience of age-related social disengagement by combining first-hand, a) in-depth interview data from older participants with b) focus group and telephone interview data obtained from service provider participants and with c) interview data from key higher-level individuals with policy development and service management responsibilities.

The study was approved by the Tasmanian Social Science Human Research Ethics Committee.

Sampling

A purposive sampling strategy was used to select a sample of independent living, cognitively competent, older rural people and ensure representativeness across variables of age, gender, rurality and individual experiences of engagement and disengagement. Every effort was made to ensure that the sample of older participants was age and gender-balanced in terms of generational cohorts, and included individuals of varying partner status, with a range of levels of formal education, occupational status, and from across the social gradient. The sample included individuals living in different residence types, with varying experiences of residential mobility and a range of levels of attachment to the place in which they were currently living. Older participants were largely Anglo-Australian as expected given the composition of the communities from which they were drawn.

Inevitably, the sampling strategy was reliant on the researcher tapping into local knowledge and networks (a variation of ‘snowball’ sampling) and this strategy has an inherent bias toward connected individuals - a major issue for a study into social engagement. This bias was minimised as far as possible by the researcher eschewing a simple numbers approach to spend time ‘hanging out’ within the communities, visiting a wide range of community facilities and seeking to broaden contacts as widely as possible to seek out those who may live their lives somewhat on the margins of the community. It is likely that the study still missed many of the truly disengaged and this needs to be taken into account in interpreting the findings.
Data Collection

Interviews with Older Rural People Aged 65+ years

Sixty-nine older rural older rural people took part in extended semi-structured interviews of up to 90 minutes. A survey format was used to collect demographic data. The interview took a narrative approach to exploring older participants’ present and lifelong patterns of social engagement and personal community, changes over time in these patterns and the reasons for, and consequences of those changes with an emphasis on the processes and events underlying any changes. It also explored their expectations, aspirations and levels of satisfaction with their social networks and roles.

Focus Groups and Telephone Interviews with Rural Aged Care Service Providers

A total of 32 service provider participants took part in four focus groups, one in each study LGA, and one in the regional centre outreaching to Circular Head (four to ten participants per group). A further four service provider participants who were unable to attend the focus group contributed in writing. Four general practitioners from the three regions were interviewed individually by telephone due to their restricted availability for participation in a focus group. The focus groups ran for approximately 90 minutes and the telephone calls for between 30 and 60 minutes. Both focus groups and telephone interviews explored service provider participants’ experiences and understandings of the events and processes that challenge the ability of older rural people to maintain their preferred patterns of social engagement. They also captured service provider participants’ knowledge of local services and supports for older rural people.

Interviews with Key Policy Developers and State Level Service Managers

Individual interviews were conducted with 11 individuals from the Department of Health and Human Services, the Department of Health and Ageing and non-government organisations involved in policy development and service management at the state level. Interviews lasted for between 30 and 60 minutes. As with the focus groups and telephone calls with service providers, the interviews explored these key individuals’ knowledge and insights regarding events and processes that affect older rural people’s ability to stay connected and involved in their communities. In addition they documented present policies, levels of service and the impact of these on older people’s ability to maintain social engagement.
Data Analysis

All interviews and focus groups were audio recorded with the consent of participants. Interviews were transcribed verbatim and focus groups/telephone calls transcribed in detailed note form. The interview and focus group transcripts, researcher field notes and all audio files were imported into the qualitative analysis software package NVivo© and subjected to multi-level, thematic analysis.

The analysis involved two researchers in a continuous collaborative, iterative process of coding, checking and recoding. The analysis of older participants’ data centred on meanings and on how they understood their experiences and situations. The analysis of data from focus groups, individual interviews with general practitioners and from the interviews with key policy level individuals and state-level managers of service provision focused on identifying major factors associated with ageing that most challenged older people’s capacity to maintain their former levels of social connection and involvement. Implications for health services and supports were also central.

Analysis enabled both a focus on the complexities of older participants’ lives and on various change, challenge and opportunity factors. It also permitted examination of relations between these and larger contexts. The interpretive and reflective nature of the analysis highlights key themes that facilitate a better understanding of the process of growing older in a rural community.

Limitations of This Report

This presentation of the findings is of necessity very broad-brush. It is designed to tease out the major themes and insights in order to guide the work in Phase 2 and 3. The study has accumulated a considerable body of complex data which is deserving of fine-grained analysis. This will be accomplished through a future series of more tightly focused papers and presentations.

FINDINGS

Research Aim

The overall aim of Phase I was to explore the process of age-related social disengagement in rural communities by identifying the triggering factors to disengagement and the mechanism though which they function.

This aim was embodied in four research questions:

1. What events, issues and processes associated with the ageing process challenge rural older people’s capacity to maintain their social networks and habitual levels of social engagement?
2. What are the mechanisms and processes by which these challenges act on networks and social engagement, particularly in the rural context?

3. Is it possible to identify particular crucial points to this process that may be amenable to interventions designed to circumvent or slow the disengagement process?

4. Are individuals able to identify services or supports that they believe would assist, or would have in the past assisted them to maintain social engagement in the face of age-related challenges?

Underlying the study aims was the expectation that it would be possible to identify particular events, issues or processes related to ageing, that could be seen as potential social disengagement ‘triggers’ that in turn would flag the need for heightened service provider surveillance and support. While virtually all older participants reported age-related ‘events, issues or processes’ that had the potential to challenge their preferred patterns of social engagement, understanding the actual impact of these on individuals’ lives is a much more complex issue. Any impacts vary widely between individuals and can be shown to be the unique interactive product of an individual, a biography, a physical and social context, and a process of meaning-making and agency. We therefore use the more neutral term of age-related ‘changes’ rather than the more value-laden ‘challenges’, and then seek to understand these changes in the context of the range of factors that shape their impact on individuals’ lives.

Similarly, while the original concept of such an event acting as a ‘trigger’ prompting a need for increased service support remains valid, the findings suggest that any future interventions need to be carefully designed to supplement and leverage off the existing informal culture of watchfulness and care that survives to some extent in all or most of the study communities. There is clearly a need for government support services for older people and although present health-related services appear to be working effectively, if not always conveniently, for most older participants, there are certainly further opportunities for government support to maintain the social quality of older rural peoples’ lives. However, government services will always struggle to replace ‘community’ in the sense of informal supportive connection developed, and sustained, through a shared culture and history. That community, though still evident in the data particularly in respect of long-term resident older participants, appears to be under immediate threat from demographic and social change. The challenge for present and, particularly future service planning is to find ways to fill the gaps and exploit the opportunities arising from this change.

The data from the two main sources - older participants and service provider participants – identify the same issues but contain quite different perspectives on the ageing experience and are therefore largely reported separately. Older participants, immersed as they are in the experience, provide not only a less reflective and objective perspective than service provider participants but also a more positive one in that they are focused on ‘making the best of what they have’ rather than on the problems and pathologies of ageing. Service provider participants on the other hand have, quite understandably, a more problem-focused view of
ageing. Both views are, in their own ways, fully legitimate and together provide a more complete view of the rural ageing experience.

**Introductory Comments**

**Maintaining Social Engagement**

Before embarking on detailed discussion of findings around the effects of age-related changes in health and capacity, it is necessary to re-visit both the use of the term ‘habitual levels’ of social engagement in Question 1 and the rationale behind the study aims. Both issues relate to complex matters around preference, choice and the ageing process, and elaborating on their meaning will aid understanding of the main findings.

We now believe that ‘preferred’ level of social engagement is a more apposite term than ‘habitual’ levels. This change acknowledges firstly, that habitual levels and patterns of socialisation may have been, at least partly, the result of constrained choice rather than preference and, secondly, that, over time and under the influence of the ageing process, previous patterns and levels of social engagement may no longer be either appropriate or preferred.

The study title *Community Engagement for Productive Ageing* acknowledges a well-established, robust correlation between levels of social engagement and ageing well, and carries an implication that maintaining or even increasing social engagement in ageing may provide a better ageing experience and outcome. It is clear from both the emerging literature and the study data that this is an over-simplistic assumption. The correlation between engagement and successful ageing is unlikely to be a simple straight-line causal relationship but rather bidirectional and mediated through a wide range of intervening variables such as preference, choice, psycho-social resources and styles and the balance between expectation/aspiration and experience in ageing. That is, higher levels of social engagement may well be just one marker of a complex of lifelong traits that taken together are associated with decreased morbidity and mortality in ageing. To aspire to substantively changing these in late age is likely to be, in most cases, a forlorn hope. Rather we suggest that the aim in supporting healthy ageing through social engagement is not necessarily to increase or even maintain lifelong patterns of social engagement but rather to minimise the age-related constraints on individuals’ ability to maintain their preferred patterns and levels of social engagement at any given point in the ageing process. This will primarily mean services and support to address social and environmental constraints although there may also be opportunities to strengthen personal physical, psychological and social capacities.

**Cohort Issues**

The older participant group for this study forms a distinctive cohort; especially those in the sample who have spent much of their lives in the study communities (the majority). This
group not only share a great deal in terms of history, culture and experience but also have experienced and are facing major disruption in the world as they knew it. Coming cohorts of older rural people are likely to be a very different group with very different needs to the majority of the study population due to the rapidly changing nature of rural communities and rural life related to economic, technological, social capital, demographic and mobility changes. Such change suggests that while these findings will be immediately and specifically useful in informing service and support options for the current cohort of older rural people, we should recognise the need for policies and service models to be continually evolving and reflecting changing times and changing cohorts. This means maintaining an ongoing process of environmental modelling and evidence gathering designed to inform the reflective adaptation of policies and service models.

**Ageing as Pathology**

The findings appear to support the literature in showing some general shrinkage towards ‘home and hearth’ in patterns of social engagement in ageing. However, from many older participants’ point of view, this is not necessarily seen as a pathological process and it would be risky to draw negative implications for morbidity and mortality. Apart from the confounding effect of social disengagement as a reflection of, rather than a causal mechanism for increasing morbidity, there is a need to avoid pathologising the ageing process. Without getting entangled in philosophical arguments about the extent to which ageing is a ‘natural’ process, certainly, for older participants, there is a strong compensatory element to their ageing experience. That is, there is evidence of some degree of compensatory accommodation between changing capacity and changing expectation in ageing. While they are now longer able to live the life they did when younger, for many, there is no desire to either.

Thus, there will always be a need to find a balance between allowing people to age in the manner of their own choice and service providers’ desire to intervene to minimise the impact of the physiological and social changes associated with ageing. There are arguments on both sides. In general, older participants are inclined to be strong believers in personal choice and minimal government interference in personal lives - social isolation is generally viewed as the individual exercising personal choice. However, those who work with older people are aware that choice is often constrained not only by environment but also culture. At times some service providers may deem it necessary to provide some ‘push’ and gentle persuasion to overcome inertia and reticence. This will always require sensitive judgement in individual cases but it needs to be grounded in an overall understanding of ageing as a natural, rather than pathological, process. Certainly, this view of ageing as a natural process appears widespread among older participants and could be argued to be highly adaptive.
Older Rural Participants

The older participant sample was gender and age-balanced and was drawn quite evenly from across the study sites (Tables 3, 4 and 5, Figure 2, below).

Table 3: Older Rural Participants by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
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<td>Female</td>
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</table>

Table 4: Older Rural Participants by Age in 5 Year Categories

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
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<td>80-84</td>
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<tr>
<td>Total</td>
<td>14</td>
<td>20.3</td>
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</tbody>
</table>

Figure 2: Older Rural Participants by Age in 5 year Categories
Table 5: Older Rural Participants by Community

<table>
<thead>
<tr>
<th>LGA</th>
<th>Community</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Central Highlands</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bothwell</td>
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<td>11</td>
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<td>Ouse</td>
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<td>12</td>
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<tr>
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<td>23</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Circular Head</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smithton</td>
<td>16</td>
<td>16</td>
<td>23.2</td>
</tr>
<tr>
<td>Stanley</td>
<td>7</td>
<td>7</td>
<td>10.1</td>
</tr>
<tr>
<td>Hellyer</td>
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<td>2</td>
<td>2.9</td>
</tr>
<tr>
<td>Total</td>
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<td>25</td>
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</tr>
<tr>
<td>Queenstown</td>
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Factors Shaping the Ageing Experience: Interviews with Older Rural Participants

The ageing experience for older participants is in some senses a very individual one, and in other senses, quite generalisable. For older participants, the major driving force of age-related change is a virtually universal experience of declining health and capacity, but manifests at the individual level as widely divergent ageing experiences. This appears to be a complex product of the interaction of three factors: the extent and nature of declines in health and capacity, the nature of changes in individuals’ patterns of connection with family, friends and community, and the personal, social and physical resources they bring to dealing with these changes. An understanding of how these factors work together to shape the ageing experience and mediate the impact of change, is necessary in order to both identify and assess social threats to successful ageing and to design interventions to circumvent these threats.

Changes in Personal Health and Capacity

Defining Capacity

The term capacity is used here in a very broad sense to encompass the full range of physiological and cognitive resources that support activities of daily living. Older participants are most likely to explicitly mention changes in objective physical capacities arising from diagnosed pathologies; however, there is ample evidence in the data of the impact of a much wider range of incapacities such as declining cognitive capacity, and declining physical and cognitive energy and stamina leading to a reduced drive and commitment to former activities and an increasing interest in more passive pursuits and ‘home and hearth’.
Virtually all older participants report some, often a marked deterioration in health and physical capacity with ageing and for most this is the defining feature of older age in terms of impact on quality of life.

*Researcher (R):* So what assistance do you consider you could need to remain involved in your community as you age?

*Male (M):* Reasonable health.

*Female (F):* Reasonable health and the ability to drive because that would be, that’s probably one of the main factors, isn’t it P..., health and ...?

*M: Yeah, it’s just health.

**Health**

While the study was not designed to provide an objective measure of the health status of older participants, the list of conditions affecting them covers almost the full spectrum of pathologies with musculo-skeletal (arthritis in particular), diabetes, cancer, respiratory and cardio-vascular conditions mentioned most often. Most report more than one health problem and some multiple morbidities.

*R: So it’s mainly the asthma?*

*F: Oh, and I’m an insulin-dependent diabetic and I’ve got a silly ticker.*

*R: And you’ve got a …?*

*F: Silly ticker: it goes all erratic.*

*M: …but over the last few years I’ve had a lot of health problems. I’ve had a heart attack, I’ve had a stroke and … I’ve had leg trouble…*

There is a general, almost matter-of-fact acceptance of declining health as part of ageing.

*R. So, what are the major things you have stopped doing in recent years?*

*M: Age is the reason I have stopped doing things.*

*R. So how long since you have been on council?*

*M: 15 years.*

*R. And you were involved with the [names] societies as well, you were saying?*

*M: Oh yes, and all the other things.*

*R. And the farming organisations…?*

*M: Yep,*

*R. Did that involvement change over the years?*

*M: Yes, all involvements change over the years.*

*R. How have they changed since your son has taken over the farm?*

*M: Well, I’m running downhill, so things have got to change. And that is evolvement, isn’t it?*

Despite the litany of health issues, over half of the older participants still rate their personal health as ‘good’ or ‘excellent’ (Table 6, below).
Table 6: Self-assessed Health Status

<table>
<thead>
<tr>
<th>Assessment</th>
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<td>Good</td>
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</tr>
<tr>
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<tr>
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Older participants, by and large, acknowledge their health issues without drama and retain a focus on living their lives as best they can within any limitations imposed by health and well-being issues.

R: Would you say your usual state of personal health is excellent, good, fair, poor?
F: Oh it’s excellent, I think, on the whole, isn’t it?
M: Oh well, you discount the things that don’t matter, no it’s good!
F: I think we do pretty well. You’re a diet-controlled diabetic, I think that’s pretty good at your age and state.

R: So you think [your health is] fair or poor?
F: My health’s fair, isn’t it? Or good?
M: Fair.

However, older participants express concerns and fears in relation to age-related health declines and these are centred on two issues: declining capacity and service access. Taken together, these represent the vast bulk of older participants’ ageing concerns and difficulties and at the heart of both lies the dominant issue for older rural people: mobility. This matter is of such crucial importance and is so integrally linked into the rural ageing experience that it will be only be flagged at this point and explored in detail in a separate section.

As mentioned above almost all older participants report some decline in their performance around the activities that had formerly comprised their day-to-day life. As with health, older participants vary widely in the extent and nature of reported decline – from a mild reduction in energy, motivation and commitment to being virtually chair-ridden. However, at every level, declining capacity has implications for maintaining preferred lifestyle and levels of social engagement.

At the most benign end of the scale, older participants report a declining energy and interest leading to reduced commitment and involvement in community activities. This may not mean ceasing to attend altogether but it may mean a reluctance to shoulder organisational leadership responsibilities and to commit to reliable and/or regular attendance at functions or activities.

F: ...because I was involved with the club. And that really kept me occupied.
R: So how long since you have given that up?
F: I think that next year will be the third year. ... But I gave it up because I wanted to give it up. Not that I didn’t enjoy it, I just wanted a change. It was a tie.
This trend can be a major problem in rural communities where changing culture means that many traditional community organisations – the Country Women’s Association (CWA) is a prime example in the data – are struggling to maintain membership and to renew themselves. Some older participants have already experienced the negative impact of this on their social relationships.

**F:** I suppose after I gave up the club, and I mean that is not so very long ago, I suppose it was not [being] associated with the community so much as, well, [feeling] empty. Empty is more the thing.

Others may feel that they face the choice of either maintaining full commitment or losing a cherished socialisation opportunity.

**F:** I don't know how to explain it. Because for years I’ve belonged to the CWA and that was another group that’s folded so that’s altered another dimension of it [her social relationships].

**R:** Yeah. So how long ago did that fold?

**F:** Well I reckon it must be ten years since that folded. Oh yes, it’d be at least ten years.

**R:** Yeah.

**F:** We ran out of members and inclination mainly. But the members we had just got old.

**F:** … and once you join Lions I’d say our social life was sort of um [full and varied]. Then we come down here we had, there was half a dozen of us, and we’d just have dinner parties and things. But then one of the men died and a couple moved away and [laugh]. It’s ended up there’s nobody here either, doing that so, so um.

For those whose community engagement is heavily based around physical pursuits such as golf and lawn bowls (both genders) and hunting and fishing (males in particular) declining physical capacity – most often in terms of musculo-skeletal and cardiac issues – brings a major shrinkage in socialisation activities.

**F:** Then they wanted to redo – start the ladies at the golf club. So they came to me and asked me would I would help. . . . Help them get started. And I became their president and stayed there until I couldn’t swing the club any more.

**R:** Because you’ve got problems with your arm…

**F:** Yes, both arms, really, but this one particularly.

**M:** Yeah, yeah me and my two boys and nephew, my twin brother’s boy he goes (hunting) with us a fair bit. . . . We go on two or three different properties, but I’m getting a bit old for it you know, I don’t do any walking much now, I get out of the ute and go a few hundred yards, that’s it, sit on a stump and nothing comes past, nothing comes.

Some older participants find (sometimes ingenious) ways of working around these limitations or finding substitutes, for example, carpet bowls is highly popular among former lawn bowlers, but for many those limitations imply a significant loss and pose a major challenge to their continued social engagement.

**R.** Did you used to drive to Hobart quite a bit, did you?
M: Oh yes. Yeah.
R: So how long since you would have driven down to Hobart?
M: Oh, what would it be, it’d be a couple of years now.

At the extreme end of the scale, severe incapacity literally shrinks the social world to a home - or even a room or chair - and interactions with an intimate partner.

F: I said, “T... if anything happens to you I’ll buy a blow up doll and put your clothes on and just sit it in that chair”, ‘cos that’s where we spend most of our time … until after tea and then we move up to the TV.

Even here, there is evidence of acceptance and adjustment. While some are clearly heavily burdened by age-related loss of physical capacity, very few older participants could be said to be ‘railing’ against their condition and in general showed an impressive capacity to accept what cannot be changed and ‘get on with it’. For example, a male who was no longer able to drive and relied on his wife said, “Better just sitting down watching, you see more don’t ya?” and a female who had trouble getting in and out of vehicles said, “I’ve tried swivelling round, I’ve tried putting one leg in at a time. There is no comfortable way. I haven’t found it yet”.

These attitudes, behaviours and practices have major implications for the development of a service model in the next stages of this study. This is likely, to some extent, to be a rural generational cohort effect. The self-sufficient stoicism of this rural generation in Australia is well established in the literature (see below for discussion of its impact on service demand and acceptance). Whether such a culture is ultimately protective of morbidity and mortality is well beyond the scope of this study. However, to the degree that the pathological effects of disengagement are related to the expectation/experience match, it could be argued that it is likely to be protective, certainly of quality of life and possibility of morbidity. It may also signal a more general compensatory ageing mechanism but that also is beyond the scope of the present study.

Regardless of older participants’ ability to accommodate and cope with loss of capacity, it does frequently pose a challenge to maintaining preferred levels and patterns of social engagement and lead to significant frustrations and concerns. One source of tension arises when one partner in a couple experiences significantly greater capacity loss than the other leading to differing recreational and socialisation needs and capacities.

F: I mean the things I’d like to do... I’d probably go to the theatre more and that sort of thing... and I don’t - I wouldn’t leave J [husband] at night.

As noted above, concerns and frustrations around age-related capacity loss relate principally to two areas: restriction of choice and control, and service access. In the latter case this appears to relate more often to future fears - in respect of service needs and access - than present difficulties.

Loss of capacity restricts choice and control and limits options in a variety of ways, decreasing the range of activities older participants can physically engage in.

R: Do you go fishing at all now?
M: ... last fortnight we had that competition and I was out. Usually I only go out for one day now, but that’s as much as me body will allow me...

F: Well I was doing embroidery, but I’ve got an arthritic thumb now. And I have just finished the last one.

F: It seems to be a slower pace. I don’t bustle around like I used to.

There is also increasing reliance on the support of others - partners, family, friends and care providers - to manage the activities of daily life such as shopping, house and home maintenance, recreation and community engagement.

F: My daughter comes in and runs the vacuum cleaner over it every now and again.

F: ... and my son comes in to do any little things that I can’t do.

F: ... I found when he [husband] first died that I couldn’t make a decision at all and it fell on my daughter... Even now at times if I get in, I got to do something, you know it’s her I ring [and say] “look I think I’m gonna do this but what do you think?” I still do that to her.

M: He [son] takes me out [fishing] every now and again.

F: A [daughter] would take me wherever I want to go.

R: So A... goes over to [Senior Citizens Club in nearby township] with you?

F: Yes she takes us [herself and a friend]. I wouldn’t be able to go if she didn’t take us over there.

Loss of capacity also greatly complicates service access especially in the rural study areas with their distance from urban-based services and lack of local services. The most pervasive effects in all of these cases are those flowing from a loss of mobility, both personal and geographical.

There are a number of areas of declining health and capacity that are barely mentioned by older participants but figure quite prominently in focus groups and interviews with service provider participants (see later section). This reflects the quite different perspectives of the two groups and encompasses many issues that the older participants’ generation is likely to be reluctant to acknowledge or discuss such as neuro-degeneration and incontinence. There is a consistent theme throughout the data around declining health and capacity with age. Although there are clearly very wide variations in the rate, nature and level of decline among individuals some loss of capacity seems almost a universal experience. Older participants’ stories, however, are far from the depressing tale of decline and loss that this might imply. Rather the majority are relatively upbeat narratives of acceptance, adaption, coping and living one day at a time. Many certainly have present concerns and fears for the future around access to needed services, their capacity to age in place, and in some cases, finances and health and well-being of partners.

In these matters the older participants’ and service provider participants’ concerns largely coincide but there are notable differences in perspective. The stoic acceptance that marks the older participants’ stories means that the less obvious (but no less important, at least in
the theoretical underpinnings of this study) effects of loss of health and capacity - social disengagement and disenfranchisement and increasing loss of independence and agency - go largely unremarked and unaddressed. In contrast, service provider participants who daily deal with the end results of these processes are acutely aware of the need for better services and supports that respond to the social and psychological as well as the medical consequences of loss of health and capacity.

Psycho-social and Emotional Responses to Ageing

Older participants vary widely in the nature and extent of the changes they face as they age and this variation, as would be expected, has a major bearing on their satisfaction with and quality of life in ageing and the constraints they experience in seeking to maximise their quality of life, although, in general, older participants are at the very least sanguine about the ageing experience (Table 7).

Table 7: Older Participants’ Rating of their Experience of Ageing

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<tr>
<td>Case Total</td>
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</table>

Much less expected is the degree to which psycho-social styles and resources appear to define the ageing experience, almost independent of the nature and extent of change faced.

Resilience and Adaptive Capacity

Insights in regard to resilience and adaptive capacity are only really evident at the case level – where an interview is considered as a whole - rather than at the thematic or detail level. Older participants’ positioning on an informal continuum scale that rates personal psycho-social styles and resources from active, resilience at one extreme to passive, defeatism at the other, appears to provide a sound indication of likely satisfaction with their experience of ageing and quality of life in ageing, that are largely unrelated to personal, social and environmental change. The active resilient response end of the scale is marked by an ability to recognise and accept age-related change while finding alternative, positive, forward-looking strategies to maintain quality of life. This approach is encapsulated in what is generally known as the Serenity Prayer a common tool used in certain behaviour change programmes such as Alcoholics Anonymous:
God grant me the serenity

to accept the things I cannot change;
courage to change the things I can;
and wisdom to know the difference. (Niebuhr, 1943)

It shares much with the ‘selective optimisation with compensation’ theory of change adaptation proposed by Baltes and Baltes (1990) and identified as being associated with successful ageing. Selection is associated with dealing with reduced capacity by increasingly focusing on a reduced number highly-valued life domains, optimisation refers to actively pursuing strategies to augment and maximise quality of life returns within those selected domains and compensation refers to the process of finding alternative approaches to pursuing valued end goals where usual approaches have been blocked by a loss of capacity.

As already evident in some quotes from older participants’ responses, a wry, sometimes self-deprecating sense of humour appears to be used to good effect by those whose response is at the active, resilient end of the scale.

M: I’ve had two new knees and I’ve got two new hips – only thing I’ve got to get now is two new wings!

M: Saturday nights lately I’ve been taking myself out to dinner ... up to the M... Motor Inn. I’m starting to get to know the owners up there.

M: I go down to the S... Club of a night ... I do that a certain amount because I don’t get a lot of visitors or anything else and I need to talk, for the exercise, the talking, well that’s my excuse anyway [Laughs]

Active, resilient responses to dealing with change and anticipating change were also evident.

R: Have you ever been to Senior Cits?
F: I used to be secretary of Senior Cits., a long time ago when I was in my 70s but I haven’t been to Senior Cits for a long time.

R: So, what, what made you stop being involved in Senior Cits?
F: Oh, because I was ...I was painting and I was painting for a living more or less. Yeah and I used to, I’d rather paint than go to Seniors. [Laugh]

R: So, could you tell me what you most enjoy doing now?
F: That’s interesting. I’d like to do a bit more water colour painting but I don’t get time to do that. Told myself the last three years that I'll get back into it but I haven't. I guess when I'm less involved with the voluntary work I will do it more.

In summary, those who appear to be ageing most successfully are not necessarily those who face the least challenges or even those with the widest support networks. Rather, those who are most able to recognise and accept the inevitabilities of age-related change and to work through and with these to find alternate ways of pursuing valued goals and preserve quality of life, appear to be ageing more successfully. Such individuals are less likely to report negatively on the ageing process, be optimistic about their present quality of life and the future and are less likely to be alienated or isolated from key contacts.
F: I’ve got a silly ticker... It goes all erratic. But I live with that. I can’t be bothered worrying about it.

F: There isn’t a turning point in my book for ageing. There is no time. If at 80 I wanted to do something, then I am going to do it.

F: Now I’m saying, “OK, I think I need to step back a bit [from volunteer activities], younger ones can continue doing things”. I’m still available, I’m not going to drop out totally but we need to have a life of our own. I now feel I need to be free to say, “Ok we’ll go and look at that today”, [when previously she would have felt committed to the volunteer activity].

F: I don’t have anybody come to do my housework… and if I am having a bad day well then I just have to say, “Well I’m sorry but it’s a bad day and I can’t do things”, and they have to wait till the next day.

F: I think I’m doing fairly good considering all the things that’s going on with me. I mean I’m a Lupus sufferer as well so I mean I’m not doing too bad.

F: I don’t have anybody come to do my housework… and if I am having a bad day well then I just have to say, “Well I’m sorry but it’s a bad day and I can’t do things”, and they have to wait till the next day.

At the other end of the scale are those, a lesser number, who are consumed with what is lost and lacking hope for the future. Individuals on this end of the scale are more likely to be more unhappy, alienated and/or isolated and overall report a negative ageing experience.

F: I’d just as soon not know that I have diabetes. It was very frustrating when I found that out because it makes your life miserable. Everything rotates around it, especially if you get the proper one. I’ve only got diabetes II and that’s bad enough.

M: I used to have a computer. I don’t worry about it anymore because the brain and hands don’t work anymore.

These findings have a number of implications for services. Firstly they suggest that a substantial portion of the ageing experience is dependent not on external supports and services but on the individual’s psycho-social resources. It is well beyond the capacity of this study to draw any conclusions as to the degree to which such resources are innate, genetically-determined or learned traits; however, it is likely that there is some scope for services and supports aimed at building these resources, particularly, but not only, if begun earlier in life. Secondly, the findings reinforce the need for services and supports that ‘know’ the client in the sense of a developed relationship. This is crucial in many rural areas where services providers have existing knowledge and relationships with clients or operate in a way which allows them to build these relationships (see below).

Sociability

Older participants differ widely in their levels of sociability. Some of this variation is context and age-related and the story is one of progressive withdrawal from social engagements as capacity and energy wane. However, for a minority of older participants, this late age decrease is superimposed on a lifelong pattern of low sociability.

F: I’ve not been interested in the bowls, it’s just something that hasn’t ... and we’re not card players, well I’m not a card player, so therefore, we haven’t become
involved with that, perhaps, which in hindsight would have been a good thing if we’d got into that a few years ago uh, because then we would have um, sort of known people.

M: But we haven’t missed it have we?

F: Yeah I guess this is the thing, we haven’t felt the need to …, to be sort of, go outside our comfort zone, I don’t know.

R: What about when you go downtown, do you tend to have chats with people that you know or…?

M: No, no.

R: So you pretty much just go and do your own thing?

M: I’ve always been a loner.

In contrast are those who report a lifelong pattern of being widely engaged and eager for the company of others, continued, albeit with some reduction, into older age.

F: If you had of been here yesterday you would have had to knock your way through.

M: Yeah

F: Although the day before was pretty fair, I reckon we would have, yesterday we probably would have had, the day before Wednesday I think there was about eight or nine and yesterday there was about six or seven or something.

M: I suppose it’s too because it’s convenient it’s opposite the doctor’s and people going by.

F: And we love people, we just love people I think but it isn’t just that way

R: Yeah so your house has always been a bit of a drop in?

F: Every year all round my life, all our lives.

M: ‘Cos there’s always, even in a small town like this, there’s plenty of activity if you want it.

Overall, older participants are most likely to report networks that increasingly become differentiated as they age: an outer circle of casual acquaintances who they know by sight and name and to ‘say hello to’ and a small inner circle of key family members and close friends who provide the majority of physical and emotional support. Even the most social appear to have modest requirements in terms of their wider level network contacts.

There appears to be a very strong pattern in the way in which older participants talk about their sociability, with males much more likely than females to describe themselves as ‘loners’.

F: Well we’re looking for... probably the social aspects of it. More so for me because N...’s pretty reserved ... he’s quite happy just to be with me and not ... At the moment he’s got his outlet of work but he’s not ... you know, he’s quite happy just to potter around home and he’s got a workshop in the garage or something like that, that’s his thing, but I like to get out and get amongst it.

Although both genders clearly seek out clubs and organisations for their socialisation opportunities, females are more likely to identify their need for a ‘cup of tea and natter’ whereas in males’ responses socialisation opportunities often appear to be seen merely incidental to ‘doing things’. There also appears to be a trend towards wider and more diverse patterns of socialisation among in-migrants many of whom have moved multiple times and lived in a range of community situations. These networks are perhaps less deeply
rooted and based more on shared interests and activities than shared history and experience. Most however, report a small and often shrinking social network.

It is important to acknowledge these variations in lifelong patterns of sociability when considering interventions to support social engagement. ‘Preferred’ socialisation is clearly a combination of innate sociability mediated by the realities of ageing. There appears to be little correlation in the data between actual, objective levels of social engagement and ageing well. Rather those older participants who appear to be most content are those who have found an accommodation between their socialisation aspirations and their personal capacity.

**Social Connection and Engagement**

A chief rationale behind the study was to design supports and services to promote and maintain social engagement in ageing. The interviews were therefore largely designed to explore age-related challenges to social engagement. At the most general level, the answers provided in the data are both straightforward and unsurprising: declines in health and capacity affecting both ageing individuals and contemporaries who comprise their social networks, make it increasingly difficult to maintain former levels of social engagement. Again at the general level, this trend must result, eventually and inevitably in some diminution in levels of social engagement, especially in terms of the breadth and variety of connections and engagements. This matter is largely confirmed in the data and would infer a broadly functional and largely irreversible process. This does not mean that it cannot be modified. The goal therefore of any services and interventions must be to work at the level of the individual to ensure that these changes occur at a rate and in a manner that optimise quality of life in ageing. This work will require an understanding of age-related changes in preferred patterns of socialisation and of the manner in which personal and environmental factors affect the degree to which changes are either welcome and life-enhancing or unwelcome and detrimental to quality of life and the experience of ageing.

**Consolidation of Personal Networks**

Although the evidence around overall network size changes with ageing is still confusing there appears to be a general consensus in the literature that networks consolidate in ageing with close high-value ties becoming increasingly dominant especially family ties and especially among the old-old (Strain & Chappell, 1982; van Tilberg, 1998). Networks become more emotionally dense with drop-offs occurring mainly of emotionally more distant links (Lang, Staudinger & Carstensen, 1998). While there are certainly exceptions, this appears to be broadly the case for older participants although we do not have hard measures of network size since the present study was more concerned with understanding mechanisms of change than with quantifying changes in network size. There are two major pointers to this insight in older participants’ stories. Firstly, a small number of key family and close friend contacts dominate the recounting of their day-to-day lives, even for many of those who still maintain wide social networks and for those with large family networks.
Secondly, all but the most active and engaged, tell of a reducing circle of casual or general social contacts, partly the results of their less frequent involvement in community activities, or of involvement in fewer community activities and partly the result of reducing membership size of those organisations in which they are involved.

This pattern fits well with Carstensen’s theory of socio-emotional selectivity (Carstensen, 1992) which posits that as capacity diminishes and the need for support increases, older people increasingly husband their social and emotional energies and expend them in areas where they gain maximum emotional support. For many older participants, their social engagement needs appear to be met by a very small number of intimate social linkages - in some cases only an intimate partner - supplemented at intervals by some casual socialisation. The word ‘appears’ is carefully chosen because it is difficult in many of these interviews to penetrate an attitude of stoic acceptance and a lack of reflexivity to understand how much this stance is a reflection of reduced need and desire for wider engagement or is simply ‘making the best of what you’ve got’. Prolonged immersion in the data leaves these researchers with the strong perception that, for the majority of older participants, socio-emotional consolidation of networks may be driven as much by circumstance as choice, but is not wholly unwelcome in that it preserves limited social energy for expenditure on the most valued and valuable relationships.

Again, we must address the implications of this insight for the study aims. It certainly speaks against a simplistic approach that ‘increasing engagement will lead to better ageing’. The matter is, again, one of preference and choice constraints; a matter complicated greatly for service providers by the well-known tendency to stoicism and self-reliance among rural people, especially older cohorts. It is clear from the older participants’ data that, regardless of individual socialisation styles and preferences, both loss of personal capacity and changes in the rural environment are reducing opportunities for and choices around social engagement. Regardless of whether some of this network consolidation may be voluntary and welcome, any services and supports which increase older people’s ability to make their own decisions about preferred patterns of engagement, are likely to be vital in determining quality of life, especially when considering that perceptual measures (satisfaction, the match between expectation and experience, loneliness) prove the better predictors in engagement and quality of life studies rather than objective network measures such as mapping linkages. Because these matters are so individual, broad and blunt approaches to service provision are unlikely to be effective. Properly individualised responses are required which in turn rely on the service provider having nuanced understandings of the individual - and these are only possible within personalised professional relationships. Service providers interviewed in this study would appear to be notable in this respect; embedded as they are within their communities they have opportunities to build multifaceted, long-term relationships with, and have more intimate and broad ranging knowledge about, their clients.
Intimate Partners

Almost all older participants have at some point been partnered and two thirds remain so (Table 8).

Table 8: Partner Status

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<td>Total</td>
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For the long-term partnered, the ageing experience can only be fully understood in terms of the dyad rather than two separate individuals. The central importance of intimate partners in the ageing experience shines through the interviews to the extent that it would be difficult to overestimate the centrality of this relationship to the ageing experience.

M: Actually F and I lean on each other. We are pretty damn self-sufficient.

In many cases this relationship appears to largely fulfil the social needs of the partners and in some appears to constitute a fully contained social world for much of the time.

R: So what do you most enjoy doing now?
M: Sitting in the chairs looking at one another....

There is always the sense that being together remains paramount, even when, as with some older participants, differential rates of deterioration in health and capacity mean that a large carer burden falls on one party, bringing with it considerable stresses and worries, curtailing their independence and social engagement and even in some cases, forcing unwelcome residential relocation.

F: I’d really rather be looking after him as best I can rather than be here on my own [while husband is in respite care].

As intimate partnerships become more central in ageing, the increased intimacy and, often widening, differences in health, capacity, social energy and aspiration can exacerbate difficulties and tensions.

F: S... goes mad sometimes. I said...
M: Oh well, only when there is bad weather on. We had three days of... you know ... what can I do? I can only sit in the chair.
F: Yes, but I don’t.
M: What do you do then?
F: I go to the school and...
M: Oh yes.

There are a number of notable examples in the data of wives (always wives), feeling the need to ‘lean on’ their husbands to socialise.
F: Um, he’s quite content not to get out, ... It’s only me badgering him to get out and stop looking at four walls you know.

F: It [Senior Citizen’s Club outing] gives him something to do. And gets him out of the house.

The loss of a long-term intimate partner through death is clearly, for virtually all experiencing this loss, one of the most challenging changes in older age.

F: Well the two of you are sitting together for 43 years and then he’s gone. It changed the bloody lot.

Apart from the loss of the intimate relationship with its caring and protective aspects (for example: “She [partner] saved my bacon sort of thing. It’s good to have someone to keep an eye on ya”), the loss of an intimate partner results in the disruption of wider social life and connections partly because what was done, was done together as a unit.

F: Oh I love the football. That’s another thing I … we used to always go to the football together when he was alive but I haven’t been since, but I watch it on the wireless, on the TV rather.

Rebuilding a social network and new patterns of engagement after loss of an intimate partner is a major challenge especially when the death was preceded, as it was for a small number of older participants, by an extended carer role. A sense of the magnitude of the social network rebuilding task is captured in the following excerpts from one interview.

F: ...we used to, when D... was alive and we lived in R...we had a very full life. We had, people used to come and visit and we used to go and visit...we’d go to parties... we used to have trips up the coast, but there’s none of that now.

F: I’ve been so many years [caring for her husband] that I’ve had nothing, you know I couldn’t do anything. And here I was, D... had gone and I had an empty life, didn’t know anybody, didn’t know what to do. I still feel that way [eight years after his death] at times, you know, there must be more for me to do… he’d gone and I’m sitting here doing nothing, I felt guilty…what do I do?... and that was how, what I found hard to cope with.

The loss of a partner is made significantly worse when the deceased was also the couple’s driver. The latter was the case with a small number of older participants and, according to service provider participants, a widespread problem in rural areas as many rural women of this cohort never learnt to drive and the incapacity or death of a partner means the loss of the family car.

The other area in which differences and tensions can arise between intimate partners is in deciding where to live. These decisions are often forced on couples by present or likely future service and support needs. They generally involve significant compromise in terms of preferences and lifestyle aspirations and can sometimes bring into sharp relief existing difficulties or tensions within the dyad.

R: [To wife] So would you like to be living in this area 5 years from now?
F: No.
M: [Laughs]
F: Only because I would like to be, not that I think there is anything wrong with the area, I would just like to be closer to H..., instead of having to drive an hour and a half to get to... J... is going to stay here by himself! [Laughs]
R: So is this a point of tension is it? [Both laugh]
F: It will be [Laughs].
R: [To husband] Would you see yourself here 5 years from now?
M: I don't know. I certainly don't want to go and live in the city. I lived in Melbourne for about 18 months in Grade 4 and half of Grade 5 and then I had eight years in H.... And I've never been attracted to city living.

Family

Over half of older participants had children living close-by and three quarters had at least some family living locally (Table 9).

Table 9: Family Living Locally

<table>
<thead>
<tr>
<th>Family</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children only</td>
<td>22</td>
<td>31.9</td>
</tr>
<tr>
<td>Children plus Extended Family</td>
<td>15</td>
<td>21.7</td>
</tr>
<tr>
<td>Extended Family Only</td>
<td>8</td>
<td>11.6</td>
</tr>
<tr>
<td>No Local Family</td>
<td>18</td>
<td>26.1</td>
</tr>
<tr>
<td>Effective Total</td>
<td>63</td>
<td>91.3</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>8.7</td>
</tr>
<tr>
<td>Case Total</td>
<td>69</td>
<td>100.0</td>
</tr>
</tbody>
</table>

It is significant for later discussion on in-migrants, that five out of the six interstate in-migrants and five of the nine intrastate in-migrants reported no local family (Table 10).

Table 10: Residential Status - Family living locally Cross-tabulation (Frequencies)

<table>
<thead>
<tr>
<th>Residential Status</th>
<th>Children only</th>
<th>Children plus Extended Family</th>
<th>Extended Family Only</th>
<th>No Local Family</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-long Local</td>
<td>11</td>
<td>12</td>
<td>2</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td>Returning Local</td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Intrastate in-migrant</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Interstate in-migrant</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Missing Cases</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>21*</td>
<td>15</td>
<td>8</td>
<td>16*</td>
<td>69</td>
</tr>
</tbody>
</table>

*Discrepancies with Table 9 data relate to missing cases

A long life is likely to bring major changes in the relationship with family. There was an expectation that given current demographic trends, older participants would report losing
contact with, and support from family members who would be increasingly scattered in pursuit of educational and employment opportunities. On the contrary, while older participants certainly reported that many of their offspring were geographically dispersed, they remained absolutely central to the lives of most and many had at least one adult child who remained both emotionally and geographically close.

F: I think we are all quite family oriented rather than outside friends.

At times this familial attachment is expressed very directly and unequivocally.

F: My family are my life.

F: If only for my family, I don’t think I would be here today.

Loss of a son or daughter - and in some cases more than one - had been experienced by several older participants, sometimes resulting in disruption to social engagement.

R: So you’re involved in both Senior Cits. and CWA?
F: No, not CWA now. I was involved with CWA ... I was in that in Q... and I come down here and got into it down here but then as I said, A [daughter] dying changed all that. I just couldn’t sit where I couldn’t get up and go when I wanted to, you know. I was always going to go back though. Not that I was, … oh I don’t know what, not that I didn’t get over, well you don’t get over it but I mean not that I was sitting home moping about it all the time. But going to a meeting if it goes on and on and gets, you know, I’ve got to get up and go so.

Mostly, however, it emerges from older participants’ stories of their day-to-day lives that family appears to provide much of the support that allows them to continue living independent and rich lives. In terms of change, the picture is one of a ‘turning of the wheel’ as children begin to become the main support for ageing parents.

Very few older participants have co-resident adult children (although a small number do, one for example saying, “I couldn’t live alone”). Most long term or returning locals have at least one adult child living in the neighbourhood - close enough, both physically and emotionally to provide hands-on, day-to-day contact and support - and/or at least one child living in the wider region - close enough to visit on a day trip. The remainder have children who are largely living elsewhere within the state or interstate, with very few reporting children living outside Australia. This finding is perhaps at odds with expectations given current demographic trends which suggest a substantial loss of younger people in rural areas.

Children provide a wide range of supports both day-to-day general support, for example there were frequent mentions of family members “popping in”, and in terms of responding to specific needs and crises.

F: I mean we’d find that we would miss L... terribly [if she moved], she’s our left and right arms, isn’t she?
M: L... brings us our cooked meal over, or she wants to every night.

F: If our daughter happens to come down at the weekend and it’s fine, she’ll mow our lawns, or our son-in-law or something.
R: So do you ever go fishing now?
M: No, only when somebody takes me, very rarely.
R: So who'd take you?
M: Oh my daughter or son.

F: I think every day we [herself and daughter]'re on the 'phone to one another, ... just to make sure that ... if I needed anything, well she’d see that I got it. ... I rang her this morning and said to her, “The man's coming to clean my carpet... so I'll be moving furniture tomorrow”... and she said, “Do you want J [granddaughter] to come and help you?” So I mean they’re willing to come and help me do things like that.

Most of all there was mobility support. Many older participants rely on their children for transport associated with day-to-day activities and occasional longer distance trips.

F: My daughter, yes and ... I’ve got others you know that’ll take me. The one that was here this morning she takes me sometimes.

R: So do you, you travel with others at all?
F: Hardly. When we go up the coast we do. We go with me daughter or her husband nearly always. They make sure they take us plenty of places ...

Even where children live at some distance, regular telephone contact is highly valued.

F: I want to hear my family’s voices. I want to speak with them on the telephone. I email them occasionally. And they send me photos, which is wonderful ... But communication wise, I like to hear their voices.

Some do regular ‘rounds’ staying with their children or are prepared to travel to help out in times of need.

F: [Following death of husband] Well I can roughly say um, D [husband] died in [year], I had Christmas with P ... I had Christmas with S..., then I had Christmas with R..., I had another one with P..., went back to R... and that’s [when] R... said to me, “You’re on the mend mum aren’t ya?” he said, “you can see the difference, you’re coming out of it now”.

However, some mention the increasing costs and difficulties associated with travelling to visit family.

F: I go for holidays and I mean, my holidays are not just a week, they’re months and you know I go for a couple of months with them ‘cos they’re all away. .... so it costs a lot of money to get to them and so when I do I stay for a couple of months because otherwise I’m wasting money sort of thing you know.

Older participants are generally cognisant of other demands placed on their children and of generational differences in attitude and so are reluctant to make demands or impose, but some feel the loss of the parenting role.

F: The other boy is still working and his job takes him all over the place, so he contacts us not quite so regularly, and … because he’s working he hasn’t got the time to come down so regularly, but yes every three or four years he comes down.

F: …they’ve got their own things to do and I don’t hardly ever see them.
F: My daughter particularly is married and they are in Melbourne, they’ve settled. And my three sons are settled also. You can visit but they don’t need you in their homes now.

F: What I’d ideally like to do, but I wouldn’t do it while my husband [currently in residential care] was still alive, was to go up and spend the winter up there. But then I’d probably have a fight with my son and have to come back anyway so. [Laughter] ‘Cos the old and the young don’t agree at times. My kids, they have their lines of thought and I have mine. And of course I’m too old-fashioned for them.

A small number are disaffected with all of their children and a greater number, perhaps the majority, report considerable variation in the level of support and contact from different members of the family - summed up by one older male.

M: And I’ve got a daughter lives up here ... They go up and down the road, they don’t know where I live. They got all they could get out of me and they can’t... once they can’t get any more out of you they don’t bother coming near you. That’s... you only get one good dog in every litter.

Most often there is one child providing major support with others either scattered geographically and/or socially and emotionally more distant. Older participants generally express appreciation for the support they do receive and take comfort knowing that support is there if needed even when it is not as overt as they would like.

M: The boys don't bust their gut to help out but if you ever ring they're on the job.

There are some however, who jealously guard their independence.

F: Yeah. Independent [Laugh]. Yeah that’s what I said. “If I wanted a carton of milk”, I said, “I’d just go without before I’d ring”. ... I’d have me Weetbix with water before I’d ring them [family] up and get them to get me a carton of milk.

Another feature of the data is the place that grandchildren and great grandchildren occupy in older participants’ lives and the contribution they make to older participants’ quality of life.

R: Do you have much to do with your grandchildren?
F: Oh yes!! In our immediate family.
M: Oh yes! They mean everything to us.

This is, in most cases, clearly a reciprocal relationship where older participants feel that they are, supporting their children by looking after grandchildren or ‘foster’ grandchildren, taking them on outings, picking them up from school or by simply spending time with them.

R: So you often look after your grandchildren?
F: Yeah, they’re not a problem, because as I said they’re nearly eight and nearly ten.
R: So how often would you?
F: I’ve had them three times this week. No, they’re easy; they found a book and some things they want to make. I’ve got to get some chicken mince and we are going to make chicken nuggets next time they come.
F: [To husband] You look after, you help A... with T ..., with your grandson. You help L... with her grandchildren. [To friend] He helps quite a few, doesn't he? It's all help. You aren't getting any money for it.

M: I enjoy seeing my grandkids... oh I take them anywhere they want to go – spoil them [laugh] play with them, act the fool with them.

F: She [daughter who is a single mother] works in the pizza parlour, which is night work, so I look after the kids a lot - probably three nights a week.

In return there is a strong sense that this involvement adds, or has added in the past, considerable richness to older participants’ lives. The following quote reveals the quality of relationship that can develop between an older participant and his/her grandchild.

M: Oh! I go down and torment my grandson.
R: So he means a lot to you?
M: Oh yeah. Oh yeah. Yeah, definitely. He’s a rum ‘un... [long story of teasing grandson on a school visit about a possible girlfriend and grandson complaining to his mother] ... so he came the following fortnight after and... he said, “Hello Pop”, and I said, “I didn’t think me and you was talking”. ... “Why, what have I done now?” So I told him, he said, “but you humiliated me Pop”. [Laugh] Oh dear, I just shook my head, but he’s a rum ‘un.

Even where grandparents are separated by considerable distances from their grandchildren they still appear to remain an important source of engagement, although it may be intermittent or conducted on the telephone or via email.

A grandchild’s transition from childhood to adolescence can be a mixed blessing with some older participants regretting the loss of a formerly close relationship with a young grandchild and others talking of mature friendships with grown-up grandchildren and their children.

F: …your grandchildren are all sadly growing up so we don’t have them as much as we used to when they were babies and they had desperate parents.

F: We’re still in close contact with them [grandchildren] and that’s lovely and, you know, that’s... they come and go now they drive themselves, which is nice. They come and see us.

There are also reports in the data of older participants losing contact with grandchildren through their children’s divorce. The role of grandchildren in maintaining quality of life and a sense of a useful role for older people is perhaps well enough known but the potential for loss and gain as grandchildren transition through older people’s lives is perhaps less well recognised.

One area of particular interest is the role of dispersed offspring in influencing parental decisions to move. There was an expectation that older participants would feel pressured to move closer to children who wanted to be able to more easily provide support; however this did not emerge from the data. Older participants appear to be driven much more by their personal attachments to place (see below) and/or desire to retain their independence and were generally quite prepared to put up with compromises in access to supports and services in exchange for living where and how they want.
F: I’m very happy to be here ... all our friends thought we were mad and my daughter that’s a police officer in Sydney she was terribly upset ... that we were moving so far away ... but she’s been down and seen where we’re living and knows it’s very remote but, you know that we can get out, we can go to Burnie or somewhere like that in two and a half hours and we’re not stuck somewhere we can’t get out - except I don’t know what’s going to happen in winter, but anyway, we’ll come to that (laugh). We’ll worry about that when we come to it.

F: ...M [son] has often said, “Sell up mum and come over and live with me”, but ... at my age I, I, I like my own peace and quiet too you know and ... it just doesn’t work out.

It appears likely that many older participants are highly dependent on the social and physical support of offspring in order to maintain a balance between independent life-style choices and a preferred level of social richness. The nature of the relationship is usually one in which the older participant can ask for assistance without feeling they are imposing and be comfortable that the caring offspring knows them well enough to ‘give them their space’.

The major concerns would have to be those - a minority of the sample - who moved into the area in later life for lifestyle reasons. Most of these talk of family scattered across the mainland and very few of these appear to have close family living nearby.

R. Do you go backwards and forwards a bit?
F: Yes. I don’t need to go quite as often now that they are older. My daughter particularly is married and they are in Melbourne, they’ve settled. And my three sons are settled also. .... And my little mother, ... she has died also.

F: As D... knows, if I was in any way not be able to be here I would very much like to be back in my own, Melbourne-based family. Because there would be no-one that would ever visit A [herself] here. I mean, I know friends do. But friends don’t regularly do. And I do miss my children and grandchildren very much.

The same older participant comments on the rapid throughput of ‘sea-changers’ in her small coastal community, that is partly driven by a separation from close family.

F: But you will see in our street at least five for sale signs. People may come, and people came from the mainland when there was a boom here. They thought, “What a wonderful place and how reasonably priced compared to Sydney or Melbourne”. They don’t stay. The older gentleman over here, his family in Sydney are desperately wanting him to go back to Sydney so they can support him. And so that is the same sort of story, isn’t it?

This disconnection from family is made worse with declining capacity.

R: So what sort of things would you be missing?
F: What would I be missing? Oh, just travelling, no not travelling, no. Just going and seeing the kids and things like that. I mean they can’t come to see me. Well I can’t get around to see them.

Despite tales of loss, siblings and siblings-in-law are also frequently treasured as sources of socio-emotional support although many are too old and infirm to provide much support.

F: I talk to her [sister-in-law] a lot. I tell her a lot. She lives here in [township]. I talk
to her quite a bit ‘cos she’s, uh, three years older than me and she sort of knows how I feel, think. We sort of think along the same line.

**M:** They [wife’s sister and her husband] were very supportive to me when my wife was ill .... They’re only a telephone call away. … They come and visit. … once a month or more often if I need them of course. My wife had a long illness and you sort of prepare for it [her death] but you can’t. ... You’re not prepared.

**Key Friends**

The data suggest that it is more important to the well-being of older participants to have a strong reciprocal relationship with one or two key friends or confidants than to have a wide network of contacts and engagements. Most older participants can name one or two individuals on whom they rely, and who rely on them, for practical and emotional support and who have regular highly-valued contact.

**F:** I was friends, as I say the lady was from Q... that lived round L... and her husband died and ... sort of visiting her and saying that it [house next door] was for sale so she bought it and we put a gate in the middle so [laugh]

**R:** Oh, so that’s a very good friend?

**F:** So that’s a very good place. She’s been coming over [since participant returned home from hospital] and making my bed of a morning and, and ... - she’s away today for the day - and bringing me over... she said, “I’ll send you some flowers when you’re away”. I said, “No, no, just make me a pot of soup when I come home, just save your money, don’t buy me flowers”. So I’ve had soup, we’ve had soup for lunch most days which has been lovely, better than flowers.

**M:** ...I’ve got a chap that picks me up nearly every afternoon ..., we spend an hour, we make the excuse we go to get the mail ... and have a little run round, have a look at the town and see if things have changed anywhere [laugh] But … he’s a regular, nearly every afternoon he picks me up, and we only spend about an hour just driving around.

**F:** I do like to keep in contact with my friends. They are very faithful to me. They will come here and visit us here, which is lovely.

**M:** Oh and as we've grown older I've noticed people bring tucker to us, blackberries and cherry plums, and we cracked the jackpot next door. That paddock was empty for years, up till three years ago, and the couple that bought it and built that house, well, she cooks for us and he cuts me wood.

**F:** Yes we've been very lucky.

**M:** Absolute rippers.

These individuals appear to become increasingly important as the capacity to maintain larger networks decreases but it places individuals in highly vulnerable situations, especially since these key contacts and confidants are usually of similar age. As discussed above, in some cases an intimate partner may fill this role although this appears more likely to be the case with males rather than females with the latter more likely to have a close friendship group outside of the marriage.
Connection to Place and Community

As noted above almost three quarters of older participants were either life-long residents or returning locals (Table 12).

Belonging

These data go to the heart of the concerns that drive the study: how to support older rural people to remain engaged in their communities. There is a very notable divide in the data in this respect between long-term resident and in-migrant participants who have very different relationships to place and community even though they may share a strong sense of attachment to both.

R: So do you think you’d like to be living here in 5 years time?
M: Will I be?
R: Would you like to be?
M: Oh yes, yes it’s my kind of country.

It is a truism, repeated a number of times in interviews, that in rural communities you have to be born in the area to be a ‘local’. This is to some extent born out in the data, not in the sense of conscious exclusory practice but rather by virtue of the depth of network, historical and cultural ties that develop over a lifetime of shared experience. To live a lifetime in a community is to know and be known and to be multiply-linked through ties built up over years - social, work and multigenerational ties.

M: Ah, yeah well, when I went down the street this morning it took me ... what, three-quarters of an hour, and another three-quarters of an hour to get from the Post Office to the Medical Union which is a distance of about, what, ... half a block and there was all the different miners wanting to know how I’m going and how’s H... and I reckon there was about six or seven different people I was there talking to. So, yeah, you’d no sooner get down there, well even when I’m sitting in the car at times in the street, people come up and start talking to you while you’re sitting in the car, so yeah, time soon flies.

Many long-term resident older participants report knowing, or at least having in the past known, virtually everyone in the community and they gain a strong sense of belonging and security from this fact.

M: ...yeah so everybody sort of seems to stick together, that’s the beauty of west coast people and Tasmanians pretty well in general but west coast people seem to be very, very, very ... wonderful people to help one another and whatever. Any bad times or what, stick together well and no matter where you go. I was up in Q [nearby town] this morning, ‘cos everybody calls me C... you see, “Hey C...” [laugh] you know, shopkeepers and all, I’ve known them for years.

R: So in the past 3 months have you had a conversation with anyone in your local neighbourhood either in person or on the telephone beyond just saying hello
F: Oh gosh yes
M: Yes
R: [Laugh.] What about in the last week?
M: In the last week, yeah
F: This is the local lawyers and everything, paper[s] for everything, that needs to be
signed, filled in [for someone in the community].
M: A dozen people in the last week.
F: Yes absolutely [laugh]
R: So are you a JP?
M: No, not now they take it off ya when you’re 65. Well they don’t take it off ya but...

However, as new people move in this pattern is breaking down in virtually all of the study
communities, although faster in some than in others. The study cohort may be the last who
go into their old age with this sense of support and belonging. Recent in-migrants appear to
be drawn from three groups: those seeking a rural lifestyle change; those associated with
tourist ventures and those in search of affordable housing. The first group appear to
integrate well and to find a way to build connections although they generally lack the
deeply-rooted and family supports so valuable to long-term resident older participants in
their old age.

R: So at the moment you’re very much feeling your way into the community by the sounds of
it?
F: Yes, yes, that’s going to be a slow process I think. I sort of half expected that, I
got a bit down about it oh, probably a month or so back … and I sort of, I just sort
of said to N..., “Oh, I can’t be bothered, I think I’m banging my head up against a
brick wall here and you know, we’ll just go our own way”, and then all of a sudden
after I’d said that, the craft club went back and they, the lady in the supermarket
actually came looking for me and she said, “Oh you know the craft club’s started
and they’ve been looking for you”. ’Cos they thought we was still down the other
house. So I thought, “Well that’s nice”, and now everything sort of you know,
come together so that’s good.

In-migrants associated with the tourism industry are most prominent in two of the study
communities. These populations are relatively mobile and younger and are largely
irrelevant to our ageing cohort apart from the fact that they, along with the other in-migrants
signal a shift in the older participants’ perceptions of knowing their community.

R. So how many people would you know in S... on a first name basis?
M: Oh, these days we have a few strangers come…..there are some housing
commission units and flats, we have people come and go. But I suppose I know
about 90% of the people on a first name basis.
F: Knew them all once.
M: …there are a few come and go though nowadays.

The third group of in-migrants (those seeking cheaper housing) have a greater impact in that
they are seen to bring social problems with them which threaten the safety and security of
some older participants.

F: It used to be a quiet neighbourhood. It was a good neighbourhood and then we
got some neighbours that moved in and uh, it’s not a good neighbourhood now.
R: So is this in your street?
F: Yes.
R: So are they, tell me about that change? How’s that changed?
F: They, they’re into drugs and they drink a lot. They have a lot of parties. She is
very abusive and things like that.

Overall, the picture is one of changing community. Most older participants recount a history of community involvement through club and organisational membership. These involvements are lessening as they age (see discussion below) and one of the factors in this is a decline in traditional rural organisations in most of these communities and that in turn is partly driven by a lack of interest in these organisations among in-migrants and younger residents. It is important not to take a nostalgic view of traditional rural ‘community’ - there is some evidence in the data of substantial historical social schism and dysfunction in at least some of the study sites; however, the sense and reality of ‘belonging’ appears to provide powerful emotional and material support in the ageing process.

Community and Support

The majority of support, physical and emotional, for older participants comes from three sources: family, key friends and confidants and government-funded services. These are all discussed elsewhere in this report. For most, ‘community’ support takes the form of being there for others when needed.

F: I’ve got friends that I keep in touch with, an elderly lady, she’s 94 and she lives in G... she used to live next door across the road, and we ring one another up, and I rang her about two nights ago about half past eight and I thought, “Oh I think I’ve left it a bit late, I reckon bikkies in bed”, but anyway she answered the phone. “I didn’t get you out of bed D...?”, and she said, “No, no, no”, and we chatted for an hour and I said, “I’ll let you go to bed now”. “Oh”, she said, “I’ve enjoyed that hour, it’s the nicest night I’ve had for long time”, and I thought “I’m pleased”. Yeah, ‘cos she lives on her own, she’s got no family.

R: Do you visit your neighbours a lot?
F: Not a lot, but we are always there for each other. I perhaps see the one next door a couple of times a day but then sometimes we go for a week and don't see each other.

Older participants appear to feel that even when they are not presently receiving regular help and support from neighbours - as a good number are - they generally are confident that there are one or two that they can call on if needed.

R: So this very much runs as a little community to itself, does it?
F: Well, we have got to look after one another. We have T... over here not very well. We have two others here that are not very well. You do! You look after one another. It is handy to have someone come in and say, “Here, we will take your bin down” or “Here, we will take your washing in, because you are not well enough”. It is these kinds of things that I think make a community. You are given your own space but you are being helped along the way. And I hope when it comes our time that they will do it for us.

Older participants are, however, very mindful of respecting other’s right to privacy and although some report frequent contact with a near neighbour or friend, more often it is a case
of maintaining sufficient vigilance to know when others may be in need of assistance but being very circumspect in offering support.

F: The old bloke that lost his wife the other day, they were on their own, and we only just heard about it at tea time one night, and I said to M... “Gosh I got to go over and see what’s going on there”. He was on his own and was just so grateful when I got there. Here he was, you know he’s 82, not a soul, and they’re the sort of things that you put, really make, make a thing for, but if everyone else is all right then that’s ok... But there again they’re strange or strange to us ... [another] he had a son that wasn’t well and well I first think, “Oh take something and put it over the fence, scones or a cake or something”, but you go to the door and they don’t want to answer the door you see, and then you don’t go back anymore do you?

This reticence to impose is even clearer when the older participant is the person requiring assistance. There are multiple comments that demonstrate an extreme reluctance to ask for help, not only from the wider community but even from family and close friends.

F: They have a bus that you can get. It has all that access for wheelchairs and stuff. It’s just that some people like to be independent. I hate ringing up friends and saying, “Come and pick me up”. ... [It is] demeaning.

This tendency means that many are probably struggling without help because they are reluctant to ask. This is identified as a major issue by service provider participants.

In summary, for this cohort at least, the study communities appear, by and large, to function in a supporting and enabling manner, providing the security of knowing that help is available if needed without making people feel dependent. The degree to which this trend holds for in-migrants or the truly isolated is not evident from the data. In respect of the truly isolated, it must be acknowledged that no more than one or two older participants could be said to be isolated. Of the two most isolated, one might be said to be an eccentric or difficult personality and the other reports being badly hurt in a marriage breakup and extremely wary of any close emotional connection. It is possible that the small numbers of disconnected or isolated participants in the study reflect a sample bias given the difficulty of recruiting such participants but there is no way of verifying this either way. The findings add weight to our overall argument that interventions are likely to be more effective if modelled on a supportive community framework.

**Changing Community Involvement**

As discussed above, the data suggest that personal networks do become consolidated towards family and close friends as older participants age, driven largely by the effects of declining health and capacity. There is also strong evidence that, in general, older participants progressively withdraw from or wind back their community organisational commitments and involvements as they age.

The data present a history of widespread and long-term community engagement and contribution for the vast majority of older participants, running well into late middle age-early old age. Engagement is predominately with three forms of organisation: churches,
sporting clubs (especially golf and bowls) and social or service organisations such as CWA and Senior Citizens Clubs. Involvements go well beyond simple participation with many telling of long periods as office holders, organisers and volunteer workers. These engagements are, or were, clearly central to these people’s lives.

F: [A] lot of them play... there is bowls here, I can’t do it on a Wednesday ‘cos I’ve always got something else like CWA... Mm. I’m afraid CWA’s my life now.

There are many examples showing a powerful sense of the importance of these involvements as an affirmation of community belonging and identity through contribution.

M: What do I mostly do now? Well I’m one of them blokes that does a bit of anything and everything, there’s always people wanting something done of course. You’re never ever out of a job. No one here should ever be out of a job I can tell you, you know ‘cos there’s always somebody wanting something done.

M: Oh, being involved in the, helping other people you know, who are probably worse off than what I am, you know health-wise or maybe older that what I am. Or maybe they’re unable to do what I can do yet. It’s a great pleasure to do that or I’ll give them something out of the garden. It’s simply much better, a bigger thrill than to give than to receive [laugh]. More or less take it from my work, my regular employment that I used to do.

M: This month we got a farmers day on over there and if we get all the bowlers there that’s ... 16 teams, 64 bowlers there, and she [his wife], she’s gotta get all the meat, 16 kilos of corned beef, cook that and organise all the other different stuff for the morning and afternoon teas, she’ll bake the sponges, she reckons she’s got to start next week baking sponges but she’s got to have at least 10 sponges for that and then she’s got bowls the … on the Saturday before it and she’s got to have another at least perhaps four sponges, three or four sponges for that, yeah, … so she’s, it’s … one of those things.

Despite such activity, there is also a clear indication in the data that most have severely curtailed their community involvements and contributions as they have aged. It would seem logical to expect that this curtailment would lead to a diminished sense of self-worth and belonging, however, there is little in the data to suggest that such is the case. Rather, the overall sense is of having ‘done their bit’ and being entitled by virtue of their age to step back a little and leave things to others and to have more freedom to decide what to do with their time and (declining) energy.

M: I’m not involved in taking on any major roles in anything anymore. Let someone younger do it.
R: Sounds like you have done in the past?
M: Yes, I have been.

R: So are you involved in any other organisations?
M: No not really. I used to go to Rotary.
R: How long since you’ve been involved with Rotary?
M: Oh 10 or 15 years. My wife never wanted me to go to Rotary. She was never an outgoing person. There were ladies nights and she would be feeling right out of it. So I quit. They were on my back the whole time, [inaudible], do jobs all the time, and you have to give time to them.
Implicit and explicit in these accounts of reduced community engagement is the spectre of declining health and capacity, not so much ruling out involvement but tipping the decision against making the effort to leave home and hearth.

M: ...also going out at night to meetings and, I mean, some nights here it’s absolutely freezing.

F: And that was a case of coming driving home at night by myself at 10, 11 o’clock at night. But if you are in town, you are not late. But when you add another hour and a half onto it and the weather, not that it really bothered me. It probably bothers me a bit more now. I think, “What if someone stops me?” Or, “there could be someone lying injured on the side of the road or something, what do you do about it?” Just things like that that go through your mind. That’s what I think about.

F: I said [to daughter], “Just wait and see, when the time comes, how I feel”... ‘Cos I don’t make things in advance very much now, I just, just wait and see how I [feel].

M: I love her [wife’s] company... she’s such a nice woman. I’ve got six lovely kids, I’m, I love staying home now because I’m getting older I guess, getting slower, getting tireder. I love staying home, I still love to go fishing, but I love staying home, it’s the best of all.

Senior Citizens is one organisation that is frequently mentioned as a valued source of ongoing social engagement opportunities for older people. Because it is professionally run, it does not require the level of volunteer labour inputs and commitment needed to sustain involvement in more grass-roots community organisations. However, there are those who do not wish to get involved in any organisation that is specifically labelled as being for older people, seeing them as something for those who are ‘past it’ or believing that they are not yet ‘old enough’ regardless of their chronological age.

R: And you’re obviously involved with Senior Cits ‘cos that’s where we met yesterday?
F: Yes, I didn’t get involved in that for quite a while ‘cause I wasn’t an age [laugh].

Others simply say they do not get involved simply because it doesn’t suit them or because members are ‘not their sort of people’.

M: So I am not one of those people who go on an outing with the older people. I don’t do that. I don’t consider myself ‘old’, if you understand me.

F: I would think that I should be helping, not...

M: you see a lot of people go out in the bus with others.
R: It is not your thing?
M: it is not my thing. I mean, if they enjoy it, good luck.

Most older participants expressed a firm view that those who were disengaged were making a choice rather than being victims of circumstance and that it was ‘up to them’ to make the effort, an attitude that likely flows from a general culture of self-sufficiency among older participants. This culture probably goes a long way to explaining the general feeling in the data of acceptance and coping and has some important implications for help seeking.
**R:** Can you comment on what is most important to you in remaining active and involved?

**F:** It’s just us, isn’t it? I think it’s just us. What’s important? Well I think there’s a lot of elderly people who could do more but they don’t seem to want to. It’s not that they’re not asked; they are. CWA’s very good for a lot of the elderly ones but there again they don’t come forward. They [CWA] sort of ask them to go to things, you know, and they don’t go. So I feel that it’s a personal thing, really, whether they don’t feel like going or - I don’t know.

In relation to the study aims, the task becomes to understand the policy and service provision implications of these findings. Firstly, heavy-handed, direct or overt encouragement of older rural people to engage in community activities may be fruitless with some, and alternative, more subtle means may be required. Providing a range of attractive social activities and facilitating access to these may be a start. Secondly, and importantly, the findings highlight the need for policies and programmes that recognise that some changes in engagement associated with ageing are natural and functional but that all such change is not necessarily so, depending on timing and impact. This insight calls for interventions that are sufficiently sensitive to the particularities of individual cases – in respect of personal and environmental factors - to know when and how to intervene or not.

**Factors Restricting Opportunity**

Besides declining capacity and motivation, a number of other factors can have an impact upon age-related disengagement, including organisational decline, loss of role-related socialisation opportunities, finance, carer responsibilities and, above all, mobility issues.

**Organisational and Community Decline**

One area of concern in the study sites is that it would appear that, in the past, older community members could safely step back from organisational commitments in the knowledge that others were coming through the ranks to take their place thus ensuring that the opportunity to engage was still there without the need to commit to a leadership role or even regular attendance. However, the data suggest that for many of these traditional organisations, especially the CWA, this is no longer the case and many older participants find that cutting back their commitment will mean the organisation will fold robbing them of access to long-standing friendships and support.

**R:** So you’ve enjoyed CWA for 52 years?

**F:** I have, yes. I loved it and still love it. I think if I didn’t have CWA I’d go clean off the planet.

**F:** … and once you join Lions I’d say our social life was sort of [full and varied]. Then we come down here we had, there was half a dozen of us, and we’d just have dinner parties and things. But then one of the men died and a couple moved away and [laugh]. It’s ended up there’s nobody here either, doing that so, so um.
For some, this organisational decline reflects a wider loss of community as they knew it, as demographic and social changes impact on the study areas. The use of the word ‘towny’ in the following quote is symptomatic of widely-expressed nostalgia for an earlier, remembered, ‘caring and sharing’ community that older participants juxtapose to a idea of city life as impersonal or uncaring. The validity of this view or the evidence, or lack of, on which this perception is based, is not the issue – rather it is the feeling of loss that compounds the ageing experience and fears around the possible future need to move to town to be nearer to supports and services.

M: We used to have fair grounds here and people got really involved in that.
F: We used to have a fair. Things have dwindled off.
R: So you can see that change?
M: You can. It is getting more ‘towny’ instead of getting interactive, if you know what I mean.

F: … but they, you know, before that generation… I suppose it was the generation before, they were, they were sort of leaders of the town, all farmer’s wives, you know, they formed the CWA when they were a branch when it first formed they...
M: And the Red Cross
F: Yeah, they were that and they were the church craft shop and they started all these things off you know and that doesn’t happen now it gets back to the town people.
R: Mmm. So that’s a generational shift too?
F: Yeah.
M: Yeah and caused a bit by the economy I suppose.

Role-linked Socialisation

Most older participants are long retired but many, especially the men, still look back on ceasing work as the time when networks were fractured never to be fully rebuilt.

R: Did it change when you went up to the Hydro, was that a different sort of?
M: Oh yeah, oh well the blokes you work with … some of them … you only sort of knew them and socialise or sort of thing when working with them but part, once you got away from work and that sort of thing, no you didn’t.
R: [To his wife] So had that eased off even when he retired because of his illness?
F: Yes, that did because the minute he finished work his mates didn’t bother coming anymore.

For some, volunteer work within the community is an important way to build new connections and for in-migrants is a way into the community.

F: …but you talk; everyone’s friendly around the op shop … you know it’s worked on a, I only work there every so often, you only work for a month … and … you meet people … and that’s a good roster there and then well at Christmas time you always have a sort of little all get together and you meet up with everybody. You mightn’t see them, the next ones that take over from you, you mightn’t see them again until the next time you take over but you’ll see them in town.
Finance

Although it is clear that very few older participants could be described as ‘well off’ it is
difficult to judge how much of a role finance plays in constraining or enabling social
engagement. They were asked directly to rate their financial situation and almost two thirds
rated it as ‘comfortable’ and only about one in ten as ‘difficult’ (Table 11).

Table 11: Rating of Financial Situation

<table>
<thead>
<tr>
<th>Financial situation</th>
<th>Frequency</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comfortable</td>
<td>42</td>
<td>63.6</td>
<td>63.6</td>
</tr>
<tr>
<td>Somewhere between comfortable and difficult</td>
<td>18</td>
<td>27.3</td>
<td>90.9</td>
</tr>
<tr>
<td>Difficult</td>
<td>6</td>
<td>9.1</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Such ratings have to be interpreted with caution. As with many aspects of the ageing
experience, perception and lifelong patterns have to be taken into account. Certainly, only a
minority of the sample spoke of finance as a major concern in their life perhaps reflecting
many older participants’ lifetimes spent managing on low incomes. However, for many,
finances were likely a constraining factor on their choices and would have been for much of
their lives, therefore frugality and a degree of financial constriction was a way of life
balanced by the un-costed benefits of their rural lifestyle. When asked directly, only a small
minority saw financial constraint as an issue and in those cases it often related to loosely
held aspirations such as travel and holidays.

R: So how often would you miss something you’d like to do because you don’t have the finances?
F: Not really, I don’t think. We’re not destitute. No we’re not – I mean, we’re not
terribly ambitious about things we want to do.
R: Are you on a pension …?
F: Yes.
R: Or a part pension? Is it a full pension?
F: Full pension.
R: Okay. How would you describe your present financial situation: comfortable, difficult, or somewhere in between?
F: Well we consider ourselves rather comfortable.
R: Okay.
F: Because we’re not scraping the bottom of the barrel every fortnight. So we reckon
we’re reasonably comfortably off. Of course we grow our veggies and so forth and it
makes a difference.

Ratings were also partially skewed by the timing of interviews which were conducted at the
height of the global financial crisis leaving those older participants self-funding their own
retirement fearful as they saw their capital and income eroded.

F: Well, I try to manage on a, we are self-retirees, you know? I have got a health
card, but it is all I get. And, yeah, managing.... with the economy at present things are not so good because the interest rates are not good, are they? We find it a little bit more difficult at present.

**R:** So you are mainly living on investments, are you?

**F:** Yes.

**R:** Like a superannuation?

**F:** No, not a superannuation. When we sold the farm we just had the money put away, with Westpac and they just sort of manage it. But it is dwindling instead of growing. Like a lot of other people.

There is a sense that those most affected by financial concerns are those, many of them immigrants, who perhaps have both greater assets and greater expectations. Again, the resilient, ‘make the best of what you have’ culture among much of this cohort, makes it difficult to judge when and how additional funds, supports and services might contribute to higher quality of life but greater government spending on general infrastructure, services and supports would be welcome.

**Carer Responsibilities**

A small number of older participants were caring for a partner. The impact of this role on the level of their social engagement varied, depending on the needs of the care recipient, the carer’s personal style, the nature of the personal relationship between carer and care recipient, their past history of social engagement, the amount of carer support available and how that support was utilised.

Most carers tend to allow their caring responsibilities to take priority over everything else and this prohibits or severely limits their own social engagement and community involvements.

**F:** I think it’s because ... the last 10 or 12 years... my life has become with T... because he has so many unwell days that I don’t feel happy going away and sort of leaving him because if he’s not good, some days he’s not real steady on his feet, ... so therefore my activities, ... even going out for a coffee occasionally, we don’t do that much, or I don’t. L [daughter] and I used to quite a bit....When he’s good that’s fine, yeah I’ll go off but other than that, no I tend to hang around just in case.

Others were able to strike a better balance between their caring responsibilities and continuing their existing activities or taking up new ones that fitted in with their current circumstances.

**F:** Well we have a Red Cross monitor which has given me some sort of – what’ll I say?

**M:** Peace of mind.

**F:** ...Yes, I mean before I had that I wouldn’t leave him. I was too concerned about what was, you know, what might happen. Particularly when he started having all these falls.

**F:** [After her husband began attending Day Care Centre] I just got involved in those sorts of activities [Day Care Centre activities]. So I just sort of changed, like from
going dancing, to going to socials and going on bus trips with the respite group. And I would go up there if they had entertainment or something.

**Supports and Services**

Many older participants had concerns about the local provision of health services - related not so much to the availability of services per se but to issues of distance and travel and the extra inconvenience and expense those generated - however, most did not have major complaints about the present level or direction of spending on other forms of government supports and services for ageing. Nor did they express strong views on what could be done in terms of supports and services to improve social engagement in ageing.

\[ F: \text{Well I can only say that I reckon the government ... organisations in rural areas are absolutely marvellous. I know everyone always wants more but you know I can't think of anything extra that we would want in a place like this.} \]

A small number expressed concerns about the length of time they or others known to them had to wait for non-elective but much-needed surgery.

Interviews in Ouse represent a special case due to local changes in the Tasmanian Government health service model immediately prior to interviews. These changes and the community dynamics around them manifest in a high level of angst among older participants driven by fears about future impacts which may arise from the loss of local hospital beds. This singular issue raises more general issues about rural services, and requires separate analysis and reporting.

Overall, apart from issues around health services and residential options, older participants appear very happy, in a taken-for-granted way, with the ageing supports and services they are receiving - principally day-to-day home help and access to community transport - and were modest in their additional expectations.

\[ F: \text{I think probably transport for people who can't... Once you get to the stage of not being able to drive yourself. And better medical services. That's not meaning a better doctor, I just mean better all round medical services. But as again, when you choose to live in the country, it is one of the things you pay for. You just don't get the same services.} \]

Most often these expectations concerned help with irregular home tasks such as spring cleaning and minor repairs and some partly formed ideas around provision of drop-in centres for older people — ideas with similarities to the Day Centre model.

\[ F: \text{What I would really like to see is a building so the elderly can get together, instead of a, ... town hall, just have a room that they can all go and mix and play cards and things like that. Well, see we haven't got that.} \]

Older participants appear to expect little of the government in the matter of supporting successful (as against ‘healthy’) ageing. In fact, when asked directly what government could do to better support successful ageing, most appeared to find the idea novel.
F: I don’t think the government would have much to do with it!

Only a few had suggestions and those who did, needed prompting to flesh out their ideas, which again reflects the culture of self-reliance and a clear line drawn between government and personal responsibility.

M: They can encourage the people to do something for themselves instead of coming in here and trying to run it. That is different, but trying to encourage the people to do something. And I think that would make the country come together. [But] if they have a party, like people saying in the streets, “Look, we would like everybody to come to the town hall”, and, “You must do this”, or, “You must do that”, well, I don’t like that.

The most valued social engagement support services seem to be those that offer quite infrequent but regular and highly-valued opportunities to ‘get out of the house’ such as monthly outings and other one-off activities most of which are funded by HACC. These appear to have a quality of life dividend well out of proportion to the cost and effort required. For those whose world has shrunk due to declining capacity and mobility, the monthly outings provide something to look forward to without requiring or taxing their capacity for commitment and physical effort.

R: The outings you go on with Senior Cits, you enjoy those?
M: Yeah, they’re all right.

R: So can you tell me what you most enjoy doing now?
M: Oh, mostly enjoy going out on these trips. See a lot of people and …
R: So the ones N... arranges?
M: Yeah, yeah, yeah. N...’s a coordinator for the HACC trips.

R: So you go on the outings don’t you?
F: Ooh yes, wouldn’t miss them for all the tea in China [laugh].

F: I suppose, you know, as I was saying, the groups that are organised from O..., you know, as long as there’s always money available to do those sort of things and every now and then they organise a big pamper day, you know, and they’ll, you know, people will come up and give you massages and – I mean, things like that are good because I notice when they happen that you see different people there. Probably the more reclusive people that, you know, are probably passed the, or that are doing all the things we’re doing at the present. So it brings everybody out. They have senior citizen lunches and things like that and I think, you know, they get that at quite a reasonable price because of the money that’s put in from the government. So all those things are important, [but] probably not for me just yet but, yeah.

While all of these factors impact on the ability of older participants to stay part of, and engaged in their communities, the most significant factor by a wide margin is the issue of mobility.
Mobility

Most older participants appear to have been walkers for much of their lives and still value that activity. This may reflect their awareness of the need for physical exercise and of walking as a strategy for coping with age-related change.

R: Do you go walking at all?
F: I do.
R: So where do you usually walk?
F: Oh I wander all over the golf course, up and back and round the road. ...
F: I like meandering over it.

F: I try to go walking. I used to be regular, did my two kilometre circuit every day but I am a bit lazy lately, I have....
R: So that is just around there….?
F: Yes, there is a gate you can come in. But you can go that way, up the road and down and come back.

R: Are you finding that you have not got the same energy that you used to have?
F: That’s right.
M: Not quite as much. But I still go [walking].
F: He is good at catching things.
M: I can run when I want to.

R: How frequently do you go outside the house?
M: Oh, just locally?
R: Or, yeah, just getting outside – outside the four walls.
M: Yes, at least two or three times a day. Even if it’s only to walk up around the garden and back again.

For many, however, declining capacity is taking a heavy toll.

R: I guess you are out and about walking?
M: I don’t need to go walking to go walking. Mind you, these days I do a lot of riding on the ATV [all-terrain vehicle] instead of walking, but still...

M: The walk in the... walking up hills and that. Bloody kills me at times.
F: I could walk round [to the shop] but I would probably break down halfway.

M: Oh, I used to go around a lot of the sport shows and that, like, one thing and another.
R: So you don’t do that so much anymore?
M: Oh, no, no, no.
R: So why?
M: Walking about knocks me up a bit.

Both older participants and service provider participants identified that a loss of mobility is the most challenging age-related change.

Walking was not only a recreation, and an essential means for getting supplies and doing daily business but also a way to maintain social contacts and keep in touch with the community through chance encounters.
F: We need a community hall and library and that, that is closer. Because I am on a walker. Fortunately enough I can still move. I can’t get down.

R: I notice you have a stick to pick things up off the ground.

F: Yes, I have a walker in the car. And walking sticks. I am very limited in what I can do.

R: So how far can you walk, what distance?

F: I go up into the cemetery, but as I said I have a walker in the car and I couldn’t walk without that.

F: If I’m going down the street I’ll take the car. ‘Cause at this stage I’m not sure if I can get back. I could walk down, I used to walk everywhere but, with it being uphill and with my medical condition I haven’t risked it yet.

Declining health and distance increasingly confines many to their homes. Even for those with a degree of preserved capacity, the topography, condition of, or lack of footpaths and adequacy of lighting restrict the times when they can get out of the house on foot.

M: Well, that is the other thing. You have only got the L... highway. It isn’t safe to walk on, not with log trucks on it....

F: I don’t walk on the L... highway.

M: ...or the V... road.

F: ... our footpath between here and the supermarket is terrible

R: So do you feel safe walking about your neighbourhood during the daytime?

M: Yeah.

R: What about after dark?

M: I don’t go out after dark.

R: So...

M: Not that I’d be afraid to. It’s in case I fall or do anything like that.

R: So it’s more a... the fall...

M: A safety thing.

The potential ramifications of any loss of mobility reach into every area of life.

R: Can you comment on what is most important to you in remaining active and involved?

F: No, well I don’t really know. I haven’t got a clue. Transport – we really need transport.

R: Yeah.

F: Because even some of the girls that used to drive cars to bowls and that, they’re not able – they’re getting too old to drive. And in fact, the girl I went to New Norfolk with on Saturday, I think she’s not going to be able to drive for much longer.

R: So that’d be your number one priority?

F: Yes, transport.

This is likely to be as true in urban as in rural environments but in the latter it is amplified by a number of factors: the dispersed population with large distances between both people and significant population centres, the paucity and poverty of locally based services, facilities and opportunities, both compounded by almost complete lack of public transport.

M: Well, we haven’t got access to public transport. That’s – we haven’t got a bus or anything. We can only go when they decide to take you. There’s no bus that you
can go on any - say if you got up tomorrow morning and said, “I want to go to
town”, you couldn’t. There’s nothing to go in unless you take yourself.

F: There is a bus to H…. leaves at a quarter-to-seven, I think, quarter-to-seven every
morning and back home by five-thirty at night.
R: So is that mostly school children or …?
F: Mostly.
R: So have you ever used that bus?
F: Ah, only once. Too early!

In the absence of a workable public transport system older participants are forced to rely on
private cars and/or government transport options.

R: How do you usually get out and about?
F: A car.
M: A car. No other way. No public transport, no.

The vast majority of older participants still hold a driving licence (Table 12) and many of
those who do not are likely to be living with a partner who does (eight of the thirteen not
presently driving are co-resident with a spouse/partner).

### Table 12: Driver Status

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<thead>
<tr>
<th>Status</th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Unrestricted Driver</td>
<td>41</td>
<td>59.4</td>
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<tr>
<td>Local Area Only</td>
<td>11</td>
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<tr>
<td>Not Driving Temporarily</td>
<td>2</td>
<td>2.9</td>
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<tr>
<td>No Longer Drive</td>
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<td>10.1</td>
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<tr>
<td>Never Driven</td>
<td>4</td>
<td>5.8</td>
</tr>
<tr>
<td>Effective Total</td>
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<td>94.2</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>5.8</td>
</tr>
<tr>
<td>Case Total</td>
<td>69</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Despite this, mobility still appears to be a factor in missed socialisation opportunities with
almost a quarter reporting this happens ‘frequently’ or ‘sometimes’ (Table 13).

### Table 13: How Often Older Participants Missed Social Occasions because of Transport

<table>
<thead>
<tr>
<th>Rating</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently</td>
<td>7</td>
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<tr>
<td>Sometimes</td>
<td>10</td>
<td>14.5</td>
</tr>
<tr>
<td>Rarely</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Case Total</td>
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</tr>
</tbody>
</table>
The reality for most is that without access to a private car their lives and world rapidly become circumscribed and isolated and they become highly reliant on others. For people who are generally self-sufficient and reluctant to impose or who have to rely on others this is a very serious constraint.

**R**: So have you ever missed things because you don’t have transport?

**F**: Well, I would. You would be in a real predicament if you couldn’t drive. You know with doctor’s appointments and shopping. I know W... runs a bus on a Friday for the elderly and widows. They pick them up in S.... but it’s only for two hours. And if that didn’t work in with your appointment, you’d be....

Loss of driving licence is well recognised as an issue for older people and as a trigger for disengagement. These concerns usually focus on the compulsory withdrawal of a licence. However, judging from the data, this point is often just the most visible and final in a long process of progressive self-imposed restriction on driving as people lose confidence in their own ability: not driving at night nor in bad weather, not in winter, not venturing outside the local area or not outside the region nor into the city; and increasingly driving only for the most essential purposes.

**M**: Not now, I don’t drive a lot.

**M**: Yeah, yeah, I don’t drive to H..., you know, a lot. If I’m going down there I’ll get my daughter or my son to take me down, daughter-in-law. I don’t think I could handle the traffic in H... now.

**R**: So you’ve got a car. You’re still driving?

**M**: Mmm yeah.

**R**: So do you go out of town at all?

**M**: I try not to nowadays.

**R**: Did you used to drive to H... quite a bit, did you?

**M**: Oh yes. Yeah.

**R**: So how long since you would have driven down to H...?

**M**: Oh, what would it be, it’d be a couple of years now. I sort of lost confidence when I broke my hip.

The most obvious effect of this trend, and the one that raises most concern, is access to services. While the travel involved in accessing medical services is a major concern for many and a catalyst for at least thinking about moving home for some, it is not the major issue in terms of not driving. There are a number of reasons for this. Firstly, all of the study sites have good quality government provided transport options for those needing to access medical appointments. Secondly, this is an area of need where help from family and friends is more freely offered and/or requested and accepted. Thirdly, there appears to be some preference, even among those who have their own transport to use transport provided by either government, family or friends, so that they have some support and avoid adding long-distance driving to the strain of the day. This is not to say that there weren’t some concerns about transport service availability and many concerns about service access but the latter were more about issues of separation, cost and availability of accommodation, inconvenience and stress than whether people were able to drive themselves.
F: We were down in H... I stayed ... for months with him while he was having treatment ... he's elderly and we're both elderly and we've both been together, when he goes into hospital he likes me to be there with him .... when you're both there, there's nowhere for you to stay and it's costing you a fortune to be near the hospital or somewhere. There's absolutely nowhere to go and they don't have anything for people who have to travel to a specialist or anything. Up in B... fair enough, they have two or three little units - but most of the time they're already filled up when you need to go there and you can't get in there.

R: So ... is that an assumption that you can get to H... or B...easily for services?
F: Yeah, I think that, yeah, I think that all the surgeons and so forth think that you're only... [you] live around the corner. They don't realise that you're over two or four hours away from where they are and it's a big strain. Well, it's not so bad I suppose in the last couple of years, the roads have improved a lot, but ... it's still a big drain to get to H... or B... to see anybody.

In fact, very few in the sample did not have the use of a private car for at least essential purposes, either driving themselves or being driven by a spouse or adult child. Often, only one person in a couple did most of the driving, either because the other had never had a licence or had lost the confidence or capacity to drive. In some cases, it is probably a relief to the stay-at-home partner to be relieved of duties such as shopping.

R: Do you go downtown at all? Down to the shops down here?
F: No, very seldom, [husband], thank heavens, M... does all my shopping, he's the goer-outer. I just stay at home.

While there is ample comment on how crucial it was for older participants to have access to a private car, and on how devastating a loss of licence could be for other older rural people, only a small number in the sample had first-hand accounts of this. This does not diminish the impact of those cases but as with many of the issues identified in this study, much of the erosion of quality of life and engagement comes from the incremental, accumulating and subtle effects of loss.

Precipitous effects such as loss of licence do not come out of the blue but are likely to be preceded by a long process of incremental mobility restriction. This is a common story in the data. Woven through are multiple themes of incremental loss and adaptation (or mal-adaption) and in many cases of compensation. This pattern provides a picture with both positive and negative dimensions of age-related change and mobility is a case in point. Government-provided services in most areas have gradually expanded beyond provision for health and medical purposes to encompass shopping trips and social outings. These activities are highly-valued and for some it is likely that the group shopping experience is preferred to the solo one because it provides a social element to an otherwise routine task.

R: So the transport issue will be one of the crucial issues for you in the next transition you make in your life?
F: Yes. I believe transport for all rural areas is the prime consideration. Communication and transport is everything. But there are a lot of older people who are not able to put it together themselves. So I believe that government and community must have that in place for them. And seek them, seek their needs.
M: I think we do have pretty good help, like W... and in a way the ... I say W.... are better because W... will even take old people shopping and take their groceries home and put them in the cupboards for them.

F: Once a month I go on a bus - little bus and we go and do a bit of shopping and visit some nursing - a couple of [city] nursing homes because they've [ex-residents] moved away, so we make use of the bus.  
R: Oh is this the one that's down at the …?  
F: Yeah, the little yellow, the little yellow monster, Tweety Bird bus.

There are multiple stories of adaption and compensation through regular recreational or social outings with an adult child or friend, and car pooling or making less frequent, multi-purpose trips, for instance a medical appointment combined with shopping.

F: So we’re inclined to car pool a bit more now. Like, you know, I might be going shopping to O... this week and I’ll say to a couple of friends, “Would you like to come with me this week?” And they’ll come, and then the next time I’ll go with them and stuff like that.

F: We go down there [city] a bit you know like once a month and that sort of thing and we’ll go there for dinner, say on Sunday, well we’ll call into C… at G… on the way home and get a bit of groceries, that’s really all, or if we’ve got to go to town we go into the shops in G… and that, C..., the vegetable places and that.

Yet, even for the most resilient and adaptive, the underlying story is one of a gradual shrinking of their social world and formerly valued activities foregone: holidays, trips to visit close family, organisational participation and regular or spontaneous recreational activities.

F: Well we visit my daughter on the north-west coast at least once a year and I guess I visit my other daughter. I don’t stay much now because of the problem of all the gear that has to go down, injections and - it’s almost easier to be at home to be really honest. But we have daytime visits of course.

F: I think we’re fortunate because we’re just not stuck in the community, either. We’re lucky to be able to go to other places and friends come down and, you know, we get out. We sort of are not... But there’s quite a few elderly living here who very much... I don’t know how they, you know, they get on, [to husband] do you, S...? They’re living alone and I don’t know whether their families visit them or anything like that.

The degree to which this reducing engagement is a welcome adaptive response to reduced energies and capacities or a gradual impoverishment of life is both individual and difficult to ascertain. Those older participants who are increasingly confined to home and hearth often speak of the comforts they find in reading or sitting by the fire but the degree to which in any individual case this represents a preference or simply ‘making the best’ of the situation is difficult to judge from the available data.
Residential Resources and Relocation Options

Service access is the issue that dominates thoughts and decisions about moving among the sample. Only one or two older participants had made a clear decision to move and at least one or two others were wrestling with the decision. For the others, a question about where they see themselves in five years elicited one of two reactions: some were determined to stay where they were - that is, within same community or area not necessarily in the same house, unless forced out, and some were prepared to consider moving to a regional centre or city should their health deteriorate to a point where they needed to be closer to services. Among the latter there was a further divide between those who would move very reluctantly - usually the long-term resident older participants - and those who would do so quite readily if and when the balance of benefits tipped in favour of moving - more likely to be recent migrant participants.

Decisions to move, or not, hinged on a balance between ‘stay’ and ‘leave’ factors. The dominant ‘stay’ factor is attachment to place.

R: So do you think you’d like to be living here in five years’ time?
M: Yes, they won’t shift me now.

F: S...’s a nice place ... on the whole the weather’s pretty good and you’ve got the sea and you’ve got the scenery haven’t you ... ‘Cos when you get old you don’t want to leave here to go if you, you’ve got to go somewhere, if you’ve still got your ability to you know, and you’re not funny or anything like that, it’d be nice to still live in the location you’ve lived in wouldn’t it, instead of having to go say, up the coast somewhere where you’ve never been to and don’t know the environment or anything.

Almost all older participants expressed a strong attachment to their communities and their area. The nature of this attachment varied considerably between long-term resident older participants and more recent in-migrant older participants. While the latter have generally been quite strategic in moving into the study communities in search of a certain qualities associated with rural lifestyle - good scenery, close community, safety and quietness - they appear to have less depth of local attachment, be more mobile and have other ‘pulls’ such as family or cultural interests. For them moving is in some ways an easier decision. Long-term resident older participants on the other hand express a much deeper and unequivocal attachment and for them, the thought of having to move is generally highly traumatic.

F: but we feel that that’s a huge step to go – to burn all your bridges. You know, you’re going away from sort of everything you know to a strange place at this age which is not an easy thing to do.... And we still haven’t decided what we’re going to do yet. We’re weighing up the pros and cons at the moment...

M: The other thing regarding getting older as it were if you’re going to go to H... what do you do? When you’ve been used to having space and moving about and walking about and doing things and that sort of thing, if you haven’t reached the sort of totally sedentary stage. I mean it’s a frightening prospect for me to think going to H... living in a little box. What the hell could I do?

R: Yeah, that’s a – that is a huge transition for people who have lived all of their life on a property ...
F: And more for men, I think, than for women.

Three factors, family, friends and finance, can function as either incentives to stay or to leave and, again, the difference is partly divided on long-term resident/in-migrant lines. While most older participants’ families are scattered, those of the long-term resident older participants appear less so and many have at least one adult child emotionally and spatially close. Few members of this cohort discuss moving to be close to family as a primary factor in any decision, although it may well be the secondary factor, after service access, that drives the decision of where to move to. That is, for this group, family appeared on balance to be as much if not more of an incentive to stay put, as an incentive to move.

M: But once you’ve been born here, there is something about S..., the water...
R: You can certainly see the water from here...
M: Seven generations of my family have lived in S...

Fewer in-migrant older participants had family members in the area to which they had moved, and more of them spoke of the ‘pull’ of distant family as a likely factor in any eventual decision to move.

Similarly, friendship networks were a powerful ‘stay’ factor for long-term resident older participants. For those individuals the bonds that comprised their vital support networks had been forged over many years, in some cases over lifetimes (or longer if connections to families are taken into account) and to leave these would strip the older participants of much that gave meaning and structure to their lives.

F: I’m very involved here, and I have a lot to give up if I move to H....
R: So you have to then make all those networks again?
F: Which is not easy at this age...

For the in-migrant older participants who have already severed or disrupted those connections elsewhere in moving into one of the study areas, while most report good supportive local networks, their attachments lack the multidimensional depth of those of long-term resident older participants, and friendships and connections left behind are likely to exert a ‘pull’ balancing those forged within the area.

The strain on limited incomes arising from the additional expense of living in a rural location associated with both higher prices and costs of travel was mentioned by both in-migrant and long-term resident older participants but this was not generally cited as a reason for moving.

M: Everything is so expensive. If you want, like we brought that TV here not very long ago and they charged us $35 freight to send that TV from B... and that’s wicked really, and that’s the biggest killer on the west coast... everything is so expensive and even wood, we’re paying $85 a metre for a load of wood and ... a load of wood doesn’t last long here on the west coast with the weather we’re having. It’s the same as the electricity, ..., we probably use twice as much electricity here than what [people in] H... or B... use and that’s one of the things, I think why a lot of people are trying to get into the ... elderly people’s home up here at the hospital, because they just can’t afford to pay the, the cost of everything that’s going on.
A crucial factor in moving decisions appears to be the costs associated with buying and selling homes. For long-term resident older participants, especially those who own their homes and have done for some years, selling up and buying anew in or near a regional centre or capital city brings with it considerable financial penalties and an almost inevitable downgrade in the process in terms of the home/building itself, outside space and environmental amenity.

F: I mean we've sort of been looking at houses and you look around and you think, “Oh yeah, this is a house”, you know, and the other thing is that we don't know whether we're going to be able to sell this house and if we do we won't get much for it and you need a lot of money to be able to go and live in H..., to buy a place down there. You're not going to be able to buy a house in H... with what you can get for this.

M: Very difficult I think with the economic situation yes. I don't know how much we're going to lose.
F: No we don't at the moment.
R: So is that something you've been thinking about, pondering the move, the costs involved?
M: Mmm ... and the lesser value of your residence.
R: Yeah.
M: You might not even get for it what you paid for it.

In-migrant older participants were likely to have more freedom. Apart from the fact that they had demonstrated a propensity to mobility by moving in the first place, overall they appeared to have fewer concerns about financial implications of moving.

By far the dominant ‘leave’ factor was the need to be closer to supports and services as health deteriorated. Apart from one exception, an individual with high services needs associated with severe multiple morbidities, the impetus to move appeared to be based more on fears about possible future scenarios than present difficulties.

F: We probably would move to H... I think, simply because that's been, I suppose, more traditional for us, we ...
M: There'd be a point in time where we could no longer look after ourselves, or for health reasons we couldn't live here.
F: Yeah, we said, “All right, we've just had a year when I can't drive...”
R: Yep.
F: So the crutch for us is probably going to be if suddenly neither of us can drive and it would make sense that we were near taxis and public transport and ...
R: So the decision then would be to go to H...?
F: Yes, where we could more easily cope than ...

F: I mean, J [husband]’s no longer driving for example, and if I’m not able to drive, and I’ve got all sorts of health problems so, you know, they [adult children] feel that we should move now or at least make some plans or have some decisions made, and we're actually going through a pretty miserable time just at the moment, to be honest. ... Well, we're being torn at the moment between the north-west coast and H... mainly because that's where our two daughters live and - not that we ever intend to be following our children - but when it comes to suddenly there being ... having to move somewhere, the daughter who lives on the north-west coast feels that they have more to offer up there for us ...
A minority of older participants considering relocation were prompted by greater social and recreational options elsewhere, especially where one or both partners were restricted by ill-health to more sedentary options.

F: ...we do miss out on a lot of things and that is another reason why we’re really strongly thinking, ... perhaps it’s time we made a move, perhaps to B... which I think we would go because there is a lot to, more on that you can go to, entertainment, plus there are more places that you can get in the car and go for a drive, take your lunch. There’s more, I think there’s more life to be lived up there now than what there is in S... for us.

R: Would you have considered staying on in the area if that option was available or do you think that there are other pull factors?

F: I think that there are other factors that um, we would, we, I mean even though with T [husband]’s disability we don’t want to spend the next five or six years, hopefully, just sitting looking out the window and just going for a drive round the headland every two days or out to [nearby beach].

M: There’s more in life than that.

F: There’s more life to be lived if we could have access to it yes, yeah.

Given the degree of ill-health being managed by some quite geographically-isolated couples, it could be speculated that the majority will move only when unable to live independently and then only if suitable residential aged-care facilities are unavailable locally. It should be noted that there was no attempt in this study to audit residential aged-care infrastructure since our concern was with older people living independently. For long-term resident older participants the equation is this: service access issues balanced against attachment to place. While long-term resident and in-migrant older participants both talk of missing urban-based social and cultural opportunities denied them because of declining capacity and mobility, there is a sense that this is less a factor in moving decisions for the long-term resident older participants than for in-migrant older participants, likely because, for the latter, these cultural activities are an integral to a certain lifestyle whereas for the former they had become accepted as more of an occasional ‘treat’.

Seen in terms of coping with age-related change, long-term attachments to place and community are both beneficial in terms of place-linked supports and detrimental in terms of disincentives to adapt through moving. For in-migrant older participants the opposite would appear to be the case.

F: They [in-migrants] move to W... where they have family, [to] B..., or back to the mainland. Yeah. It is partly because it is too difficult to get transport or home help.

R: So that is as simple as not having a shopping bus?

M: Or even doctors. There are no doctors in S... they have to go to [regional centre] for treatment.

F: But if we were in B... [mainland city] it would be a 20 minute drive too, to get to some medical services.

M: But at least in B... there are taxis.

These differing patterns of older age mobility are likely to complicate future service planning.
Being Informed

It is clear from interviews that older participants are not particularly well informed about what services and supports are available, nor about how to best use them. Though rarely mentioned specifically by older participants, the issue of not being informed came up strongly in the service provider participant data. This is largely a case of ‘not knowing what you don’t know’. A majority of the older participants were using home support services and taking advantages of government-provided social opportunities such as HACC outings. However they were not well informed about who was providing these services and did not appear to curious to know, reflecting the strong culture of self-sufficiency where most saw government’s role largely restricted to the provision of ‘health’ services. Yet these same people were enthusiastic users of the wider ‘well-being’ services: they simply did not actively equate them with government and had little concept of government as a potential source of support with the social aspects of ageing. This insight means there are other tasks involved in attempting to shift policy and practice more towards supporting healthy ageing in addition to providing health services. If government is to seek to provide older rural people with greater social engagement opportunities these have to be presented in a manner that does not confront the existing culture of self-reliance. If older rural people are to be better informed about the availability and possibilities of these supports, channels of communication and information need to be developed that take account of entrenched learning and information gathering styles. Older participants appear more likely to seek information from friends and family than from official sources and to seek that information only when and where they see an immediate need.

Rural Aged Care Service Provider Perspectives on Factors Affecting Older Rural People’s Ability to Maintain Social Engagement

The stark contrast between data from older participants and from service provider participants highlights just how different the view of ageing is from the inside and the outside. Service provider participants largely conceptualise ageing in terms of a series of problems to be addressed whereas the older participants see it simply as a continuity of life with its own particular set of changes and compensations to be managed. While this difference of perspective is wholly logical and understandable given their different positions it does raise questions about the design and delivery of services when these are currently designed in terms of specific responses to a series of problems rather than in terms of a complex life experience.

Overall, service provider participants were ‘in tune’ with the original drivers for the study. They were supportive of the need to expand the strategic objective of aged policies, services and supports beyond their present focus on end-of-life frail age to including supports for ‘ageing well’ or ‘successful ageing’ strategies. This expansion would entail expanding
primary health care services to support community-dwelling, non-frail aged to remain engaged and productive members of their communities for as long as possible.

But if they [research team] are looking at more of the social aspects of providing HACC services, I think that’s really good. We struggle with the criteria having to be frail aged. Up here the fact that people are socially isolated should be a criteria to access services. [General agreement]

The older people are really, I guess, jumping on board with any social activity that’s happening at the moment. ... They’re just soaking it all in. ... The need is there, every week we’re finding more people that’d like to come.

And I mean we have [recently, since new arrangements in Ouse] found clients out there that didn’t participate in Seniors Cits. because they couldn’t get there or they were in some of the outlying areas. ... And some of the health issues that we’ve come across with those people, again it’s creating that next step, making sure we can manage and refer those people.

It was amazing, the people we discovered out there that had dementia - and their principal carer was their partner – and were really just surviving, and managing. I think we were even surprised at the number of clients that there were like that out there.

Service provider participant data can be divided into two themes: those associated with the ageing process and those relating to services. The data relating to ageing largely reflect our prior understanding obtained from the literature and from the older participant interview data. However the data around services raise new issues.

The following draws on a combination of service provider participants’ focus groups, interviews with local general practitioners and interviews with policy makers and higher level service managers.

**Ageing**

**Access and Mobility**

Service provider participants identify getting around as one of the major problems facing older rural people. There is a paucity of public transport in all areas and even when it is available timetables do not meet the needs of older people, particularly those who live away from the main population centres.

A particular concern was expressed for those who are unable to drive or access a private car and driver.

... because that’s one of the worst things... when people lose their [driving] licences. That’s when a lot of problems start.

In relation to this loss, service provider participants particularly mentioned the experience of older rural females, many of whom never learnt to drive, who find themselves without transport once their partners die or cease driving. With family and community transport
options and assistance to manage appointment times, most people seem to be able to access needed medical services and undertake essential shopping but often at a considerable penalty in cost, inconvenience and effort. Mobility for social purposes is seen as a greater problem. Service provider participants are very concerned about those who are isolated because of a lack of easy, flexible transport options and especially where most community activities are town-based.

... getting them to, not just to medical appointments but for them to participate in things happening in the community, whether it be the Day Centre ... the Coordinator tells me there are so many who want to participate.

For outlying ones, that's [community activities] often not available to them because they can't come in. They can't get in to their functions. If their family are away working they've got no transport.

Virtually all service provider participants acknowledge the high value of HACC services to older rural people especially its funding of regular bus outings.

I do the monthly bus trips and they're always... The bus holds 38 but sometimes I also take the community car, as well, to fit them all in.

Psychological Resources and Personal Styles

Those who work with older people acknowledge the crucial role of psychological resources and resilience in making the best of old age. They also recognised that many older rural people exhibit a high level of stoicism and independence which manifests in the desire of many to accept only those services which entail a low level of contact with service providers.

The beginning of service is again a very subjective thing for people and a lot of older people say, “If you take away my doing my housework, what am I going to do with my day”? [or] “I don't want Meals on Wheels because I still want to prepare my own meals”. And I think that's a very valid point. People are going to have different perceptions about 'when I'm not able to do that’. Some people will hang on with, to grim death to not let go their independence.

Some people like a lot of socialisation and others do not. You have to be mindful that just because you think that it’s important that a person should have socialisation, just be mindful that some people do not want that and are very happy to stay in their own home in their own chair. ... We can't put our understanding of what should be, onto someone else.

People will say, “I’m 85 and a lot of my friends have died”. They haven't got the energy to put into making a whole new network of friends. Or they will say, “I’m going to die soon myself”. They probably think just you [service provider] popping in for five or ten minutes is just nice. ... Meals on Wheels, when they call in are usually very well received, they’re pleased to see them and they would wish they could stay a bit longer ... It's just that person coming in and their [asking], “Oh how are you doing”? And they [older person] are chirpy and ...

R: So what you're saying is that it could be a quite small interaction that is adequate and they
They don’t necessarily want to come to the day centre, they don’t necessarily want to go on a bus trip, they don’t necessarily want to go on a picnic, but they like to think that someone is coming in. To have a whole 24 hours and see no-one can be quite daunting. But if someone comes in, even if the Meals on Wheels, or the home help twice a week, that’s socialisation to them. In fact some of the helps say, “We couldn’t get anything done, they just wanted to talk”.

Gender differences were noted, with males more likely than females to appear to, and/or express a preference for brief and low level contact.

Old blokes, they’re different to older women, particularly in that socialisation thing. I’ve got six old blokes that I would tend to call in to. The visit is never more than 10-15 minutes. I would stay longer if they wanted, but generally, just that low level of “G’day mate”. “Yep I’m alright”. You know that really basic thing and then they want to get on with what they are doing. And respecting them and giving them their space is what they want. [General agreement] I just keep those people on. Now technically I suppose I should finish up their cases, but you don’t because those blokes need that basic low level stuff.

A failure to recognise the fact that many older rural people are happy receiving this low level of contact and find it quite adequate and satisfactory for them may lead to a tendency at the policy and/or service management level to over-estimate what might be required to meet older rural people’s needs.

Service provider participants were concerned particularly for those who adopted a negative approach to ageing by not accepting help, tending to withdraw into themselves, sometimes lapsing into quiescence and disconnecting from others.

... and they’re too proud to ask for help.

There’s a whole lot of people out there in rural areas who don’t know that they can access these services. They don’t know, they just manage, they survive.

There are some that don’t... they’re [isolated] and they don’t want it [services]. There are always those that say “No thank you. I’m happy just doing this”.

There was also concern that older people fail to plan for deteriorating health and capacity and delay important decisions about issues such as finding appropriate housing until the last minute.

It’s still a big problem getting people to access services early on.

We might argue from the older participants’ interview data that the refusal to acknowledge ageing and delay dealing with age-related issues for as long as possible is not only understandable but in many cases functional.

**Deteriorating Health and Capacity**

Deterioration of health and capacity with ageing is very evident across all interviews. While there is considerable overlap in the older participant and service provider participant data,
there are also areas where the differing perspectives of the two groups are particularly evident. One of these is health. Service provider participants give prominence to a range of age-related health issues that are largely missing from the older participant data. These include: disorders of cognition, disorders of balance and gait, chronic disease, frailty, sensory loss, incontinence, nutritional risk and decreased physical activity. All of these conditions are likely to have substantial detrimental impact on individuals’ ability to maintain their social engagement and quality of life. They are also, however, all conditions that are likely to be accepted largely unremarked by older participants as the ‘normal’ consequences of ageing, insidious in their onset and impact and, in some cases, matters not to be spoken about. The existence of these differing perspectives highlights the value of taking a ‘triangulated’ view of the experience of ageing in designing policy and services and the need to draw from both the informed professional and lived experience points of view.

**Changing Social Relationships**

Similarly, service provider participants identify many of the same non-health related threats to social engagement as older participants but, again with some different emphases related to their different perspective. The network shrinkage that emerged in older participant interviews as an accepted, and even to some extent functional, consequence of ageing, was seen as more problematic and detrimental by service provider participants. Service provider participants also identified a loss of confidence and self-esteem, especially after acute episodes or falls, as a major trigger to disengagement. Again this is an issue less likely to be articulated in older participant interviews, as is another issue raised by service providers: disengagement pressures flowing from inadequate financial resources.

Service providers were particularly concerned with the impact of rural change on older residents. They identified a major and growing problem with recent in-migrants, particularly those who came in search of more affordable housing. The lack of family and well established friendship and community support is exacerbated for those who, unlike the majority of in-migrants represented in the older participant sample, have severely constrained choices due to lack of social and financial capital. Service provider participants were also very cognisant of the effects on older residents of rural economic decline (and associated loss of working age families), loss of social capital (particularly volunteers) and changing of services and infrastructure.

Lack of family support, family moving away from rural areas. The support’s not there.

They particularly noted the way that the transformation of service and support delivery resulting from advances in information technology (IT) is disadvantaging older rural people both through their lack of technological competency and the relatively poor IT infrastructure.
Residential Issues

Service provider participants identified an acute lack of suitable aged-care accommodation options in rural areas forcing older people to move away from communities of attachment, or to persist too long in unsuitable accommodation - too large, too difficult to maintain, too costly to heat and too far from services and supports.

An issue for older people in Q... is that they've had their own homes for ever - probably up on hills, they've got steps, and they require a lot of maintenance. They're not eligible for Housing Tasmania [a public housing rental home/unit] because they own their own home. But they desperately need to get out of this home to make it safe for them to live on their own. And there's no other affordable housing here that they can hook up on here, other than [the limited number of] Housing Tasmania [homes/units]. One old lady we know of ... [detail about her situation] she won't go out as often as she used to because she cannot manage the steps. She doesn't want to go out for fear of, she'll have a fall and break something. She knows that it's inevitable because it's such steep steps so she's made the choice to stay home.

Services

The majority of these findings are drawn from the focus groups and telephone interviews conducted with service provider participants. They provide a unique insight to the issues and realities of services delivery at the local level - which does not always conform completely to the model as constructed at the management level. Programme constraints have an impact and result in some service provider participants ‘bending of the rules’ in order to provide necessary care/service.

Adequacy of Services

Not surprisingly, service provider participants were concerned about the resources presently available to support older people in their community.

I visit for half an hour once a week - for a shower and a bit of housework and that’s about it.

... not so much with house help, more lack of services - we have waiting lists.

There’s no money for overnight care.

There's not enough money to really keep people adequately in their homes. ... There seems to be a perception in the community that there is enough funding... because really if you think about it [there is not]... really people volunteer a lot of their services... volunteering their time to care for people at home ... and the government very much likes voluntary work - the SES, auxiliary fire fighters where people don’t really get paid for the work they do... really we’re just on a shoestring.

R: Once they're getting services are they getting the services they need?
Not necessarily. Sometimes, yes, the services are exactly what they need, and it’s very progressive, and it works well, but for others it is not. And I can’t honestly say
why that happens. Sometimes it happens simply because it may be whatever part of
the year you come on. At the beginning of the financial year there's more money,
others there's been an increase in HACC money and this particular person gets the
luck of the draw, or they may have carers in that area. It's a very ad hoc system.

Most agreed that both funding and personnel were badly stretched and functioned only by
virtue of service provider participants’ preparedness to go ‘above and beyond’ formal
requirements of their jobs.

You can’t just walk out - our jobs just don’t fit into a set mould, not a square
mould. You certainly don't fit into that half-past four finish time, you stay until the
client has finished what they want to talk about or you’ve finished whatever you
want to do for them.

We have to be very flexible, each and every one of us.

Like, I have 44 hours of flex time and there’s no way I’m ever going to be able to
take that.

I [community nurse] do a lot of podiatry work as well, and without that there's no
way the podiatrist coming down here would be able to fulfil the service at all.

Someone’s got to do it [cut toe nails, trim corns]. Oldies can’t get down. It keeps
them mobile, and having that mobility is so important.

If they're having services going in we follow it through. ... Beyond what we are
supposed to. ... Like they usually say one or two grief sessions after someone’s died
but it depends on the person, but, like, normally we’ll follow them through for 12
months. And if they’re doing alright before that and they say, “I don’t need you to
come”, well [we] back off.

They were concerned about how much of the burden of care was falling onto families,
particcularly adult children, putting enormous strain on them and their families.

...people are volunteering their time to care for people at home so the perception is
that it is very well covered in the government’s eyes.

Of particular concern was the transition from the acute to the primary care setting where
older rural people were discharged from hospital - often at inconvenient hours in terms of
arrival home after a long journey - to return to homes where they had no-one to look after
them. Even with home help and community nurses to provide care, there were long periods
after hours where the only source of help was family.

They can be sent home from hospital with a post-acute care package which gives
them one hour a week - when the family are expecting 24 hours a day service...
They get a huge shock. They expect this package to care for them [their relative]
and it’s not there. The family’s got to pick it up.

This is compounded by the difficulties of recruiting staff, especially carers, in rural and
regional communities.
Transport

Transport was perhaps the major area of need identified by most service provider participants.

Transport is the big issue. [People are] very reliant on the community transport from W…. We don’t have public transport. One early morning bus [7.00 am] that can get them through to B… and that's full of school children and comes back in the afternoon [5.00pm]. It is a struggle for people living out of town because they can’t get to the bus unless they get up really, really early - a lot of clients are based in outreach communities. [You] have to catch that one [bus] to travel on [to all other centres].

Quite a large proportion who don’t have licences, have never learnt to drive or have handed their licences in.

Wives move into town when husbands die [because of transport issues].

In terms of ageing the loss of the driver's licence is very important here because we haven't got transport. Loss of the driver's licence is horrendously difficult for them.

However, detailed questioning revealed that most areas had a range of transport options which appeared to be operating quite effectively and to be reasonably adequate to present demand but faced two major hurdles - although these do not manifest to the same degree across all sites. Firstly, there is a chronic shortage of volunteer drivers.

Volunteers are thin on ground now. They have a periodic drive for volunteers every now and then. They get a few but only a few because it’s a long way to [nearest large centre] and mostly they [clients] want to do it in a day - which is a long day for volunteer drivers.

Volunteers provide the cheapest, most effective and flexible option for rural communities but service provider participants in all areas worried about the increasing burden this placed on a restricted pool of volunteers who were themselves generally in the older age categories. This is particularly an issue on the west coast where a medical transport job may involve a fourteen hour day and many hundreds of kilometres. A second major hurdle is a lack of coordination and information sharing. In one area at least, even service provider participants were not well informed on the range of options and the protocols around the use of each.

R: There is a reasonable number of vehicles. Is there any central coordination of those vehicles?
   That’s the challenge. Because they are all happily doing their own thing and there is really no coordination. Also they have specific criteria to meet to actually ride on those buses.
R: How would I as an older person understand what transport was available?
   [laughter] Talk to your neighbours, talk to anybody.

It appears that while the protocols and regulations around the various transport options do limit flexibility to some extent, restrictions come more from a lack of understanding among both clients and service provider participants about the degree of flexibility already available.
and a reluctance to find and fully utilise the range of options and ‘test the boundaries’. There is likely a lot of misunderstanding, particularly among clients, about the allowable ‘social’ uses of community transport. Both service provider participants and clients may routinely rank social use of transport less highly than medical use; however it is difficult to evaluate the relative value of the two types of use since social and medical well-being are closely linked.

Help-seeking

Service provider participants spoke of the tendency for some older rural people to be reluctant to seek or accept help. This reluctance accords well with the strong culture of independence and self-reliance revealed in the older participant interview data.

There are old ladies who say, “No, I will not...”, “You will not...”.

A lot of people find that sort of home help invasive. There needs to be some sort of community education programme that goes along with it [service provision] that says, “It’s ok for you to do this”. We tend to be reactive at the moment, we need to be proactive.

We’ve got some people in the community who are so independent. When they fall on the floor, they won’t even ring the alarm because they are scared of being hospitalised and they know once they’ve gone into hospital they’re not going to see their home again.

It’s human nature that, you know, ‘this is somebody I’m looking after, and I can do it’. ... People try very hard to do it but, they’re doing that really not knowing what is ahead of them and then before they know it they’re in a situation, you know, where they are saying this is a bit more difficult than I thought it was going to be.

This probably means that a significant number of older rural people are living a lower quality of life than need be because they do not accept help for fear of losing their independence. Some service provider participants believe this is driven largely by myths and misunderstandings that see aged care in terms of residential care leading to the fear that help-seeking automatically leads to residential care and then subsequently, death. Any attempts to expand the scope of aged care to encompass support for healthy ageing faces a major challenge in counteracting misplaced fears and engaging apprehensive and sometimes suspicious older rural people. This is particularly an issue with engaging older males in organised activities, such as those at day centres, although once the ice is broken they can become enthusiastic converts. Service provider participants tell of employing protracted, patient and innovative strategies to build relationships and trust in reluctant, but in need, older people.
Fitting Services to the Rural Context

The service provider participants demonstrated a willingness to adapt both the services they offered and their way of working to meet the needs of the rural context. Team work, flexibility, cooperation and coordination were seen as essential when working in small teams in relatively isolated settings. They reported finding the formal rules and regulations surrounding the programmes and packages that funded their work frequently hampered their ability to meet their clients’ needs and, as indicated above, were prepared to at least ‘bend’ the rules or work outside the strict ‘letter of regulation’ when they saw it to be in clients’ best interests. Of particular concern was the fragmentation of funding which segments carer teams and frequently leaves the client either passed between differently-funded programmes and areas of responsibility, facing delays in access to needed support, or worse, missing out altogether.

It’s very fragmented in this community because there’s us, there’s the State, ... we’ve got [organisations] who’re all doing basically the same stuff with a different packet of money so the administration costs for all that’s happening, you could probably fund more services... so it’s really... not very well coordinated.

They talked of the absolute necessity of minimising territorialism and formal protocols and keeping open lines of communication between programmes and providers.

The overall evidence from the focus groups and telephone calls with service provider participants and the interviews with policy makers and higher level service managers is that there is less mismatch between the views of these two groups than we had first assumed. Both want rural service provision to be as flexible as possible. Some misunderstandings were apparent, many of which appear amenable to exploration and resolution; however, more intractable issues were raised where rules were perceived by service provider participants as “getting in the way” of service provision and meeting older rural people’s needs.

The distances encompassed in rural catchment areas mean that even where transport is adequate, the travel times to access services become a major barrier and the principle of ‘taking the services to where the people are’ was a basic tenet of practice. Service provider participants explained that being a resident, rural service provider positioned them uniquely, in that they were community member first and service provider second. This meant that many expressed a willingness to go as ‘far’ as necessary in ensuring that they were able to service those in their communities.

We are like sponges and we make it fit into the mould that we’re supposed to be in. ... If we had to do a job description people would say, “No, one person couldn’t do all that”, and, “It’s not practical”.

75
A Triangulated View of the Ageing Experience

Older participants and service provider participants have quite different but not incompatible perspectives on the ageing experience. The service provider role by its very nature tends to problematise ageing, whereas the lived experience tends to normalise it. Both perspectives are important in building our understanding of the ageing process and in shaping policy and services provision. The older participant perspective alerts us to the nuances of individual experience and the strengths and coping capacities of older people, while the provider perspective alerts us to the vulnerabilities, risks, and challenges that can be downplayed by those who are coping and overlooked in those who are marginalised.

INFORMING PHASES 2 AND 3

The study confirms the underlying hypothesis that the ageing process changes and challenges the individual’s ability to maintain their earlier-life patterns of social engagement but tempers this by revealing, firstly, that there are wide variations in how this plays out for different individuals (depending on a range of personal, historical and contextual factors) and, secondly, that age related social network contraction is rarely entirely without some element of volition, entirely unwelcome or wholly negative in its impact. The study sought to identify specific age related triggers to disengagement. While such potential triggers were identified (for example, major health events, loss of drivers licence, death of spouse), their effect and the overall contraction of the social world in ageing is most likely to be a drawn out, subtle process of adaptation; a complex product of the nature of the changes and challenges faced by each individual and the resources they bring to responding to those changes and challenges. Such contraction may in some cases and to some extent protect and preserve quality of life and in others threaten or decrease it. The task for service providers is to understand which is which and to know when, how and how much to intervene to address the issue when quality of life is under threat. Given the complexities of the disengagement process, and the reticence of older rural people to seek help (well-established in the literature and confirmed in the data) it is likely that this will depend on having key providers who are both familiar with the local community and context and have, over time, built a relationship of trust with the individual. This insight will inform the development of a services framework planned for Phases 2 and 3 of the project.

REFERENCES


