Ageing in Place in Rural Australia

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Contribution of Others

Chapter Number	Publication Details	Nature and extent of the intellectual input of each author, including the candidate
Six	Anderson, Emily, Larkins, Sarah, and Ray, Robin (2017) *Media reporting on ageing in rural and regional northern Queensland.* In: Proceedings of the 14th National Rural Health Conference.	EA and RR conceived the idea. EA wrote the manuscript with all authors contributing to discussion of results and final manuscript.
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Six	Anderson, Emily, Larkins, Sarah, Beaney, Sarah, and Ray, Robin A. (2018) Should I Stay or Go: Rural Ageing, a Time for Reflection. Geriatrics 2018, 3, 49	EA and RR conceived the idea. EA wrote the manuscript with all authors contributing to discussion of results and final manuscript.

Summary

In Australia a disproportionate number of older people live in rural and regional communities. This population is made up of residents ageing in place and older people who have moved to these areas for a change of lifestyle or economic reasons. Given the difficulties of delivering aged care and support services in smaller and remote communities, this study explored the experiences of older people along with members of their social networks.

To explore these issues, an ethnographic multiple embedded case study was undertaken within three diverse rural towns in northern Australia. Throughout this study, a social constructionist perspective was used to capture the ageing experiences in these unique environments. Two semi-structured interviews with field notes were undertaken with each of eleven individuals and fifteen members of their social networks, approximately 18 months apart. At each interview social networks were visualised with the use of ecomaps and any changes noted at the second interview. This allowed for the capture of the lived experience of ageing from both the viewpoints of the primary interviewee and their social network members. Data collection occurred as an iterative process to inform further interviews. Data analysis was then structured utilising grounded theory, using the first two stages of coding with emerging concepts then mapped to Anthony Giddens' social theories.

The social construction of ageing in these rural communities was explored using discourse analysis, in order to examine rural and regional papers within the study area. Analysis demonstrated that negative stereotyping of ageing exists within these communities. Dependency discourses positioned older people as being vulnerable, conversely both deserving and underserving and a possible burden on existing healthcare systems. This ambivalent attitude towards ageing in rural Australia may construe ageing as a time of loss of independence and agency.

However, participant interviews revealed that although older people were aware of these social constructs, often propagated via the media, they maintained a positive age identity and exhibited reflexivity when considering their own age identity. Older people demonstrated agency in the coping mechanisms that they employed to enable them to manage the challenges of ageing, using both emotion-focussed and problem-focussed strategies. Yet when asked to consider future care needs emotion-focussed strategies such as avoidance were evident.

In these rural towns, both practical and emotional support for ageing was provided by both kin and non-kin, although if increased health needs were required family was still considered the main source of support, regardless of distance from each other. However, there was uncertainty about what this support would entail and a lack of discussion about the risks of ageing and possible future care needs within social networks. This lack of discussion may be related to the uncertainties of whether and when these risks may occur, such as loss of a partner or cognitive and physical decline. Given that the specific impact of these risks is unknowable, older individuals in this study presumed their ability to manage risk to a certain extent, but in order to cope with these risks they needed to have trust in their social networks. They are required to undertake risk management as part of living in a contemporary society in which both risk and trust need to be reflexively negotiated within social networks in response to detected risks. For participants in this study, ageing in place is a risk, but it seems to be a risk that they are willing to take.

Given the risk to identity and negative dependency dialogue in ageing, this study suggests that government policies need to re-evaluate the social construction of older people and move away from the legitimisation of agency through paid work. In addition, given the evolving dynamics of the family and its integral role in support for aged persons, there may be a role for health practitioners to promote conversations surrounding possible future care needs within families.

Reflection

As a young women I worked in a locked psychiatric aged care unit and found it one of the most rewarding periods of my life. Although I did not continue in nursing, this experience and the women I cared for have stayed with me. These experiences led to reflection on how ageing is a diverse process and an interest in the lived experience of ageing. In contrast to these women, my grandparents were very independent and in control of their life. All of my grandparents had good physical and cognitive health and did not require any formal care in their lifetime, although they received family support.

I moved to Australia in 2007, and in 2014 started this research looking at the lived experiences of ageing in rural Australia. My parents aged at home in Scotland supported by my sister Jill, a teacher who lived in the same small town and had a close relationship with them. A few years ago they moved from outside of town to the town centre, as there was no public transport, and if they could no longer drive they would have been dependent on family. They are members of the local church and have many friends in the community, along with family members in the nearest city (grandsons, sisters and nephews).

My older sister provided informal support and I call them twice a week, as well as making the trip back to Scotland every 18 months. However, in 2018 after a short unexpected illness my sister died. This loss impacted heavily on my mother, causing an acute psychiatric episode, followed by several hospital admissions. She is now a shadow of her former self and refuses to leave the house. As a result, this research has taken on more personal meaning for me as it progressed. Similar to people in my study my parents receive emotional support from the Church as long-time members and after providing many years of service. The stress my father experiences as the main carer is underlined with the guilt that I feel as the remaining child, not being there to support them. I feel the stress of having my children, my life and job in Australia and family at a long distance.

As I progressed through this study, I found that, for the participants, the loss of a child was not unusual. Seven out of eleven social networks experienced the loss of a son or daughter to illness or accident. Whilst loss of a partner is expected, the loss of a child is not. This has brought home to me is that in ageing, life events can change the experience overnight – regardless of planning.

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Chapter 1 Introduction

Rural life is often portrayed as less stressful than life in the city, with cheaper housing costs and lower crime rates. It does, however, present particular challenges in terms of the provision of health care and support (Inder, Lewin, & Kelly, 2012). The problems of recruiting and retaining staff in rural areas, along with implementing a health care system usually based on economies of scale, makes the provision of care more expensive in smaller populations. Rural residents may have to travel to gain access to health resources, leading to reduced uptake and compromised health status (Baldwin, Stephens, Sharp, & Kelly, 2013).

The Australian population is ageing, with an estimated 25% of the population to be over 65 by 2056 (Australia. Department of Health, 2014). In response to Australia's ageing population and the increasing costs of residential care (currently 77% of the aged care budget) , the government has re-evaluated aged care policy, implementing changes in order to promote ageing in place (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). "Ageing in place" is defined as "the ability to live in one's own home and community safely, regardless of age, income, or ability level" (Simons, McCallum, Friedlander, & Simons, 2000). For rural Australians (and the majority of Australians) staying at home is the preferred option, with most planning to remain – either in their current home or after a planned move within their community (Boldy, Grenade, Lewin, Karol, & Burton, 2011). Entry into a residential care home is not viewed as a progression of normal ageing, but rather a last resort (Stones & Gullifer, 2014).

The "Aged Care (Living Longer Living Better) Bill 2013" promised enhanced consumer choice for older people ageing in place, with its implementation structured over a 10-year period. This bill offers consumer directed care, but has also introduced asset-tested co-payments. As well, there has been a separation of the cost of care and accommodation and a capped number of home care packages and residential care places (Australian Parliament, 2013). Currently in Australia there is a national unmet demand for home care packages, particularly in rural areas. Long distances and small populations involving higher running costs can make traditional health care services difficult to sustain, leading to private providers being reluctant to offer these services. This leads to an increased reliance on not for profit organisations and a lack of the services that are usually available in metropolitan areas. Only 4.1% of residential aged care for profit services are located outside major cities and inner regional locations, despite 11.3% of the population over 70 years living in these locations (Baldwin et al., 2013).

The new policies designed to support ageing in place are entirely dependent on the continuation of informal care provided by friends and families, which currently provides 80% of the support for ageing, and is worth an estimated $ 8 billion dollars per year of government spending (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). Implementation of policies based upon a fiscal interpretation of informal care situated within a welfare state model leads to concern about an over-reliance on informal care in a changing society (Broese van Groenou & de Boer, 2016). At the same time the media is raising concerns about the "boomergeddon" threatening to overwhelm the health and social systems with their dependency, promoting a negative stereotype of ageing (Cook, 2018).

An ageing population is more noticeable in regional and rural areas, with an over representation of older Australians largely due to the economic migration of younger people into the city in search of employment and education opportunities. This is compounded by retirees relocating to rural areas, adding to the resident ageing farming population which may accentuate the lack of availability of informal care providers (Winterton & Warburton, 2011a).

1.1 Research Gap

Against the background of these social changes, there is a need to explore rural ageing in its own right. How is an ageing identity socially constructed by older rural residents? Previous studies on ageing have described rural and urban comparisons, but have not delved into the diversity of rural culture and its challenges (Davis & Bartlett, 2008). The heterogeneity of older people and the diversity of rural communities needs to be captured in order to explore the lived ageing experiences of residents in small towns (Carver, Beamish, Phillips, & Villeneuve, 2018). Given the importance of informal care, few studies have explored the expectations of support from the rural social network which enables ageing in place, and more study is recommended (Herron & Skinner, 2013; Keating, Swindle, & Fletcher, 2011). Whilst many studies list the challenges of ageing in place, few address how healthy adults plan to deal with these challenges (J. R. Bacsu et al., 2012).

1.2 Research Aim

This study aims to explore the perceptions of rural Australians and members of their social networks about ageing, and their expectations and strategies for preparing for ageing in place (AIP) in rural Australia.

1.2.1 Guiding questions

- How is age identity socially constructed in rural Australia and what does ageing mean to older people?
- What are the challenges to ageing in place in a rural community and how do older people cope with these challenges?
- To what extent are rural Australians planning ageing in their own homes?

1.3 Selecting a Research Methodology

An exploration of ageing in place in rural communities requires a methodology that enables each participant to tell their story and their experiences of ageing. A qualitative interpretative methodology was chosen, which allows for the capture of participants' lived experience over time. In order to document older peoples' beliefs, systems and behaviour related to ageing I chose an ethnographic multiple embedded case study approach (Huberman & Miles, 2002). This required me to enter the rural environment, spending time with each participant in their social world, enabling me as a researcher to participate in and observe their experiences of ageing in place. Three diverse rural sites were chosen, with each community forming a case, and individual participants and their social networks were embedded cases within these communities.

Throughout this study a social constructionist perspective was employed that supports human agency in construction of the social world and enabled the capture of a broad experience of ageing, including rural culture and environment. In order to explore the experience of ageing I conducted two semi-structured interviews in each participant's home, with the second interview taking place about 12 months after the first one. During the first interview social networks were mapped using an ecomapping technique (Hartman, 1995; Ray & Street, 2005), which was revisited to map changes at the second interview. Ecomaps were used as the basis for selecting members of the social network that participants would like to nominate for inclusion in this study. In accordance with ethnographic methodology, multiple data sources were used and interviews, observations and field notes were completed after each visit.

Data collection and analysis occurred in an iterative process in order to inform on the content of further interviews. This process drew on the structures of Charmaz's grounded theory, using coding, categorisation and comparison (Charmaz, 2017). Interviews were initially open coded, and then the data were expanded into multiple topics. In the second phase themes and concepts emerged (Birks & Mills, 2015). These concepts were then reflected upon and

mapped to larger concepts based on Giddens' social theories (Giddens, 1984, 1990, 1991; Kaspersen, 2000)

1.4 Theoretical Lens

Ageing is primarily defined as a social construction which is an ongoing process, and is experienced uniquely by everyone. The application of sociological theory was required to understand the interaction between the individual (the participant ageing in place) and the society (communities and social networks).

The theories of contemporary British sociologist Anthony Giddens influenced this thesis as although his work built on classical sociology, he questions traditional society and its changing nature. His theories allow for an exploration of a changing process (ageing), along with systems that enable older adults to act to change the world around them. Giddens proposes that both human agency and social structure interact with each other to construct society; applying the term structuration to define "the structuring of social relations across time and space" (Giddens, 1984, p. 376). Expectations of society can enable or constrain action, through cultural norms and values, procedural rules and the legitimacy of action. It is the individual's reflexive appraisal of these structures and their ability to accept, modify or reject events that guide their actions. When making the decision to age in place in a rural community an individual may reflect upon whether they expect support from their family (cultural norms) and whether there are enough resources (medical services, home care services) to positively influence their decision. In ageing, there is uncertainty or risk that changes in health and cognitive decline might impact on independence and upon the agency to act.

Giddens' perceives the interaction between risk and trust as pivotal to living in a post-traditional society in which risk is now part of society, specifically in ageing. In order to trust people, we need to have an awareness that human activity is socially created and now has an increased capacity for action: societies are no longer controlled by fate or God, but risk has now taken its place. Trust is about having an awareness of this social risk. There are many risks in ageing including loss of identity, health decline and a decrease in financial resources. To successfully negotiate ageing, trust is essential. In the traditional world, trust was achieved through kinship, community, tradition and religion. The evolution of science and social mobility removed fate and introduced risk; trust is no longer blithely given and is now more of an abstract concept. Risk management and an individual's reflexive capacity are now part of negotiating trust.

Giddens proposes the transformation of intimacy in which relationships between partners and family members are now negotiated rather than defined by traditional roles. Tradition and obligation alone no longer dictate aged care, and it is now increasingly dependent on individual agency and the available resources. Expectations of care and caring obligations are now constructed and evaluated from a position of reflexive awareness. In this way, the existence of a social network alone does not guarantee support. It is the evaluative thoughts (reflexivity) and the capacity (agency) of the network that will enable the provision of support.

1.5 Incorporating Published Material into the Thesis

I order to fulfil the university's requirements an alternative format for this study was used. The introduction, literature review and social constructions and methods are set out using the traditional thesis format. This is followed by two results chapters, in which the second chapter consists of four journal articles, each of which details different findings from this study. Two of these articles are published and two are under review. The thesis is completed by a final discussion that brings all these findings together and discusses them within my theoretical framework. Articles have been re-formatted into the style of the thesis, with the methods section removed to prevent redundancy (except for the discourse analysis) and the references collated in a common list for the whole thesis.

1.6 Thesis Overview

1.6.1 Terminology

In this thesis the word older refers to an "individual" aged 65 years or over. Due to the negative connotations of the word "elderly", this term has not been used unless in a direct quote. To maintain consistency, I have used the English spelling of the word "ageing" rather than the American spelling "aging". Ageing in place is defined as older individuals who are living in their own home, where an older person moves from the farm into the local community. This is still defined as ageing in place as they are still within the same community.

Rurality is defined by the Modified Monash Model (MMM), which model of classification takes into account both remoteness and the size of the local population (McGrail & Humphreys, 2015). For the purpose of this study rural is defined as MMM as level 5-7.

1.6.2 Chapter One

This chapter starts with a background to rural ageing and the challenges faced by rural communities, along with a description of reliance on informal support and the negative social

construction of ageing. This is followed by an introduction to Giddens' theoretical constructs of structuration. The main constructs explore human agency along with reflexive monitoring within the social network and their impact on how older people act, ending with a discussion on the enabling and constraining effects of social structures and resources. The role of these constructs in relation to trust and risk in the post-traditional world is then postulated. Finally, it outlines the thesis structure including an introduction to the journal articles that make up this study.

1.6.3 Chapter Two

Chapter Two presents a systematic review of twenty-five independent studies into the social factors that support ageing in place. It identifies the role of resiliency and place identity for older adults, along with the outlining the importance of community cohesion and informal support. The discussion explores both the negative and positives aspects of these supports and their role in ageing in place.

1.6.4 Chapter Three

This chapter provides a more expansive explication of the social constructs of ageing. This assists with understanding the evolving post-traditional world, the drivers of modernity (time and space, disembedding systems and human agency) and their impact on ageing. Giddens' Structuration Theory and the evolution of trust and risk as they relate to ageing in the post-traditional world follows. The role of social networks and how they may support ageing in place concludes the chapter.

1.6.5 Chapter Four

This methodology and methods chapter discusses the use of an ethnographic multiple embedded case study to examine the lived experiences of healthy adults as they age in place. It details the selection of ethnographic case study methodology, then defines each case, along with its selection and a detailed overview of each rural town. Then follows a discussion of the recruitment and consent process, along with approaches used for visualisation of social networks. This is followed by a description of the methods used for data collection (interviews, field notes and observations) and data analysis. Finally, the chapter concludes with a consideration on the researcher's reflexivity and how study trustworthiness is preserved.

1.6.6 Chapter Five

Chapter Five is the first segment of the results section and provides the results of the participant screening. This is then followed by descriptive case studies of each embedded case along with their social networks. In order to understand participants within their contexts rich ethnographic description was needed, to situate them accurately within this study.

1.6.7 Chapter Six

This chapter contains the mapping of coding concepts to Gidden's theoretical concepts, which are then discussed in the journal articles below:

- Anderson, Emily, Larkins, Sarah, and Ray, Robin (2017) Media reporting on ageing in rural and regional northern Queensland. In: *Proceedings of the 14th National Rural Health Conference. 14th National Rural Health Conference*, 26-29 April 2017, Cairns, QLD, Australia.
- Anderson, Emily, Larkins, Sarah, Beaney, Sarah, and Ray, Robin A. (2019) Ageing and Identity in Rural Australia*. Submitted to Research on Aging May 2020*
- Anderson, Emily, Larkins, Sarah, Beaney, Sarah, and Ray, Robin A. (2019) Coping with Ageing in Rural Australia. *Australian Journal of Rural Health* (In press March 2020)
- Anderson, Emily, Larkins, Sarah, Beaney, Sarah, and Ray, Robin A. (2018) Should I Stay or Go: Rural Ageing, a Time for Reflection*. Geriatrics*, 3 (49). 3030049.

1.6.8 Chapter Seven

This chapter presents a discussion of the concepts in Chapter Six and interactions between trust and risk as they relate to Giddens' Theory of Structuration and how they influence ageing in place. Study limitations are discussed along with policy implications and future research.

Chapter 2 A Systematic Review of Social Factors That Support Ageing in Place in Rural Communities

2.1 Introduction

Policy makers have defined ageing in place as "the ability to live in one's own home and community safely, regardless of age, income, or ability level (United States. Centers for Disease Control and Prevention, 2009, p. 1). Most people prefer to and are planning to continue living in their own homes and community as they grow older (Horner & Boldy, 2008; Löfqvist et al., 2013; Stones & Gullifer, 2014). Ageing in a residential care facility is not regarded as a natural progression of care in their life journey. Many older people perceive residential care as the last stop, to be avoided at all costs, because those moving there will never leave (Löfqvist et al., 2013; Parker, 2011). Statistically the majority of older Australians will age in place, with only 33% of older people eventually taking up the option of residential care (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014; Stones & Gullifer, 2014).

Government policies supported ageing in place with the introduction of "The Residential Aged Care Reform Package" in 1997 as an alternative to relocation and the institutionalisation of older people. Recent policies such as "Healthy Life Better Ageing Agreement" have implemented both high- and low-level home care packages tailored to individual requirements in order to promote independent living in the community. The introduction of the "Healthy Life, Better Ageing Agreement" (Australian Liberal Party & Australian National Party, 2013) promised increased residential places, and enhanced consumer choice for those wishing to stay at home. However, it could be argued that these policies are mainly fiscally driven by the high cost of residential care, (estimated to be 70% of total aged care expenditure), rather than based on a philosophical inclination towards the provision of enhanced aged care in the community (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). The age profile of rural populations has become much older than urban populations, with adults aged over sixty five over-represented in rural areas (Heenan, 2010). This is associated with the migration of younger members to the city for education and work and the immigration of older people to these communities, joining ageing farm workforces (Winterton & Warburton, 2011a).

Health status indicators and the availability of rural health services have dominated much of the discourse on rural ageing (Keating et al., 2011). There have been many research studies

published on the disadvantages of living in rural areas, with residents generally experiencing poorer health compared to their urban counterparts (Cubit & Meyer, 2011; Lau & Morse, 2008). Rural residents have lower life expectancies and higher risk factors for ill health, such as increased weight, smoking, hypertension and high cholesterol (Byles, Powers, Chojenta, & Warner-Smith, 2006; Davis & Bartlett, 2008; Inder et al., 2012; Winterton & Warburton, 2011b). In addition, the lack of available local services results in more emergency room visits, longer inpatient stays, and, in some cases, inpatient care for services that otherwise could have been provided as outpatient care (Byles et al., 2006; Davis & Bartlett, 2008; Inder et al., 2012). Small isolated populations in non-metropolitan areas make the traditional healthcare workforce models difficult to implement and sustain. Lack of aged care staff is already a national concern, with workforce shortages already evident in rural and remote areas due to lower wages and the lack of training and development opportunities (National Rural Health Alliance, 2011).

Rural residency in both Australia and North America is associated with lower incomes and higher rates of poverty, with rural residents having lower educational qualifications and more limited employment opportunities (Glasgow & Brown, 2012; National Rural Health Alliance, 2013). This disparity may lead to riskier health behaviour such as limiting healthy eating and an increased rate of smoking. Lack of financial opportunity carries over into old age with lower superannuation and less savings to fund retirement (Davis & Bartlett, 2008). A recent study by Hodgkin (2018) has shown that the lower levels of financial resources held by older people impact negatively on their perceived wellness (Hodgkin, Warburton, & Hancock, 2018). There may also be a reluctance to claim government support due to stigma or lack of awareness of support available (Dwyer & Hardill, 2011). Many older rural women are more likely to live in poverty, having never worked in paid employment, but having instead spent years contributing to the farm work, raising children and supporting families. This financial disadvantage adds to deficiencies in basic services, community resources and an economy to support infrastructure needs, compared to those experienced in urban areas (Byles et al., 2006; Davis & Bartlett, 2008). The challenges and high cost of delivering these services to dispersed small populations can make services difficult to sustain (Keating, 2008). As younger families leave rural areas for work and educational opportunities, demand for local services decreases and businesses close (Heenan, 2010).

Loss of license in ageing has an enhanced negative impact in rural areas where public transport is minimal and distances greater, leading to increasing isolation and lack of access to services (Hancock, Winterton, Wilding, & Blackberry, 2019; Keating, 2008; Walker et al., 2013).

Limited public transport reduces access to health services and to social events, making the loss of a driving license a life-changing event (Byles et al., 2006).

There is a perception that life and work in Australia outside larger cities is second rate. The erosion of infrastructure and the dwindling services experienced in rural areas support the feeling that this may be the case (Humphreys, 1999). Indeed, much of the research on rural ageing has used a "degree of marginalisation" conceptual lens positioning older adults in rural communities as being at risk due to lack of health care and resources to meet their needs. Given the disadvantage experienced by rural residents (Erickson, Call, & Brown, 2012; Golant, 2008; Horner & Boldy, 2008) the question is: Why do ageing rural dwellers stay in place?

Against the background of known health disadvantage, this review will critically analyse the published research on sociocultural factors as barriers or enablers to ageing in place.

2.2 Methodology

A systematic review of social factors that support and challenge ageing in place in rural communities in developed countries was undertaken and is reported according to the preferred reporting items for systematic reviews and meta-analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, & Altman, 2009). As in the rest of this thesis, the benchmark for older age was set at aged 65 years or more.

Prior to the search, the following criteria were agreed by the researchers. This thesis adopts the social constructionist view that the process of ageing is socially constructed by society (Shilling, 2003). To build on understanding of ageing in the Australian social context this review is limited to similar societies and resourced countries (with the exclusion of lower resourced countries). This allows an exploration of the social reasons of why people choose to age in place when other options such as relocation to a city or entry into residential care may be available.

The Human Development Index (HDI), which includes life expectancy, years of schooling and gross national income per capita was used to determine relevant studies (United Nations Development United Nation Development Programme (UNDP), 2019). Countries were benchmarked by using the HDI with the inclusion only of very high human development countries, in order to allow for comparison between studies in similar social welfare systems. Fifty nations that were identified in this group were then further constrained to predominantly western societies, with the exclusion of Middle Eastern and Asian countries.

In addition, studies published prior to 2000 were excluded, due to changes in the social geography of rural families, with the emergence of smaller families, the increase of paid employment outside the home and the spread of families over larger distances. The dates were also limited to reflect the increase in social discourse about the ageing population and the benefits and burdens over the last twenty years (Fine, 2007).

Studies where no English translation was available were also excluded.

This review included a small number of qualitative studies along with larger scale quantitative studies. The Oxford Critical Appraisal Skills Program (CASP) qualitative tool was used to evaluate selected articles, but was not used to exclude them from this review.

A literature review of the SCOPUS, CINAHL and Informit databases was undertaken using the search terms as described (Table 2.1) and applying the inclusion and exclusion criteria stated above. Results of the search and eligibility assessment process are summarized in Figure 2.1.

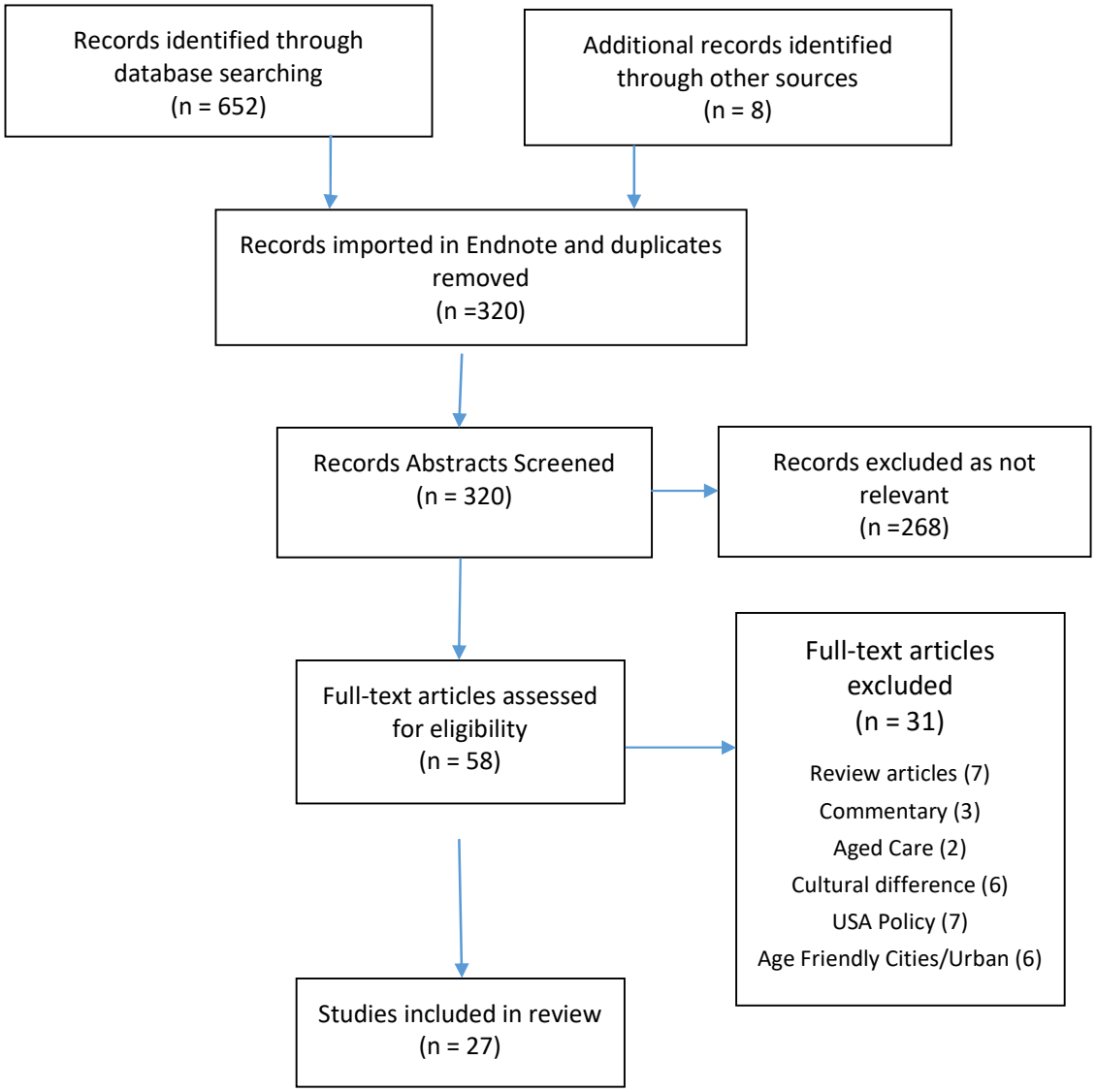
Table 2.1 Literature search strategy

Search undertaken 22/12/2016 updated 25/11/2019

SCOPUS (Title Abstract or keyword)	**Document Number**	**After Abstract Screened**
"ageing in place" OR "aging in place"	1551	
"ageing in place" OR "aging in place" AND "Rural"	100	19
"ageing or ageing" AND "rural" AND "Australia"	160	25
"ageing in place" OR "aging in place" AND "Australia"	51	10
CINAHL		
"ageing in place" OR "aging in place" AND "rural"	53	8
INFORMIT (96 Databases)		
"ageing" OR "aging"	281	6
AND "rural'	7	4
	652	72

Figure 2.1 PRISMA 2009 flow diagram

From: Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement. Annals of Internal Medicine, 151(4), 264-269. doi: https://doi.org/10.7326/0003-4819-151-4-200908180-00135



2.3 Results

Studies were situated in Australia (9), Canada (6) and the USA (7), with a smaller number coming from Europe and New Zealand (5). A mixture of both qualitative (17) and quantitative (10) studies were included, with a narrative metasynthesis thematic review then undertaken to summarise factors that may enable or challenge, “ageing well” in a rural community.

Three of the quantitative studies were part of large on-going longitudinal surveys, The Australian Longitudinal Study on Women’s Health ("Australian Longitudinal Study on Women's Health (ALSWH). Women's Health Australia,"), Australian Rural Mental Health Study (ARMHS) and the Irish Longitudinal Study on Ageing (TILDA). The large sample sizes used in these studies may increase the reliability of the findings. Most of these studies used validated screening tools such as the Short Form-12 survey and the Lubben Social network scale. Overall, the quality of these studies was high (Table 2.2), however, there was a lack of detail in the discussion of ethical considerations in some studies.

The seventeen smaller qualitative studies originated from the USA, Canada, United Kingdom and Australia. These studies were primarily ethnographic, and provided rich narrative data from 8 to 62 participants. Studies covered issues such as older residents’ knowledge of place, desire to remain in their own homes and social engagement along with what factors allowed for older people to age in place. Each study was summarized by date, setting, methodology and outcomes in Table 2.3.

Table 2.2 Overall Analysis of Quality of Publications

Both quantitative (QT) and qualitative publications were analysed with the quantitative studies shaded in blue.

	Was the a clear statement of aims in the research	Is a qualitative methodology appropriate	Design appropriate to address aims	Recruitment Strategy appropriate to address aims	Data collected in a way that addressed research issue	Relationship between researcher and participants considered	Ethical Issues taken into consideration	Data analysis sufficiently rigorous	Clear statement of findings
Manthorpe, 2004	?	QT	YES	YES	YES	NA	?	?	YES
Byles 2006	YES	QT	YES	YES	YES	NA	YES	YES	YES
Stark-Wroblewski, 2008	YES	QT	YES	YES	YES	NA	?	YES	?
Wells 2009	YES	QT	YES	YES	YES	NA	YES	YES	YES
Evans 2009	YES	QT	YES	YES	YES	NA	?	YES	YES
Inder, 2012	YES	QT	YES	YES	YES	NA	YES	YES	YES

Erickson, 2012	YES	QT	YES	YES	YES	NA	?		
Burholt, 2014	YES	QT	YES	YES	YES	NA	?	YES	YES
Boldy, 2014	YES	QT	YES	YES	YES	NA	YES	YES	YES
Kendig, 2016	YES	QT	YES	YES	YES	NA	?	YES	YES
Vogelsang, 2016	YES	QT	YES	YES	YES	NA	?	YES	YES
Rosel, 2003	YES	YES	YES	YES	YES	YES	?	YES	YES
Arbuthnot, 2007	YES	YES	YES	YES	YES	YES	YES	YES	YES
Heenan, 2010	YES	YES	YES	YES	YES	NO	?	YES	YES
Terrill, 2010	YES	YES	YES	YES	YES	YES	YES	YES	YES
Dwyer, 2011	YES	YES	YES	?	YES	NO	YES	YES	YES
Bascu, 2012	YES	YES	YES	YES					
O'Shea, 2012	YES	YES	YES	YES	?	NO	?	NO	YES
Winterton, 2010	YES	YES	YES	YES	YES	NO	YES	YES	YES

Herron, 2012	YES	YES	YES	YES	YES	NO	YES	YES	YES
Bascu, 2014 a	YES	YES	YES	YES	YES	NO	YES	YES	YES
Bascu, 2014 b	YES	YES	YES	YES	YES	NO	YES	YES	YES
Stones, 2015	YES	YES	YES	YES	YES	NO	YES	YES	YES
Warbuton, 2017	YES	YES	YES	YES	YES	NO	?	YES	YES
Neville, 2018	YES	YES	YES	YES	YES	NO	YES	YES	YES
Strommen, 2018	YES	YES	YES	YES	YES	NO	?	?	YES
Hancock, 2019	YES	YES	YES	YES	YES	NO	YES	YES	YES

Although these studies all involved contact with the participants, only three studies detailed consideration of the impact of the researcher on the participant.

Review of these articles conceptualised three emerging themes, although there was some overlap between each theme: (1) Rurality and resilience; (2) Identity and attachment; and (3) Enhanced community cohesion and informal support. These themes are discussed in turn below.

2.3.1 Resilience and rurality

"I think I am in perfect health, except for the old creaky joints, the stiffness and the soreness that happen to us all as we go along" (Arbuthnot, Dawson, & Hansen-Ketchum, 2007).

Identification of being a "country person" was a theme in many studies, with this role seeming to promote an expectation of coping with challenges that the country produces.

Rural residents are often described as being stoic and self-reliant individuals (Buys, Roberto, Miller, & Blieszner, 2008) with many authors describing the stoic rural Australian and promoting the image of a rural ideal. Well's (2009) study on resilience in rural residents in New York State suggested that rural people had high levels of resilience and that this resilience did not decline with age. Rural residents generally focused on making the best of the ageing process with its related aches and pains (Wells, 2009). The Australian Rural Mental Health Study (ARMHS) showed that despite increased rates of chronic illness and poorer physical health, older rural Australians reported better well-being than their younger counterparts, perhaps reflecting an increase in resilience (Inder et al., 2012).

Concurring with Well's study on resilience, which showed a stronger correlation of mental health with wellbeing than physical health, Stark-Wroblewski also identified wellbeing as being more than a physical state, with frame of mind, spirituality and religion as important (Stark-Wroblewski, Edelbaum, & Bello, 2008). Arbuthnot's ethnographic study on 22 older women ageing in rural Canada suggested that social and emotional needs had as much importance as physical needs for maintaining health and well-being in ageing in place (Arbuthnot et al., 2007).

The Australian Longitudinal Study on Women's Health looked at differences in health service use, and showed that although the self-reported health of women living in rural areas did not differ from that of their urban counterparts, they made more use of informal services in their areas when formal services were not available (Byles et al., 2006). This substitution of care indicated the resilience of older women in rural communities making the best of what is

available to them. Erickson's (2012) study on 24 rural communities in the USA suggested that consumers' feelings about a service mattered more than an accounting of the available service. This would allow an inadequate service to meet the health needs of a resilient rural community. Erickson also found that significant numbers of individuals forwent healthcare rather than then leave their community because of the distances involved.

The identification with the resilient stoic ideal may lead to an increased pressure to be perceived as coping, with residents more likely to put up with health problems and lack of services; indeed making it more difficult to request help (Herron & Skinner, 2013; O'Shea, Walsh, & Scharf, 2012). In Herron's (2013) qualitative rural Canadian study, participants suggested that by making the choice to live in a rural community people needed to be resilient. It is unclear whether this is by choice or necessity, indeed Davis and Bartlett question whether rural dwellers are coping because they want to or because they have no choice (Davis & Bartlett, 2008; Williams & McHugh, 1993).

2.3.2 Place and identity

"Home is where I am, where I can be a slob, do exactly as I please. Because I live on my own my home is my dominion where I do as I like" (Gattuso, 1996)

The role of home and place was prevalent in both the qualitative and quantitative studies, indicating the importance of the home in socially constructing and maintaining identity. The maintenance of identity whilst ageing is important for the social self, especially in the face of the challenges of declining health, household maintenance, distant family members, loneliness and reduced social resources (Arbuthnot et al., 2007).

Place identity is the relationship that people have with their location in the way that it supports and regulates their sense of self. A good person-place fit supports their identity through beliefs, feelings and values directed towards their rural environment (Hidalgo & Hernández, 2001; Keating, 2008).

Winterton (2012), in her qualitative study of 16 residents in rural Victoria, used Breakwell's "place identity process theory" as a conceptual lens to examine how rural cultural ideologies are important to the sense of self. This study identified that the distinctiveness of the environment (how their place differed from others), continuity (how they fitted the place, their history), self-esteem (pride in their place) and self–efficacy (how their place supported their living) that rural environments can offer, all play a role in maintaining the sense of self (Winterton & Warburton, 2012) .

Boldy (2011) proposed that attachment to home increases with the amount of time spent there (Boldy et al., 2011); the abstract concept of home becomes more filled with meaning as time progresses. It is where children were raised, the marriage home and an integral part of an ageing individual's identity. This complex relationship with home can offer both comfort and sadness in equal measure as homes become warehouses of memories. Home also provided independence and autonomy, giving a sense of control over daily events, individuality and social status that maintain identity as people age (Gattuso, 1996; Rosel, 2003; Stones & Gullifer, 2014). Rosel's (2003) phenomenological study on ageing in place in rural Florida describes the value of the home in ageing, as well as the importance of the surrounding community. Home is not just the house, it is the neighbourhood, the community, the place where local people are the experts as well as being the source of both comfort and knowledge.

Identification with the community and neighbours to leads to increased positive feelings about home. The Housing And Independent Living study (HAIL) indicates that when people have the desire to stay at home they are more likely to change their behaviour to fit the home than modify the home to fit the individual (Mackenzie, Curryer, & Byles, 2014). Ties to the land are also important as the source of family history (income and inheritance) and the cultural context of land ownership - if a farmer no longer has land, is he still a farmer?

Additionally there is a much fear and apprehension in transferring to residential care along with the fear of loss of independence and severing ties to the role of the home in identity (Stones & Gullifer, 2014; Terrill & Gullifer, 2010). Moving into residential care may carry a sense of failure, being perceived as giving up (Horner & Boldy, 2008). Given that decisional control to transfer into residential care can be outside the individual's hands, the role of home and identity can then impact negatively on individual well-being in ageing (Jorgensen, Arksey, Parsons, Senior, & Thomas, 2009; Krout, 1988). The high level of attachment shown by rural dwellers may negatively affect their life, tying them to a community that no longer meets their health or social needs.

2.3.3 Community cohesion and informal support

Growing old and living with it as opposed to dying with it involves friendships (J. Bacsu, Jeffery, Abonyi, et al., 2014)

Several studies have highlighted the perception of community spirit and neighbourliness found in rural communities, with the finding that this support was superior in rural areas (J. R.

Bacsu et al., 2012; Heenan, 2010; Inder et al., 2012; Winterton & Warburton, 2012). Social relationships are a cornerstone of wellbeing and can have a positive effect on health in the ageing journey (Fiori, Antonucci, & Cortina, 2006). In rural areas informal support from spouses, family and friends to support ageing was accessed more than formal support. However, these sources of support were less likely to be directly identified as "informal support", rather constructed more as a social exchange (Allen & Wiles, 2014).

Evans' (2009) study comparing life satisfaction and the difference between rural and urban populations found that rural adults had more social interactions. Satisfaction with social support was more important than network size or the amount of support provided (Evans, 2009). Inder's (2012) study on wellbeing linked higher levels of perceived community and personal support to well-being and protection from psychological distress. Burholt (2014) investigated poor health and loneliness as part of The Irish Longitudinal Study of Ageing (TILDA) and found that it is not the frequency of social interactions that is protective but rather that the expectations of the amount of interaction being met that was important (Vanessa Burholt & Scharf, 2014).

Arbuthnot (2007) also concurred with this finding in her research on the role of emotion in informal care and the tensions and expectations that surround this and the need for more studies (Arbuthnot et al., 2007). Herron's 2013 study investigated the role of emotions in providing informal support to age in place and suggested that the perspectives and experiences of both older people and their supporters is missing from the literature. For older people and their networks in the provision and acceptance of informal care there is no discussion about expectations of care leading to feelings of being let down causing guilt or tension within relationships (Herron & Skinner, 2013).

Cantor's Social Care Model suggests that informal-kin is the first preference for support followed by friends and formal-social agencies, however in rural ageing there is debate in the literature as to whether this is determined by preference or availability (J. Bacsu, Jeffery, Novik, et al., 2014; Evans, 2009). There is also debate in the literature as to which forms of informal care are more supportive, with Wells' study suggesting peer support from networks of friends produces greater resilience than family networks (Wells, 2009) and Bacsu's study of rural ageing in Canada also highlighting the role of peer friendships in ageing (J. Bacsu, Jeffery, Abonyi, et al., 2014).

There has been a significant level of discourse on older people receiving support in rural communities. However, the support that older people provide to those communities also

needs to be acknowledged. This is particularly true for older women, whose provision of care to others increases as they age. (Byles et al., 2006) Many community services like 'Meals on Wheels', The Country Women's Association and church groups would be unable to function without their older members (Boneham & Sixsmith, 2006; Rosel, 2003).

2.4 Discussion

This review indicates that having a rural identity, attachment to place and community cohesion are major socio-cultural factors for supporting ageing in place. For those people embedded in the community with good health, financial resources and mobility there are minimal downsides to rural ageing in place as they can travel and pay to access services that are not locally available (Erickson et al., 2012). However, the loss of these factors can put older people at risk and compromise mental and physical health.

Rural identity, resilience and place attachment act as drivers to promote ageing in place. However, these drivers may also have negative impacts and cause older residents to remain in place when they are unable to cope and ageing impacts upon their quality of life. Indeed they may act to alienate older community members who desire to age outside the community (Horner & Boldy, 2008). Care must be taken not to idolize the self-reliant farmer, the beautiful landscape and the connection to the land when the reality may be daily struggle to make ends meet in the face of a three year drought (Keating, 2008).

While community cohesion and engagement are supportive mechanisms for ageing in place, not all communities may be well engaged, as engagement relies heavily on resources such as transport and health. There is also a risk of social exclusion for older residents who may not be socially embedded in the community, leading to loneliness and unmet needs, particularly for those with caring responsibilities (Keating, 2008). As many of the rural volunteer groups are run by older members, there is a risk that these groups may be unsustainable with the increase in the older population requiring support leading to burnout and health issues for volunteers (Warburton & Winterton, 2017).

Ageing in place is not for everyone, as many older people also choose to leave rural communities to be close to family and health services (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). Others may desire to leave but be "stuck in place"– unable to move into the city for financial or social reasons (Erickson et al., 2012).

Given the over-reliance on informal care in rural communities there are concerns that the needs of the older rural population cannot continue to be met in the informal arena (J. R.

Bacsu et al., 2012; O'Shea et al., 2012). There is a need to explore the expectations of healthy older residents for family and informal support, along with their plans for the future. Further work needs to be undertaken on how this care is negotiated and the expectations and cultural norms of giving and receiving care between family and friends (Herron & Skinner, 2013).

2.5 Policy Implications

Given the Government policy focus on providing more resources promoting ageing in place, there is a need to understand the capacity for rural communities to cope with these procedures. It is evident that rural seniors have different needs and different ageing experiences from their urban counterparts, and this distinction needs to be understood and managed. It is not just about increasing services, it is about working in partnership with the informal carers in the community to provide complementary care and to support existing informal systems (Arbuthnot et al., 2007). Studies have shown the importance of government partnerships with rural communities in order to support healthy ageing and the need for further research on policy and kin interactions (J. Bacsu, Jeffery, Novik, et al., 2014).

Table 2.3 Quantitative studies

Author	Aim	Methodology	Participants	Comments
Manthorpe, 2004 (Rural England)	Older people's views on rural life: a study of three villages	Survey containing both closed and open - ended questions undertake in individuals home. Descriptive and thematic statistics used	48 households containing 72 participants over 60 for women and 65 for men. All sites within 50 miles of an urban centre	Emergence of 3 main themes • not all rural villages are the same • not all inhabitants have the same experience (access to funds) • Strong evidence of family and informal support
Byles, 2006 (Australia)	To explore differences in quality of life and health service use for older women living in urban, rural and remote areas of Australia.	The Australian Longitudinal Study on Women's Health completed mailed surveys in 1996, 1999 and 2002. Quantitative (SAS)	8387 women aged 70–75 years	• Health service use differs significantly across urban, rural and remote areas of Australia. • Urban participants used more general practitioner, specialist and allied health services, whereas non-urban women used more community services and alternative health practitioners. • Possible substitution of GP for informal care. "making the best of what we have"

Author	Aim	Methodology	Participants	Comments
Stark-Wroblewski, 2008 (Rural USA)	Examines perceptions of ageing among rural-dwelling senior citizens	Survey of closed question using Likert Scales and one open-ended question. Presents as a mixed method study but purely quantitative.	348 people participated in the study (203 women and 112 men), 317 aged 65 and older. May be a selection bias due to recruitment at meal sites and questions limited to investigate healthy ageing.	• Women were less likely than men to report health problems as interfering daily functioning. • Identifies frame of mind, participating in activities, and religion/spirituality as important contributors to successful ageing.
Evans, 2009 (Rural USA)	Study looks at differences between rural and urban adults on levels of life satisfaction and depression focusing on the effect of social support	Structured face-to-face interviews at senior centres	140 participants aged 65 + (70 urban, 70 rural) recruited form seniors centres to be included they needed to have lived in a rural or urban area for at least 15 years	• Urban adults reported more depressive symptoms than rural adults. • Rural adults had more social interaction and felt they were doing well in spite disadvantages • Satisfaction with social support is much more important than network size or amount of support given. • No significant difference reported in life satisfaction between urban and rural although social support was positively related to satisfaction

Author	Aim	Methodology	Participants	Comments
Wells, 2009 (Rural USA)	To look at Resilience levels in rural communities and investigate any correlations between socio-demographic factors, social networks and health status	A cross-sectional design. Postal Survey 30% response Descriptive statistics along with multiple regression models.	106 registered voters, aged 65 years or over.	• Rural adults had high levels of resilience and it did not decrease with age. • Weak correlation between resilience in rural adults and social networks consisting of friends but not family • Both physical and mental health has a positive correlation with resilience (in a regression model mental health status was the strongest predictor).
Erickson, 2012, (Rural USA)	Whether rural residents aged 65+ plan to remain in their local communities	24 rural communities total of 621 rural residents aged 60+ years. Limitation of study 80% of sample Latter-day Saints and religion has a role in attachment.	24 rural communities total of 621 rural residents aged 60+ years. Limitation of study 80% of sample Latter-day Saints and religion has a role in attachment.	• People stay for attachment to the community and lifestyle which may off set the downsides cognitive dissonance it is how people feel about the services rather than what services are available much more than an accounting of what is available • Residents with financial resources were more able to obtain care regardless of where located. Older married, wealthy and healthy residents had high community satisfaction and attachment.

Author	Aim	Methodology	Participants	Comments
Burholt, 2014 (Ireland)	Use cognitive discrepancy theory to test a pathway from poor health to loneliness, hypothesis that poor health will have a negative influence on social participation and resources which will be amplified in rural areas.	Cross section of the Irish Longitudinal Study on Ageing (TILDA) used cluster approach for sample selection forty households selected from each cluster. 8178 interviews were conducted with adults over 50+ and respondents retuned a self-completed survey. Comparison of rural and urban responses	Community dwelling people aged 50+ and younger partners 6,613 participants	• Looks at the relationship between poor health and loneliness in later life and the mediating factors. It is not the amount of social interaction that stops loneliness it is how people feel about the amount of interaction. This is bound in cultural norms. • How people feel about social interaction is dependent on their mental health. • Showed an indirect pathway from poor health to loneliness meditated by the variables of social resources and social participation
Boldy, 2014 (Australia)	To explore reasons for moving or thinking about moving or staying put with a focus on ageing in place.	A postal survey of 3050 members of Western Australia's members of national seniors Australia, followed by structured interviews with a sub sample Age groups 60% under 65	A postal survey of 6859 members of Western Australia's members of national seniors Australia, followed by structured interviews with a stratified sub sample 39 who responded to questionnaire Age groups 60% under 65 Large national study on older resident's intentions to move although data from rural areas not identified.	• Almost half were intending to stay in their current residence as they aged, this proportion increased with age. • A key reason for staying was having a 'comfortable' home. Related to moving, lifestyle change was particularly important for younger respondents and upkeep/maintenance difficulties for older respondents. • Uses Stimson and McCrea "push/pull" factors (place related and people based) all age groups in favour of pull rather than push factors "where you want to live for the rest of your life" • People move to keep their independence for longer

Author	Aim	Methodology	Participants	Comments
Inder, 2012 (Rural Australia)	Investigates the determinants of wellbeing in a sample of older adults in rural and remote communities with a focus on social factors	Baseline Cross sectional survey data from the Australian Rural Mental Health Study ARMHS (a population-based longitudinal cohort of adults aged 18–85 years randomly selected from electoral rolls). Wellbeing was measured using the modified Telephone interview for Cognitive Status and K10 Score (Likert scoring)	2,624 participants with 722 (28%) aged between 65 and 85 years	• Despite increased rates of chronic illness and poorer physical health, older rural Australians reported better well-being than younger groups. • Higher levels of perceived community and personal support improve current well-being and are protective for moderate to high psychological distress. • Community and social support is a key factor in health and wellbeing in rural populations.
Kendig, 2016 (Australia)	This article reports older Australians' preferences for ageing in place and predictors of their subsequent experiences drawing on a longitudinal study in Melbourne over 16 years.	Based on the MELSHA longitudinal survey that measures multiple personal, social, and environmental influences on ageing from 1994 to 2010 linked by resident with the most recent death data in 2008 and residential care use data in 2006	This study is based on the survey data for older residents aged 65 and plus in 1994 (born 1929 and before) who belonged to the Depression cohort (born in 1944 and before).	• From the baseline year 1994 to the last round in 2010 (or death), the proportion of older people who continued to stay at their 1994 residence was 67% (lower than the preferred 75%), while those who entered residential care were 17% (higher than the preferred 5%) • Those aged 75 and over, women, and respondents who had lost partners or never married were less likely to age in place. • Those who had moved on from their homes were found to have done so mainly for reasons such as moves to care settings and/or they had died after short periods of dependency and/or illness

Author	Aim	Methodology	Participants	Comments
Vogelsang, 2016 (Urban & Rural USA)	To investigate whether and how social participation among older adults varies between rural and urban settings. To identify whether the relationships between social participation and health differ between these contexts	This study uses the Wisconsin Longitudinal Study (WLS).	Analytical sample of 3006 adults aged 65 plus from rural and urban environments along with linear regression models	• This study finds that older adults living in rural counties are less socially engaged than those living in urban ones; and these differences were primarily attributable to three types of social activities—amenity related activities (restaurants, the arts), meeting friends, and exercise groups. • Adds to the contradictory literature of social participation

Table 2.4 Qualitative studies

Rosel, 2003 (Rural USA)	An exploration of elders' personal knowledge of where and with whom they are ageing in place	Phenomenological Interviews based on Rowles concentric circles. Thematic narrative	10 elderly residents living on a peninsula northern Maine 72-91 – 8 women and 2 men	• Discussed home, surveillance zone, neighbourhood and community ○ We are the experts here - comfort of home - the place where we exist. ○ A small study may not be generalizable to other areas

Author	Aim	Methodology	Participants	Comments
Arbuthnot, 2007 (Rural Canada)	Looks at what is important to maintaining health and well-being for women living in a rural community	Ethnography- Participatory evaluation guide – data collection involved observation and open-ended interviews then coded and analysed for common themes	One on one interviews. 22 senior women (65-80) and 10 informal and formal providers (provided by participants)	• Desire to remain in own homes despite challenges household maintenance, distant family members, loneliness, lack of transport or social resources. • Burdens placed on informal caregivers. Finding needs exceed the available resources. Importance of family • Association of level of health with level of independence. • Need for more studies looking at formal and informal needs of rural people - Physical infirmity is only one part of their life social and emotional needs have as much importance
Heenan, 2010 (Rural Ireland)	Can the concept of social capital be used to inform our understanding of social networks in farming families?	Glaser and Strauss grounded theory	Interviews with 65 people aged 65-85 from farming families (42 females)	• Informal support within families is in both directions (childcare etc.) • Participation in local clubs and community is not required for social capital and strong community spirit can still exist at low levels of interaction – unspoken code of practice- • Importance of faith-based activities • Good support for exploring older rural experiences use to support study.

Author	Aim	Methodology	Participants	Comments
Terrill, 2010 (Rural Australia)	Growing older: A qualitative inquiry into the textured narratives of older, rural women	semi structured interviews and thematic analysis 3 main areas: lived experience, age related changes and social engagement and productivity	8 Anglo-Australian women aged 65-75	• Three themes: free an busy me, secretly positive, pragmatic • Later life can be seen as a period of liberation, resilience and growth • Many of the gains in ageing are hard to define constructs such as contentment, compassion and integrity.
Dwyer, 2011 (Rural UK)	Do ageing and rurality interact to cause social exclusion and what is the impact of village services (lunch clubs, advice services and befriending schemes) on promoting social inclusion	Structured interviews, focus groups and PAR approach. Based on English Longitudinal Study of Ageing seven social exclusion parameters	25 key informants of each village service and interviews/focus groups with older service users 44 age range 58-93 years	• Most services are accessed by women than by men; who tended to be more connected via previous community roles, need to find ways to include more men. • Resistance in rural areas to claim social security benefits due to ignorance or stigma. • Main problems transport options - both for users and service providers. • Providers tended to focus on the negative but residents more positive

Author	Aim	Methodology	Participants	Comments
Bacsu, 2012 (Rural Canada)	To examine the key determinants that support healthy ageing in rural communities	Ethnographic methodological approach using semi structured interviews, fieldwork and observation notes. Using Cantor's 1989 Social Care Model as the theoretical framework	42 participants aged 65 and over (18 men and 24 women)	• 8 key themes were identified that relate to healthy ageing housing, transportation, healthcare, finances, care giving, falls, rural communities and support systems. • Age was not indicative of support required in contrast to Cantor's model but preference of support was proved needs extended beyond access to healthcare. • Informal support such as family, spouse and friends accessed more frequently than formal support, less likely to identify informal support only accessed formal support when informal not available.
O'Shea, 2012 (Rural Canada)	Exploring community perceptions of the relationship between age and social exclusion in rural areas. Role that age plays in exclusionary processes	Ecological multilevel approach through the lens of community stakeholders using Focus groups. Thematic analysis - Four Themes Place, economic circumstances, social provision and social connectedness	Participants included voluntary service providers, home-care workers, community workers, public health representatives, retired professionals and local representatives from national bodies and charities typically lasted 90 minutes, and involved 62 participants across the ten sites.	• Social inclusion factors identified in this study were related to the informal aspects of support social provision and social connectedness. • Reduction in public services places an increasing burden on families and voluntary community groups. Interdependency and cooperation seem as a fundamental of rural life. • Need to consider the lived experiences of older people within communities. Stigma of accepting help for some?

Author	Aim	Methodology	Participants	Comments
Winterton, 2012 (Rural Australia)	Uses Breakwell's identity process theory to investigate how older rural Australians use place to sustain and build a sense of self in the face of age-related loss.	Thematic analysis followed by a deductive approach using Breakwells Identity process theory as a theoretical lens - specifically data was analyzed in terms of distinctiveness, continuity, self-esteem and self-efficacy. This followed by ordering themes in place attachment concepts - sense of community, place dependence and place attachment	16 retired individuals aged between 64 and 98 (average age 73.1)	• Distinctiveness for residents through small closely knit communities which provide multiple roles identities and personalised interaction – not like the city • Place congruent Continuity (fit between person and their environment) is achieved through the ability of rural places to cater for qualities that salient to the self, clean air, nature scenery, community spirit. (referent continuity links with the past) • Self-esteem through pride in scenic locations and community spirit and ability of rural; locations to facilitate • Self-efficacy through easy access to groups and facilities, safe environments and supportive communities (how place enables daily functioning)

Author	Aim	Methodology	Participants	Comments
Herron, 2013 (Rural Canada)	Looks at emotion, health and place by investigating the emotionally complex experience of ageing and care in rural settings	Thematic analysis - 3 different scales of care used: interpersonal (caring relationships), household (caring places) and community (caring environments')	30 older people and their unpaid carers from small town settlements. The 30 older participants were 70 to 92 years of age, 22 of whom were women and all experienced an array of distinct health needs including chronic illness and disabilities. A subsequent purposeful sample of self-defined carers of the older participants was recruited by telephone based on nominations from the older participants.	• The central role of emotions in carer and care relationships- the guilt felt, expectations and negotiations involved in this care informal tended not to be discussed. • Tensions about expectations guilt playing it part in providing care. • Care cannot be separated from the relationship in which it occurs • Challenge of providing care while maintaining self-respect and independence. • Does government policy promote a sense of entitlement to age at home? • The situated individual, family and community experiences of ageing and caring in rural contexts remain relatively under researched.

Author	Aim	Methodology	Participants	Comments
Bascu, 2014 (Rural Canada)	Rural adults' perceptions of healthy ageing in place Part of a three-year longitudinal study that examines interventions that support older people to remain in place.	Two waves of in-depth qualitative interviews using a semi structured open ended interview guide based around 1. What does rural healthy ageing in place mean to you? 2. What factors do you think are important to healthy ageing in rural communities?	40 older rural adults. (80 interviews in total)	• Five themes identified to support ageing in place keeping active, optimistic mental outlook, independence, social interaction and cognitive health. • Rising concerns about capacity of rural communities to address the needs of an ageing population • The importance of older adult's perspectives, experiences and input must be recognised when developing policies for ageing in place. • As cultural group rural seniors may face different ageing experiences from urban seniors.
Bascu, 2014 (Rural Canada)	Policy, Community and Kin: Examining interventions that support healthy ageing (population health intervention research) Part of a three-year longitudinal study that examines interventions that support older people to remain in place.	Qualitative semi structured interviews one in 2011 and one in 2012 Based on Cantors hierarchical compensatory theory of social support 1979 model.	40 older rural adults. (76 interviews in total) One participant was well and 3 unavailable	• Policy level interactions transport, homecare, health services, ease of environment, meals on wheels, senior housing • Community level interactions physical activities, church groups, social activities, handyperson and senior's centre • Kin level meals, social interaction and, driving and care giving. • Reinforces Cantors theory that informal support is preferred • Study shows the importance of government partnership with rural communities to improve healthy ageing. Need for more research to support research on policy and kin interactions

Author	Aim	Methodology	Participants	Comments
Stones, 2015 (Mostly Rural Australia)	To understand thoughts and feelings about ageing in place and what psychological, social and practical strategies they use to cope. Experiences of very old people who are committed to staying at home, exploration of gains as well as losses.	Overview of ageing theories control theories and their role in ageing. Selective optimization with compensation theory. Decisional control versus instrumental control when help was needed to allow them to age in place. The importance of a sense of control in ageing. Continuity Theory – drawing on the past to support the future-preservation of enduring self. Attachment to place – home and community – autonomy sense of self, interaction.	23 very old adults 19 women and 4 men (mean age 90.7 range 85-101) living independently 20 from rural towns and 3 from a larger provincial city	Emergence of 4 themes: • Beholden to no-one: home affords maximum autonomy and privacy, • Residential aged-care is stagnation of the self-whereas home sustains self-identity, • Home, a warehouse of memories connecting the past to present self, • Attachment to place: independent living has relational utility and gives purpose to life. • Importance of trust in ageing by cultivating faith in others. Participants defined their capacity to live at home by their functional abilities and control rather than by their limitations.

Author	Aim	Methodology	Participants	Comments
Warburton, 2017 (Australia Rural)	Critically explores the relationship between communities of place, voluntarism and wellness for rural older Australians. A sociological approach to explore the intersection between communities of place, voluntarism and wellness	Semi-structured qualitative interviews	60 adults aged over 65 at six rural sites selected at stage two through community profiling communities and wellness	• Findings support the dual perspective of strong community sentiments through social embeddedness in rural communities; and personal interests, associated with rational choice theory, both aspects have demonstrated positive impact on wellness, but also risks to wellness associated with over-expectations of volunteers. • High levels of volunteering have the potential to enhance the resilience and adaptability of rural places
Neville, 2018 (New Zealand)	The aim of this study is to understand the influence the physical and social environments have on enabling those aged 85 years and over to remain engaged in a rural community.	An environmental gerontological approach, semi-structured interviews were undertaken with 15 people who lived independently in a rural community.	15 people aged 85 and over	• Two themes were identified; "Negotiating the physical environment: 'Getting there and back'" and "Maintaining social networks: 'Places to go, people to see'". The findings provide insight into the importance of driving, parking close to amenities and negotiating the local environment to this group of older people and their ability to engage with their community. • All participants agreed social engagement with friends, family or neighbours was important to them. Family were acknowledged as important, but having an established social network of friends and neighbours was more highly regarded.

Author	Aim	Methodology	Participants	Comments
Strommen 2018 (USA)	To examine the attitudes of community change among older adults remaining in rural areas	This study used a basic interpretive approach	13 interviews with participants who ranged in age from 69 to 90 who resided in community for at least 15 years.	Four themes emerged: • Community loss; loss of young people and services, newcomers • Social loss and isolation; loss of friends to moves or death, family at a distance • Attachment to place; more attachment in rural elders • Commitment to stay, acknowledge would move when health fails but no plans
Hancock, 2019 (rural Australia)	How rural community-dwelling older adults' views on what is important in maintaining health and wellbeing align with the eight age-friendly domains proposed by the World Health Organisation, and which domains are most salient.	Thematic analysis of open-ended responses to the following question: what is important to you as you grow older (or your loved one), in terms of keeping healthy and well?	261 rural older adults, carers and family members	Under the 8 WHO domains community and health services was the most frequently mentioned followed by transport, accessibility to outdoor spaces and social participation.

Chapter 3 Social Constructions of Ageing

Given that ageing is an ongoing process which is unique to each individual, a theoretical framework is required that allows older individuals to be reflective and consider their actions. It also needs to recognize the modernisation of society, moving towards the needs of the individual rather than the collective, along with the impact of history and tradition. Giddens' Theory of Structuration, including his concepts of modernity and self-identity, offers a theoretical perspective with which to frame the lived experience of ageing at home in rural societies (Gauntlett, 2008; Giddens, 1984, 1990, 1991). This chapter introduces Giddens' work and explores the role of social capital and social networks in ageing (Keating, Otfinowski, Wenger, Fast, & Derksen, 2003; Keating, Swindle, & Foster, 2005; Putnam, 1995).

3.1 The history of Giddens and the Theory of Structuration

Anthony Giddens is a contemporary British sociologist who mixes classical sociology with an awareness of the changes within society. Giddens was born in 1938, wrote his first book in 1971 and continues to publish (Giddens, 1990, 1991, 1998, 1999b, 2013a, 2013b). His work encompasses the classical sociological style mixing established social perspectives with his own unique contemporary views on the changes in society. Throughout his career, Giddens' theories have evolved to keep up with the constant social change in the post-traditional world. Giddens' work questions traditional values and reflects the changing nature of society, including gender roles and the family (Kaspersen, 2000). This was demonstrated by his criticism of the far right policy of "back to basics" which vilifies single mothers and alternative family structures in the United Kingdom. This was followed by his support for and then disillusionment with "New Labour" and its third way approach (Gillies, 2003). It is Giddens' interest in social changes in the post-traditional world that allow his theories to be applied to the lived experience of ageing.

The role that the individual plays in shaping society has encountered much scrutiny from sociologists, with different theorists taking a range of viewpoints. In the 1970s, Giddens' work challenged the long-held views of functionalism, structuralism and dualism. Functionalism categorised society into four distinct types of "actions" (cultural, social, personality and behavioural) with each type working together to meet the same four functional needs (adaptation, goal attainment, integration and latency). Functional theorists Parsons, Marx and Durkheim focused on the role of societal structural organisations in maintaining order by the enforcement of thinking patterns and behaviour, thereby limiting the capacity of the individual to make changes, with social control being the main imperative (Durkheim, 1964; Kaspersen, 2000; Marx, 1954; Parsons, 1991).

Interactionists criticized structuralism theory because its static nature did not take into account the potential for change with the modernisation of society.

Structural theorists Mead, Goffman, Weber and Habermas (Goffman, 1959; Habermas, 1984; Mead, 1934; Weber, 1966) adopted a more interactionist position that depicted societal institutions as cultural and historical entities which influence rather than dictate human action, allowing more freedom to be assigned to the individual. In this model, social structures and institutions exist independently of the individual. However, institutions could influence the behaviour of the individual. This system would allow for change but still limited the role of the individual in the social system (Tucker, 1988). Dualism theories go one step further, seeing individuals and their actions as separate entities co-existing with social institutions (Kaspersen, 2000).

Giddens moved beyond dualism and stated that this interaction works both ways, with social structures (resources) and the individual interacting and shaping each other. By considering social structure as both a means and a result of human agency, he argues that structure shapes action and action influences structure and together they both shape our social systems (Giddens 1989). This interaction between the social structure and human agency led to the development of Giddens' Theory of Structuration (Giddens, 1990).

Through giving the individual agency to act and impact on social systems, structuration theory underpins the making of the "runaway world," which operates in contrast to evolutionist or functionalist views, which support a fixed path of development (Giddens, 1990). Giddens stipulates that the choice of the individual to act is a "reflexive" process based on the ideas that people have about their own identity and their place within the global environment. Reflexivity is a balance between trust and risk based on individuals monitoring their own actions as well as the actions of others. This allows social practices to be changed based on newly acquired information or a change in circumstances; this power to act is human agency (Giddens, 1984).

Agency gives individuals the power of choice within their multiple social systems, in which individuals may experience competing demands in their roles as family members, employees or friends. Agency and the power to act is enhanced by control over the social structures of procedural rules, societal norms and values, resources and authority. It is this high level of awareness of the practical consciousness that underpins structuration theory (Giddens, 1984; Whittington, 2015). When considering the provision of informal care for older relatives, individuals will be aware of societal norms and values supporting the provision of care. However, reflexive monitoring of competing demands (resources and authority) such as paid employment may take precedence over these norms and values.

Giddens acknowledges that the structural properties of the system can be both constraining and enabling, with reflexivity occurring to a lesser or greater extent based on individuals' perceived power and scope to direct their actions and/or authoritative resources (Giddens, 1984). His humanistic approach may overestimate individuals' power to act, which is relevant to the older population. Growing older may affect one's agency to act, as by ageing alone individuals are at risk of resource loss. Retirement may lead to financial insecurity and loss of work-related social network support. As people age, they may suffer declining health and become more dependent on those around them. Accumulated financial resources (allocative) can provide the power to buy care and increase independence. Social networks and families can provide care for ageing residents; however, without either of these resources, older adults may become dependent on the welfare state. Although Giddens discusses old age as being an artificial social construct, he does not consider the limiting effect of ageing in a post-traditional society. Individuals cannot decide not to grow old; it is both biological and social, and he does not consider the unavoidable role of the ageing body in this construction.

Giddens tends towards optimism, crediting each individual as a thoughtful rational actor and excluding irrational emotions that may lead to adverse or risky behaviour. Dementia in the ageing population robs older people of their reflexivity. They are no longer rational actors, but still part of the social system. Lacking agency, individuals must trust others to act on their behalf, relying on the structures and power of others to act. Giddens has also been criticised for over-generalisation about processes without determining or describing the precise mechanisms involved (Kaspersen, 2000). Although Giddens talks about a post-traditional society, tradition still plays a role in society and dictates human action. Individual and collectivistic societies live side by side and the world is still in flux. In some societies the care of older people is determined by a traditional moral code, whilst in others it is reflected upon and negotiated as structuration theory describes. Nevertheless, Anthony Giddens is one of the most influential contemporary sociologists attempting to combine both classical and modern theories in order to understand how society works. This combination allows the interplay of both traditional and contemporary forces in which older people and their social networks navigate the ageing process in rural Australia.

Giddens outlines in some detail the forces in the post-traditional world that can impact upon human action especially in ageing, citing capitalism, military action and Industrialisation along with internal factors such as trust and risk (Giddens, 1990; Kaspersen, 2000). Industrialisation and capitalism play pivotal roles in ageing, with healthcare being one of the world's largest industries supported by large pharmaceutical companies. This has driven to the increasing medicalisation of ageing, making a natural process now an opportunity for profit (Ebrahim, 2002). It was Giddens' interest in the

increasingly post-traditional aspects of society that led him to develop four themes that were driving change: the separation of time and space, the disembedding of social systems, the reflexive nature of action, and the continuing erosion of tradition and culture (Giddens, 1991; Kaspersen, 2000). All of these themes will be considered in this thesis.

3.2 Theory of Structuration and Ageing

Giddens takes a social constructionist view of ageing, applying this perspective to the way in which assumptions are created by society through specific policies and ideologies. These shape individuals' attitudes to ageing and impact upon the relationship between individuals and outside agencies (Powell & Hendricks, 2009). When discussing "late modernity" Giddens defined old age as socially constructed by government policy in terms of an arbitrary retirement age, thus regulating and shaping human agency in the older years. The retirement age of age sixty-five was adopted in 1908 upon the implementation of the Aged Pension. However, in that era, most people did not live long enough to collect much of it (Powell, Wahidin, & Zinn, 2007). Mandatory retirement was discontinued in Queensland in 2004, but age discrimination in the workplace is still common (Australian Human Rights Commission, 2012).

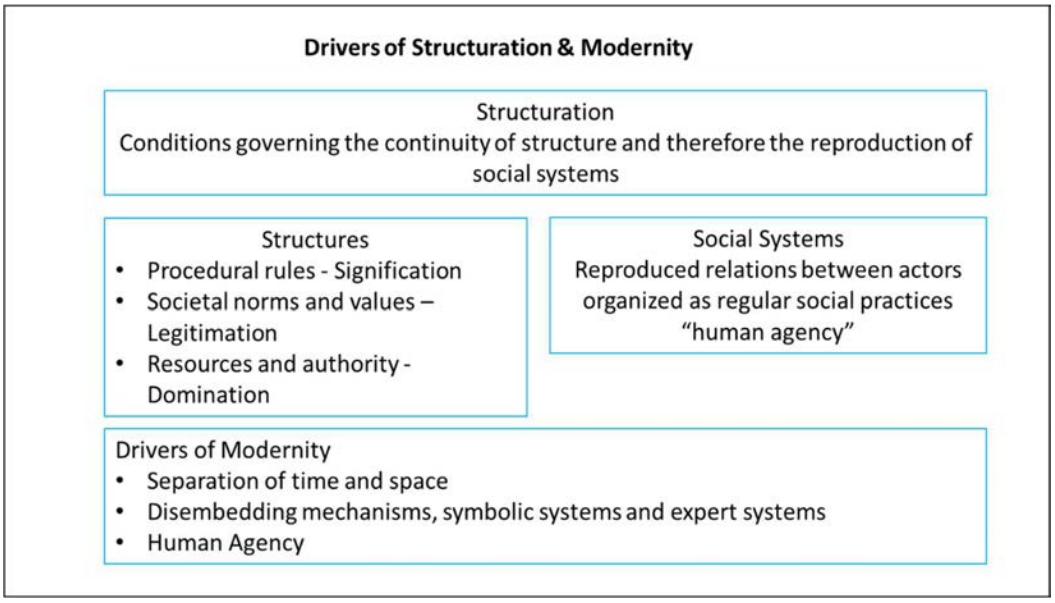
"Old age at sixty-five is a creation, pure and simple, of the welfare state. It is a form of welfare dependency much more widespread than any of the dependencies noted by the rightist interpreters of the underclass. [And]:- A society that separates older people from the majority in a retirement ghetto cannot be called inclusive" (Giddens, 1998:120).

When considering risk, Giddens tends to overplay the role of the agency of the individual. Although he described old age as being purely a social construction (Giddens, 1998) he did not elaborate on how this negative construction robs older community members of their agency, with the media depicting older people as dependent and employing paternalistic language in their discourse. Indeed the forces that create this social construction cause a breakdown in trust, a key modernist principle in today's society (Powell & Hendricks, 2009).

In order to understand ageing in contemporary society, I wanted to explore the ongoing challenges of the modern age and the impacts of modernisation on both social structure and individual action. The social construction of ageing requires each individual to take a risk on the uncertainties of a changing self-identity along with a likely age-associated decline in health, by trusting the future. Giddens perceives this interaction between trust and risk as central to living within a post-traditional world that is moving away from tradition and fatalism. Depending on the life views of the individual, ageing may be seen as either a descent into dependency or the beginning of new freedoms. To age contentedly individuals need to have trust in those around them – their social networks (Keating,

2008). The next section will discuss the drivers of modernity in the post-traditional world leading to Structuration Theory (Fig 3.1) and the implications of both for the ageing process in rural society.

Figure 3.1 Drivers of modernity



3.2.1 Separation of time and space (inhabiting the future)

Giddens characterizes social encounters by the distance of the social interaction whereby face-to-face interactions have a low distanciation and remote interactions have a high distanciation. Changes in social interactions are growing, with the move from a traditional to a post-traditional society resulting in less interaction taking place face-to-face. This reduction in face-to-face communication is indicative of a post-traditional society ruled by capitalism and consumerism (Giddens, 1990, 1991). Introduction of mass communication facilitated by modern technology brought about the class society (capitalism). In turn, separation between the economy and the state brought about globalisation of business governed by capitalism. Locales can now be artificially created (Kaspersen, 2000). Now daily life no longer occurs just locally and time is now a uniformly understood concept, which allows meetings to be separated from place. Individuals can now meet at the same time but not in the same place. In rural areas health services which were previously unavailable due to distance or staff shortages can now often be accessed by telemedicine.

Social practices are also changing: individuals can shop for groceries and clothes online, pay bills and bank online. Disconnecting time from space can come at a cost to rural towns, with services closing and retailers only maintaining a virtual presence rather than bricks and mortar, in order to increase profits. Social interactions that used to take place in rural areas in town at the bank or the shop are

in decline, resulting in reduced face-to-face interaction and reducing trust. Transitory zones such as the queues in post office are important social places for older people, being key sites for informal meetings, thus strengthening cohesion in local communities (Gardner, 2011; Herron & Skinner, 2013).

The development of communication technologies along with globalisation and standardisation of time allows interaction with family and friends residing at a distance. At any time of the day personal electronic devices can provide information about what time it is anywhere in the world. Relationships are conducted over the worldwide web and can offer love and support via technology. Family members crossing the globe in the past were lost to the social system, with the expectation of an occasional and yearly hurried phone call. However, in today's society they are just a FaceTime or instant message away.

In rural areas from which family members are often absent and dispersed internationally for work and educational opportunities, not all social contact now takes place locally. In the modern world, grandparents can now video chat with their granddaughter in Paris. Satellite communication allows individuals to communicate with workers and family working on the property and check in on them. Although older Australians are less familiar with new technologies, they are a way to connect them with the social world and their families. However, resources may influence use of this technology as hardware can be expensive and older people may have trouble in their use, especially those with limited previous exposure to technology (middle old and old old). It is becoming impossible for older people not to accept these forms of technology due to their prevalence in social, medical and financial dealings. To overcome this barrier many local authorities run training sessions for older people in local libraries.

3.2.2 Disembedding mechanisms –abstract and expert systems

The capacity of modern communication to extend time and space disembeds social systems which were previously embedded in the community. Giddens distinguishes between two types of disembedding mechanisms: symbolic systems and expert systems, which together form abstract systems. Symbolic systems such as financial systems lift transactions out of time and space allowing buying and selling goods and services based on trust in this abstract system. (Giddens, 1990). By contrast, expert systems are arenas of technical accomplishment and professional expertise that form the basis of the material and social environment in the modern world (Giddens, 1990). Trust in these systems does not rely on being able to master the knowledge or understand the services they offer but to have "faith" in them. To have faith in these systems means that in our experience of the system they generally work as expected, in the same way as do doctors, lawyers and hospitals.

However, in the post-traditional society, expert systems are no longer automatically trusted as society has become more reflexive and trust in these expert systems is now more based on demonstrated outcomes (Giddens, 1999b).

3.2.3 The reflexive self

Individual reflexivity is a mechanism by which people make decisions through the ongoing internal process arising from constant interaction: thoughts they have about ageing, what kind of person they perceive themselves to be, and whether they have the power or scope to provide support for ageing. In this thesis, reflexivity occurs throughout the social network as a mediator to action being taken regardless of who takes the action. Engaging in reflexivity is an essential part of ageing when determining which action to take in facing the challenges of functional decline. Giddens believes that self-identity is a reflexive project in progress. To maintain ontological security we need to have a stable sense of identity and biographical continuity (Giddens, 1991).

3.2.3.1 *The ageing body and self-identity*

Scientific knowledge indicates an increased risk of physical problems and diseases of the mind in the ageing body. Ageing is a natural biological process that cannot be halted and will inevitably result in death (Stumpers, Cohen, Pooley, & Mander, 2015). Advances in medicine encompassing more intervention in chronic illnesses have led to the increasing medicalisation of ageing and an increasing association of older people with decreased physical health or illness resulting in increased demands upon the healthcare system (Ng R, Allore H.G., Trentalange M., Monin J.K., & Levy B.R., 2015).

In order to restrain increasing health costs, policies and messages from governments are based around financial independence and good health. Messages using the terms “successful ageing” or “healthy ageing”, place obligations on older people to practice healthy lifestyles to limit decline and the need for social support (particularly amongst those aged 65 -80 years). It seems now that to be considered a good and responsible citizen there is an expectation (and perhaps imposition) of good health in ageing. This may lead to the perception that ageing is an adversary rather than a natural aspect of life (Breheny & Stephens, 2010; Harris et al., 2016). Whilst these messages are well intended, they may disenfranchise older people with chronic disease or ill health as non-contributors, negatively affecting self-identity (Harris et al., 2016; Higgs, Leontowitsch, Stevenson, & Jones, 2009). Those who are dependent or infirm are judged incapable of self-governance and lacking in agency to make their own choices (Breheny & Stephens, 2010).

In ageing, the primacy of the body must be considered, as the body acts as visual symbol of how identity is viewed by the by external observer (Biggs, 1997). The body and its physical and mental

functions are required for individual agency. The body is the vehicle for action, which in turn shapes social structures and provides the means for interaction. For individuals to act they must first trust their bodies, their control over the sensory aspects and their mobility (Giddens, 1984). Unlike many social theorists, who often ignore the role of the body in the social construction of ageing, Giddens (Giddens, 1999b) argued that in post-traditional society the body has become more reflexive. Individuals are now responsible for the design of their bodies. He points to the rise in cosmetic surgery, implant surgery and the use of genetic technologies in body modification as evidence of the body's increased malleability (Giddens, 1999b). However, the increasing malleability of many of the modern interventions are designed to make the body look younger. Giddens sees the body as a reflexive projection of the self and we attempt to control it to fit with our self-identity. Yet like Giddens' "juggernaut" in the Runaway World, the body can be modified, but stopping biological ageing is beyond human control (Giddens, 1990, p. 139).

Leder's (1990) work added to the perceptions of the body that can be applied to ageing. Leder argued that the body is mostly absent from daily awareness (the cleavage of body and self) when it is working well. One small deviance or pain and the unwelcome body re-appears, so-called "dys-appearance" (Leder, 1990). As people age, they become more aware of their body's limitations. The body's changes demand attention, reminding them that this natural process is beyond their control. People may lose trust in the body when it is now at risk and health becomes less certain. Although not actively in a disabled state, certain activities may be deemed too risky for fear of falls or injury because "we are too old". If someone's name is forgotten, this may generate a fear of early signs of cognitive decline. Our body takes on the appearance of ageing: hair, skin and muscle tone changes, bones become more brittle. In a society that values youth and vigour the body becomes more visible to the person but invisible to others and this in turn impacts on self-identity (Aged Concern, 2006).

Goffman's (1959) theories on body management also presented the body as playing an important role in both self-identity and social identity. It also plays a central role in supporting ontological security (Goffman, 1959; Shilling, 2003). Gaps between virtual and actual social identities can cause negative reflections on self-identity. In this way, when the ageing body is negatively perceived ontological security is threatened. Conversely Featherstone and Hepworth (1991) suggested that ageing individuals' perception of their bodies is mediated by direct and tacit judgements of others in interactions and our own reflexive judgements of their view, compounded by what individuals perceive in the mirror (Featherstone & Hepworth, 1991, 371-390). In their "masks of ageing" theory, Featherstone and Hepworth argued that rather than identify with societies' views of being old we view the ageing process as a virtual identity which is not in conflict with the concealed youthful self but still embodies a lack of fit between our inner and outer experiences (actual identity,

Featherstone & Hepworth, 1991; Rozario & Derienzis, 2009). Lastly, in concepts of late life identity is the "ageless self" which proposes a continuity of self-identity, with older people viewing their older identities as a continuation of their younger self despite the physical and social changes associated with ageing (Kaufman, 1986).

Leder's (1990) work on the disappearing body is a useful theory when dealing with pain and injury. However, he also questions the transfer of the term "dys"functional to natural processes such as ageing and childbirth, resulting in associating a natural process with illness. Although the body is going through changes and ageing individuals are aware of these changes, these changes are not indicative of a disease or dys-function. Goffman's and Featherstone's theories put self-identity in ageing at risk as both conceptualize the ageing body as having a negative impact and being a source of anxiety. However, Giddens' theory of structuration provides for reflexivity enabling change in self-identity and creating new positive identity. Despite the negative ageing discourse many older people are content with their lives, most are not anxious and many contribute to society. When older people have the capacity to be reflexive agents, they can maintain a stable sense of self-identity through social networks and biographical continuity. Reflexivity allows for changes in goals, maintaining biological continuity. Trust in social systems and positive relationships are essential to self-identity; identities are supported by the social network. Yet in every relationship there is also an element of personal risk.

3.3 Trust and Risk in Ageing

Giddens perceives risk as an essential component of the post-traditional world; a key feature of a society moving away from traditional ties and societal values. In recent generations, faith in the state and welfare has diminished. Nye's work on trust in abstract systems suggested that in all democratic countries there is declining trust in political leaders and people who hold positions of authority such as lawyers and doctors (Nye, 1997; Rowe & Calnan, 2006). Life is no longer controlled by fate and tradition, rather it is shaped by the forces of science, technology and the economy (Giddens, 1991, 1999b; Powell, 2008). People have more knowledge than ever before at their disposal, and rather than bringing more certainty it makes life more uncertain. Knowledge constantly changes and what science decided was good one day can change the next. Risk is concerned with control of the future; by controlling the future individuals can provide safety and security for themselves (Kaspersen, 2000). Risk management has become an essential part of living at the global and the individual level (Giddens, 1999a; Powell & Hendricks, 2009). However, risk can be assessed and managed. If ageing individuals have no trust in public services, given the right resources they may choose to engage private provider care (Beck, 1996, p28). This suggests that people may still choose to accept a risk

even if they have a lack of trust in expert systems. Based on media reports an individual may have no trust that they will be well looked after in an aged care home, but the lack of choice in their rural community may cause them to choose to take that risk in order to stay close to friends.

While there is a general lack of trust in financial organizations these expert systems are still needed to facilitate daily life. People saving for their retirement via superannuation funds have to take the risk that their money will not be mismanaged. Giddens' perceives the interaction between risk and trust as pivotal to living in a post-traditional world, with risk perception relative to knowledge and trust. Individuals are always at risk in the juxtaposition of everyday life with planning for the future. In order to function in day-to-day life individuals need to put the awareness of potential risk and harm into the background and have basic trust in the world around them(Giddens, 1990, 1999b).

Trust is contingent on an expectation that a certain action will occur. Thus, trust is predicated on knowing something about the possible future event that may happen, and while one might not have control over it one maintains an empathic belief in a favorable outcome. Trust also implies taking a risk (Giddens, 1991). Older disadvantaged people may have fewer opportunities to avoid risk. If they have not had the opportunity to accumulate financial resources prior to retirement, they may have to trust social welfare or family to provide support. The post-traditional world is not bound by fate, but lack of resources can mean lack of choice.

The most prominent expert systems that involve trust and risk in ageing are aged care welfare and healthcare (both in and outside the home). The Australian Government plays a welfare role through aged care policies such as deciding the age at which individuals will receive the age pension and means testing the individual's accumulated assets to dictate the amount of pension to be allocated. Welfare is rationed centrally by capping the amount of residential care beds and home care packages. Bed shortages and supportive services waiting lists may lead to the risk of older people waiting for or not receiving aged care at the time they most need it.

By taking a purely economic approach to ageing, the Australian Government has changed the existing social contract between the state and its population. The "cradle to grave" welfare system principles have been replaced by fiscally driven policies encouraging those who have built up the resources during their working life to self-fund their retirement (Powell, 2008). These neo-liberalist policies have put the financial risk on to the individual, with policies adopting a narrowed definition of social legitimacy (mainly through work) and the fiscal focus on risk of health decline and financial insecurity for older people. By promoting policies framing risk and ageing, the act of ageing itself now seems "risky" (Biggs & Kimberley, 2013; Powell et al., 2007).

In line with Giddens' post-traditional world the government has endorsed a capitalist and consumerist culture through contracting care to private service providers, thus decreasing its role in the provision of care and reducing the risk to itself. The older individual is now socially constructed as a consumer who needs to navigate the provision of Aged Care services with individual contractors, relegating western governments to faceless systems. Giddens argued against this trend, opposing the UK Blair government policies that treated the individual merely as a consumer rather than a reflective agent (Kaspersen, 2000).

In the provision of home care, trust is essential in two areas: firstly, in the expert system providing the care and secondly, in allowing the individual carer into the home (face-to-face trust). Home care spans two areas: that of the expert and that of the non-expert. Tasks which were previously the domain of the individual (the expert), such as cleaning and home maintenance, are now undertaken by the carer (the non-expert) and trust is required for the expert to relinquish this role. In small rural towns, home care provision may be difficult as the carer may be known to the older person and the need to maintain independence and privacy may be a concern. Regular long-term carers (representatives of the system) may be viewed and trusted as friends, but in agencies with high staff turnover this trust may remain undeveloped, thus causing anxiety and lack of trust. Trust has now become more reflexive and more risk aware and once lost it is not easy to regain (Giddens, 1990). The importance of building on trust in relationships will be explored further in the next section.

3.4 The Role of the Family?

While the role of expert systems in ageing is important, the majority of care is provided by family and friends, with a substantial proportion of older people never accessing formal aged care (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). A recent study showed that 84% of Australian born people would turn to their families for help in troubled times, emphasising the continuing importance of family in the post-traditional world (J. Baxter, 2018). Family help is not uni-directional, with resources flowing in both directions such as elders caring for grandchildren or providing financial support to younger family members (Silverstein, Gans, & Yang, 2006).

The role of tradition is evident in Australia's aged care policies, which are built upon the traditional role of the family with the expectation that partners will provide care for older family members as well as younger family members continuing to do so. One million Australians currently access age care services, but 80% of aged care support in the community is provided by partners, family, friends and neighbours (Hodgkin, 2014). This informal care saves the government $40 billion each year (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). Given that these current policies

are built around traditional care models, there may be conflict in a post-traditional world where the role of the individual has increasing primacy.

When examining the traditional role of care for older generations, society has always placed this care within the context of the social network and support was given out of love, reciprocity, respect or obligation. In the 1960s, Australian Government polices moved to promote residential care homes as an alternative to family care, removing aged care from family into expert systems. However, in the last 30 years there has been a paradigm shift to home care, although policy change was more likely due to fiscal pressure than societal pressure (Vasunilashorn, Steinman, Liebig, & Pynoos, 2012). This move places the family right back in the middle the provision of aged care.

In contemporary society, many researchers talk about the breakdown of the family through factors such as women joining the work force, along with increased mobility and technology (Putnam, 1995). These changes may drive a reduction in social capital, resulting in civic disengagement. Although Putnam identifies family as the basis for social capital, he takes a negative approach to this, placing the social capital that exists within the family unit in opposition to the social capital in wider society. Giddens and others do not agree that the notion of the family is in decline. Rather, it is changing and becoming more democratic (Silverstein et al., 2006). In contrast to Giddens' views, Putnam identifies the reduction in social capital as an inherent part of the post-traditional world. He views women's involvement in the workplace as working towards gender equality and democracy with increased mobility and technologies acting as the drivers of modernity rather than representing a decline in social capital (Giddens, 1999a; Putnam, 1995). Both theorists focus on tradition, with Putnam lamenting its loss and Giddens celebrating its end; to Giddens no modern society can be ruled by tradition.

The loss of tradition and breaking of traditional ties needs to be balanced against the rise of the individual in social systems and the positive potential and opportunities these diverse social constructions may offer to both older and younger members of society. Contemporary middle-class western societies experience some freedom from the traditional gender roles, changing society's expectations and leading to diversity in family units. There are now larger numbers of sole parents and merged families after divorce, however, the traditional heterosexual couple is still the norm (J. Baxter, 2018; Giddens, 1999a; Gillies, 2003). These social changes are often heralded as the demise of the "traditional family" which may have implications for future aged care, with smaller family sizes and an increasing number of lone retirees who have chosen never to marry or have been divorced (Gillies, 2003).

The notion of the family unit has not declined in value but it must move forward in the post-traditional world (Giddens, 1998). Past research shows that traditional model of care of older family members was not without its problems. Rather than the often idealized or romanticized view of historical multigenerational families living together in harmony, older people were often placed in the workhouse (the aged care equivalent of this time). In addition, despite the commonly held misconception of non-western societies treating their elders more considerately, research argues that this is not the case (Stuart-Hamilton, 2012). Looking at the mixed evidence for and against the decline of the family in society it is clear that the family has changed but the effects of this change in the post-traditional world and specifically in aged care are still unknown.

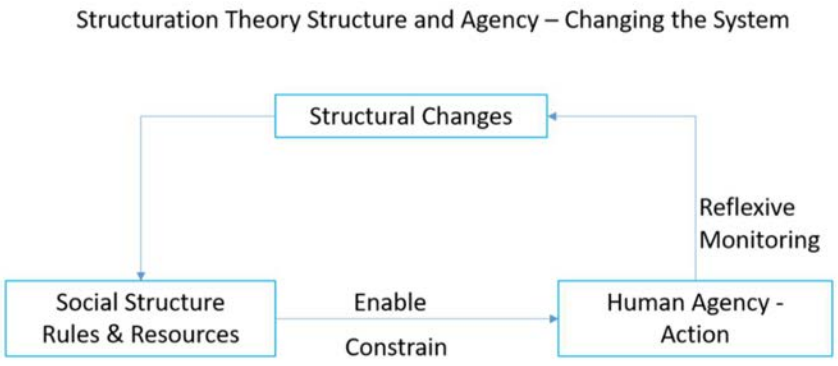
Giddens (1999) writes extensively about the impact of modernity, positing that society is no longer bound by tradition and our actions are no longer decided by what came before. In essence, individuals are now obliged to be reflexive prior to action. In the post-traditional world, family relationships are now more conditional, characterised by risk rather than bound by stable and obligatory rules and rituals. Aged care is no longer provided in response to tradition alone and is increasingly provided conditionally upon individual decisions within the family. Given that family is located strongly within the sense of self, "personal identity" to maintain ontological security may obligate younger family members to provide care to older members. In this way whilst the individual may be aware of family expectations (traditional requirements) and societal norms to provide care, they can now be reflexive about what care they are able to offer whilst still maintaining their self-identity. In this way the individual creates an "effort bargain" which Giddens describes as a compromise between the public society and the personal values of the individual (Giddens, 1999b).

He argues that in the post-traditional world, societies or indeed institutions still influenced by tradition operate in opposition to modern reflexivity and are stuck in the past (Gauntlett, 2008). Nevertheless, tradition still plays a part in directing action and maintaining self-identity in Australian rural society. Australia is an ancient country with a relatively new multicultural population, in which tradition still has a role in directing action among Indigenous peoples and migrants, creating a society with both collectivistic and individualistic cultures.

In Giddens' Theory of Structuration (1984) (Fig 3.2), support from social networks in ageing is based upon human action (the decision to offer help and accept help) and its repetition in social structure forms a social system. To conceptualize the social system in which this assistance occurs, I needed to explore the effects of post-traditional life and its impact on human action. To understand human action we need to understand structure as an internal construct that is "both the medium and outcome of practices which constitute social systems" and is both enabling and constraining at the same time (Giddens, 1984, p25). Considering ageing in place, structure then arises from the thoughts

and interactions that individuals have with their social networks as bounded at a certain point of time and space. Changes to this support and engagement would be dependent on how individuals viewed themselves, the relationships and what the outcomes would mean for them. This would include the social capital held in the social network along with an awareness of available services and trust in these expert systems.

Figure 3.2 Structuration theory



To explore the lives of older adults the personal and social networks that surround them need to be understood (Keating et al., 2005). These relationships are central to the ageing process; it is these kin and non-kin friendships that support the ageing experience. Social relationships held within these networks can provide companionship, practical assistance and emotional support (Domènech-Abella et al., 2017; Keating, 2008; Keating et al., 2003). Each network holds the potential "assets" or social capital created over the duration of the relationship built by trust, kinship and reciprocity. This social capital is the resource within the network that can be used to help one another (Putnam, 1995). Older people have social networks built up over long periods and they must trust that resources will be forthcoming if required. They must trust that the resources that they have given to the network will be reciprocated. In this way trust and reciprocity are related conceptually and one cannot exist without the other. For example, it may be extra support after a partner dies in the expectation that this support would be repaid if this happened to the supporter (Keating et al., 2005). In families, reciprocity is an ongoing process and the strong norms of reciprocity within the family allow for uneven exchange, delayed exchanges and indirect exchanges due to familial obligation. Research into modern intergenerational transfers shows an uneven flow of goods and assistance from older generations to younger generations (Finch & Mason, 2000; Silverstein, Conroy, & Gans, 2012). This is in direct contrast to the dependency stereotype of older adults which depicts older people as net receivers of intergenerational transfers.

However, the existence of a network tie does not guarantee support, as the decision to provide support is multifactorial (Keating & Dosman, 2009). The social networks of older people are dynamic, with losses and gains in the network throughout time: losses such as death of partners or siblings and gains such as the consolidation of new friendships (Schiamberg & McKinney, 2003). In this thesis I adopt the conceptual view that older people have the agency to influence the network, but are also influenced by the network, rather than acting in a passive or dependent manner. Social networks have been extensively studied, as well as the beneficial effects of social connectedness in supporting healthy ageing (Giles, Metcalf, Glonek, Luszcz, & Andrews, 2004; Golden, Conroy, & Lawlor, 2009; Wenger, 1997; Wong & Waite, 2015). Many studies on the ageing experience have identified an association between large social networks and improved health outcomes in later life (McLaughlin, Vagenas, Pachana, Begum, & Dobson, 2010; Wenger, 1997; G. C. Wenger & Burholt, 2001). However, the complex relationship between social connectedness and health (cognitive decline and overall mortality) has been inconsistent (Green, Rebok, & Lyketsos, 2008; Hodge, English, Giles, & Flicker, 2013). Nevertheless, having an active social network and sufficient social support is linked with better self-rated health and increased wellbeing (Fiori et al., 2006). Sociologists have studied the typology of social networks of older people to predict the support they may be able to access or determine well-being outcome measures (Fiori et al., 2006; Litwin & Shiovitz-Ezra, 2006; Wenger, 1997). These network typologies may indicate the sources, quantity, quality, and type of available support. The available support in these networks can affect the ability to age in place.

3.5 Chapter Summary

This chapter introduced the social construction of ageing, Giddens' Theory of Structuration and the drivers of modernity, as well as an in-depth discussion on the role of the body in maintaining self-identity in ageing. The role of both risk and trust was discussed as being pivotal to ageing in the post-traditional world along with the role of social networks.

Research that explores social constructs of ageing and social interactions will be enhanced by a methodology that captures social dynamics and rural contextual experiences of older Australians ageing in place. This methodology will be detailed in the next chapter.

Chapter 4 Research Methodology – An Embedded Multiple Case Study Approach

Research into ageing in rural communities requires an approach that allows for the study of social constructs and their interactions, and how these affect the lived experience of those ageing in in these communities. The chosen methodology must also enable the free expression of thoughts and description of the experiences of ageing within a structured framework. This chapter discusses the methodology and the methods used to examine the social support systems of older people living in their own homes, and the lived experience of healthy older adults as they age in a rural environment.

4.1 Selection of Methodology

This study was based on a qualitative interpretative methodology with constructionist epistemology, in order to allow for the identification and documentation of the thoughts and views of older Australians on the ageing process (Hammersley, 2002). Given that I wished to study the social processes of ageing, I choose an ethnographic approach to the research. Ethnography is a qualitative research methodology that has it has in roots in the disciplines of anthropology and sociology, and is concerned with the documentation of societies and their systems, beliefs and behaviours (Miles & Huberman, 1994). This field-based method is undertaken in the cultural context of study, in this case study of the rural environment over a period of time, in an attempt to capture the social phenomenon under study. The ontological and epistemological properties of the ethnographical process enabled me, as a researcher, to participate in and observe the social phenomenon of ageing in rural towns (Holstein & Gubrium, 2008). Visiting and spending time in each town along with interviewing people in their own homes and local cafes enabled the data to be captured in an embedded environment, while allowing the researcher an insight into what ageing in place meant in each town.

There is some debate about whether a social constructionist theoretical perspective can be employed whilst engaging in ethnographical research (Holstein & Gubrium, 2008). However, I have used this approach as ageing itself is socially constructed, as has been previously discussed in Chapter Three. The constructivist approach supports human action as having a major role in construction of the social world, both in individual actions and in the interpretations of those actions by others. This approach acknowledges that each individual interprets the world differently, and it locates the research process in social and situational positions (Charmaz, 2017). Some theorists argue that the constructionist perspective is based in relativism rather than in the doctrine of

realism (Hammersley, 2002). However, constructionism provides the tools to explore cultural groups (in my research, older Australians in rural areas), their beliefs, values, behaviors and adaptations to and around ageing. Thus, the social phenomenon of rural ageing can be captured without any preconceived ideas that may limit emerging issues (Miles & Huberman, 1994).

Using the constructionist perspective also enabled me to take a broader view of the experience and actions of older people ageing in place (in a specific culture and environment) and is in line with the epistemological underpinnings of ethnography (Hammersley & Atkinson, 2007; Lopez-Dicastillo & Belintxon, 2014). This allowed for adoption of the following assumptions required to understand ageing in place:

1. A person's behaviour is inextricably linked to the meaning that the situation has for them;
2. A person's understanding, and hence behaviour changes as they interact with others;
3. Within a situation there will be different perspectives;
4. A person's behaviour and beliefs can only be fully understood in the light of broader aspects of organisations or culture; and
5. The group or culture must be studied as it is (Hilton, 1987).

Exploring the lived experiences of ageing Australians and their social networks in rural areas over a year using an ethnographic approach enabled me to understand the issues that older people faced in everyday life as they occurred. Immersing myself in the community was essential, given the large role of the home and community in the ageing process, along with the impact of rurality upon personal identity (V. Burholt, 2006; Rowles, 1983).

4.1.1 Design – Ethnographic embedded collective instrumental case study

The ability to age in place is dependent on the support networks and local services available to the individual, so a methodology was required that captured the whole experience of living in a rural town. I also wanted to look at the impact of ageing in diverse locations and compare these findings to those in other rural areas. Case studies provided the advantage of capturing detailed participant narratives and documenting both continuity and change (Grbich, 1999), with each different location bounded as a case.

There are two main approaches in case study research. Stake and Merriam's approach is situated in the social constructivist paradigm, while Yin takes a post positivistic viewpoint (Merriam, 1998; R. Stake, 1995; Yazan, 2015; Yin, 2009). Stake and Merriam propose that constructivism and non-determination should be the epistemologies that are the basis of case study research, since

knowledge is constructed socially rather than discovered. To develop his conceptual framework Stake uses "issues", about which he states "issues are not simple and clean, but intricately wired to political, social and especially personal contexts" (R. Stake, 1995, p. 17). Yin takes a more rigid approach to case study research using pre-determined specific propositions (similar to Stake's issues) to form a conceptual framework, which is then applied to data collection and analysis (Abma & Stake, 2014; Yin, 2009). Given that ageing itself is an on-going process, a pre-determined framework may not capture emerging issues and may limit the construction of new knowledge.

This research study had no predetermined hypotheses about the findings, but rather a series of issues related to ageing in place that I wished to explore. Stake's conceptual framework, therefore, offered the best approach consistent with ethnographic methodology. Stake (2003; 151 -153) describes three types of case studies:

1. instrumental, when the case is to be used for greater understanding of a particular issues or theory;
2. intrinsic, when the case is being studied for further understanding about that particular case;
3. collective, in which the researchers use multiple cases of instrumental studies.

(P. Baxter & Jack, 2008; R. Stake, 2003; R. E. Stake, 1978).

Comparison of instrumental cases may show that the events and processes that happen in one context can also be found in another. To improve transferability of my findings of ageing in rural Australia I selected three diverse study sites, bounding each site as an individual case study. Participants and their social network members were treated as embedded cases, resulting in a collective design. This design allowed for a contextual comparison across embedded cases in rural environments and across cases between different communities (Buys et al., 2008). This enabled deeper understanding of ageing in place in rural Queensland and how local conditions and structure can impact upon the nature of ageing (Miles & Huberman, 1994; Ruddin, 2006).

4.1.2 Defining the case

It is crucial that each case had a defined boundary that clarified its uniqueness or context (Crowe et al., 2011). In this study, cases were defined as study sites with each site bounded geographically and located at a sufficient distance apart that there was no crossover between the sites. Three research sites were selected, one located near the coast, one in the rainforest and one in the outback. Each town was defined by different local industries (Sugar Town, Cattle Town and Mill Town). Originally four cases were chosen (the other being Coal Town), but despite visits to the local community promoting the study, no-one volunteered to take part. All study sites were located in north

Queensland, with eleven embedded cases (social networks) across the three sites. As the experience of ageing is diverse, each of these embedded networks have their own context, making each case understandable as a whole (Abma & Stake, 2014).

Figure 4.1 Map of north Queensland, covering the geographical area of the study sites

4.1.3 Case study selection

As the purpose of this study was to explore ageing in regional and remote areas with small populations, I used the Modified Monash Model (MMM) to select the research sites. This model of classification takes into account both remoteness and the size of the local population (McGrail & Humphreys, 2015). The MMM was developed by Monash University in 2015 to overcome the limitations of previous models by more accurately representing the livability and accessibility of rural towns.

The MMM ranks areas from one to seven, with one being a major city and seven being very remote. Remoteness classification is determined by the Australian Bureau of Statistics, which uses the Australian Statistical Geography Standard-Remoteness Areas (ASGS-RA) residential population data from the 2011 Census to determine the five remoteness categories (RAs). The MMM uses the ASGS-RA data as a base, and further differentiates areas in Inner and Outer Regional Australia based on

local town size. The category five sites were classified as both inner and outer regional, due to their location of more than 10 km distance by road from a large town with a population between 5000 and 15,000. The category seven site was classified as very remote, due to its geographical isolation (Table 4.1).

Table 4.1 Modified Monash Model

	Geography	Remoteness Area	MMM
Sugar Town	Coastal	RA 2-3	Category 5
Cattle Town	Outback	RA 5	Category 7
Mill Town	Rain Forest	RA 2-3	Category 5

Source: http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/MMM_location*(Australia. Department of Health, 2014)

Table 4.2 Demographics of the three rural towns

	Population	Median Age	% Aged 65+	Personal Median Weekly Income
Australia	24,206,201	38	14	$662
Sugar Town	4426	50	30	$507
Cattle Town	1136	44	20	$623
Mill Town	1400	48	24	$432

Source: (Australian Bureau of Statistics, 2016)

It is important to understand the context and different characteristics of each town in order to explore the effect of rurality.

4.1.3.1 *Case one – Sugar Town – Three embedded cases*

Sugar Town is the largest and most accessible of all the towns included in this study. It is located 110 kilometres from the nearest regional centre and a 17-hour drive from Brisbane, Queensland's State capital. The town has a population of 4426, with double the national average of residents aged over 65 and median personal weekly income of $507 (Table 4.2)

Sugar Town is a vibrant regional hub, with two large national supermarkets represented, and is a destination for travellers/tourists as well as for rural residents from the surrounding areas. Smaller residential settlements along the coast surround Sugar Town, which also draw visitors to the area with fishing opportunities. In addition, the town is situated in an area of biodiversity, offering both wetlands and waterfalls within a short distance. The main industry is the sugar refining, with a mill located just seven kilometres outside the town which employs 10% of the town's population. The town contains many people who migrated from Europe in the 1900s to work in the sugar industry (Henderson, 1978). Sugar Town is the most familiar environment for me, as I grew up in a small regional town in Scotland. Although not as remote as other sites, this type of town offers residents both a sense of community and a degree of separateness.

Three social networks were recruited in Sugar Town. Although each network was unaware of the participation of the others in the study, within the two networks there was a large degree in overlap in attendance at community and social activities.

4.1.3.2 *Case two - Cattle Town – Three embedded cases*

Cattle Town is the most remote town in this study, and is located 383km from the nearest regional centre, a 15.5-hour drive from Brisbane. During this study the town was experiencing a major drought and the drive was lonely, with red earth kicking up clouds of dust. Stray cattle were encountered on the road and the occasional spinifex blew over the road. This added to the feeling of remoteness, and for me (coming from northern Europe), a sense of otherness. Although remote, the town is a major centre for the cattle industry, and is surrounded by large grazing properties. The main highway runs through the town, and throughout my stay, large trucks thundered past on their way out west. These massive trucks were filled up at large petrol stations perched on the edge of town. To an outsider, the few shops and the trucks combined to give the town a transient atmosphere, not a close community feel. However, this was demonstrated not to be the case.

On arrival, the town was quiet, with a few cars parked in the wide main street and about three people walking in the town. There were a few shops and one small independent supermarket (with a limited selection and higher prices than the national chain), but not many customers, and I wondered how these businesses could survive. At lunch, I was one of three customers in the café. At my second visit a year later two of the original shops had closed.

This was the smallest case and it was very hard to recruit social network members. This may have been associated with the drought and the time of year (cattle were being mustered), and many members of the network (including older people) were under extra pressure to work. At the second interview rain had come, but sporadically (not all properties had benefitted), and the town was still

feeling the pressure. One year later this town suffered extreme flooding conditions that decimated the cattle industry resulting in the death of 500,000 cattle.

All cases in this study were living or had lived on cattle properties with some moving into town after handing over the management of the property to younger family members. The networks within this town were all intertwined with social and community activities. Although I did not discuss the study with other participants, each were aware of the others taking part.

4.1.3.3 *Case three – Mill Town – Five embedded cases*

Mill Town is situated in the hinterland of north-east Australia approx. 123km from the nearest regional city. The surrounds include both rainforest and mountain pasture, the town itself is situated at a higher altitude so it has a different climate from the coastal and inland towns. The town has the lowest median household income of all sites with 16% of residents unemployed (Table 4.2). The town has a large resident Aboriginal population of 14% compared to 4% nationally. Traditionally, the industry in Mill Town was timber, however in the 1980s Government Heritage listed the surrounding rainforest. This disrupted the forestry industry, causing many job losses in the community. The closure of the mill resulted in many people leaving the community and a consequent loss of family members for support.

More recently the town has re-invented itself as a tourist destination, with arts and crafts shops and cafés for visitors to the area. The main street was busy with tourists and local residents doing their daily shopping both times I visited. The local area is popular with retirees and many "tree changers" have relocated to the area, settling on large blocks of land outside town. There are a couple of independent supermarkets but no national chains, leading to food being more expensive. There are many community groups focused around the church and crafts. Again, although I did not discuss my study, participants were aware of one another and my arrival in town was quickly noted.

4.2 Data Collection

4.2.1 Interviews

Given that the issues relevant to ageing are not visible, I wanted to discover the individual constructions of the ageing experience. In order to do this, I selected a guided interview format. This format evolved in response to iterative analysis throughout the research project, formulated to produce a greater understanding of participants' ageing journey (Grbich, 1999). Prior to the first interview, I undertook a pilot interview, testing the guide with an independent older local community member. During this testing we discussed the research, along with proposed questions and issues included in the guided interview, in order to ensure cultural appropriateness and

relevance to older community members. The feedback from this meeting was then incorporated into the study.

4.2.2 Ethics

Approval as outlined in the ethics documentation in the appendix was gained from the James Cook University Human Research Ethics Committee (Appendix 1.1) from the 28th August 2015 until 31st of July 2018. Two additional amendments were made and approved (Appendix 1.2, 1.3). Data collection was completed on the 19th July 2018.

4.2.3 Confidentiality

Cases were not identified by location name, due to the small local populations. In addition, pseudonyms were used for all participants.

4.2.4 Recruitment

Once the three sites were selected, local clubs, churches and doctors' surgeries were contacted and asked if they would be happy to display a leaflet, including researcher contact details, advertising the research study (Appendix 1.4). Once approval was received from local organisations, I posted or dropped off leaflets to each location. As part of the process of ethnography it was important that I spent time in each town visiting local communities, church leaders and hospitals. Leaflets were also distributed by my advisors to local contacts at the study sites.

Interested participants were invited to contact the researcher, and times and dates were then set for an interview. After the primary interview, participants were asked if they were happy for the researcher to speak to a member of their social network. If consent was given, I then contacted the suggested network member to invite them to participate.

If the participant needed further explanation before involving their social network, information packs were given to the participant to distribute to their social contacts, with study and contact details. Included was a request that they contact the researcher if they wished to participate. Recruitment of network members was less successful than had been hoped, especially in Cattle Town, as primary network members did not "want to bother" family or friends who were working on the property.

4.2.5 Consent

At the first meeting participants were given an information sheet (Appendix 1.5) about the study, along with the consent form (Appendix 1.6). Consent was obtained prior to the commencement of

the screening process interview, along with an assurance of confidentiality. During consent, participants were offered the option of receiving a newsletter reporting on my PhD progress, as a strategy to promote and sustain engagement. This process was also repeated at the time of the second interview, and written consent was obtained at both time points. One participant declined a second interview but allowed the data from their first interview to remain with the study.

4.2.6 Screening

Table 4.3 Inclusion criteria

Inclusion Criteria	Exclusion Criteria
Aged 65 or older	
Living in house or unit independently	Living in residential care
Good health and able to mobilise	Unable to mobilise
Sound cognitive function	Cognitive impairment as determined (Screening process described below)

The aim of study was to capture the lives of older people independently living at home. Therefore, older people in aged care homes and those with complex formal support needs were excluded. Given that in Australia a large proportion of older Australians will never need any formal care in their lifetime (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014), I wanted to explore experiences of the healthy older adults living in the community who form this majority. Primary participants were assessed for health and cognitive function (as described below) to purposefully select this population.

After discussion about the expectations of the research and gaining consent, two validated screening tools were applied in order to check inclusion criteria: Lawton's Instrumental Activities of Daily Living Scale (IADL) and General Practitioner Assessment of Cognition (GPCOG) (Brodaty, Kemp, & Low, 2004). Training in the use of these tools was undertaken under the supervision of one my advisors, a psychiatrist for older people. The IADL, developed by Lawton (1969), assesses functions required to remain independent. It consists of eight items that cover competence in skills such as telephone use, shopping, food preparation, house cleaning, laundry, transport, medication and finances (Lawton & Brody, 1969). Whilst IADL is in common use, a few of the male participants commented on the skewing of this tool to perceived gender specific roles.

The GPCOG is a reliable, valid and efficient instrument used to screen for dementia, specifically in a primary care setting. The GPCOG score is not influenced by the cultural and linguistic background of

a subject, which allows its use in many different settings, especially for patients with multicultural backgrounds (Brodaty et al., 2004). A score of 7/9 or above was used for inclusion to the study. During screening some participants became concerned when they did not score 100% on the GPCOG. This will be discussed further in Chapter Five.

Prior to the study I had discussed the ethical considerations arising from potentially uncovering hitherto unknown cognitive impairment, and prepared for this eventuality under the guidance of my advisor. During the study two participants were excluded because they scored low on the General Practitioner Assessment of Cognition (GPCOG). On exclusion, one participant stated that they had concerns about their mental recall and had recently sought medical advice about this problem. This was a difficult situation, as they had welcomed me into their home and provided lunch prior to the screening, and a friendly relationship had formed. It seemed that they felt they had let me down, and were apologetic that they were unable to take part in the study after my travelling to their house. I managed this situation by informing them this was also part of my research training process, was expected and would still help with my studies, and that I was in no way disappointed.

Applying these screening tools prior to Interview one gave baseline data for the screening process, and prior to Interview two this was used as a benchmark to detect any physical or cognitive changes over time. Results from the screening tools were not used as exclusion criteria in the second interview.

4.2.7 Interviews

Interviews and observations were conducted at a venue of the participant's choosing, options including the participant's home, local coffee shop or by telephone, with the majority of interviews taking place in participants' homes. Conducting the interviews within a naturalistic setting helped to prompt more relaxed conversations and observations. Participants often added detail to responses by pointing out objects and places (Abma & Stake, 2014). Of the four telephone interviews three of were follow-up interviews where settings from previous visits could be visualised. Most interviews were undertaken alone with the participant, however on some occasions other family members were also present. When family members contributed data during the interview, formal consent was obtained and they were included in the social network.

To put participants at ease, each interview started with a general question about the participant's story to date. This approach enabled them to express what was important to them and what brought them to this community. This was then followed by more focussed questions concerning their ageing experience. At the second interview, which took place approximately 12 months after

the first, themes and questions from the first interview were followed up and any changes discussed. This also helped validate responses from the initial interview.

Interviews were undertaken based on a guide, which covered four main themes (Table 4.4) and included the completion of ecomaps (discussed in detail below), as well as collection of observational data. Interviews were audio-recorded (with participant's permission), with most interviews taking between 30 -60 minutes (although some secondary participant phone interviews were shorter). Field notes were completed within a few hours of leaving the interview venue.

Table 4.4 Summary Interview Guide

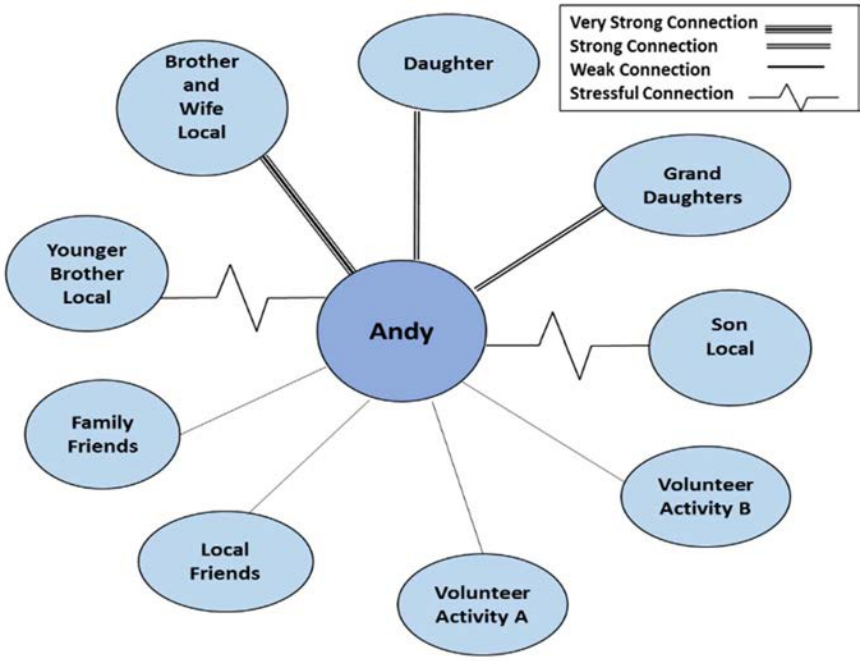
Ageing	Support	Home	Social Interactions
• How do you feel about ageing? • Concerns about ageing • What are the positives in ageing?	• Formal services accessed • Informal support received • Informal support given • Support and ageing • Family	• Plan to stay in home • Suitability and home modification • Thoughts on aged care accommodation	• Social groups clubs, churches etc. • Involvement in community • Social connection and ageing

4.2.8 Visualisation of social networks

This study sought to explore social networks and the informal and negotiated support available through these networks. I used ecomapping to represent these social relationships, which enabled the visualisation of relationships between family members, friends, neighbours and social organisations (Hartman, 1995). Ecomapping provided both the interviewee and myself with a diagrammatic tool to discuss the social interactions and the level of support derived from each relationship (see Figure 4.2).

Relationship strength within the network is depicted by the number of lines from the primary participant to their social contact, with stronger relationships having more lines up to a maximum of three. Frequency of contact was also notated, as this may not correlate to relationship strength. Where relationships were perceived as problematic jagged lines were used (Ray & Street, 2005).

Figure 4.2 Milltown Case 11 Andy



I introduced the concept of ecomaps by using a sample ecomap showing types of social relationships. Maps were developed during the interview, in a collaborative process with the primary participant. Member circles were added throughout the interview process, with categorisation of relationship strength completed towards the conclusion when the interviewee was more comfortable (Ray & Street, 2005). These maps were then used to describe the social support available and allow classification into social support networks using Wenger's typology (Wenger, 1997). On the second visit, I brought a photocopy of the original ecomap and any changes were discussed and marked on the copy.

4.2.9 Data collection comments

As a relatively inexperienced qualitative researcher at the start of this process, I found that I did not consider an exit strategy and found the breaking of the connection unexpectedly hard. Although the study information stated two visits would be made, many participants asked when I would be back again. I explained that this was the last interview but that I would be sending out my newsletter (Appendix 1.7) detailing my progress and thanking them again for giving up their valuable time to help me. As a thank you for their time, each participant received a $10 voucher for a local supermarket and a small gift of biscuits.

4.3 Analysing the Data

Data collection and analysis occurred as an iterative process to inform the interview guide for subsequent and follow-up interviews. One of the key features of case study and ethnographic research is that data are collected from multiple sources. In this study, screening tools, interview transcripts, field notes and ecomaps were merged in the analytic process in order to better understand each case (P. Baxter & Jack, 2008).

Interviews were transcribed verbatim and audio recordings were reviewed to ensure validity. This was important, as although interviews were transcribed verbatim with some comments, capturing "tone" was important to the analysis of the data. Case summaries were then compiled, incorporating memoing and marginal remarks. As researcher I found that these summaries allowed a clear sense of the whole case (the main concepts, themes and issues) and grounded the case before the data was broken up in the coding process and all the data sources were subsequently reintegrated. These "write-ups" also enabled me to focus on the important issues to follow-up on in the second interview. Summaries were shared with the research team to ensure credibility and confirmability when discussing emerging themes and analysis. (Miles & Huberman, 1994).

4.3.1 Coding

Data analysis was managed using NVivo11 qualitative data management software (QSR International Melbourne, Australia) and borrowing from the principles of grounded theory methodology. The procedures of coding, categorisation and comparison can be applied to constructivist data as long as the work is grounded in social construction (Charmaz, 2017). A first round of open coding was undertaken with new codes being added as more interview data became available. In this open coding period, I used topic coding, breaking the data down into individual nodes and employing constant reflexivity to ensure that each code was based on the individual participant's response rather than any pre-conceptions. Codes emerged directly from the data. Coding and fracturing the data continued until the themes emerged which were then merged into larger concepts. These concepts were then reflected upon, discussed with advisors and mapped to larger theoretical concepts based on Giddens' Theory of Structuration, as discussed in Chapter 3 (Birks & Mills, 2015; Giddens, 1984; Kaspersen, 2000; Chapter 3).

4.3.2 Case analysis

I had originally planned to focus on each case as a separate entity and undertake a within-case analysis which would then be followed by a cross case analysis. However, completion of the summaries and iterative analysis of data showed only minor differences in each case regardless of

the unique communities. It was then decided that to avoid duplication all cases would be conceptually analysed. Analysing and comparing findings across all cases highlighted the similarities and differences between each case, deepening my understanding of the social context (Miles & Huberman, 1994; R. Stake, 2006).

4.4 Trustworthiness

Trustworthiness of the data was established using Lincoln and Guba's (1985) indicators for qualitative research; credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985).

4.4.1 Credibility

To demonstrate credibility, this research study used two triangulation strategies. Methodological triangulation involved gathering data through different sources, in-depth interviews, field notes and observations. Investigator triangulation was applied by means of involving my advisory team in the conduct of my research, including the development of data collection tools and analysis. Initial interviews were co-coded by both myself and my advisors, with discussion of coding discrepancies and mentoring in the analysis process. Source triangulation was also employed, as sources were interviewed at two different time points, utilising two different data sets with the same method. In addition, the second interview also enabled validation of themes raised in the first interview (Hansen, 2006; Korstjens & Moser, 2018; Lincoln & Guba, 1985).

4.4.2 Dependability

Project dependability was addressed by discussion of suitable methods with my advisors, both experienced qualitative researchers. Earlier in this chapter these methods are clearly documented, as well as the justification of their use and my conceptual perspective. Use of a decision audit trail in data analysis confirmed that the results were bounded in the data (Korstjens & Moser, 2018).

4.4.3 Confirmability

To ensure that the results were the true views of the participants and not distorted by bias, I questioned my neutrality prior to interpreting the results (Hansen, 2006). As a researcher it was important to recognise my previous assumptions and experiences of ageing. All my grandparents aged in place and exclusively received informal family care. In particular, my grandfather, an eccentric veteran from WW1, would only accept help under sufferance. When I reflect on the love that I gave my grandparents I feel that it moved from looking up to them as a child to a perhaps somewhat paternalistic/protective approach, in that they needed looking after, as I moved into my

young adult years. In admitting this to myself, I was careful to ensure that my perspective did not affect the study in any way.

To optimise neutrality in analysis, I constantly used a reflexive process to query myself and advisors: What is the participant telling me? What is this about? (Korstjens & Moser, 2018).

4.4.4 Transferability

Transferability is concerned with the degree in which the results from this study are relevant to similar rural ageing populations. I have outlined the conduct of the study in detail (methods, sampling, case notes and results) to enable the reader to decide whether the results may be relevant and transferrable (Lincoln & Guba, 1985).

4.4.5 Data management and protection

Given the amount of data generated in this study it was important to set and implement a clear data management plan to ensure that my data could not lost, mislabeled or miscoded (Miles & Huberman, 1994). This was also required for ethics approval. The following strategies were used:

- All research data collected was stored on the University intranet (backed up daily) and password protected.
- Consent forms, screening tools, and ecomaps were stored in a locked cupboard within the Student Office. In addition, electronic copies were made.
- Audio files were deleted from the digital recording device once transcribed.
- Coding of transcripts followed set naming rules to allow for easy retrieval.
- Data collection and analysis progress were recorded on spreadsheet
- QSR NVivo was used to organise and manage data in the study.

4.5 Limitations

In ethnographic research, the interaction between the researcher and the participant must be considered, in that the researcher becomes part of the society which is being investigated. The age difference between the participants and myself may have influenced responses, in that I was seen in the role of the adult child (in some cases receiving advice). However, this also may have worked in my favour by lowering the power differential and enabling entry into the participants' social community. There may have been a degree of sampling bias in the research, as more socially minded

people are likely to respond to the flyer advertising the research. However, this study also attracted people with restricted social networks, indicating that this bias may have been avoided.

4.6 Chapter Summary

This chapter described the selection of an ethnographically focused multiple case study methodology, case selection and use of interviews to collect views on ageing in place. It then described the data analysis process and the testing to ensure the trustworthiness of the data. The next chapter will detail the case studies and their embedded cases, in order to develop a greater understanding of ageing in place.

Chapter 5 Results– Descriptive Case Studies

In order to understand the lived experience of ageing it is essential to explore the social context of each individual. This chapter introduces each participant and their social networks, describing their constructions of ageing in their daily lives. Three descriptive case studies are reported on: Sugar Town, Mill Town and Cattle Town, along with the embedded cases contained within them. As discussed in Chapter Four a cross case analysis approach was not used because, during preliminary analysis, each case revealed similar issues.

5.1 Participants and Screening Results

Thirteen older people responded to the invitation to participate, with two participants being excluded during cognitive screening. The remaining eleven older participants aged 71-92 years, including 4 males, and 7 females, were interviewed over the three sites. In addition, 15 social network members were recruited, including partners, family and friends aged between 26 and 80 years (Fig. 5.1). Aliases for the case locations and all participants (chosen by the researcher) are used to ensure confidentiality.

Figure 5.1 Participant overview

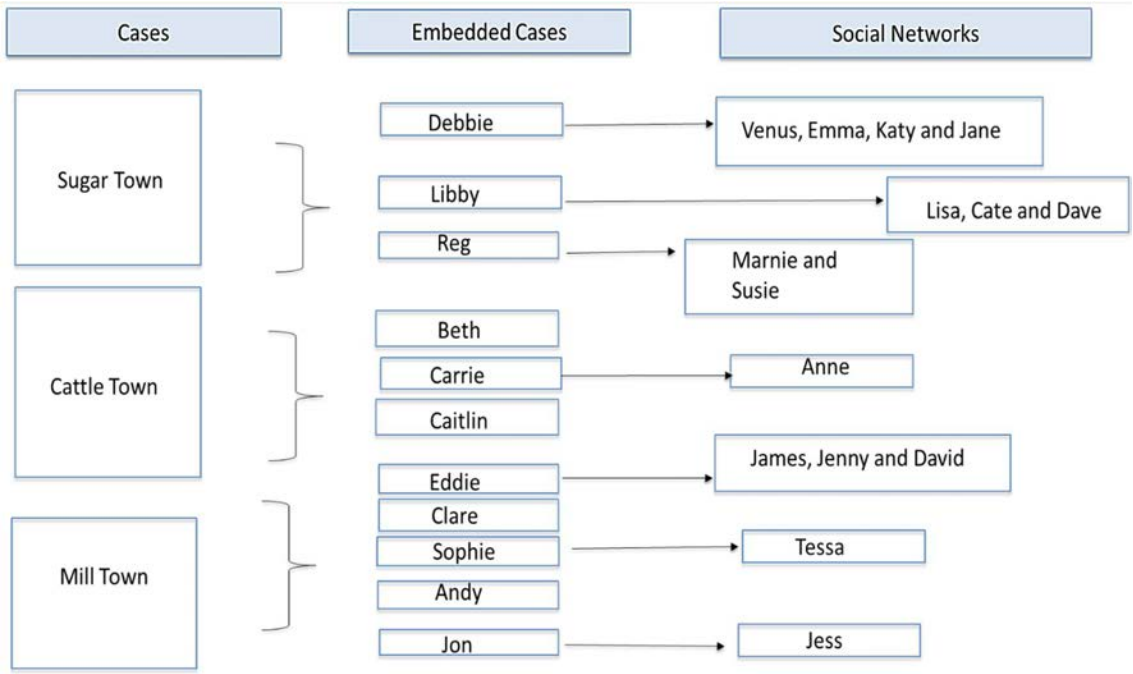


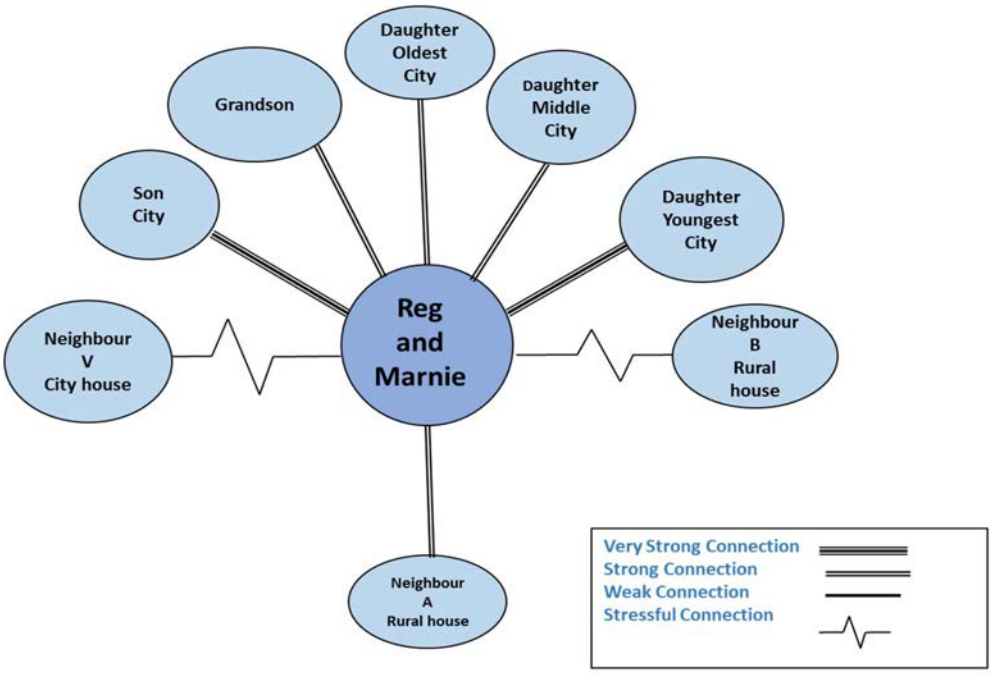
Table 5.1 Results of screening

	Visit One IADL	Visit Two IADL	Visit One GPCOG	Visit Two GPCOG
Reg	8	8	7	7
Debbie	8	8	9	8
Libby	8	6	9	7
Caitlin	8	8	8	8
Clare	8	8	7	6
Carrie	8	8	9	8
Beth	6	5	7	7
Jon	8	8	8	9
Eddie	8	8	8	8
Andy	8	8	9	9
Sophie	8	8	8	8

Note: Overall between Interview one and Interview two there was very little change in participants as measured by the GPCOG and IADL with only four participants scoring lower on the screening tools. Changes to each of these individuals is discussed within the case studies below.

5.2 Sugar Town Embedded Case One

Figure 5.2 Reg's family dependant network



5.2.1 Reg– Interview one

Reg (72) lives with his wife Marnie and they divide their time between their rural property located 30 minutes from Sugar Town and their property in [Regional city]. Currently they spend more time at their rural property than at the city one. Although Reg admits, the rural property is now too big for them it is clear that it is where he would rather be, *"It is one of the most peaceful places you could ever want to be"*. He has a deep connection to the property *"It's different but it's very relaxing and the old people (spirits) come to visit"*. He finds urban living more challenging than living in the country with noise and close neighbours a major annoyance. Currently he has a problematic relationship with his neighbour. He also has a problem with one of the rural neighbours (after a run in with a shotgun). When they are in [Regional city] another neighbour with whom they have a good relationship looks after "the chooks". Reg reciprocates this favour by fixing and repairing things around her property when he is home. When at the rural property they attend the local medical centre if required.

Reg views every *"birthday as a bonus"* and that *"the older you get the better"* but does not enjoy the medical side of it and his existing health problems. Reg had bowel cancer 8 years ago and suffered serious complications during the operation that still cause him problems. This can sometimes make him *"feel that life is on hold"* as he likes to keep active. Loss of vision has limited Reg's hobbies as he

can no longer polish gemstones, however he keeps his mind active by crosswords in a case of *"if you don't use it you lose it"*. Reg is an ex-engineer and continues to work on "*projects*" and helps out his family with his skills; although now in a more advisory than physical role.

Reg and Marnie have four children and grandchildren who live in Regional city who they *"don't see often enough"*. When they are in [Regional city] they see their children quite often, with the eldest daughter visiting every second day and are *"a good close knit family"* that *"stick together"*. Reg states he is *"allergic to clubs"* due to the social hierarchy that he perceives as existing in these regulated social environments.

5.2.2 Reg – Interview two

Reg's health has continued to decline over the last year and his daughter has also been unwell, which has added extra worry to the family. He has been to hospital with angina attacks and told not to worry, although his wife is unhappy with this view *"what they know about medicine isn't much really".* They have spent less time on the rural property and are in the regional house most of the time. Reg describes this; as *"15 acres compared to this, there is no comparison this is like going to hell without dying"*. He feels that his *"time is limited"* so he will be stuck in this house. Since spending more time at [Regional city] house they have seen more of their family who live close by (two sets of grandchildren were in the house for the interview), and have been helping, one daughter with after school childcare, although this has now stopped due to the number of hospital appointments and Reg's declining health. They have found family issues are resolved more easily when there is more contact between them. Reg is an involved grandad who helps the neighbourhood children with their bikes, his daughter has two foster children who call him "*grandad*".

When asked about the role of family in caring for their elders, Reg sees some already doing this but feels more help will have to be provided due to *"the cost of nursing homes being out of reach to most people"* and these costs *"will take the house and everything else"*. He has a friend who is planning to move into his parent's house to care for them. His hearing has deteriorated, which impacts on his social life, but he refuses to try hearing aids as he feels they will just amplify all the noise around him. His hearing is worse in larger groups, but his wife seats him next to his son so they can talk directly, which helps. Reg still only socializes within the home and family. After much persuasion from his family he recently went out to a restaurant, but the experience was not a good one, with slow service and bad food.

5.2.3 Reg's wife – Marnie Interview one

Marnie (57) is of Aboriginal and Torres Strait Islander descent and hopes "*to be a crotchety old lady one day".* Getting older does not really worry her now, and her main concern would be the loss of mobility, but she feels that she could handle this. Both of Marnie's parents died at a young age and she is the youngest of five siblings. Marnie is in good health and is currently undertaking further studies.

Marnie sees ageing as relative and more a state of mind *"some people are old when they are bloody 30, they practice being old"*. However, she perceives that this can be a stereotype with older people also being enlightened, open minded and quick witted which she hopes to be. Marnie has already experienced ageism *"being treated like an old lady"* mingled with a bit of racism, sexism and bad manners at the local shops. Marnie has found ageing gives her a greater sense of security and identity and *"knowing herself better"*. From an Indigenous, cultural point of view her age has given her a confidence and maturity in her spirituality, and being a grandmother in her community bestows a certain amount of "*gravitas*", with her knowledge being valued. She feels that non-indigenous societies show less respect for older community members, but in Aboriginal and Torres Strait Islander communities this lack of respect is rare, due to community keeping younger members in line.

For Marnie the purchase of the [Regional city] house was prompted by Reg's ill health and she too would prefer to live in the rural property *"but it is just too much"*. She was finding it *"increasingly difficult to cope with the stress of Reg's precarious health that can see him going from being fit and well to needing an ambulance in the space of an hour or less. This has happened too often"*. She can see Reg getting worse and it takes him longer to do the things he once could and his pain is increasing, she does not want to think of a future without him and *"when the time comes she will worry about it"*.

Marnie does not see herself as Reg's carer, although it is clear that she cares for him, but prefers to use the term enabler, she *"likes to be near him in case he needs something"*. It is clear that they are a partnership and that she promotes Reg's independence, remaining very aware of his need for autonomy. They had looked into a Carer Allowance at Centrelink at various times but did not proceed.

When Marnie is not around, the children check on Reg to make sure he is OK. She sees the family as providing the main support for ageing. They are a close family and do not really socialize outside the family group, and this has always been the case. Marnie does not see aged care homes as an option for her future, *"for many I see it as a final punishment for being old"*, and feels that there is the

opportunity for physical and financial abuse especially with the for-profit model. She feels like it is *"a hostage situation"* where families cannot complain, as there is no choice. This may be particularly important in rural areas where there is likely to be only one choice within travelling distance.

5.2.4 Reg's wife Marnie – Interview two

Marnie has had a rather "*chaotic*" year with Reg's ill health, her daughter's illness and the death of her brother. She is also looking for work. The upkeep of the rural property *"is becoming a bit of a mission"* and they plan to try to sell their house. She had worried that they would leave their move *"too late"* and would be unable to cope and she now feels that this is the case and the property is *"overgrown"* and a *"bit of a mess"* and they will have to try and sell it in this condition. Many of their belongings are still there and they will require assistance to clear them out, as they are unable to do this task themselves.

Marnie is finding the number of doctors and hospital appointments a burden *"the bloody appointments are horrendous"*, as it is difficult to make plans in advance and she has considered looking into getting a carer if Reg requires more assistance. Although she feels her husband's health has declined his mental function is still sharp. In the hot summer this year, they had to install air conditioning to help with Reg's breathing which caused further restrictions, *"it is just what it is"*. Reg is currently getting his cataracts done and she hopes this will allow him to cut gems again (his hobby) and keep his driving license. Marnie is enjoying being a grandparent and feels *"it is Gods reward"* for bringing up her own children.

Marnie feels that there is an expectation that children should look out for their parents *"and do what is best for them"*. However, she feels that this is not always the case due to a lack of respect to older people and fears this may feed a "*growing resentment*" towards parents who may need help resulting in "elder abuse". Marnie feels that aged care homes are expensive and that there is a lack of government support for ageing in place.

5.2.5 Reg's daughter Susie – Interview one

Susie (31) is married with two children and moved to [Regional city] aged 21 when she got married. She is looking forward to growing older and as she ages, feels that she is becoming more confident in herself and "*standing her ground on issues that are important to her*". Susie feels that society views older Australians as a burden and as a group are unfairly treated with the increasing pension age, "*they have put in the hard yards to give us the country we have now*".

Susie is happy that Reg and Marnie have moved to [Regional city] as she felt that they were isolated on the rural property and now they are closer to their four children who can provide support. She

enjoys the opportunity for herself and her family to socialise more with her parents, however she recognizes that her dad is not enjoying the move all that much. Family members drop over to see Reg frequently in the [Regional city] home, taking him on trips and ensuring that he remains active in his hobbies. Reg also provides support to his children in both world advice and technical advice.

Like Marnie, Susie feels that it is better for Reg to be closer to medical services due to his poor health, and she is happier now that she and her siblings can now "*lend a hand*" to both Reg and Marnie. Susie also recognizes that her Mum needs support and that her carer role can take its toll on her, *"at least us being around we can give her a little bit of relief, some female company".* The main support given by the family is social as Reg is independent and *"he would get pissed off if us kids kept trying to do things for him",* and has only begrudgingly accepted help when he was very sick. Susie's family is there to support her parents and she believes that by showing support to her parents her children will learn the importance of family looking after one another. On provision of support to her parents Susie states, *"I have never even thought about it, it is something that you do though whether it is right or wrong hard or easy you just do it".* This support is grounded in the way they were raised and the attitudes of the community about providing support to their elders. However, she is concerned that her children may be burdened in the future with care for her and her husband and views aged care residents *"becoming like numbers on a page, an inconvenience at times to the staff working there".*

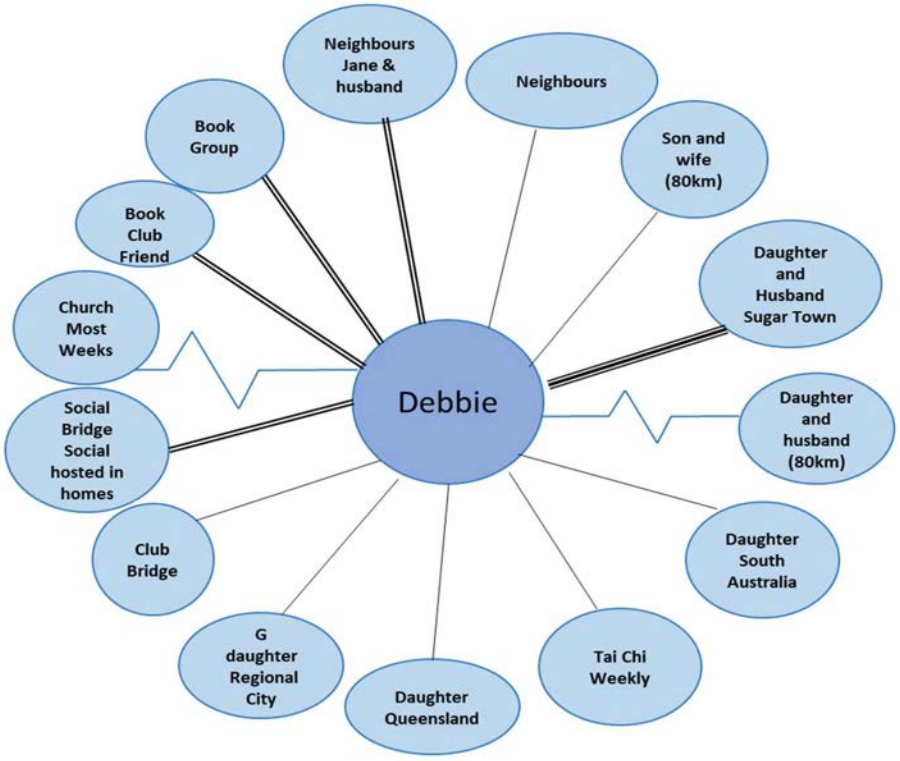
5.2.6 Reg's daughter Susie– Interview two

Susie has seen her dad's health decline over the last year and feels that whilst he is happy to still be here his poor health *"gets him down".* She feels *"he has been more settled"* in the town house mainly due to increased social interaction keeping him busy. When discussing the move into town she feels that they should have made the move *"a good five years earlier".* The family are offering to help clean up and prepare the rural property for sale but feel Reg and Marnie are being "*stubborn*" in accepting help. Susie is concerned about the stress of Reg's ill health on her mum, that her mum's anxiety about this has been increasing since Reg's first major operation. She feels this anxiety relates to her mum's fear of losing her dad and with each health setback this fear increases, this anxiety also affects both her and her sister *"we can just share it around, take the anxiety and pass it along".* She feels Reg is aware of his limited time and that her dad is supporting her mum to find work to ensure that she is going to be OK. Susie and her family drop in to see Reg and Marnie about three to four times a week and provide mostly emotional support and physical help if required. She feels that her parents would not accept formal services.

Susie discusses her owns plans for ageing and the dream of the sea-change and now wonders if this is realistic after her parents' experience with having to move back to town. She feels that her family are *"in a holding pattern we can't move out of town, we won't move out of town because we know that Dad isn't going to be around for a long time"*. *"Then Mum is really going to need our support so you sit in a holding pattern and you wait and I don't want to do that to our kids when we are old".* However, although Susie worries about being a burden on her children, she does not see her parents as a burden.

5.3 Sugar Town Case Embedded Case Two

Figure 5.3 Debbie's wider community focussed network



5.3.1 Debbie – Interview one

Debbie (85) lives alone in a bungalow that she and her husband built when he became ill and they had to move off their property to a more manageable home. She felt that the move into town was *"perhaps too late, as when it came time for him, he could no longer live there".* They designed the house to manage his illness with a modified floorplan and larger rooms to allow wheel chair access and medical equipment. She has lived in the Sugar Town area for 57 years, after moving there for her husband's work; but states she does not have a strong attachment to Sugar Town. Debbie has five children: one son and four daughters.

She states she is healthy and active, walks each morning, is a keen gardener and attends the local church on Sundays. She is a member of the bridge club, tai-chi and book club. She graduated from University of Queensland and as a Physical Education Teacher and taught for a short time before her marriage. She was offered the chance to work at the local school in her 30's and was keen to do this but her husband would not allow it. In response to this *"I did a lot of volunteer work",* Debbie has spent a lot of time volunteering in the local community. She was heavily involved in setting up local services for dementia and respite care. She would have liked to have done more but felt held back due to being a female and the traditional homemaker role *"he was lovely but liked to be the manager".*

Debbie is not worried about her ageing journey. Although she has a few pre-existing health problems (heart condition and macular degeneration), she insists that these do not slow her down. Debbie goes to [Regional city] to get treatment for both these conditions, and for minor problems sees the local general practitioner. In the past, her husband used to drive her but now she her goes with her son in law or takes the community bus. She enjoys taking the bus (covered by the travel allowance) which gives her the chance to do some shopping in at the [Regional city] shopping centre. Although Debbie still drives, she is not confident to make the [Regional city] trip, due to trucks and the increase in traffic. She limits her driving to local trips in Sugar Town. Debbie does not worry about dying and *"just want to drop off the twig with not a lot of pain".* She is happy with the way she is living and has lots of friends and acquaintances who are supportive, and in some cases, *"too supportive"*.

Debbie has a fear of losing her memory (perhaps developing dementia?) and keeps her mind busy with crosswords, book and bridge and this reassures her that her memory is working well. Being a member of social groups is important to Debbie as it connects her.

Debbie's daughter Emma lives close by and is retired, and she helps Debbie out around the house for tasks she can't manage herself. Emma visits most days, but sometimes is away for long periods during the holidays. Debbie has a cleaning service come in three times a year for larger tasks, as she now will no longer climb ladders for fear of falling, and has an alert alarm in case she falls. Her grandson also lives locally and helps by fixing things around the house. Debbie often bakes and cooks for family members. Debbie overall has a positive relationship with her family, although there is some conflict with one daughter who has mental health problems. To Debbie the hardest thing about getting older is the loss of friends and family and the inevitably and unpredictability of these losses.

5.3.2 Debbie– Interview two

Debbie is still living in her home and ageing in place. She has had a couple of health problems including a Transient Ischemic Attack and a positive test for bowel cancer, and she is currently awaiting a follow-up colonoscopy to confirm this. She is unsure about whether or not to do anything if the test is positive unless treatment was straightforward and simple. Debbie had pneumonia last year and was cared for by her daughter and neighbours at home. She did not want to go to the hospital, as it is *"full of sick people and old people waiting to go places".*

Debbie's house is still meeting her needs and she has added to her garden and is still driving – although she is coming up for her driving license renewal soon and thinks they want to test her (if she does not pass she accepts that she may have to give up driving). She now only drives locally on country roads and prefers not to drive at night if she can. She has cleaners who continue to come a few times a year, and if needed Debbie would increase this - but not through aged care services as she feels the service is substandard *"they do not do too much".*

Debbie is still concerned about memory loss and completes crosswords and quizzes *"to test herself",* and she now does this on an iPad rather than paper. Her father *"wasn't very well in his mind"* at her age. She keeps busy, but finds things take longer than they used to, and feels that her arthritis is making her more "*clumsy*". Debbie still attends the book club but has reservations about being the oldest there, *"they're all younger than me but don't seem to mind me".* Debbie is still interested in the Church and identifies as being Christian although *"not the best Christian"* as she has does not *"know whether I believe in God properly or not"* but finds the interest and the *"charismatic priest"* keep her going. The local church has recently started up a support club for people with dementia and their carers *"we do good things down there".*

Debbie is about to became a great grandmother and is looking forward to this. She will go and see the baby, but is finding travel becoming more difficult, as she needs to travel firstly overland to [Regional city] and then fly. Her daughter Emma who usually checks in on her every day is currently on holiday and Debbie "*misses her*". When Emma and her husband are around Debbie enjoys cooking for them, this proves her independence *"showing that she can still cook a meal".* In her cooking, she uses fresh vegetables given to her by her neighbours. Debbie's grandson and partner are currently staying locally for a short time due to work and she is enjoying catching up with them. Although Debbie has a busy life and lots of good friends, she does not have a close confidant *"not somebody she would tell everything to"* and sees herself a private person. Most of her friends are her own age and she is starting to lose them – *"they die, that's what you do when you get old, eventually".*

Thinking about the future Debbie says she would not like to be in an aged care facility and thinks it would be "*dreadful*". However, she would *"have to consider it, I wouldn't become a burden on my family, if I had to go in I wouldn't say – no, they've got the power of attorney*". Debbie does not think she would want her family to look after her and *"if it came to the point"* would go into a unit and "*just cope with that if she lives on".* She feels that her daughter Emma who lives nearby may be burdened, *"it is always left to one person in the family to do it seems".* Debbie's daughter has a unit under her house and Debbie has considered whether this might be suitable. She is unsure whether this is an option for her as Emma's husband's father was not offered it and *"she would not like to push any boundaries"*. She does not think that in Australia there is an expectation that children should look after their parents but for her *"it is much better"* and *"if she was destitute they would do anything thing for her".*

Debbie's father and her stepmother went into aged care after they could no longer cope at home, and prior to this Debbie and her children had provided some support when something went wrong. Debbie had a problematic relationship with her stepmother so could not have provided live in support. Neither parent was keen on receiving help, and would not let her know if there was a problem. Eventually illness forced them to move into a hostel, where they were quite happy. Debbie's father suffered cognitive decline (possibly dementia) and *"wasn't very well in his head".* After the death of his wife she felt he *"dropped everything".* He lived on in a nursing home for another four years, *"which wasn't good".*

5.3.3 Debbie's daughter – Emma Interview one

Emma (61) is a retired teacher. She has two sons and has lived in Sugar Town for 30 years, having returned after working in other parts of Queensland. Emma always wanted to live in a small town and returned after the birth of her first child. Emma is fit and healthy, but her husband has a health issue and she worries how she would cope without him.

Emma has been retired for two years and taken up hobbies and volunteers with Volunteer Isolated Students Education (VISE) to *"keep engaged".* Her husband always joins her in this, and she sees this as giving something back – although she feels she gets more out of it in enjoyment and sense of worth than she puts in. Her main concern about retirement is to maintain a sense of purpose. She has retired early and perhaps worries about how to fill the days. Prior to her retirement, she did not take part in voluntary work due to the pressures of work. *"That's the thing when you retire you suddenly think this is great but you find out that life is more than that and to be fulfilled it's good to have a bit more of a purpose".*

Emma still lives in the family home and feels that there is too much space and upkeep. They looked at selling and building a new low maintenance home but the cost was prohibitive. She wishes Sugar Town had a retirement complex such as [Regional city's] Carlyle Gardens, where garden maintenance and so on is included. She feels that there is insufficient aged care in the local community. Emma mentions a friend who has to travel to [Regional city] to visit their partner in an aged care home due to lack of local availability.

Emma supports her mother and thinks, *"she seems to be coping very well with living alone"* and often goes over with her husband for dinner that Debbie cooks. She also phones every morning and visits every day. Debbie has both a computer and iPad but struggles with online bill payment. Emma helps her out with this and finds this frustrating and perhaps is worried that these struggles are an indication of cognitive decline. Emma also voices concerns over incidents such as Debbie flooding her house and locking herself out of her house. Emma worries about her mum when she is away and "*feels guilty*" as she knows her mum misses her. Emma's brother lives locally, and before going away she asks them to help with her mum. Both Emma's brother and his wife work and Debbie would like to see more of them. Emma sees them as supportive but feels her mother seems reticent about asking for their help.

Emma supports her mother's driving by adding fuel to the car and undertaking basic car maintenance (tyre checks and washing). She is happy with Debbie driving as it gives her independence and *"would hate to see her give that up".* She sees old as being about 80 years, when people get frail and need help – she sees Debbie as old. Emma voices her mum's fear of dementia, which is whenever she forgets things a conversation they have *"over and over again".* This fear is most likely due to the recent diagnosis of Debbie's older sister with dementia. She recognises this as something that will continue to worry herself and Debbie as she ages. When Emma's dad was dying one of things that he told his family he was most thankful for was he still had his mind and his family.

5.3.4 Debbie's daughter – Emma Interview two

Emma is just back from overseas travel, visiting her children in northern Europe (travel this year has meant that they have not volunteered again with VISE). During her absence she had discussed who would provide support to her mum. Her son is on placement in the local hospital and helped during this time along with her brother and sister in law. She feels that her mum's health has not changed greatly during this time, although there a few more small health issues. Emma is happy that her mum continues to drive but has some reservations *"I think she is not a great driver but I think she is careful. I think she is safe enough around town"*. As the closest child, she does feel that the main responsibility for her mother falls to her and *"although this is part of her life"* it can be limiting when

it comes to travel greater than a few weeks. When Emma travels, Debbie usually breaks up the time by visiting her sisters who live in other States. The four siblings have never had a formal discussion about the future if further care is required.

She feels that her mum is coping well at the moment but *"can see that this will not always be the case"* and although a friend of her mum moved to assisted accommodation in the [Regional city], she knows that her mother would not like this. Home is where her mother is happy *"she has told me she doesn't want to go into a home".* Emma notes that although they have the space, she does not think living with her mother would work out; *"she would just impinge too much on my personal …. I know that sounds horrible but…."*. Emma still checks in on her mum most days and calls her on the phone daily.

5.3.5 Debbie's grand-daughter – Katy Interview one (Telephone)

Katy (26) grew up in Sugar Town and moved away for work opportunities after finishing school. She now works in healthcare. As a health professional she is aware of the health issues of ageing but within herself is enjoying becoming *"a little bit older and a bit more mature".* She sees Debbie her grandmother as *"as quite a young 85"* and views a person being old at age 75 years. Katy sees creating a family around you as you age a wonderful and positive aspect of ageing *"she is keen for grandchildren"*. She sees older people as having a better sense of community than their younger counterparts.

Katy is very positive about retirement villages and sees them as providing services and support networks for their residents. In contrast, her experience of aged care homes (via her profession) is that they can vary, *"great experiences with some and then others which I think I would never ever want to be in"* and sees them as necessary but can also be a *"worse place to be".* If she had to consider for herself, she would do a lot of research into which home to choose. Katy does not think her grandmother would enjoy the restrictions of an aged care facility and that it is not necessary as Debbie is coping well with independent living. Katy is concerned about Debbie's driving, that she is easily distracted and that *"safety is not always ideal".* Katy sees Debbie about once a month and has a happy, enjoyable relationship with her grandmother. She saw her more frequently in the past due to work placements in Sugar Town.

5.3.6 Debbie's grand-daughter – Katy Interview two (Telephone)

Katy feels her grandmother's health has declined over the last year mainly due to a few health issues but overall is *"doing fairly well".* She is aware that her grandmother is cutting back on social engagements due to her health decline and now plans to have someone accompany her when she is

planning a large trip. Katy sees less of Debbie than before due to work commitments changing. She no longer works in the Sugar Town area, although she tries to meet with Debbie when she comes to [Regional city] for hospital appointments. Katy works in healthcare and sees social disengagement due to age related health decline as having a negative impact and causing loneliness and isolation.

Katy sees the family as the main support for Debbie, with support mainly provided by her daughters. Whilst she thinks this is *"lovely at the same time it could get to be a burden if more than daily visits were required".* Although she is aware that her grandmother wants to age at home, she has not been involved in any discussions about how the family will provide support for this. She comments that, *"I haven't been involved in any of those discussions but they have had them as part of the sisters who are the daughters. I am almost certain, they would have".* Katy feels that her grandma is not at this stage yet.

5.3.7 Debbie's neighbour – Jane Interview one (Interview two declined)

Jane (80) was born in Sugar Town, and worked in [Regional city] for a period before returning to Sugar Town, where she lives with her husband and her son. Jane has health problems and uses a wheelchair when she goes out. Ageing does not worry Jane apart from not being able to get around, although when asked she does not see many positives. She feels that after the children have grown up *"there is not much to do – for an old person you enjoy yourself with friends just carry on".*

Jane visits [Regional city] twice a week and goes to the Casino as it is wheel chair accessible. She also sits on the local daycare committee where her daughter works. In her spare time, she makes sheets and crafts for them. Her husband (80 years) also helps occasionally with Meals-on-Wheels.

Jane has known Debbie for five years, since she moved to the house next door. Debbie comes over for coffee, as Jane cannot get over to Debbie's due to her lack of mobility. Jane and her husband check on Debbie and hold keys to her house. If they do not see her around her husband goes over to check she is OK; if they are not around, they let someone know to check. Jane's husband and son also help in Debbie's garden and swap vegetables with Debbie and others in the neighbourhood.

Jane sees retirement communities and aged care homes as good for people who "*haven't got anywhere else to go"* but very expensive.

5.3.8 Debbie's friend Venus – Interview one

Venus (64) is a retired teacher who lives with her husband and has been living in Sugar Town area for 31 years. They have no children. She met Debbie through the local book club. Venus comments that the ageing journey *"is not for the faint hearted"* and *"it is not something that she is looking*

forward to". She does not feel mentally older but *"is physically reminded"* by her body of the ageing process. Chronologically Venus feels that 80 years is old but sees mental alertness as a component of age *"I wouldn't call them old because fortunately for them they are still mentally alert".*

Venus is *"very aware of mortality",* having close friends who have died, and feels that in a small community you are more aware of loss. Venus had just attended a funeral yesterday – so this may account for her reflections on mortality. Her husband has cancer, she fears the day that *"he will go",* and does not want to be on her own; *"it is not a wonderful thing to be the last man standing".* They have been married for 37 years and have no children. Currently they both volunteer at a local cattle station, which provides opportunities for children to experience rural Australia.

Venus was an acquaintance of Debbie and her husband but their friendship did not start until after Debbie's husband's death, when Venus joined the book club and started visiting her, as she knew she lived alone. They have been friends for about three years and go out socially, they are now *"firm friends".* They have many similar interests and Venus is aware that Debbie is very independent and is keen to do most practical things herself. Venus does not worry about Debbie, as she is aware that Debbie has a lot of support from her family and friends. Venus states that Debbie is *"very, very fortunate, very fortunate"* to see so much of her family.

Venus feels that Sugar Town lacks opportunity for younger residents and its numerous ageing population needs more nursing homes and independent living units.

5.3.9 Debbie's friend Venus– Interview two

Venus has become *"less agile"* over the last year, but is accepting of this change as the natural progression of ageing. Venus has also noticed a deterioration in Debbie's health, although she feels that Debbie is still coping and paying attention to her health *"she's very, how shall I say, very attentive to her own health"*. Venus has been visiting her mother-in-law (95 years), who has had a fall and has seen a change in her. She has been upset with her mother-in-law's increasing frailness and memory loss, which she feels is due to ageing. *"She hasn't been a vibrant lively person for a while but I mean she's, in her own way, she has been and now she's less so".*

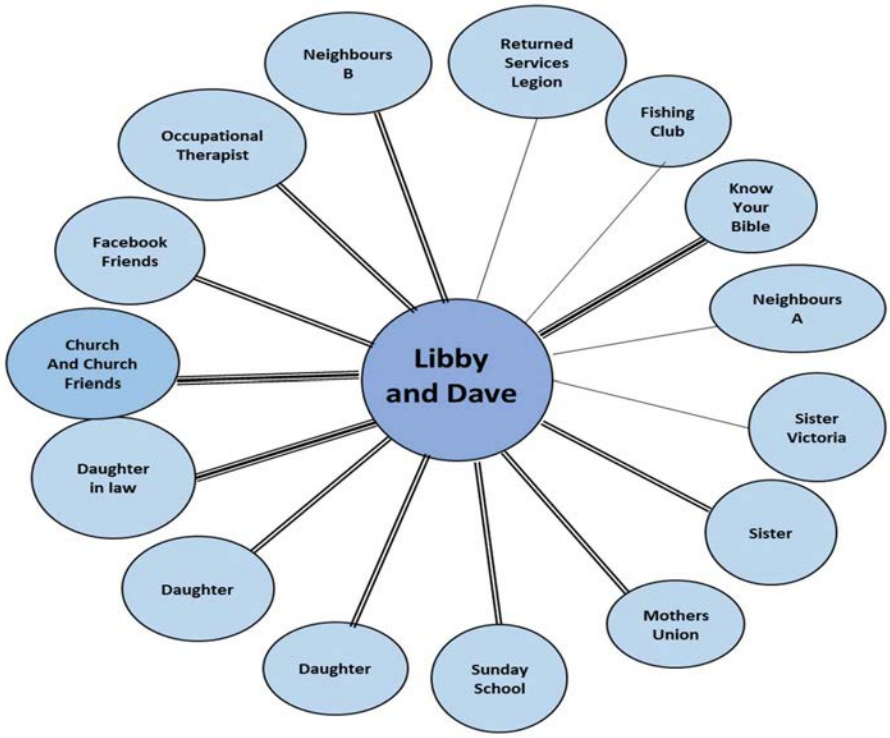
The family hoped that their mother would return to her home after the fall as this was what she wanted, but the ACAT (Aged Care Assessment Team) felt that she was unable to cope and recommended residential care. After discussion her mother-in-law chose to stay close to her original community rather than move closer to her children and a suitable nursing home was found. *"Fortunately, she didn't want to come to Sugar Town and she didn't want to go to interstate where the other brother is".* Venus felt that Sugar Town would not be suitable as there were no places and

her own home is unsuitable. Her mother-in-law has now *"accepted the situation and now likes the place".* Venus found the decision process difficult, as she knew her mother-in-law wanted to stay at home. *"She wanted to go home so we said yes then she shall go home, but then of course, the team said no". "No, she can't go home and so we thought then, oh my goodness, this is dreadful because, you know, how do you approach, you know?"* Venus's mother moved to a nursing home in Sugar Town from [Interstate capital] to be near to her after a series of strokes, which left her *"completely incapacitated".*

When considering her own ageing Venus wishes to remain independent for as long as possible and *"bow out".* However, she is now happy with the care her mother-in law-has received and feels there are good services with *"respectful care".* Venus feels Sugar Town is supportive of ageing due to the large older population, although admits, *"it doesn't have the vitality that you get in a town with a mixture of ages".* Friends are very important to Venus and she spends a lot of time with her peers, *"she thinks friendship supports you when you are ageing"* but the downside is the loss of these friends when they die. Venus thinks the local services will support ageing but for *"anything serious"* travel to the [Regional city] would be required.

5.4 Sugar Town Embedded Case Three

Figure 5.4 Libby's wider community focused network



5.4.1 Libby – Interview one

Libby (77) lives with her husband in a small beach side settlement 15 minutes from Sugar Town. She has complex health problems. They have lived in their current home for 25 years and her husband has relatives in the area, which he used to visit as a child. Libby's husband acts as her carer. Prior to her health problems she was her husband's carer. In reality they support one another.

Libby is a committed Christian whose faith gives her strength. Her faith plays a large role in her life, giving her *"goals to reach and complete every day".* Currently she works four hours a day on completing the Parish role. Libby was a music and religious education teacher for 35 years and met her husband through a Christian youth group.

Libby currently has good and bad days with her health and has ulcers on her knee that cause a lot of pain. In addition she has heart and kidney problems, which result in hospital appointments in the [Regional city]. She is frustrated with the [Regional city] hospital changing appointment times, cancelling procedures at short notice and the different departments not communicating with each other. For rural residents this is inconvenient, as they arrive the day before and then are informed the next day that the procedure is cancelled. Libby has been waiting on a knee replacement for 20 years and currently consults with a dietician, physiotherapist and occupational therapist which she finds quite time consuming. When they travel to [Regional city] Libby's husband drives and they stay with Libby's son or the Returned Services League of Australia accommodation. Their children insist that they stay over and no longer make the trip in one day. If Libby's husband were unable to drive, they would need to rely on friends, as she is unable to access public transport due to her restricted mobility.

Libby has aids around the house to help her with her mobility, and they are currently waiting for a shower bench (she has not been able to shower for 18 months). She also has a sleep apnoea machine and needs wedges in the bed to sleep.

Libby and her husband have considered moving into an aged care home but her husband feels it may be too restrictive and wants to stay. If Libby had the choice she would go.

Libby has three living children two daughters and two sons (one son died when he was 30). Both daughters live a long distance away, but her daughter-in law-lives in about three hours' drive away and looks after their "*affairs*". They are both close to the daughter-in-law, who often telephones to see how they are. Libby is the president of the local church women's group but is no longer able to cope and is giving this up and finding a volunteer to take her place. Over the years, she has acted as the treasurer for many clubs, including the local fishing club to which her husband belongs. Her main social connection is with the church and her church friends, which keeps her busy. She is also

involved with a “know your bible” prayer circle as well as playing the organ at surrounding churches. Libby also meets friends via Facebook and has visited and been visited by them and is quite familiar with new technology.

5.4.2 Libby – Interview two

Libby is still in her own home and now has 20 grandchildren, but has lost her younger sister. It is clear that her health has deteriorated since the first interview. Libby can no longer sleep in her bed and now uses a recliner to sleep, which they purchased in the local town. Her husband sleeps alone in the bedroom. On a recent trip to her daughter in law, Libby slept on their recliner couch that moved electronically (unlike their recliner that she cannot operate due to a frozen shoulder). They would like one of these to replace the bed to allow them to sleep together.

She is in pain if she lies down for any amount of time and the wedges provided by the occupational therapist no longer help. They now have a cleaner come in once a week for one and a half hours. This subsidized cleaning service is provided by a local aged age care service. The shower bench has been fitted but is of no use to them and Libby showers standing up. She does not know why it was ordered but thinks *“oh well they know best”.* Her ulcer has now healed and she has lost 20 kilos in weight, which makes her eligible for the knee replacement, for which she has been waiting twenty years. However, her mobility is now so compromised she thinks *“this is a waste of money”* and they have left *“it too late”* she has not *“climbed a flight of stairs in five years”.* They will only do one knee at a time and Libby feels she will she will be totally immobile. She has asked people who had a similar operation and they had a lot more mobility prior to the procedure.

They both have a fear of forgetting things and Libby writes everything on the board to ensure they do not forget appointments. Libby sees being old as when you *“get dementia”* and *“had a scare”* when she forgot an acquaintances name. Dave recently had a test at the doctors, but Libby did not feel that it was very rigorous and helpful, and she feels he is getting a bit forgetful. It bothers Libby *“that they can see it in each other”.* Dave also has a hearing aid, but he takes it out as it after a couple of hours because *“it makes his ears itchy”.*

Libby is still doing the prayer circle and playing the keyboard in church. In addition she plays the keyboard at the local church for the dementia carers’ club which her friends have set up. They have been on a local trip to [State capital. They travelled by train and her family helped with all the arrangements. They have organized their own funeral arrangements with their daughter-in-law and have two plots purchased in the [Regional city] where they used to live. Faith is very important in Libby’s life and she feels *“that death has no problems for her”* due to the *“promise of eternal rest and eternal peace”*. She does not *“push her religion on people”* but feels prayer can help a person go

peacefully. Libby feels close friendship is important in ageing and that close friends help rather than many acquaintances due to the depth of discussion that this allows and being able to ask for help.

A new outreach medical clinic has opened in a near settlement (two sessions each week) coming from Sugar Town and they now attend this clinic to avoid the drive to town. Libby had a severe infection in her leg over the summer that has now healed; this took three months. She found the summer heat this year hard to cope with *"that's the worst part, the heat".* She is also seeing specialists in both [Regional cities], but one has now implemented a telemedicine service, which she is going to try. Setting up the appointment has taken time due to room availability and Libby's doctor working part-time (it has already been re-booked once).

Libby *"would not mind going into a home situation"* and has looked at some in the neighboring [Regional cities] but would not like to go without her husband. If he does not go, they could not afford it. She feels that the government are keen for you to stay in your own home but she can no longer enjoy her home. They are looking at gardening service, as this is now too much for Dave. In the past they had used gardeners from the local aged care provider but were unhappy with the work. They did try selling once, which was unsuccessful. They felt this was due to their neighbour's overgrown plot. They have discussed trying Meals-On-Wheels but Dave *"would like to see a menu first"*.

Libby would "*never*" consider living with her children as *"they have all got their own lives"* and she would not want the children to feel guilty about leaving them to go to work. Libby feels that there are cultural differences in the provision of family care with aged care homes being full of *"what I call white people you know like us"*. Libby provided care for Dave's mother when she was at home by cooking and cleaning, whatever needed doing, also later visiting her in the aged care home. Dave's mother entered the age care home after a fall. She asked Libby if she *"would she ever come out,"* Libby replied, *"that I didn't think so".* Libby *"thinks that the government want you to stay in your home for as long as possible and there is nowhere to go, there is a waiting list, virtually someone has got to die".*

5.4.3 5.4.3 Libby's husband Dave– Interview one

Dave retired at 62, after having a blood clot and being prescribed warfarin (a blood thinner) for this condition. Centrelink told him at this point *"nobody will employ you".* He states that the worst thing about ageing is *"having Libby the way she is"* and being on call all the time, with never enough time to do everything. He has come from a traditional family where there were very clear gender roles around household tasks. Libby also has a traditional view of marriage in which her mother advised *"remember he's bringing in the money so don't ask him to do anything"* and still tries to do as much

as possible. This causes some conflict with the blurring and changing of roles with the ageing journey. During the interview, there is a lively discussion between them about who does what. There is agreement on the driving and that Dave could dress Libby's wounds in the case of an emergency, *"he knows exactly what to do and if he doesn't well, I tell him".*

Dave liked to fish but as a Libby's carer he cannot leave her alone. Libby sometimes thinks he uses this as an excuse not to go. Libby occasionally makes him go and just sits in her chair until he returns as she feels he sometimes needs the company of men. Dave admits the reason he does not go is that *"they're all young ones there now".*

Dave thinks that older Australians are not valued and that this has always been the case particularly in English based societies. Dave attended a recent talk on ageing and after this feels that ageing in a rural environment is advantageous, with a reduced waiting time for access to services, but acknowledges that younger people have no opportunity for work and leaving the *"town depleted".*

Dave has planned to age in place and has already planned funeral arrangements for them both; they have plots reserved in a [Regional city] cemetery.

5.4.4 5.4.4 Libby's husband Dave– Interview two

Dave (80) feels, that *"he is fit for his age"* and he would like to continue to *"climb on roofs"* but Libby *"has put her foot down".* He had a recent fall when out fishing on the rocks and his leg is bandaged. He put the fall down to new thongs (footwear) and laughs when he said he never *"dropped his rod".* He takes his role as his wife's carer very seriously and is upset when he sees others *"rort the system"* and not take their responsibilities seriously.

He describes his carer role as *"no problem"* and sees it as just *"being there"* for Libby and driving. If Dave were unwell, the driving would become a problem as Libby is unable to use public transport and in the past when he has been ill, this has been a problem, with medical appointments in both the local town and [Regional city]. Dave also uses the outreach clinic and is happy when both he and Libby are "*assigned*" their *"normal doctor"* as they have had issues in the past – Libby now refuses to answer any questions until her records are on the screen. Libby likes both Dave and herself to have medical checkups *"we have a lot of medical appointments and checkups I go there and say I want my checkup please"* and they never go into the doctors without each other.

Dave is due for a small operation and both he and Libby will travel to [Regional city]. Their son will come up from the [Regional city] to pick them up and take them home. Libby will stay in the RSL guesthouse across the road and visit Dave every day. Occasionally they ask a friend to drive, who *"loves driving"* but this time he is unwell.

Dave would not consider entry into residential care. He thinks residential care *"would be boring"* and restrict his hobbies. He does not go out much to social events on his own and he attributes this to being Libby's carer (although Libby states this was always the case and *"don't make me your excuse"*). On further questioning Dave expands that because he does not drink he feels excluded from male social events *"they think there is something wrong with you".* Dave *"thinks he is getting more tolerant the older he gets"* and laughs at more things but does get upset *"when he sees things that are wrong*". Dave recently got a ticket for speeding on the way home from a hospital appointment. They were mistaken for another car, the officer was rude and Dave is unhappy with the injustice of this event. Dave (like Libby) keeps his mind active with computer games and competitions in his fishing magazines (he has won a few times).

5.4.5 Libby's friend Lisa – Interview one

Libby's friend Lisa (64) lives in a different beach settlement outside Sugar Town with her retired husband. Lisa worked in her teens but gave up work when she married. Although retired, Lisa's husband keeps returning to work and she wants him to stop working entirely. Lisa is originally from Indonesia and has been in Australia since the 1970s, having migrated with her Australian husband. They have three daughters. Lisa's husband has family in Australia, but her extended family in still in Indonesia and she returns often to visit. She is younger than her husband, does not feel old, and has no concerns about ageing. She attributes any aches and pains as *"part of something I must have done"* rather than that she is getting old. When asked to define when someone might be considered old, she thinks about 80, but some younger people can seem older *"because of the way they talk or behave".* Lisa is pleased that people comment that her husband does not look his age *"he looks like he is in his early 60s"*.

Currently Lisa and her husband are considering selling their property and moving to [Regional city] where their three daughters and their families are living. Their property is large and it is getting too much for her husband to handle. She also feels that he is making the move for her, so that if anything should happen, she will be close to family and their support. They have been looking at retirement villages and Lisa is surprised that her husband would consider this type of accommodation. She would feel happier in the community, but as long as she can be near her children, she *"doesn't care where she lives"*. Lisa would like to help more with her grandchildren as all her daughters work.

Lisa and her husband also travel to [Regional city] for healthcare, and visit the occupational therapist there once a month. Lisa describes when her husband had a fall and went to the local hospital for treatment. They found the care substandard, which resulted in a complaint, and they feel the care

provided at the [Regional city] hospital would have been better. After this experience, they lost confidence in the local hospital and feel it would be better to be near the city hospital and the support of their family.

Lisa has known Libby and Libby's husband for about 25 years and they met through the Anglican Church (Lisa previously belonged to the Catholic Church). They meet socially at church and church functions and occasionally have dinner. Lisa comments that she has never been to Libby's home and thinks that she should *"it is just that you don't think of it you know - you are too busy in your own life"*. On further discussion about Libby, Lisa feels that she should offer more support with transport and has never thought to ask. *"I never give it a thought because every time she'd say oh, this person took me to [Regional city] and I'm thinking oh, you know, I should have taken you".* Lisa sees friendship as important in ageing, especially after the loss of a spouse. She visits the local aged care centre twice a month to take communion and run a service at the chapel and feels this can be a *"lonely life when they are just sitting in a room".* When socialising Lisa tends to socialise with older people than herself *"I'm sort of more comfortable with the older than the younger, you know, to sit amongst the older people than the younger people, sort of my age group, yeah. I don't know I've always been like that".*

Lisa's husband's parents died in an aged care home in Australia. She felt that they received good care, but the separation of the life-long couple, forcing them to live apart at this stage was inhumane. After the death of Lisa's father her mother lived alone and has now developed dementia. Lisa thinks that the year of living alone could have brought this on. Her mother has been living with elder sister (70 years) for about four years (having relocated after the house sale) and is under medication due to aggressive episodes. Dementia care facilities in Indonesia are limited and *"the family don't have the heart to put her in anything like that",* so look after her. Lisa admits that this is a burden on her sister, who also has a sick husband, and visits four times a year *"just to give her a break".* She "*is thankful her sister is there to take care of her"* and fears that her mother may get worse and require 24-hour care.

5.4.6 Libby's friend Lisa– Interview two

Lisa and Libby are still friends although she sees less of Libby due to her health deterioration, and they tend to catch up at organized church events. Lisa and her husband are trying to sell their home and getting it ready is taking up much of their time. The sale is due to ageing and the property getting a bit too much to handle. Although she loves her home, she feels that *"her heart's not here anymore like it is just too much".* Lisa and her husband had previously been interested in a retirement village but upon investigating the funding model decided against it. *"This is our hard-*

earned money I am not going to give it away". They have now decided to build their own home and have everything in place for when the house sells (it has been on the market a year). Whilst the house is being built they plan to live with their daughters. Her daughters and their families are currently working on the house to get it ready for sale.

If Lisa needed additional support for ageing, she would discuss firstly with her family and then link in with formal services. Lisa and her friend have started a monthly coffee morning (with sing-along and guest speakers) for dementia sufferers and their carers which was well received in the local community. The coffee mornings were so well received that they have had donations, which they were unprepared for and have found a bit overwhelming. They do not have the resources to expand and the current church congregation is ageing itself, with the majority over 70. The main drivers for this effort has been that both their mothers suffered from dementia, and she plans continuing with this activity after the move.

Lisa still travels to Indonesia *"to help out"* her sister with her mother's care, she laughs and says, *"that you can't expect"* her brothers to help. She recognizes the burden that this places on her sister *"you can tell, she's tired".* Her mother moved in with her sister after being unable to cope on her own. The sale of the house helps her sister with costs as well as some occasional *"bits of cash"* from her brothers. Lisa worries that if something happens to her sister there is no plan in place, but they *"will think what we gonna do".*

Lisa's family are very close and she looks forward to seeing them, although sometimes it can be tiring. She has ten grandchildren who come to stay with her on the holidays when their parents work. Lisa feels she will miss the quietness the most when she moves to [Regional city], and will still visit Sugar Town and her friends. She plans for friends to stay with her when they visit [Regional city]. She intends to join the Church in [Regional city]. Her husband has now 'finally retired" at age 74.

5.4.7 Libby's friend Cate– Interview one

Cate (70) and her husband arrived in Australia in 1971 and have been in Sugar Town for 34 years. They moved to Sugar Town for her husband's work and ended up staying. She lives with her husband and they are both enjoying retirement, *"a fulltime holiday"* and have no *"unsurmountable health problems"*. They were *"blessed to have a good superannuation"* which gives them a lot of freedom. They travel to [Regional city] for specialist appointments and currently drive. They would take the community bus if they had to; *"the last resort".*

Cate sees 90 as being old and the point at which your life will change and hopes until then life will go on *"pretty much as usual"*. When asked about society and ageing Cate feels that as long *"as she keeps physical fit and healthy and mentally alright, she will still get the respect of her peers and younger ones"*. She feels that you need to be involved with society and community to be connected, and feels connected to Sugar Town. Since she retired and had more time available, Cate's main social activity is the church. She also goes to Tai Chi, book club and both she and her husband volunteer at the local visitor information centre. Cate comments that the book club meets every two months; *"to think it is going to take you two months to read a book is quite ridiculous".*

Cate's son and family live in [Regional city] and she would like to see more of them, *"we miss our family much more than they miss us"*. She is unhappy with the amount of contact she has and feels it might be different if she had a daughter. They have considered moving there but due to difficulties in selling (slow local market) in Sugar Town and the higher price of houses in [Regional city], this is not an option. She has two friends in a similar situation.

Cate has known Libby since she moved to Sugar Town. They met through the church at which Libby plays the organ. They are together at most church functions. They often meet up for dinner at the weekend and occasionally play cards. Cate is in contact with Libby via phone or email about every other day and keeps in close touch. Cate would worry if she was unable to provide support to Libby *"I would feel like I would want to help look after them. I would like to be interested in them, both of them and we both help them out and would be very disappointed if we couldn't do that*". Cate is amazed about how positive Libby remains in spite of her health problems.

Cate does not have a *"big circle friends"* but has friends she has known since moving to Sugar Town, friends from work and new friends made since she retired. She thinks that, as you get older with *"increased time on your hands"* friends become more important. Cate is not keen on aged care home for herself and perceives it as something to *"resist as much as you can until your state of health makes you dependent"*. She feels that *"most people really dread going into a home, really don't like it and just seem to kind of endure it" "soul destroying place"*. Cate talks about the *"old system"* where elders were looked after by their oldest child or the family as being a wonderful system. Cate would also not consider a retirement village as she perceives them as being *"full of old people"* and prefers to age in a diverse community.

To aid ageing in place Cate has bathroom rails and employs a cleaner and gardener. She feels keeping a clean clutter free house is important for ageing, as people may not want to socialise if unable to keep their house clean. She has removed small rugs from around the house to decrease the risk of a fall.

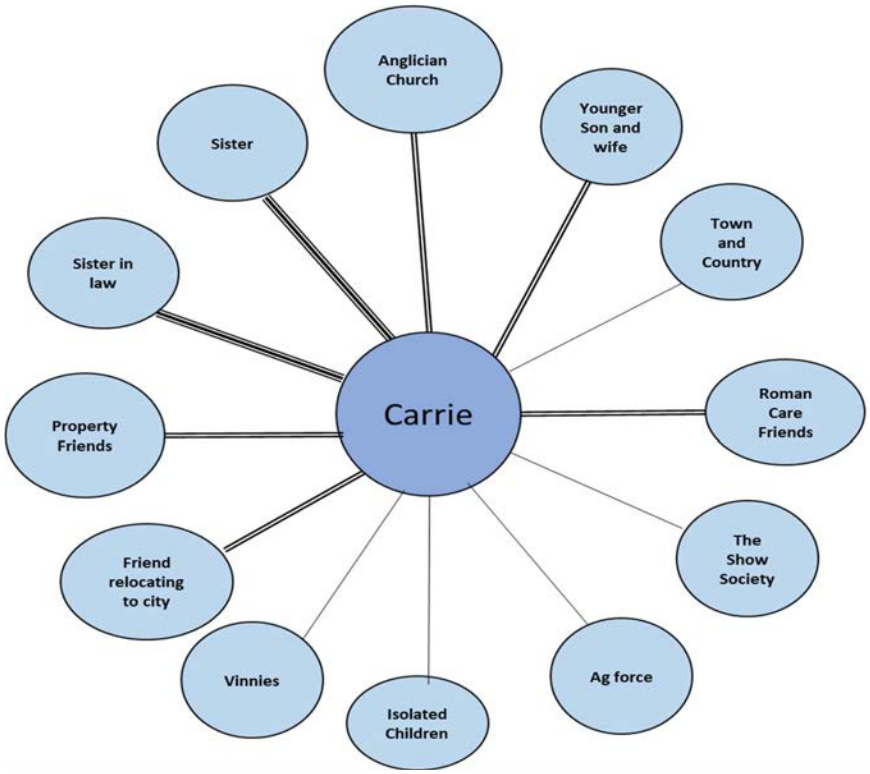
5.4.8 Libby's friend Cate– Interview two

Due to a decline in Libby's health Cate has not seen as much of Libby over the past year and they catch up mostly at church and through email and text. Cate feels that ageing can be isolating, declining health can keep you at home (as in Libby's case) and with age it is more difficult to make new social contacts.

In the first interview, they had discussed moving but are now more content to stay due to the close community and proximity to the small local hospital. For more specialized care there is a community bus to town. They had their home assessed by ACAT (under the advice of their daughter-in-law who works in healthcare), and have installed railings, which are "*fabulous*". Cate and her friend, whose mother also suffered from Alzheimer's, have started a monthly local support café. Her mother went into a home, and she felt that her mum received great care there over the 15 years. Her sister visited her mum each week. As Cate's mum lived in another country, she did not have much input into her care, *"we go back every 4 years, and you know, you just accept it and carry on".* Cate feels that, unlike in the past, children do not expect to look after their parents and that parents do not want to be a burden. She feels home services will allow them to stay home before "*eventually going to a seniors home*". Only a "*few lucky ones*" will end up living with their family, she has no expectations of family care. Cate does not see a lot of her son and grandchildren as they are "*busy people*" and "*their family time is precious".*

5.5 Cattle Town Embedded Case Four

Figure 5.5 Carrie's wider community focussed network



5.5.1 Carrie – Interview one

Carrie (78) lives alone in a medium sized Queenslander style house that she and her husband moved to, after relocating from their cattle property. The family property was transferred to her son when her husband became unwell and the property became too much to handle. Her house is located near the town centre and was re-modeled by her and her husband, adding rails and handles to aid mobility. Carrie is mobile and spends a lot of time volunteering at the local church and supporting her peers, which forms the main part of her social life.

Carrie's faith supports her throughout her life and helps her accept the limitations caused by the ageing process. She has made many friends through her interaction with the local churches, both Anglican and Catholic. Carrie also keeps up with many friends by the telephone "*which is her lifeline*". She still drives but admits she probably should not, limiting her trips locally and no longer driving to the nearest city (five-hour drive). Instead she relies on friends and air transport when she needs to travel. She has no major health concerns and is happy with the aged care community

services and local medical services (although there is a high turnover and constant continuation of medical locums).

Carrie in the past played the carer role, looking after her two younger siblings after the death of her parents, *"doing her duty*" and putting others first. She has always been active in the local community since she was a young girl (as was her father), belonging to many charitable organisations. She became acutely aware of ageing in her 50's and faith supported her in accepting her physical limitations, especially those that emerged working on the property. She is now 78, does not want to conform to the *"little old lady"* role but wishes to remain independent. Whilst not yet needing support from her family with the ageing process, she has been upset and disappointed with the lack of offers of support from her son and his wife regarding possible relocation nearer to them, and has some conflict with daughter-in-law regarding these expectations. Carrie is upset that they are not taking a supportive role. Prior to the sudden death of her mother, the family had looked after their grandmother – *"it was the accepted thing"* and that *"previous generations had a much better understanding of older people than today's generation"*. She states she will now be making her own plans and is currently weighing up her options. She is aware of older people who have had their choices limited and are facing harder challenges.

5.5.2 Carrie - Interview two

Carrie has become a grandmother to two adopted children and is enjoying this role. She has not seen much of them, but is planning to visit soon. Health-wise over the last year she has had her cataracts done and has experienced no major health issues. She is still driving *"but being very careful"*. She continues to be active in the local church, helping in the local community and visiting friends in hospital. Carrie still has no firm decisions on where to age *"and will just play it by ear"*. She feels that her son and daughter in law will be moving soon and may consider moving south with them. Carrie discusses how a few shops have shut over the last year and the main street is looking empty, which has led other shops to diversify to keep going. She comments on the burden of relying upon ageing volunteers to organise community events, which although attended by younger families, they *"don't take part in organising things"*.

5.5.3 Carrie's friend Anne– Interview one

Anne (71) has just recently relocated to a retirement village in the nearest city (approximately 5 hours' drive away) with her husband. Their retirement home is a detached modern house and has four bedrooms. At the time of interview, they were still in the process of unpacking and adjusting to their new home. Getting older was the main reason for their move, with her husband's declining

health causing him to struggle to manage their rural property *"the sooner he gets right away and stops trying to be heroic the better for him"*. Their move was earlier than planned due to this house becoming available and they are in the process of *"handing over the rural property"* to their son and *"if he is taking over it's time to move away".* The location was chosen due to family (daughter and grandchildren) living in the area, and previous business ties to the city. Ten families that Anne knows have relocated from Cattle Town to this retirement village. Many of Anne's friends in Cattle Town who ran properties have retired and moved away and she feels that it is all "*younger people*" and it *"was time to go*".

Anne feels that her ageing experience has been *"not as good as she thought it was going to be"* but that as long as she is healthy and active it will not be a problem. She finds physical limitations such as tiring quickly frustrating. Anne still drives and does not need any support but would ask family if required for small tasks. However, for large tasks she would prefer professional help. She hopes needing support will be a gradual process. Anne's father had Alzheimer's and *"ended up in a nursing home"*. After his death her mother moved to [Regional city] and Anne *"did what she could when she came to town"* to help her mother.

Anne has not yet joined any clubs but plans to do so once they are more settled. She still has a lot of contact with people from Cattle Town, mainly by phone. She socializes mainly with her own age group although it is *"getting less and less of them or fewer and fewer of them"* and does not really have any friends younger than 40 years. Her grandchildren visit occasionally. She would like to see more of them but they have school and a very active social life; *"I have to make an appointment to see them".*

5.5.4 Carrie's friend Anne – Interview two

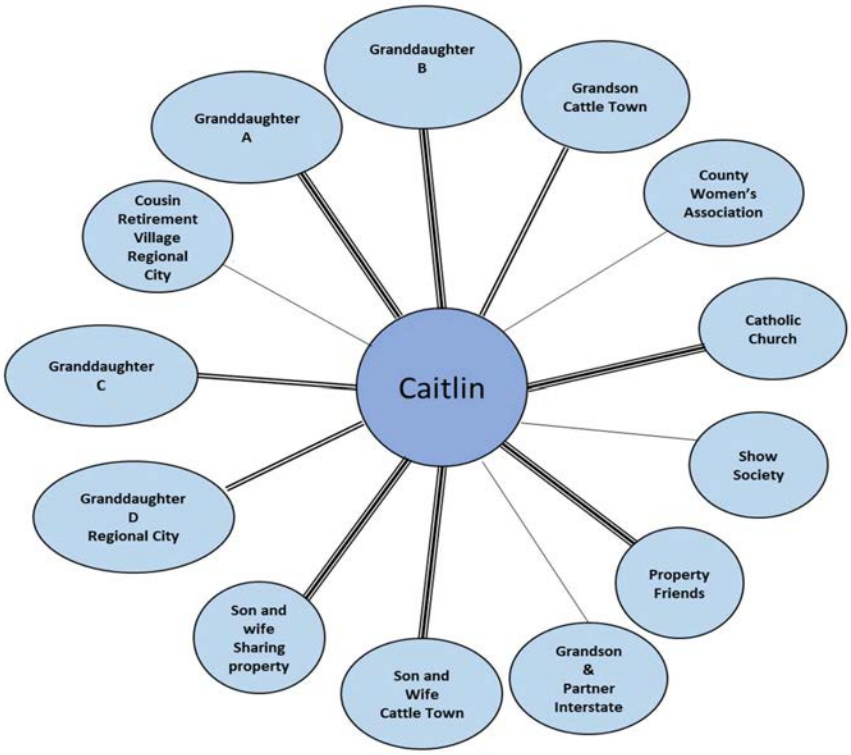
Anne and her husband have now settled in the retirement village and are enjoying the freedom that it provides. When they lived on their cattle station, they were unable to leave for long periods due to work commitments, but with the house in the retirement village, they can *"go away any time they like"*. Although they are living close to other houses, they do not find this a problem and *"hardly see the neighbours*" due to the house design. In the first interview Anne felt the move to the village was sooner than originally planned, but she now feels it was the right time and *"I don't think we could have left it any longer",* due to her husband's age and health. The timing of passing the property to her son was always an issue because of the *"drought, low prices and horrible economics".*

She has not been back to Cattle Town in the last year and keeps in touch by phone once a month. She plans to visit in the coming months when "*passing through*". Her son now runs the cattle station, and they are in contact with him most days by phone. Anne does not miss Cattle Town as

she lived three hours travel from town "*and didn't have a lot to do with it anyway*". Both Anne's mother and mother-in-law relocated to retirement villages in this area and it was always the couple's long-term plan to do the same. They both made this decision without involving their family. Anne is now seeing her daughter and grandchildren more "*we hardly saw them before at all, but now we see them pretty much every week*" and is enjoying being more involved in their life and visiting their sporting events.

5.6 Cattle Town Embedded Case Five

Figure 5.6 Caitlin's locally integrated network



5.6.1 Caitlin – Interview one

Caitlin (94) has lived in Cattle Town for 90 years, first coming up with her family in 1926. She trained as a nurse and married after graduation, aged 26. She has two sons who both live near her in Cattle Town. Caitlin's marriage was a happy one, and she misses her husband *"at every turn*". Caitlin currently lives in the main house on her family's property; her son and daughter-in -law and their family living in the neighboring cottage. Caitlin used to live in the cottage when she was younger, but on the death of her mother-in-law was "*invited*" into the main house and cared for her father-in-law. She cared for him for many years; *"he was a dear old man and we got on well".* The main house is

quite old and "*has been modified*" through the generations, both for her father-in-law and recently by Caitlin's children, to help with her mobility.

Although Caitlin looked after her father-in-law; she is very independent and would not want someone to look after her. *"I don't want to live if I can't look after myself, I don't want to live".* Caitlin believes that the family carry the responsibility of looking after their older members in a reciprocal arrangement *"you look after them when they are young so they sort of look after you when you are old".* Caitlin's family provide her with "*great support*" but "*she wouldn't live with them"*. If she felt she could not manage would consider the local Aged Care Centre. When questioned further Caitlin states *"I just don't think it is right"* the different generations all move so quickly, "*even with little things they move quickly*". However, given the choice Caitlin would like to age in place, "*I'd just like to go out in my sleep one night*", and not have to consider ever moving into a home.

Caitlin has a good relationship with her family, "*they're very thoughtful for me, it's good. I've got a nice family*". She goes on many outings with them to local events. Previously Caitlin has looked after her grandchildren, to allow younger family members to work. She sometimes now minds her great-grandchildren but only at home as she does not feel capable of taking them into town.

Currently she feels "*blessed to still have her good health*" and her Catholic faith "*supports and comforts*" her in the ageing process. She recognizes that she does not know how long her good health will last. Caitlin has a pacemaker that is due for replacement next year. She comments that the next one will last 10 years but she does not want to consider later than this. Caitlin also has problems with her knees, but due to a lack of local physiotherapy services, knee replacement is not possible, and she manages the pain with plasma injections in regional city. Caitlin travels to medical specialists in [Regional city] with her family (sons and daughters in law), or if they are not able by bus or plane. She also has a first cousin in [Regional city], who lives in a local retirement village that she stays with when in town. Caitlin visits the local dentist and doctor as required. These medical services are provided by overseas-born professionals, but this is not a problem for her. Caitlin thinks that they should have two doctors as the local doctor is "*run off their feet*".

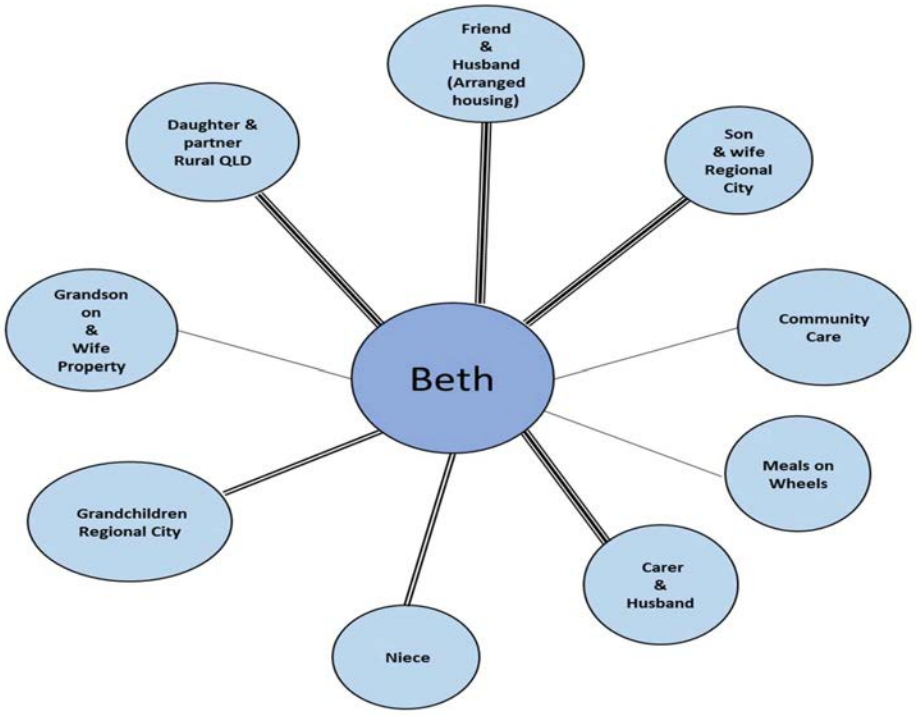
Caitlin feels connected to her local community, *"there's a great camaraderie in Cattle Town, there's a very nice feel about Cattle Town, friendly, friendliness and I don't think you would get that in the cities*". Although Caitlin is quite frail, she still drives and goes into town each Friday to catch up with friends attend church, shop and have lunch. She is also an active member of the Country Women's Association (CWA) and the Show Society.

5.6.2 Caitlin–Interview two

One year later Caitlin is still living on the family property. She still has her driving license and "*all her marbles*". Caitlin now uses her walking stick when she goes for trips into town. It has been a trying year for all the family due to the drought leading to them de stocking the cattle. She has a "*lady*" from the local home care services come in once a week to clean, and goes on their organised local outing outings for older community members, which she enjoys. Caitlin is still helping at the Church and treasurer for the CWA.

5.7 Cattle Town Embedded Case Six

Figure 5.7 Beth's wider community focussed network



5.7.1 Beth – Interview one

Beth, an ex-teacher (94), lives on her own in a small rented property in town. She has been a resident in Cattle Town for 77 years, relocating as young teacher and then marrying a local grazier. Beth gave up her teaching career on upon getting married as in the 1940s, as it was compulsory for women to resign from the service upon marriage. Community connections arranged her rental and the owners often pop by socially and help with maintenance tasks (gardening, rubbish collection and so on). Beth has compromised mobility and requires help with most household tasks. She has been in this home for about a month, after moving off her property when her family decided that she could no longer live on her own after a "*low health period*". Beth is used to living on her own and

has done so for the last 40 years. Beth has four children (two of whom have passed away). Her remaining son and daughter live about a five-hour drive away. Breaking her hip four years ago (89) in an accident, led to decreased activity, and was a limiting point in her ageing journey. At this stage she began to feel old. Beth travels to [Regional city] to get treatment for her hip, for which she usually flies and stays with her son. Locally, she accesses the doctors, dentist and aged community care.

Beth is confident that her family will look after her, but believes that people who don't have this support should receive government help. She believes that aged care sometimes falls largely to volunteers and church organisations. She accesses "*the Meals on Wheels caper*" about four times a week (arranged by her daughter-in-law) and community care, who visit each morning and evening to help with getting up and going to bed and "*always makes sure that she has food even cooking if required*". Recently there has been a lack of continuity in care, with a different carer each time, and sometimes she is unaware of who is coming on each visit. She would prefer to know who is coming each week. Sometimes the visits can be quite early in the morning to fit with the local staff schedules; "*any sooner and they would have to wake me up*".

Although Beth states that family are the main support for ageing, most of her own support is currently coming from friends and government agencies. Friends in the community run errands (such as shopping), and take her on social outings (Friday lunch and hairdressers). She has a number of people who pop in and out each day. A younger friend (who met Beth through her daughter) helps a lot; "*she has sort of taken me on*". She is the eldest (and only remaining) of three siblings. Due to issues of distance, her siblings looked after her mother in her final years. Both her son and daughter would like her to move to be closer to them. Currently she is happy to stay put as she has friends within the community, but if her health deteriorated she would consider a nursing home nearer to them. Beth hates the thought of being a burden but "*feels that the choice is not going to be hers*". Her grandchildren have also offered support but she does not think this would work. Although she "*always feels welcome*", the pace of life there is much too busy.

Friends in the community keep her ageing in place, and she would not stay without them. They pop in socially and do many things for her. Without them she would have to make decisions of relocation sooner.

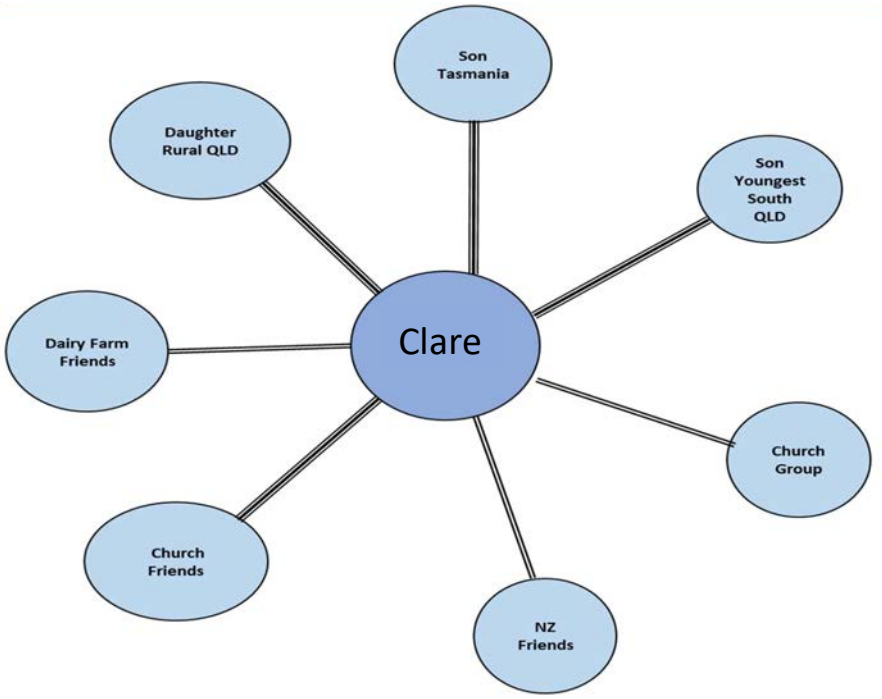
5.7.2 Beth –Interview two

Beth has now been in her home for two years, and is happy to stay. Her children would still like her to stay with them, but her son is not well and she feels that her daughter-in-law "*has enough on her hands without having me too*". Her daughter is also dealing with her own partner's ill health. Beth

now has her hearing aid, and a falls alert device. She is still receiving Meals on Wheels, although volunteers are hard to find in the local community, leading to this service being provided by paid carers. The community carer is still coming in. Beth looks very frail, although she says she is coping "*fairly well*". Beth says the local doctor is very caring (although the doctor is currently on stress leave) and visits "*us oldies of a Sunday morning*" as "*it saves people in our age group cluttering up the waiting room*". A friend takes her to town every Friday to get her shopping and her hair done, which is her weekly outing.

5.8 Mill Town Embedded Case Seven

Figure 5.8 Clare's wider community focussed network



5.8.1 Clare - Interview one

Clare (74) and her husband have lived on a dairy farm near Mill Town for 35 years. She is a retired teacher, and has three children (two boys and one girl). Clare does not worry about ageing too much except when she "*forgets things sometimes*", but overall enjoys having friends and grandchildren. Her health "*gets a little harder*" each year, and she is becoming aware that life is limited. She no longer has that "*forever feeling oh I'll do that in 10 years' time*". She used to think 70 was old but now thinks 80.

Clare and her husband have put their property on the market, and hope to sell within two years to buy something in walking distance of the local shops and Church. Their current property is too

remote, and would be unsuitable "*if something happens to one of us or we both lose our licenses*" (husband does not want her to be left alone on the farm). Her husband is still working the farm, and wants to sell up before it becomes unmanageable. Clare's children would help, but they do not live near Mill Town. They plan to build or buy a smaller home and to travel - but having room for the family to visit is still important.

Clare would only consider retirement care "*if they got really incapable*" and there is provision for such care in a local town. If anything happened to Clare, she thinks her husband would go and live with his son down south on a cane property (that they part own with him), as they have separate accommodation there. Clare, however, would prefer to stay in Mill Town, as she sees this as her home. Clare is aware of the local provision of home care packages, and attends the local Mill Town doctor (she comments that he is a lone practitioner and is also getting old). To access other health services, she travels to a bigger local town "*as much as you could expect*".

Clare discusses the influx of retirees into Mill Town after the subdivision of a large parcel of land into "*lifestyle blocks*" and the changing nature of the town. She described the closing down of the local mill, which broke up families. This caused younger members to leave the area and affected the level of family support for those remaining.

Clare is still driving but only locally and helps take people to the local gatherings. She is active in the Church group; "*there's plenty going on in Mill Town you don't need to be short of things to do*". Clare feels integrated into the local community and has felt supported from the moment she arrived. She has a lot of close friends and feels that "*family is fine but you need friendships on your own age level too – it is not fair to your family to rely on them for everything*". This does not imply that she finds it hard to talk to family, rather that, with her peers it is a different conversation. In the context of support for Clare's ageing: if required, she would discuss with her family "*but doesn't want them to be responsible for her*". If needed, she would enter a local aged care facility. She has already discussed this with her family.

Clare's parents looked after her grandmother on their farm until her death. Clare's mother's health was good until she "*had a heart turn*", and as Clare had moved to Australia from New Zealand at this point, her dad moved to a flat on her sister unit where he could be supported. "*He was very good but you know, it's always you know, get someone else to look after them, not just drop everything and go*".

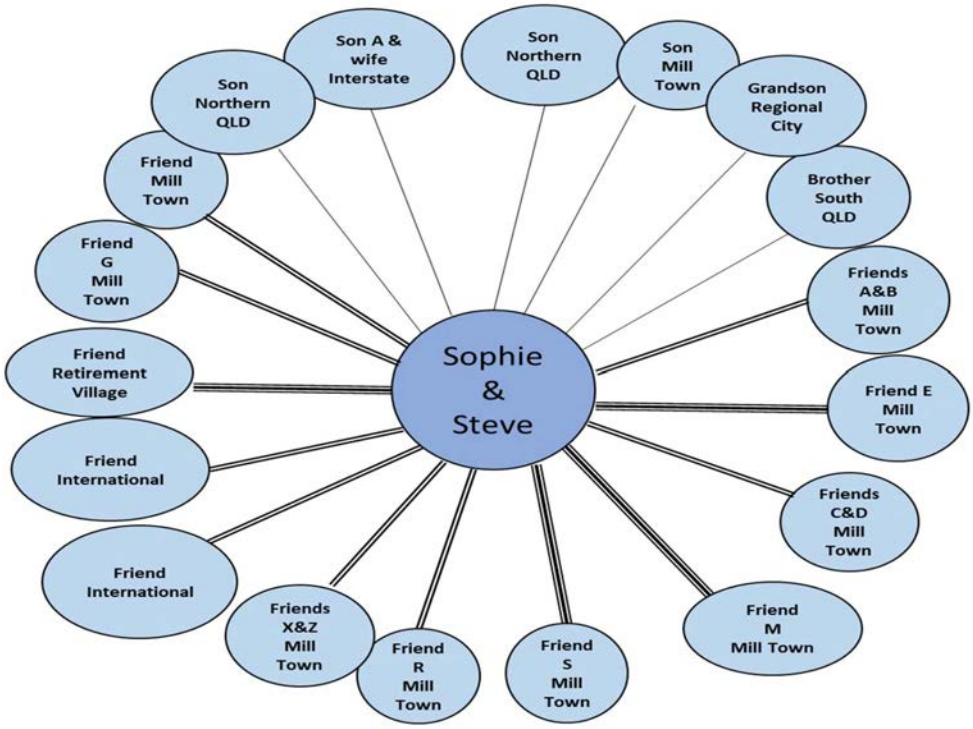
5.8.2 Clare -Interview two

Clare and her husband have now moved into town, after 35 years on the farm. They are enjoying the move, although Clare does miss her garden. Her children supported the move and were "*glad*" that they made the move and "*didn't leave it too late*". They were surprised that the farm sold so quickly, but relieved as the farm no longer provided a liveable income, and they were subsidizing it with their savings. Although the house is in town, it is in a secluded spot, which suits them. It has extra bedrooms for when their family come to stay, which is important for Clare. Her husband still plans on helping out on their son's farm during harvest. Clare feels that this helps with the move from the farm, as her husband likes to keep busy; "*he is struggling naturally*". The move into town makes socialising easier for them, as they are no longer completely dependent on the car.

Clare is upset that one of her friends is leaving town after the death of her husband, to join her family down south, and is "*going to miss her for everything*". Clare's godson has recently died (this was unexpected). This happened while he was planning to move back to Australia to care for his parents. Clare discussed the uncertainties of life and that each day is to be enjoyed. When questioned if Clare would like to add any thoughts on the ageing process, Clare discusses her fear of forgetting things: "*but that part of the trouble is that, I do remember I just don't trust it*". Her plans are too stay in this house and make the garden her own, including raised vegetable beds to save her "*bending over*".

5.9 Mill Town Embedded Case Eight

Figure 5.9 Sophie's Locally Integrated network



5.9.1 Sophie – Interview one

Sophie (73) has been in Mill Town for 17 years, after she and her husband sold up and moved to help with her children's business. Her children have since sold the business and moved interstate, but her son still lives in the area. Her son now lives with her. He moved in to help her care for his father, as Sophie could not physically manage and they "*have not made another plan*". Her son still has a house further out of town. Sophie had four sons and one daughter, her daughter died 18 years ago, and she misses her and the mother-daughter relationship.

Sophie's husband went into an aged care home for six weeks palliative care and has now been there for four years. She says he is "*happy enough I suppose*". Sophie used to be able to take him out on weekends, but now he is too frail. She visits three times a week and her resident son goes twice a week, with the other children coming a couple of times a year to visit. Sophie feels that this is the best place for him but not for her. The drive to the aged care home is a 100km round trip. Previously Sophie has helped others when she could, but spent much of her time caring for her husband, which was difficult. She felt that she and her husband left things too late to plan their ageing, and they

could have both moved to a retirement home with an attached nursing home and aged together. Sophie's dad died when she got married, and her mother moved in with her and her husband and helped with the kids and household chores. Her mother was Sophie's current age when she did this. Sophie was happy with this arrangement.

Sophie states "*ageing sucks*". She had a small Transient Ischaemic Attack a few months back and is now receiving tests; "*they've got their claws in me and they're doing every test to make so yes, it's not so good"*. At 73, she feels "ancient", yet accepts that there are many people older than her in Mill Town. She worries that she will not be able to drive because of these tests and will be stuck at home. Friends have been driving her to the regional hospital, but she does not like to rely on friends all the time. She is driving now and taking her daughter–in-law to a clinic in [Regional city] later in the week (two and a half hours each way).

Sophie enjoys living in Mill Town and has a good group of friends. Although she is Catholic, she attends the Anglican Church events as the group does most things together, and have a weekend coffee group. She keeps herself busy by attending art classes, writers' group, volunteers at the local visitors centre and helps raise funds for "*Vinnies*" (St Vincent de Paul Society) and the local school. Sophie feels friends are important in ageing "*as with friends you can talk about what you used to do whereas family you can talk about what you actually did*". She finds the Mill Town community a very accepting and encouraging community.

Sophie likes the local community and would miss it when her husband "*goes*", at which point she would consider relocation. She has a lifelong friend who lives in a retirement village down south and enjoyed her recent visit there, with the varied activities and ease of transport. She has not yet made a decision but would like to be able to "*get out of this place without relying on somebody else*" to take her. Friends offered to drive Sophie on the last three trips to the regional city for health, and each time they stayed over, which can get expensive, and took the opportunity to visit local shops. Sophie feels lucky that they have offered, but "*really and truly I don't want to have to depend on the kindness of strangers - not strangers, you know what I mean*".

Concerning informal support, family and friends would be her preference except for personal care – "*there are some things you cannot ask a friend to do*" but it is good to know there is formal care available.

Sophie has seen the services in Mill Town decrease from four doctors in the surgery to one doctor, and the cancellation of the bus service. She gets support from the local aged care services for cleaning, and her son also helps around the house and garden.

5.9.2 Sophie - Interview two

At the second interview, Sophie's husband is still in the aged care home and has declined "*he is propped up, yeah, some days he knows me, some days he doesn't. I sit there and hold his hand and he sleeps and I watch TV, isn't that exciting, and I drive 98 km a day to do that, not every day*". Sophie's son who had lived with her is preparing to move back into his own property, and her other son, who is visiting, is helping with the move and spending time with his dad. Her grandson is also staying with her after breaking up with his partner and is helping around the house. Sophie is not happy that her sons are single or divorced. She would like to go to a retirement community, but will not leave her husband in Mill Town. "*I can't do anything, at the moment, I can't take him with me and I can't leave him here*" and "*sometimes I just think that it is all too hard*". When asked if she would relocate to join her sons, Sophie has moved to join family before and that did not go as planned, so her decision on location would be "*100% hers*".

Sophie is unhappy with ageing but admits that is probably visiting the nursing home that colours her judgement, with some of the residents not being much older than she is, and if "*she wasn't going there she wouldn't really think that much about it*".

She is receiving cleaning support from the local home care services, but only for larger tasks. She is still driving and would "*go mental*" if she could not continue to drive. The local Aboriginal and Torres Strait Islander care service offers a service to allow residents to attend doctor's appointments in the surrounding towns and cities, which she could access, but for now Sophie prefers to drive. She finds the fuel costs quite prohibitive, and claims a fuel allowance for hospital visits, although she has to travel to the next town to lodge the paperwork.

5.9.3 Sophie's friend Tessa – Interview one

Tessa (65) lives on an isolated property situated in the rainforest. She is an artist who teaches classes once a week. Tessa says her home is her "*little bit of paradise*", and only goes into Mill Town twice a week to the art club and coffee morning, where she meets Sophie. She only goes at other times "*if she absolutely has to*". She feels at home with the animals and nature.

Tessa and her husband (who passed away in 2006) bought the house when they retired, and have extensively modified it. After his death, Tessa extended the house to make it more comfortable to have friends and family come to stay. The loss of Tessa's husband hit her hard, but she feels that by "*getting on with her life*" and "*honoring the time they had together*", he would be happy. She further modified the house (grab rails and so on) after she underwent an operation in 2009 to help her get around. Tessa suffers from a chronic disorder that affects her joints, and has good and bad days; "*if*

this is what it is like to be old then I am going to be prepared now". Tessa is financially stable and sees herself as lucky and having an above basic income.

Tessa's parents are "*still going*". Her dad is 96 and mum is 87 and she figures "*she will need to get comfortable*" in the coming years. Her parents are both still ageing at home, and her mum is very active, although her dad has had some problems. Her grandparents both lived until their 80s and 90s, so Tessa feels she "*has the potential to get up there*". If for some reason she has to go earlier, "*at least the grandkids have got something*". When visiting her parents, she completes jobs around the house for them (such as fixing guttering, laying vinyl) that they are unable to manage. She feels that her parents hoard belongings and this will leave a lot of work for her and her sisters. She is ensuring that she will not do this. She has three children who live interstate, and two sisters who live at some distance intrastate, so her network of Mill Town friends is very important to her.

Tessa met Sophie through the coffee club. She keeps busy by helping her friends with dressmaking and "*wastes a lot of time on the computer*" on Sudoku and Patience. Tessa is close to her group of friends and checks in on them by phone (especially her neighbour, who has early onset dementia, and cooks birthday cakes when it is a friend's birthday. Tessa feels "*friendships are the most important thing*" in the ageing process, and that social contact has a protective effect for dementia. Her neighbour "*withdrew from society for four years*" and is now suffering from dementia, and Tessa feels the isolation may have brought this on.

Tessa would never consider moving, and would only move into aged care accommodation "*if it was forced, if I couldn't look after my own self. I like my space*". When questioned about informal support and her feelings around this, Tessa thinks it would be hard to accept personal care from family or friends. Tessa's mother provided this care for both her mother and mother-in-law, and both parties were uncomfortable with this situation. It would get to the point where she would slip in the shower rather than accept help – "*she was a very private lady*".

Tessa does not access health services in Mill Town, but drives to the next town over, which is larger, to access the doctors and dentist. In the last 10 weeks, she has driven to the nearest regional city eight times to attend clinics (five-hour round trip). Only five times were for her – the other times she drove Sophie to her appointments. As Tessa is one of the "*younger ones*" in the group, she is confident to drive them to [Regional city] for hospital appointments. She also drives her neighbour to local health appointments (dentist, doctor) when required, and they try to coordinate their appointments. Previously the appointments for each clinic were set up on all the same day, but this time they are scheduled over three to four days, which is inconvenient for her. Tessa worries about

the day that she cannot drive, and does not know how she will get about, given the isolation of her house. She hopes someone will "*sort of do the same that she is doing for others*".

5.9.4 5.9.4 Sophie's friend Tessa – Interview two

Tessa is still actively involved in her crafts, and has just had an exhibition of her work. Her health is slowly declining and she has had a few falls, and sometimes uses a walking stick. A cleaner comes in to do the floors and the tasks that Tessa cannot now manage. She has friends staying, and they are helping do "*odd jobs*" around the house. This is a reciprocal arrangement, with Tessa and her partner doing the same for them. This help has been especially helpful as Tessa's neighbour (and friend) has stage four Alzheimer's disease, and they are helping her relocate to stay with her sister and clear the house. Tessa had supported her friend over the past years, but with her advanced health decline, it was "*almost a relief that her sister has taken it on*". Her friend's sister lives in the next town and they plan to use home care services. Tessa was shocked with the speed her friend's decline "*it's all just, you know a friend of 20 years and, and you say, I've been her go down so rapidly*". Tessa still "*helps out*" by driving friends to hospital visits or cooking, but now recognizes her limitations "*if I don't look after me, I can't look after anybody else*". Her friend's decline and the emotional toll that it has taken on her has affected Tessa. Tessa is happy with her level of social contact, and catches up with friends at the weekly coffee morning and at her lead lighting classes.

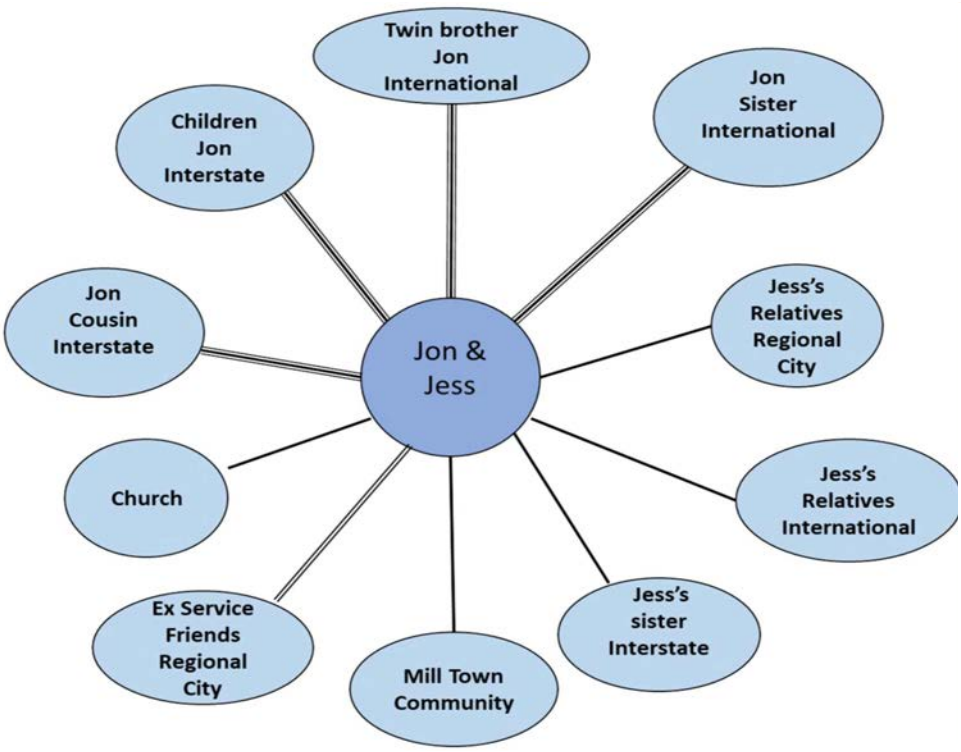
Driving is important to Tessa, as there are no other transport options available. Tessa is currently eligible for home care, due to her health problems, but does not access them – although she may in the future, "*because she can still do most things by herself*".

Tessa herself has no plans to move "*I don't think I'll ever move from here. Or if, if I have to move, it will be kicking and screaming, if I'm still lucid, otherwise, my kids can just sort of say, we are going to interstate, look after the grandchildren*". Tessa has a new partner and is happy with this relationship, "*he'd been widowed and divorced as well and, so, there's, he's got his place, I've got mine, we come, we share, we do things together*".

Tessa's parents are doing well although for a short while she thought that this was not going to be the case. Her dad had decided he was going to stop taking his tablets but he has had a "*mental turnaround*" and become re-engaged with life.

5.10 Mill Town Embedded Case Nine

Figure 5.10 Jon's private restricted network



5.10.1 Jon – Interview one

Jon (76) is from New Zealand and lives with his new partner Jess in Mill Town within walking distance of the town centre. They have been in Mill Town since 2002. They moved to Mill Town in search of inexpensive housing and it being cooler than living on the coast. Jon had previously been married for 31 years and lived interstate whilst working in Indonesia on and off. He finds the winters cold and wet but overall he is happy in Mill Town.

Jon is a writer and continues to write in Mill Town along with working with local writers to help them publish. Jon worked for 20 years in a good job, which allowed him to retire early and concentrate on his writing. He now works occasionally to supplement his pension. He admits he never wanted to work and after his contract ran out at 52 he felt he would not get another job (or not at that time) and "*was ready to adapt*" to not working. He enjoys the breakfast club at the local school and helping out "*giving a little back*" and interaction with the local children. Jon also picks up rubbish in the town (on his own initiative) he feels this has made a difference and there is now less rubbish dropped. This also has a social aspect for him as he chats to the locals while he does this. He is

always making and building things to keep himself busy and feels that even if you are not working "*should carry these interests on*".

He sees himself as "*a bit of a loner*" and an "*observer*", rather than as a joiner or committee member. He had joined the local writers' group as a member but found it "*a bit tiring*". He feels he can empathize with people having had a lot of lived experience "*I'm pretty self-contained and can get by despite bushfires and things like that; bushfires, divorce, life on the line up in New Guinea, worked over in East Timor for a short time when I was running around with a gun. I have got by. I think that gives you 'the tools'*". Jon's divorce, which took place in later life, affected him heavily.

Jon does not "*have too many close friends*", and tends to fit in with his wife's social network. Overall, he has a good relationship with his neighbours "*We've had occasionally mad people turn up, renters, and they don't last long because someone else complains but I don't*". Jon's children visit back and forth from Interstate, and Jon thinks that if required they would look after him as a "*fall-back position*" if something happened to his partner.

Jon's parents were both active, and he admired how they coped with ageing and he hopes he does the same. He has always been very active and still runs and in the past was a keen athlete and horse rider. Jon now suffers from arthritis, which has worsened since turning 70. He manages by not overdoing it along with a self-reflexology regime. He is determined to keep active and "*die fighting*", and not give up to the stereotypical *"little old ladies and little old men in their flash little cars going to their doctors' appointments"*. After his mother's death, his sister looked after his father but found this too much and, in his absence, his father was *"put in a home".* Jon was unhappy, as he had not been consulted, and had promised his father that this would not happen – *"I just blew up". "It was just too much for him" "he lasted six months".* He does comment that his Aunt went into an aged care facility and that for her it was a positive experience due to the fact *"she was a really bright women"* and *"was treated like staff".*

If Jon needed help around the house to support ageing, he would employ someone local rather than access local Aged Care services. He does not *"want to be pushed by bureaucrats because I'll give them hell like I'm giving you hell"*. Jon does admit that the house is getting too much and they are considering moving to somewhere smaller. They have looked at retirement villages, but for his partner Jess not for him. He would rather stay in Mill Town. He likes the space and climate of Mill Town and does not like the thought of living in a city. He uses the local doctor about twice a year in Mill Town.

5.10.2 Jon – Interview two

Life has been "*very good*" over the past year. Jon has had no health problems, which he attributes to following his daily exercise regime. He feels that in five years (aged 81), he will start to struggle physically and his exercise regime will no longer hold off old age "*which is not nice to think about*". He and his partner have prepared their wills, and he has picked all the wording for his order of service, including parts of the sermon. Although in the previous interview Jon did not mention religious views "*he is now more sensitive to the fact that he is here by the grace of God and should make the most of it*", and feels "*privileged that he has had a good life*" compared to others.

His partner Jess has a few more aches and pains he feels "*she is always at the doctors*" – a fact which Jess denies, laughing: "*what a load of crap*". Jon sees the local doctor for his health needs, but feels that the local lone practitioner could do with an assistant.

Jon has obtained information about local home services but still does not identify a need for them. He does not perceive himself as needing this now, and feels that "*some of those people are gaga and I don't really need to join in with that*". Although later he states that it *"would be fun but not at the moment"*. Jon expresses his fear of cognitive decline *"if I go gaga they can put me in the shed – leave me with a packet of pills"*.

When asked about arrangements should he need care, Jon feels that he "*has family to lean on … but I wouldn't want to*". Discussing further, he would join his son in another state (if his partner was not around). He has not discussed this with his son but feels they "*get on pretty well. "He is clean*" and "*such fun".* His son has mental health problems, so he would also be providing support to his son.

They discuss a change in government policy around the amount of assets and the impact on the pension, which could force them to look for another house to reduce their assets (Jess owns the house they currently live in). As both Jon and Jess got together in later life, they both hold their own assets and have children they would to like leave something to. Jon states, "*well that is why I have worked for all my life, was to look after myself and then leave something for the children".* Jon sees this as the "*right thing*" to do and how he was "*brought up".*

Although Jon is a self-described "*loner*", he describes himself as a leader and "*ready to take responsibility*". "*I felt my responsibilities, and ehh, I think from that time on, I've always been, been out in front or wanting to take responsibility to a certain extent*". He feels that since school age this has led him to feeling isolated from others. He is still enjoying picking up rubbish around the town, volunteering at the breakfast club and "*giving people advice now and again*".

5.10.3 Jon's partner Jess – Interview one

Jess (74) previously lived with her first husband in Indonesia. They had previously tried living in Australia but it did not work out, having lived in Indonesia for so long "*my old man couldn't handle living in Australia, not used to it*". They came back to Australia when he became ill, and he then died. Jess stayed on in Australia, as she could not return to Indonesia *"I have to live here unless I get a working permit*". She then met Jon through friends, and they have been together fifteen years. Jess finds the climate in Mill Town too cold.

Jess's parents both died suddenly of illness in Indonesia, and did not require any support prior to this. Jess finds the ageing process "*terrible*" and "*does not want to get any older*", and cannot think of any good aspects to the ageing journey. Jess has one daughter in [Regional city] who she would look to support her as she ages. She would like to move to be close to her daughter now, to allow her to provide support. "*It would be easier for my daughter when I needed her to do things for me and that. She's working so I can't drag her away from her job*". Jess has a sister, with whom she has discussed getting older and "*they hope they don't have to go to the old age home*". She also has a brother still in Indonesia and "*likes to see him as often as she can*", the last time she saw him was 2006. Jon does not want to go, and Jess is afraid of travelling of her own. "*It's very, very scary sort of, you know if you go by yourself being a female, it's not really safe*". She hopes to visit this year. Jess says that she would go every year "*just to get away from the cold weather*".

Jess is not keen on medication. She does not go to the Mill Town doctor, instead travelling to [Regional city] to visit her previous doctor who she has known for years. Jon does not like to drive to the City so he drives Jess to the next town, where she gets a bus to the City. Jess is quite shy, and prefers to socialise mainly with family in her house when they visit from the [Regional city]. She does not feel connected to Mill Town as a community, "*I just put up with it, put up with everybody, not that I have anything against anybody". "They don't bother me; I don't bother them".*

5.10.4 Jon's partner Jess – Interview two

Jess has been having a few more health problems over the past year and "*feels she has suddenly got old*". Jon has had "*to push her a bit*". She says they fight like cats and dogs, but this keeps "*them young*". Jon has suggested yoga, but Jess has not yet contacted the local group. She has not yet gone back to Indonesia, as discussed in the previous interview, but is still considering a visit there. Her family has had problems over the last year due to divorce, and Jess's older sister has lost her home, as she used to live with family prior to this. Jess was present for most of Jon's interview, so much of the interview above contained Jess's views.

5.11 5.11 Mill Town Embedded Case Ten

Figure 5.11 Eddie's wider community focussed network

5.11.1 Eddie–Interview one

Eddie (74) first came to Mill Town in the 1960s as part of a Church Mission, and returned in the 80's to live with his second wife, who was Australian. They both chose Mill Town to live in because they liked the place and the people. Eddie's wife (84) died last year, and he feels he now "*has to start all over again*". He also lost his son (38 years) last year, and has had a hard year. He views his ageing journey as inevitable and "*frightening*", as he becomes less able to do things. Eddie does not feel old, and although he has aches and pains and cannot do things, he feels he "*could carry on forever*". He feels lucky, "*as there are many people who seem to be terribly old at 60*". As long as he is able to look after himself, he will be happy.

Eddie "*doesn't know what he is going to do*", as all his family (siblings, children and grandchildren) live in the United Kingdom. He is "*information gathering*" about what to do and where to live. Although he likes Mill Town, it is different without his wife. In the past when he visited the UK, his wife could not go and the community "*kept an eye on her*". Eddie would hate to be on his own, and feels that if you have no family "*you have to make your own*". The phone and internet are good, but

it's not the same as meeting face-to-face. He finds it difficult to "*always be the visitor*" in the UK, and feels that if he lived closer, family could visit him.

Retirement villages are "*not Eddie's scene*": he finds them artificial and would rather live in a "*proper community*". Eddie's mother wanted to stay at home until she died, but he felt that she couldn't recognize that she was unable to manage even with home care. He does not want to end up in this situation, so may consider aged care if required. He is considering a move to a smaller house within Mill Town, as along with his other options he is currently decluttering, to be ready for any future move.

When Eddie's wife was alive, she accessed Meals on Wheels about four times a week, and a cleaner came in to help with the housework. His wife had previously worked in Aged Care and they both were on the local committee for organising aged care in Mill Town. He reckons that if he stays in Mill Town, he would access formal support (health care packages), as he does not have extended family and most of his friends are of a similar age. When offered Meals on Wheels by his friend, who runs the service, he declined as he feels he does not need them yet. He visits the Mill Town doctor if he has any health problems.

Eddie feels part of the community, although is not as involved as his wife was. She sat on many local committees, as well as being a member of the local art group, and he feels he was "*involved by default*". Many of his wife's friends have been in touch, and he is happy that these relationships are ongoing because "*he has to be careful he doesn't become a recluse*". Recently a few of the older members of the community have died, and their absence has been felt around town in various groups. Eddie used to be involved in the amateur dramatic society, but due to problems with his hearing has given this up. Eddie is also a minister and is very involved with the church, attending prayer meetings and study groups.

5.11.2 Eddie– Interview two

A year later Eddie is "*just rolling along and working out a new life*". A lot has changed for him, and he has recently spent time with his UK family, and is now planning to split his time between Mill Town and the UK and "*have the best of both worlds*". Eddie was uncomfortable with always being the visitor and being dependent on family, and so has bought himself a houseboat to live on "*and have adventures*" when he is in the UK (boating has always been a passion). In the past, his wife was unable to travel, so visits to the UK were time limited. Eddie now makes it his trips longer as "*this time there is only me to think about*" and "*there is not someone waiting at home to worry*".

In his first interview Eddie had discussed downsizing and staying in the community. However, when he tried to sell his house he did not have any success. He is now renting out the main house and is converting an outbuilding for himself to live in, with the help of friends. He discusses the help he has had from the community that has included labour, finding materials and sharing tools, saying that "*he couldn't manage without them*". It is clear he is enjoying the new project. Community is the main reason that Eddie stays in Mill Town. "*I've been here, in this area for 25 years, and I call on contacts"* and *"most mornings if I go down to the town, there's somebody sitting at the café no matter what"*.

Eddie has a health problem "*but he is working on it*" and just "*poddling along*" while having tests. When quizzed about where he thinks he will end up (when he is no longer able to travel), whether the UK or Mill Town, he is still unsure. Policies around pensions and residency may end up making the decision for him and forcing him to stay in Australia.

5.11.3 Eddie's friend Danny – Interview one

Danny is an ex miner, and moved to Mill Town with Jenny because they wanted to remain in a rural area "*somewhere not loaded with people*", with the opportunity of some work nearby. He and Jenny have both moved a lot with mining and working in Indigenous communities. He only worked for a couple of years in the nearby mine before he "*got crook*" at 65. He had planned to work until 75, but he was *"full of denial, I wasn't going to get old*". However, illness and a change in the workforce prompted his retirement from mining.

Danny is not keen on ageing due to the effect on his health. He has lung problems, and thinks the Mill Town "*thin air*" makes his illness worse, and would like to move to the coast. They worry that the property will not sell, as Mill Town is "*only a welfare place*" and there is not much money, with low wages in the local businesses. They feel that since the mill closed the only people left making good money are "*growing dope*", and the good ones have gone. Danny would like to go now and downsize, but Jenny could not take her pets and seems keen to stay. Danny sees old as being 75 years (which was his goal to reach). He has now passed this. Danny's mother is still alive and self-sufficient and lives in a retirement village that he and Jenny arranged. Danny feels lucky that he and Jenny own their own home, but conversely, "*we have all these assets that we can't get rid of*". Many of his peers are "*battling on*" and have no superannuation.

Danny has friends through the church he started attending with Jenny to "*learn a bit himself*". He now enjoys it, and "*there's people there, even in this little church if I was in real trouble I'd know where to go*". He also drives the local school bus "*a little job for old folks*". His illness does not affect his driving, and he is OK as long as he does not do any physical work. He loves his driving and enjoys

the interaction with the local children. "*A lot of these kids are from broken homes and all you've got to do is show a bit of kindness and keep it going*" and wants to keep going *"no-one will take me off my run, that's my run".* He is no longer able to manage the garden, but does not seem to be too worried – "*we're too old anyhow, who wants to be digging up blooming gardens*".

Danny thinks friends are important in ageing and has *"got very few really good friends but the ones I do have are fair dinkum"* and has *"no tolerance anymore for idiots*". Danny and Jenny are friendly with their immediate neighbours, but not the neighbours further away. He feels he could call on his family and friends, as they have already helped him through some really "*bad times*" and he does not know where he would have been without them. Danny also uses his experience of "*bad times*" to mentor a local troubled youth.

They travel to [Regional city] for specialist hospital appointments, and he is currently on medication for his lungs which is not yet on the Pharmaceuticals Benefits Scheme and costs $200 a month. Danny visits the doctor once a month in the next town over and is happy with his care. Unfortunately, Danny took ill and died later that year.

5.11.4 Eddie's friend Jenny (Danny's wife)–Interview one

Jenny was born in Queensland, and she met her partner Danny later in life. After they got married, they worked together in rural Indigenous communities. They both live on a large lifestyle block outside of Mill Town that Jenny designed; she loves the "*peace and quiet*" and her pets.

Jenny comes from a large caring family, enjoys looking after people and has looked after her aunt (mum's sister) and mother, "*I was born to be a carer*". Her parents owned a large company and were very caring of their community, a tradition that Jenny has continued. With the help of home care services, Jenny looked after her mother for 11 years in Mill Town. Jenny found caring for mother emotionally hard, feeling sometimes she "*could hit her around the head with a cushion*", but overall enjoyed caring for her mother. Jenny was not happy with the care her mother received from the Mill Town doctor, and now travels to the next town for medical care. Jenny provides a lot of support to her extended family as both her parents did when they were alive.

Jenny enjoys having space and would find it difficult to live "*in a half acre block*", and would like to age in her current home with help from the Mill Town local Aged Care services if required. She would prefer formal services as her friends are getting older; she has no children and a troubled relationship with her husband's children, who do not live locally. She would be happy to use the local Mill Town services, as they were "*good with her mum almost family*". She is concerned with having to drive 70km to the doctors and even further for hospital care, but otherwise finds Mill

Town provides everything else. Jenny does not feel any different as she grows older, but accepts that she is limited in physical work such as gardening, but does not "*think old*" or "*dress old*". She does not see 60 as old – more 85 plus, but it is really in the mind, "*it is all up there*".

Jenny and Danny help in the neighbourhood by driving their neighbours to social events, church events and coffee mornings. Jenny thinks friendship is important in ageing, and still keeps in touch with her school friend and cousins from way back. Jenny does the church accounts and is proud that she continues to do this well. Jenny met Eddie through the Church and was friendly with his wife. Both she and her husband Danny continue to support Eddie. They hosted his wife's funeral at their home. Jenny's husband Danny provided "*man to man*" support after the death of both Eddie's son and wife.

5.11.5 Pete's friend Jenny (Danny's wife) – Interview two

A lot has changed in Jenny's life since her first interview; Danny her husband has died of cancer. When Danny became sick, Jenny's brother came up to support her through his illness, and has stayed on. Jenny comments on the support from the church and local community that she and Danny received during his illness. Danny's family were able to visit him during his illness, and Jenny still keeps in touch with them.

Jenny buried Danny at his home community, and the local priest drove with Jenny to perform the service (this was a two-day trip). They also had a service at the local church. Jenny was happy with the care that Danny received, and her faith helped her through this time "*God was kind he just went to sleep*". Although Jenny loves Mill Town, she has decided to "*go home*" back down south to her extended family. Both she and her brother are moving to a small beach community and ageing together, and they are currently in the process of packing. They "*fell in love with a house down there, beside that always wanted to go home*". Jenny wished they had done this sooner when Danny was alive. Jenny describes leaving the community - "*I can leave it behind, but the church is, that's the hardest thing I've ever had to do in my life is leave that church"*. She has already selected a new congregation to join at her new home. The community that she is moving to is much larger, and the house is within walking distance of all the local services she laughs and says, "*we will have to get one of those old lady's trolleys*".

5.11.6 Eddie's friend James– Interview one

James (70) is a retired scientist. He is also a peace and anti-war activist and a practicing Quaker "*with an intense religious life*". He met Eddie through his religious life. He and his wife live on a rural property situated within the rainforest about 20km from Mill Town. They moved to this property to

escape the heat in the regional city (with it being cooler at a high altitude), and to have a place to "*spend time quietly*". Forest surrounds their large block, and they are "*coasting along*" until they hit 80, when they feel it will become too much for them – "*you have got to plan unless you die first*". At this point, they have considered building a small cottage on site having one of the children or on-site care to look after the house, moving into a small property in a close town or relocating to a capital city where their children live ("*perhaps a granny flat*"). They have started a discussion with their children "*so that they can think about it*". James thinks that if something happened to him or his wife, the distance from their children may become a problem and they may have to rely upon friends. He considered aged care villages and homes but is not sure he could live in such a close non-family environment. He "*will take what care comes*". When asked about support, he states he would not feel comfortable asking his family for financial support and that he feels that it is his responsibility. He can remember the financial pressure in bringing up children. However, currently they have no financial worries.

James parent's both died in a retirement complex in a capital city near where they lived; they were happy there. His mother was alone after his father's death but did not want to relocate to family. His mother-in-law relocated from a capital city to be with them, and lived in a small house attached to his wife's business. However, when she started to get "*really wandery and weak*" she moved to the age care units and died "*not long after that*". They had discussed a health care plan with her, but James felt "*but once a person actually slides into a bit of Alzheimer's and dementia, it is not quite so easy because they're not quite so rational*". Although there were problems, the fact that they had discussed things previously made it easier to cope.

He feels that he is in the last third of his life, a stage where his "*spiritual life which used to be important but sort of fitted in with everything else has become the dominant part of his life*". James has been a Quaker for 30 years after being born an Anglican and exploring other religions. He is comfortable with ageing and the release from the frenetic activity of working and raising children, and sees this as "*time to be with God*"– for reflection and looking forward. James feels there are five dimensions of ageing and that you have to take responsibility for this yourself: loving relationships, physical health, caring communities, intellectual stimulation and spiritual wellbeing.

James feels that grief is important to handle in ageing, as it is a loss that everyone will experience, jobs, people, and physical and mental ability. He copes with his losses through the Kubler-Ross framework. James has a small number of friends and typically meets up once a week, but certainly every two weeks. He has a good relationship with his neighbours and checks in on them, especially those living alone. He is "*reasonably handy*" and lends a hand when needed; the "*normal give and take*". He thinks friendships are important: "*you need to by and large keep contact with people who*

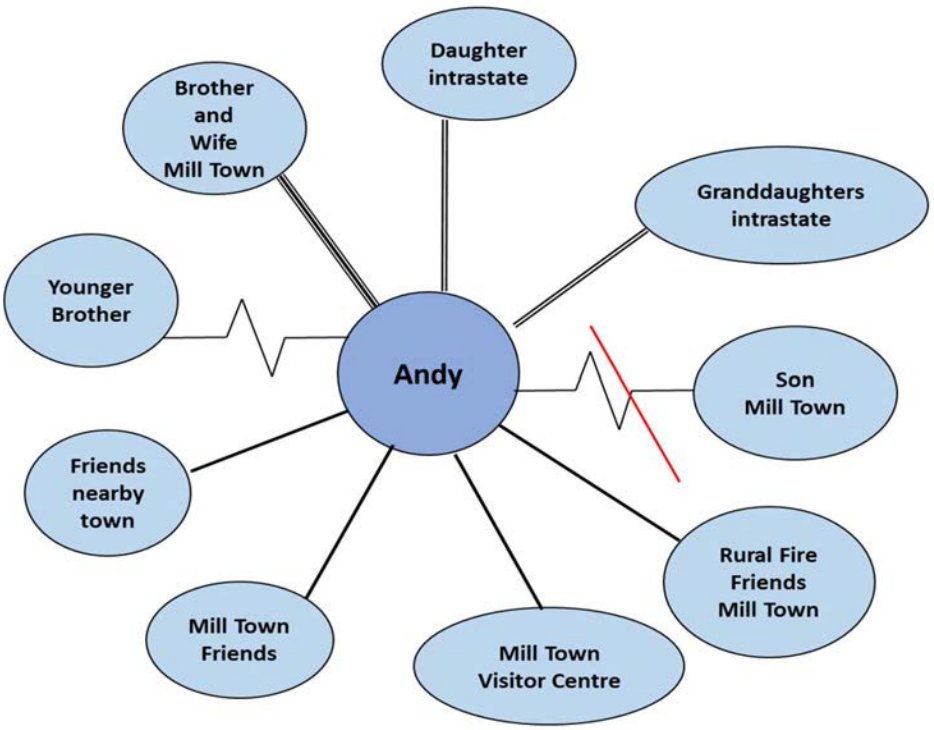
have been important throughout your life as well as the stimulation and enjoyment of making new acquaintances and stuff in ageing". He notes that to maintain friendships takes effort, and a shared history is important – "*that this is not a time for petty disputes*". Shared history of worshipping and religious life is what binds James and Eddie's friendship. James has no health problems and just accesses the local doctor and dentist for the "*stuff that happens to males as they get older*".

5.11.7 Eddie's friend James – Interview two (Telephone)

James and Eddie are still friends and see one another every two weeks for worship when Eddie is not visiting family abroad (when he is away they keep in touch via email). James feels that Eddie is split between two identities: that of a priest and that of a traveler. James and his wife are happy and healthy (his wife is still working) and have not had to make decisions relating to ageing. He still helps his neighbour with physical tasks and in return they "*look after the house*" when they go away. When asked about his mother's health care plan and its impact on the family James felt that *"It made it easier because a clear understanding that she was ready to yield her own control. An acceptance that was in God's hands"*.

5.12 Mill Town Embedded Case Eleven – Family Dependent

Figure 5.12 Andy's family dependent network



5.12.1 Andy – Interview one

Andy (76) has lived in the area around Mill Town for 40 years having moved there with his wife (his wife died a year ago). They were married for 56 years and it was a happy marriage. He has two sons and one daughter (one son was killed in an accident), and the other children relocated to Mill Town with the family. They have moved around the area, "*bit by bit we sort of progressed and found better houses and now we've got, the family between us have 50 acres and it's got waterfalls in it and it's just quite beautiful*". Andy's son still lives on the property and his daughter lived there until recently, when she moved away with her children to enable them to attend a "*good high school*".

Andy is in good health "*about 90% of the time".* He would "*rather not age*" but is "*OK with it*". He is planning on "*being around"* until about 90. Andy perceives ageing as depending on outlook in that some are old at 40 years, whilst some 90 years old may be seem as being young. He sees ageing well as keeping healthy, and ageing successfully as coping "*managing the situation at whatever situation you're in, managing it well*".

Andy looked after his ageing parents. His father died at home. His mother had Alzheimer's and they "*kept her at home as long as they could*", but in the end she needed medical attention "*so it wasn't*

like we shunted her off into a home". There is a family history of Alzheimer's. Andy also cared for his wife during her long illness, except during an ill health episode when he was unable. His wife went to the aged care facility in the next town. He was happy with the care his wife received there before returning home, and later she "*died at home in his arms*".

Andy although not keen on help with ageing, would accept both formal and informal help for medical problems. He would "*get family help if appropriate*". However, he would not accept personal care from his family, and "*would rather go into care than subject them to this*", but would be fine "*with cooking and stuff*". He would not request help from his children, as his son is unwell and his daughter now lives further south. Andy has a strained relationship with his son due to his son's mental illness, but does see him although he "*would prefer not to*". "*He has always been a planner so would look ahead and do whatever works*". Andy has made modifications to his home to support his wife during her illness, and has considered modifying it in the future to support his own needs. He has thought about moving from the block into Mill Town, to make life easier with having mains water and lower upkeep.

Andy enjoys living in Mill Town and volunteers at the local Visitor's Centre and fire brigade (although he no longer attends fire due to ageing). Prior to moving to Mill Town, he did not volunteer. He got involved with the Visitor's Centre though his wife, "*your wife's doing something and you get drawn into it*". He does not see himself as a particularly "*social person*", but knows "*a lot of people*" in town to chat to and have coffee with. He socialises mainly with close family and a few friends, at each other's home. Andy sees friendships as important, "*you need something to get you out of your head*" and as you grow older "*maybe you need them more as a trouble shared is a trouble halved*". Social media also helps and Andy has about 50 friends, mostly family, as he "*is selective*".

5.12.2 Andy– Interview two

Andy at interview two is finding it hard to cope with the house, and is in the process of organizing in home services to help with this, but "*his brain still works*". He is in pain and finding it hard to manage "*this pain to, needs to be managed - someway, who knows, I honestly don't know where I'm going from here*". He has also lost weight, which was clear to see "*I used to be 62kg and I, umm, when I weighed myself this morning, 56kg*". To cope with his reduced health, he has cut back "*on difficult things*", no longer brews his own coffee and has changed his car to an automatic.

Andy has had a difficult year, with the death of his second son who lived on the family acreage. He has also lost one of his two dogs and is feeling his mortality, "*they are dropping like flies around me, and now I'm crook. I might be next cab off the rank*". Andy misses his wife, and the remaining dog is a comfort to him "*but she is a good age*", so he does not expect her to be around for long. He is

depressed and feels that "*at the moment, the most positive aspect would be that I quietly die in my sleep*", but "*would never do anything silly like off myself*".

Andy would not join his daughter down south, as his daughter has compromised health and "*she would not need another, another burden, what a responsibility*". He would not like "*residential care*" as he prefers being in charge and would rather "*drop off the twig and save people a lot of trouble*". He still socialises with his brother, but he does not see him and his wife as often because their house is difficult for him to access in his current health state. He still volunteers (although if the pain continues, this will not be possible), and has drinks with his next-door neighbour twice a week. His relationship with his younger brother has improved and they get along better than before.

5.13 Chapter Summary

This chapter introduced the participants' constructions of ageing in place and their interactions within their social networks. In the next chapters, the issues that were raised in this chapter will be discussed over four publications, utilising the perspective of Giddens' social theories.

Chapter 6 Constructs of Ageing

In the previous chapters, I have outlined the social constructions of ageing in a descriptive sense and the rationale for using ethnographic case studies to explore the experience of ageing within a rural community. Chapter Five described the embedded cases, in addition to presenting the visual ecomaps of their social networks.

As indicated previously, due to overlapping themes all three cases are discussed together rather than attempting to compare and contrast the cases. Results are presented across four journal articles, with each article addressing a different concept. Two of these are published in peer reviewed journals, one presented at a national conference with full paper published in the proceedings and the final article is currently under submission. Although the articles have been reformatted to allow for a consistent style throughout this thesis, the text has not been changed. These articles were written over a period of five years, and with each article my research practices and theoretical understanding have evolved.

- Anderson E, Larkins S and Ray R (2017) Media reporting on ageing in rural and regional northern Queensland. *Proceedings of the 14th National Rural Health Conference*. 26-29 April 2017, Cairns, QLD, Australia: https://www.ruralhealth.org.au/14nrhc/sites/default/files/Anderson%2C%20Emma_A7.pdf
- Anderson E, Larkins S, Beaney S and Ray R (2020) Ageing and Identity in Rural Australia.

  Submitted Research on Aging May 2020
- Anderson E, Larkins S, Beaney S and Ray R (2020) Coping with Ageing in Rural Australia, A Transactional Model. *Australian Journal of Rural Health (in press)*
- Anderson E, Larkins S, Beaney S and Ray R (2018) Should I Stay or Go: Rural Ageing, a Time for Reflection. *Geriatrics and Gerontology International*, 3 (49). https://www.mdpi.com/2308-3417/3/3/49

6.1 Concept Development

The coding process was outlined in the methodology section and the results from the analysis are presented in the table 6.1. Each of the concepts were derived from constant comparative analysis of the data with four main concepts identified. Identity was the first concept in exploring how older people manage their ageing journey and both article one and article two discuss how age identity is socially constructed both by regional media and social network members. Article three then discusses the uncertainties in ageing and how older people engage with resources to cope with age

related changes. Finally article four explores the support that social networks provide for ageing in place. These concepts were then mapped to theoretical constructs linked with Giddens' sociological theories and considered within the nexus of how trust and risk "risk management" impacts on ageing in rural Australia.

Table 6.1 Theoretical constructs

Open	Concept	Theoretical
Identifying as old, still capable, societal views	Identity	Reciprocity & Social Capital Reflexivity, Autonomy, Trust Self-identity
Health losses, loss of kin and non-kin, loss of independence, how much time is left, changing roles	Uncertainty in ageing	Trust and Risk, Reflexivity Agency and coping
Home care services, residential services, rural access	Formal help for ageing	Expert Systems, Trust and Risk Tradition
Expectations of support	Family and non-kin support	Tradition, Trust and Risk, Time and Space distanciation, Social Networks

6.2 Publication: Media Reporting on Ageing in Rural and Regional Northern Queensland

Anderson, Emily, Larkins, Sarah, and Ray, Robin

Proceedings of the 14th National Rural Health Conference. 26-29 April 2017, Cairns, QLD, Australia: https://www.ruralhealth.org.au/14nrhc/sites/default/files/Anderson%2C%20Emma_A7.pdf .

6.2.1 Risk and ageing (constructing identities)

Given that ageing is socially constructed by the negative discourses promoted by the metropolitan media, I wanted to explore if this pattern was repeated in non-metropolitan papers that serve rural areas. The depiction of older people within these papers would impact on the age identity of older residents. Although towns may be hundreds of kilometres away from regional centres they still read the "local paper". Keeping within the constructivist paradigm, I used discourse analysis as a starting point to explore the construction of ageing in north Queensland as depicted in local print media.

6.2.2 Abstract

Aim: To determine views about older Australians as portrayed in rural and regional print media in north Queensland and whether these views differ from those in metropolitan papers. Methods: A descriptive discourse analysis of newspaper articles published in north Queensland between 2011 and 2014. Relevance: Negative stereotyping of older people in the media has been identified as a significant social issue. These stereotypes can be self-fulfilling and limit expectations of ageing from an individual and societal perspective, promoting discriminatory practices and impacting health and social policy. Results: Negative ageing stereotypes are evident in regional papers and promote similar misconceptions as their metropolitan counterparts. Conclusions of the work undertaken: This study identifies the need to challenge the negative stereotypes of older people within the media to foster healthy ageing in place. This is especially important in rural areas with a greater proportion of older Australians ageing within the community than urban areas.

6.2.3 Introduction

Over the last three decades media interest in the increasing ageing population has grown, with the majority of studies originating from Europe and the USA (Kelchner, 2000; R. Martin, Williams, & O'Neill, 2009; Spijker & MacInnes, 2013). Media reporting has a tendency to catastrophise the situation and problematise older people. Robert Skeffington, writing for the Wall Street Journal, compared older Australians to zombies; "granted we will face an army of the not-yet-dead as opposed to the formerly-dead-but-now-undead, but it's still a scary prospect" (Skeffington, 2010). In Australia, a recent report from The Human Rights Commission suggested that, across all ages, negative attitudes towards older people were mainly attributed to personal experience and media reports (Australian Human Rights Commission, 2013) .

Negative stereotyping of older people in the media has been identified as a significant social issue (Keating & Dosman, 2009). These stereotypes can be self-fulfilling and limit expectations of ageing from an individual and societal perspective, promoting discriminatory practices and impacting health and social policy (North & Fiske, 2012).

Newspapers are a common form of social media, with 61-77% of Australians aged 25 years and older accessing this medium both in paper and online formats. Importantly, readership of newspapers increases with the age of the reader. High distribution not only allows newspapers to be used as a reflection of social and cultural beliefs, but also to influence and shape social practice. In 2013 The Australian Human Rights Commission authorized a survey on the editorial content of three city newspapers: The Herald Sun (Melbourne), The Daily Telegraph (Sydney) and the Courier–Mail (Brisbane). Findings from this survey reported the perceived portrayals of older people in the media with the following themes; slow, burden, poor, frail, lonely and vulnerable (Australian Human Rights Commission, 2013).

Previous studies have concentrated only on national and metropolitan newspapers (Fealy, McNamara, Pearl, & Lyons, 2012), yet 36% of older Australians live in regional and a rural areas with these areas having a disproportionate amount of the population over 65 years old, compared to cities (Winterton & Warbuton, 2015).

A report into the social positioning of newspapers showed that readers differentiated between urban, national and regional newspapers, with the former bringing the outside world to them and the latter informing and advising them (Brand Navigator, 2012). This puts regional newspapers in an ideal position to have a major impact on how regional and rural society view older community members. This study aims to explore and characterise the portrayals of older people in regional newspapers and compare content to national and metropolitan newspapers.

6.2.4 Methods

As critical theory attempts to confront the injustice in society, this study employed critical theory to identify if older people were being unjustly portrayed in rural newspapers (Kincheloe J.L., McLaren P., Steinberg, & Monzo, 2011). Discourse analysis which seeks to link language and its use to power and social difference in society was used in this study to look at how newspaper reports use language to socially shape discourses on older Australians.

6.2.4.1 *Sample selection*

Newspapers from the local area of north Queensland archived in www.newsbank.com were selected; ten in total*. A search of all newspaper articles published between January 2011 and October 2014, excluding advertisements and readers' comments, was undertaken. The sample was restricted to rural and regional areas as previous studies (Brand Navigator, 2012) have assessed metropolitan newspapers and this review was undertaken as part of a larger study on rural ageing.

* Ayr Advocate, Bowen Independent, Cairns Post, Cairns Sun, Cairns Weekend Post, Herbert River Express, Home Hill Observer, Innisfail Advocate, Townsville Bulletin, Townsville Sun.

6.2.4.2 *Data collection and analysis*

Articles were selected where the following search terms were present in the headlines: elder, elderly, pension(s), pensioner(s), older workers, older drivers, elderly drivers. Search terms were validated by review of the literature and discussion with the research team.

The term old/older was excluded due to the large number of unrelated articles identified.

A total of 214 articles were initially screened, resulting in 179 for analysis. Articles were then grouped according to the subject matter in descending frequency; crime, finances, health, driving and older workers.

Articles were then read and content assessed both textually and contextually for any negative aged bias in the report (Machin & Mayr, 2013). Bias was classified as articles that made note of age along with an underlying undesirable assumption regardless of the article topic. Themes arising from the articles were discussed and agreed by the research team.

6.2.4.3 *Results*

Analysis showed that regardless of whether articles' subjects were positive or negative, words and phrases portrayed older Australians as being less capable members of society. Newspapers were found to socially construct older people as in four main ways; vulnerable victims, burden on society

and deserving or undeserving. These results closely reflect the stereotypes portrayed in metro and national newspapers (Fealy et al., 2012).

6.2.4.4 *Vulnerable*

Older Australians were categorised as more vulnerable when reporting crime, propagating a public perception that they are more likely to be victims of crime (Shannahan, 1994).

> *"He targets vulnerable victims and that's clear from their ages"—Townsville Bulletin 12 September 2013*

> *"This would have been a terrifying experience for anyone, let alone someone elderly"—Cairns Post 15 September 2014*

A paternalistic tone depicted older Australians as defenceless or helpless and unable to cope with the demands of modern life.

> *"...so little old ladies can sleep better at night knowing that you are not out and about to rob them"—Townsville Bulletin 4 January September 2012*

> *"Elderly people haven't grown up with the cynicism needed to survive in this day and age"—Cairns Post 19 February 2014*

Vulnerability was also apparent in finance reporting. Reports contained an underlying tone of protectiveness towards the older Australians, suggesting that this group need help to manage their finances so that they are not disadvantaged or taken advantage of by charlatans. This promotes the assumption that by age alone, they are intentional targets for financial fraud.

> *"The elderly and frail are being duped by funeral insurance policies that can cost up to 20 times the average price of a funeral, or up to $140,000 in premiums if the holder lives to 90"—Townsville Bulletin 21 March 2013*

> *"…banks have been accused of routinely ripping off vulnerable older Australians"—Townsville Bulletin 17 September 2011*

> *"…senior Australians can be too trusting and confused by technology, so remind them to never pass on banks details, passwords over the web or email"—The Cairns Post 5 August 2013*

6.2.4.5 *Deserving and undeserving*

The context of reporting on pensions was mixed with the dominant view suggesting that older people were deserving of the Age Pension, but this was juxtaposed by concerns about increasing

associated costs. A positive ideology suggested that older Australians are deserving of the pension having earned this right by working (and paying tax) for most of their adult life — in effect, they have paid their dues to society. However, concerns were raised that older Australians although deserving of the pension were living on the edge of poverty, which while sympathetic, positions older Australians as a group to be pitied:

> *"…difficult to decide between eating and household bills" ... heart breaking to see pensioners struggling to survive"—Townsville Bulletin 15 September 2012*
>
> *"…increases in levy would be burden to our most vulnerable citizens"—Bowen Independent 12 April 2013*

Concerns about the sustainability of Age Pensions were couched in terms of need for government restraint:

> *"The National Audit Commission has urged Tony Abbott to target the age pension as one of his "clearest opportunities" to restrain out of control government spending and linking the pension to average weekly earnings, not average male earnings, meaning pensioners would receive about $200 less a fortnight than they would otherwise have pocketed"—Townsville Bulletin 2 May 2014*

Connotations of words such as "pocketed" challenged the legitimacy of deserving pensioners giving the impression that this money is not needed or indeed deserved, with pensions an unnecessary economic encumbrance. A report of a speech by Australian Deputy Prime Minister Warren Truss clearly suggests that policy makers hold this undeserving view.

> *"Mr. Truss said that 1100 people a week in their mid-60s were moving onto the old age pension, with many accessing their super from age 60 and squandering it. Increasingly, the lifestyle and the savings for superannuation are being seen as an opportunity to enjoy a few cruises and the luxuries of life for a few years until it runs out and then people wish to fall back on the old age pension" and "The Government has been forced to act because the pension will become unaffordable as the population ages"—Townsville Bulletin 15 May 2014*

This quote positions older Australians as undeserving, playing the age pension system for their own gain, with the implication that there will be no pension when today's workers retire. Furthermore, by clearly positioning older Australians as undeserving he is then "forced" to take action to stop this undesirable behaviour.

However, positive support and sympathy underwrote articles about older workers. The problems older job seekers face as the pensionable age increases was widely reported reflecting age discrimination in the workforce, the longer periods of unemployment experienced by older workers and the need for more government incentives to employ older workers. The fact that older workers needed to work to accrue sufficient superannuation to support their retirement was nuanced as being unfair.

> *"…a quarter of Australia's greying boomers expect to work into their 80s because they are too poor to retire"—Townsville Bulletin 27 November 2013*

> *"Too broke and too bored to retire, Australia's grannies are flocking back to work, with nearly half the nation's 60-something women in the workforce". — Cairns Post 10 August 2013*

These reports implied that as long as older Australians are contributing to society or wanting to contribute, they are positively viewed as in the overall community rather than as a non-contributing financial drain.

6.2.4.6 *Burden*

Older Australians were portrayed as a burden in the area of health, requiring extra healthcare resources and needing assistance. Articles promoting "healthy ageing" used dependent and paternalistic narratives directed towards younger readers.

> *"…looking after the elderly at home"—Bowen Independent 11 May 2012*

> *"…care for the elderly during summer sizzlers"— Cairns Sun 30 June 2013*

Reporting about residential aged care was emotive and negative with the lack of beds, staff and aged care services, being the main topics.

> *"…bed crisis in elderly care, elderly turned away at aged-care facility"—The Cairns Post 9 November 2013*

> *"Aged care providers in Townsville say they cannot maintain their existing level of service for elderly people unless there is a serious increase in federal funding for the sector"—Townsville Bulletin 31 July 2013*

These articles promote negative stereotypes regarding the ageing population and the burden of caring for them, raising concerns for the future financial stability of the healthcare system.

The term “bed blocking” in common use in hospitals, media and public arenas has a negative impact when used in this quote to suggest that older patients are intentionally staying longer and purposefully impacting on the care of others.

> *“…elderly patients occupying beds at Townsville Hospital because they have nowhere suitable to go, has been a major component of bed blockage at the facility, contributing to longer patient waiting times”—Townsville Bulletin January 23 2013*

The use of negative emotive phrases within reports, whilst not overtly blaming older Australians, raises anxiety in the reader. The report would not have the same effect if older patients were “receiving care” compared to “occupying”, and “bed shortages” was used instead of “bed blockage”.

The public perception of older drivers as a burden to other road users was fueled by statements like

> *“…forget young hoons, older drivers are the new road menace”—The Cairns Post 2013*

positioning older people as less than able drivers due to their age alone, in some cases described as dangerous.

> *“A Townsville mum is calling for ‘s’ plates to be introduced for senior drivers after a near miss on a roundabout”—Townsville Bulletin 12 August 2011*

6.2.5 Discussion

Rural communities are often represented as being idyllic, with a less pressured way of life, along with strong communities and traditional values promoting them as a good place to grow old (Keating, 2008). With the larger proportion of older residents in rural areas, it is important that older people feel included and part of their local community. This study demonstrates that regional newspaper reports concerning older Australians are often negatively nuanced portraying them as vulnerable, dependent and in need of support. These descriptors concur with those reported in Australian urban and national newspapers (Brand Navigator, 2012) and have the potential completely remove any sense of agency from older people themselves.

Age stratification was evidenced in the north Queensland press through the use of collective naming terms such as “grannies” and “little old ladies”. This stratification positions older Australians as being ‘other’ and setting them apart from the rest of the community (Kelchner, 2000), and challenging the widely held belief that rural communities are typified by shared sense of values and social closeness (Keating, 2008).

Contextual analysis of crime reporting also portrayed age stratification, indicating that criminal acts against older Australians break an inherent societal moral code, with perpetrators seen as cowardly

and committing a worse offense than a similar offense against a younger person. This stratification can be viewed as both positive and negative, showing that although society wants to protect older people, at the same time it views them as vulnerable victims. The New South Wales report, Older People Crime: Incidence, Fear and Prevention discussed media reporting on crime stating that whilst the media are a valuable source of information for communities, crime reports "are skewed in favour of unusual and horrifying events, such as violent crimes against older people" (Gilbert & Zdenkowski, 1997; Quine & Stephen, 2008).

There was evidence of marked paternalism suggesting that older people need to be looked after and told what to do concerning making financial and health decisions. These reports may promote a self-fulfilling prophecy among older Australians. They may feel they cannot manage, adopting a fatalistic attitude to health and ignoring symptoms simply as ageing. This is of particular importance in rural areas, where older residents may be already be struggling with increased costs for goods and services, inadequate transport and access to health services and lack of economical parity with their community.

Articles about older people who were living well, engaging with the community (for example through volunteering) and those making a success of life in their older years were under-reported. Instead, discourses mainly focused on the promotion of extremes with greedy "baby boomers" and frail old people "living in poverty"; one designed to create conflict and the other pity or indeed blame for not accruing enough resources when young, "too poor to retire". Living in rural areas carries a life-course disadvantage when it comes to salaries and job opportunities, leading to reduced opportunities to build assets (National Rural Health Alliance, 2011, 2013). Thus, the pre-existing socio-economic situation of an older person is likely to be a reflection of their life to date, rather than a characteristic to be pitied or blamed on old age.

Reporting around pensions and welfare suggests that the Age Pension is unsustainable in its current form and will bankrupt future generations. This style of reporting places younger and older Australians in direct conflict, presuming there will be no pension for the younger generation, again reinforcing a negative divide between generations influencing intergenerational relationships and potentially, creating age related prejudice (Kelchner, 2000).

Older workers were positively portrayed; however, the term older worker was not clearly defined in the articles. Employees and employers classify an older worker as aged from 55 to 57 years (Chandler Macleod, 2012), with 10% of employers admitting to having policies avoiding recruitment of workers, usually over age 50 . Older workers experience longer periods of unemployment, which increase with age, with workers 55 years and above unemployed for an average of 75 weeks.

Growing older has a negative impact on employment prospects and increasing the retirement age may further penalize older workers.

Older drivers were negatively portrayed with calls for increased regulation. However, older drivers also tend to self-regulate their driving, adopting strategies such as not driving at night, during busy times or in bad weather, to keep their driving independence for longer. This demonstrates when older Australians feel that their driving is impaired, they take pro-active steps (Meng & Siren, 2015). Previous studies of portrayals of older drivers have found that the media are complicit in stereotyping older drivers as being incapable and a menace (A. Martin, Balding, & O'Neill, 2005).

Increasing health care requirements of older Australians and the ability of society to pay was the main concern identified in health reporting. While results and projections vary, what is clear is that an ageing population will increase demand on the healthcare system. Highlighting this burden may provoke anxiety in younger Australians who may perceive that limited care will be available for their own needs; promoting a competitive rather than a cooperative environment. Whilst there is clear evidence for increased spending in healthcare, the main drivers are not the change in demographics and our older population but higher incomes, greater expectations, health sector salaries, changes in disease rates and new technologies. Data from the World Bank (2011) indicated little association between health expenditure as a percentage of gross domestic product and the proportion of the 65 plus population (Betts, 2014). Given that rural populations already suffer from inequity in access to healthcare, anxiety about future healthcare is a valid concern but should be seen as a multigenerational issue for the community (Daley, McGannon, & Savage, 2013).

The ageing of the population is evidence of successes in healthcare, education and the increased standard of living. Policy makers should capitalize on the media's ability to influence societal attitudes to promote and encourage positive representations of ageing.

6.2.6 Conclusion

This article has discussed how regional newspapers socially construct older people living within these communities. Given this sometimes negative stereotyping for example, positioning older people as less capable than their younger counterparts the next article moves forward from this positioning and explores how older people view themselves.

6.3 Publication: Ageing and Identity in Rural Australia

Anderson, Emily, Larkins, Sarah, Beaney, Sarah, and Ray, Robin A.

Submitted to:

6.3.1 Risk and ageing (changing identities)

Given that the negative stereotyping of ageing exists in rural areas I wanted to draw on the interview narrative of how older people view themselves and whether these discourses shape their age identity. A positive age identity is important to enable individuals to exercise their agency and interact with their resources and social systems. This second paper explores how older people perceive and socially construct their age identity, supporting them to age positively.

6.3.2 Abstract

Objective**:** To explore how older adults experience ageing and view the social constructs of ageing in three rural communities in north Australia. Methods**:** Two sequential qualitative interview rounds were undertaken, with the second interview taking place approx. 14 months after the first. Results**:** Self-perceived identity was negotiated through physical appearance, physical limitations and self-efficacy. Social interaction and provision of support to the local community supported independence and in turn individual agency. Conclusion**:** For older residents of rural Australia, age identity was fluid and reflexive. Although older people were aware of ageism within contemporary society, they denied the incorporation of the role of dependency into their identity.

Keywords: Ageing, Australia, Identity, Rural

6.3.3 Introduction

The world's population is ageing and in 2017 almost one in seven Australians were 65 year or older (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). The proportion of older people in rural communities is higher with recent data showing almost one in three residents in rural communities are aged 65 years or older. This difference is a result of older people migrating to these areas and younger residents moving from rural areas to urban areas for work and educational opportunities. Given the disproportionate amount of older people in rural communities it is important to explore how they perceive their ageing journey and its impact on their identity.

Despite ageing being a natural and inevitable process, the perception of being "old" evokes negative connotations. Many westernized countries tend to value youth, associating this with competence,

independence and power while ageing is associated with incompetence and dependency (Coudin & Alexopoulos, 2010; Rozario & Derienzis, 2009). This perception (Palmore, 2001) may be related to the increasing ageing population being problematized in response to social and media discourses framing the increasing ageing population as a potential burden to welfare and healthcare systems (Weicht, 2013). These negative discourses position older people as dependent and vulnerable, setting them apart from society and perpetuating ageism (Fealy et al., 2012). The social theorist Anthony Giddens describes the labelling of "old age" as being socially constructed through government policies rather than a natural phenomenon, stating, "old age at sixty-five is a creation, pure and simple, of the welfare state" (Giddens, 1998 : 120). Giddens questions the negative views of incompetence and considers that older people still have the ability to reflect on their life and the agency to take control as part of a continuing life course.

Chronological age, although most commonly used, is an unreliable indicator of who is considered old, and is both subjective and relative (Stuart-Hamilton, 2012). Age identity is created by the interaction between physical functioning and social interactions that merge to reflexively create an age identity (Cook, 2018; Giddens, 1991). Individuals thus have the agency to create their self-identity through the narrative of self and the impact of social structures. Regardless of interventions such as exercise, Botulinum toxin injection and cosmetic surgery there are physical limitations to reflexively constructing ageing with an increasing conflation of self-identity with the body in contemporary society (Mellor & Shilling, 1993). For most individuals it is through the body that they first recognize the social and physical onset of ageing, as the ageing body signals to older adults that although they may feel younger their body is getting older (Clarke & Korotchenko, 2011). This may lead to disconnect between how an individual feels inside; their personal identity compared to their social identity. This latter social identity is the subject of many theories; three versions are detailed below.

Kaufman's "ageless self -theory" (1986) argues that later life has no specific intrinsic meaning and individuals view their inner self as ageless with continuity of identity regardless of physical or social changes. In this dualist model, the body is viewed simply as a corporeal vessel. However, whilst continuity allows for the youthful self to continue it may in fact serve to inhibit change, as ageing consists of many changes that may require re-evaluation of the youthful self (Öberg, 1996). To overcome this conflict Featherstone proposes his "mask of ageing" dualist theory that postulates that individuals separate their inner self from the external ageing body, which is then viewed as a mask, or disguise. However, once employed this mask may become rigid resulting in tension between the ageing body and the inner youthful self (Clark, 2001; Clarke & Korotchenko, 2011; Featherstone & Hepworth, 1991). The tension and rigidity explored in the above theories is in

contrast to Giddens' theories especially his focus on reflexivity. Such rigidity may lead to denial of the individuals' embodiment, and not allow for changes in the ageing process that help maintain agency and protect a positive age identity (Öberg, 1996).

Biggs' (2003) theory provides another perspective, that of social masking. Social masking allows for more control and proposes that individuals actively collude in creating their "social mask" and they have the ability to be reflexive in this context (Biggs, 1997). Identity becomes a tactical maneuver or performance that allows adoption of multiple identities that are not in conflict with the concealed youthful self in the face of social censure (Biggs, Lowenstein, & Hendricks, 2003). Giddens' work on identity supports this collusion, which enables individuals to be reflexive and forge selective identities and lifestyles whilst at the same time rejecting others, thus creating the "narrative of self" (Gauntlett, 2008; Giddens, 1991).

Given the complexity of defining age and identity, this study explores the experiences of older people living in rural areas in north Queensland, Australia as they progress through the ageing journey.

6.3.4 Methods

Twenty older participants (7 male, 13 female) aged 65 -94 were interviewed. Younger members of the social networks views were not included.

6.3.5 Results

Table 6.2 Themes and Concepts

Initial Codes	Concepts (Thematic) Codes
Who is old	Identify as old
Feeling old due to health decline	The body and ageing
Societal views	Masking (reflexive) identity
Still capable	Affirming older identity
Mentor – Grandparent	
More self-aware	
Supporting the community	Work and volunteering to maintain identity
Previous work identity	
Helping others	
Place (rural)	Other
Existing self-identity	

6.3.5.1 *Identifying as old (mind over matter?)*

Given the lack of consensus about when old age begins, participants were asked "at what age do you think of someone as old?" Venus' quote below confirms the social construction of ageing by firstly thinking about age, but then changing her view to include social interaction. This supports the construction of ageing as being both bound to chronological age as well as biological and social interaction.

"Chronologically definitely 80. Mentally, I mean I know people who are in their 90s and you wouldn't call them old because fortunately for them they're still mentally alert and physically as active as possible, but they're mentally alert. And they enjoy life; they get a lot of enjoyment out of life. So for those people I'd say well in your 90s you're old but with other people it could be much younger. You could be early 70s and old, you know what I mean?"

(Venus 65)

Although the question was not directed at the participants, many answered self-referentially with some identifying themselves as being old. In many cases these self-narratives of being old were directly related to ageing associated, uncontrolled physical changes they had experienced. These included wrinkles and grey hair, which would identify them as being viewed as old by society (Ward & Holland, 2011). For Debbie and Libby there was a connection between the ageing body and their

self-identity and an acceptance of an older identity. Whilst Venus, who was younger, described a disconnection between her inner self and outer body, she was still in the process of negotiating her age identity.

'I mean when you're really old like - I am really old I think. I let my hair go grey, I wasn't grey, it was lighter, it wasn't very dark' (Debbie 85)

'I saw myself after we found this [specialist eye doctor] I saw myself in the mirror and I've gone oh, look at all the wrinkles, look at that old lady' (Libby 77)

'I'm in my mid-60s. I suppose mentally in a way I don't feel any older than I did when I was young sort of thing, a younger woman probably 30-ish, but the body says hey you are getting older.' (Venus 65)

For other participants, society and family had reinforced a negative ageing identity, whether or not the participant was ready to embrace this image. However, Carrie discusses her lack of acceptance at taking on a dependent age narrative.

'I've just been away for a month with my family and I realised that I was being thought of as the little old lady. I'm not really prepared to accept that yet, but when I say that I can't get up on the ladders and wash the house down, I go well I have to accept that I have become a little old lady' (Carrie 71)

Jon confirmed awareness of negative stereotypes, but did not self-identify with this narrative as forming part of his identity. Instead, distancing himself from those that he perceives as being old.

'There's these little old ladies and little old men in their flash little cars going to their doctors' appointments. That's all they do… That's not the life I want.' (Jon, 75)

James had spent years examining his spirituality, for him ageing was about discovering a new identity and taking the time to become more self-aware and contented. His interest in the spiritual aspects of life may be more important to his identity than the physical ageing body.

'But now, I can just take my time. It's marvelous, I can see things. There are dimensions in my life that are opening up now that I'd never dreamed about when I was young.' (James, 70)

6.3.5.2 *Age identity and health decline*

Health and physical limitations were connected to age identity as these limitations diminished the individual's ability to be reflexive about their identity. Health decline and bodily changes related to ageing may also affect ontological security which is an essential foundation for self-identity (Giddens, 1991).

'Sometimes I think it depends on your health. I've only really felt old since I broke my hip. Up until then I was fairly active' (Beth, 82)

Some participants exhibited a dichotomy between their internal identity and physical identity, stating that although they were aware they looked old they 'felt no different on the inside'. The physical aches and pains making them more aware of their body.

'I don't know you see because I don't feel old, not when I'm thinking, physically I often feel very old.' (Eddie, 74)

Frustration with physical limitations were described frequently among participants with a farming background. This may have been associated with the long hours and physical effort required to maintain large properties, leading to identification of the ageing process much sooner. Carrie below discusses her fateful moment in the garden when she first started to feel old:

'When I started to not be able to do what I normally did it was very hard; I found it very hard to come to terms with. But by that time I mean to say I wasn't able to put out the heavy box of wiring and do the fencing and things like that that was part of the normal day to day activities of running a property. We were just saying to someone the other day that I think probably my 50th birthday was my worst one. You know, I sort of realised you half made a century and you're probably halfway through your life. (Carrie, 78)

So when you were 50 that was the first sort of (interviewer)

Realisation that yeah - and then I sort of had to - God came to me one day out in the garden and sort of said you know, you've got to accept that you can't do what you're used to doing and you've got to work through that. He's been with me all the way through my life.' (Carrie, 78)

For Tessa a period of ill health had caused her to feel old, on return to good health this image was reversed. This demonstrates her reflexive attitude towards ageing along with the importance of emotional health in her narrative.

'Twelve months ago I would have said I was old. I don't feel old anymore. After [cyclone] I was very depressed and I felt very old and very incapable of doing anything because it took nine months for the insurance company to accept it all' (Tessa, 65)

6.3.5.3 *Reflexive Identity (masking)*

Fluidity in identity was evident in interactions with younger generations, with participants changing their behavior to fit in with their perceived expectations of these age groups. Libby recognizes the power differential and preserves her self-identity by staying quiet in a non-supportive environment.

Alternatively Cate perceives inclusion as dependent on maintaining good physical and cognitive health, in effect exhibiting youthfulness. This manifests as a form of social masquerade to ensure social inclusion and reduce intergenerational conflict.

'I can tell you, so you just keep quiet. They don't want to know [church group] how you did something back in the archaic even if it worked, they don't want to know'. (Libby, 77)

'Providing I'm able to keep sort of physically fit and healthy and mentally all right, then I still get the respect of my peers and of the younger ones, yeah, I think so'. (Cate, 75)

6.3.5.4 *Affirming an older identity*

During discussions, it became evident that older participants still exhibited a large degree of independence and control over their life and that this was important for their existing identity. Regardless of age and challenges faced, individuals were still keen to assert their capability and their place in society. These affirmations were connected to bodily control such as driving for Caitlin and Danny, and remaining physically fit for Jon.

'I'm doing very well actually, I am ninety-four I might have I came back from [regional city] at the end of last year, I'd been to the cardiologist, and their eye specialist, you know, I went in and I had no trouble, getting my driver's license for a year',. (Caitlin, 94)

'Well, you know, I'm fast when I exercise, I'm fast everything, you check yourself out, I can do things pretty fast, I've still got reasonably fast reactions' (Jon 75)

'I've got a little job for old blokes. And no-one will take me off my run. That's my run.'

(Danny, 77)

6.3.5.5 *Continuation of work identity*

This may be associated with living in a consumer society where activity confers social legitimacy. The majority of older participants (all but one) were undertaking voluntary work in the community. This activity was valued amongst older participants and was a source of pride. By volunteering within the community, older participants maintained social status as an active member of the community rejecting the concept of dependency.

Previous work status was still important. Caitlin who had given up work upon marriage in the 1940s still valued the importance of paid work undertaken as a young woman enough to incorporate it into her current identity.

'I was the first girl to work in a bank in [rural town], the QN Bank. Anyone would think I had two heads, a female in the bank.' (Caitlin, 94)

Andy now retired, recalls his work-life. From this quote it is clear that he feels that post-work his status has diminished and although he also volunteers it appears that perhaps he views paid work as of higher status.

'That signature used to be worth a lot of money once. Yeah, I ended up administration officer of [name] Corporation and the first two of those [machines] I authorised the payment on them, about $1 million each. But now of course its worth about whatever the dollar, whatever the old age pension is.' (Andy, 76)

'I didn't change my life a lot when I got older and retired, and just went to the [volunteer centre] and I worked just as hard there and worked my brain as hard, so I'm still not old in what I do.' (Andy, 76)

6.3.6 Discussion

For the older individuals in this study, age identities were not based on chronological age alone, but instead formed by the interaction between physical factors, social interactions and each individual's reflexivity. This enabled their self-identify as old, but also have the flexibility to reject the label of old imposed by society when necessary.

The body still plays a large role in the self-construction of ageing identity. For many participants, bodily changes were the first sign of ageing. The body was shown to be more than a vessel for their identity. It is through the body acting as a social agent that individuals realise physical and social identity (Gilleard & Higgs, 2018). The dualism of body and self-identity in conflict was evident, but some participants had managed to achieve an acquiescence with their ageing body, seeing the ageing body and social ageing as a natural process.

Participants did however, express how a tacit understanding of some of the pejorative social expectations around ageing identity. In this study, participants were aware of negative social identities such as "little old men and ladies" and denounced this inclusion in their self-identity. Coping strategies were used to overcome negative perceptions, with one participant distancing himself from others that he perceived as being old, thus rejecting this negative identity. These findings are consistent with other studies that suggest older adults distinguish and bracket themselves from others they perceive as old (Degnen, 2007; Rozario & Derienzis, 2009). However, most of the participants who identified as old still exhibited contentment with their life. Retention of physical abilities such as driving was a source of pride and a resource for agency. In rural

communities, maintaining the ability to drive is essential for independence and social engagement and loss the ability to drive may lead to isolation or the need to relocate (Keating, 2008).

This study indicated that the role of work/volunteering and the ensuing identity was still important to older people, in a consumer society where activity confers social legitimacy with these activities supporting previous identities. This may indicate that rather than being dependent, older people are actively contributing to the community and providing support to others. This high incidence of volunteering displayed in this study may be linked to maintaining a stable sense of identity and biological continuity in the social context of rural living. Given the scarcity of resources in some rural communities without this high level of volunteering in rural communities, support for ageing would be limited.

A key challenge for policy makers is to consider and understand the lived experiences of older people in rural communities, and promote a more positive construction of ageing reducing focus on dependency and health needs.

6.3.7 Conclusion

Contrary to media stereotypes for these older residents of rural Australia, age identity was shown to be both fluid and reflexive. Although older people were aware of ageism within contemporary society, they denied the incorporation of the role of dependency their identity. This article showed that although older people are coping with their age identity there are other challenges and uncertainties related to ageing. The next article moves on to address which strategies older people use to cope with physical and social changes.

6.4 Publication: Coping with Ageing in Rural Australia

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Australian Journal of Rural Health (in press May 2020)

6.4.1 Age and risk management

Ageing is a time of change, which may involve financial, health and social losses. To maintain self-identity and wellbeing older people need to engage a range of resources to cope with these losses. However, national policies mainly focus on financial resources. This study used Folkman and Lazarus's Transactional Theory to identify coping methods engaged by older adults living in rural communities in north Queensland.

6.4.2 Abstract

Objective: Ageing is a time of change, which may involve financial, health and social losses. To maintain wellbeing, older people need to engage a range of resources to cope with these losses. However, national policies mainly focus on financial resources. This study used Folkman and Lazarus's Transactional Theory to identify coping methods engaged by older adults living in three rural communities. Design: A qualitative research design was undertaken using an ethnographic case study approach. Setting: Three rural communities in northern Australia. Participants: Older Australians living in their own homes. Main outcome: Exploration of techniques that older adults use to cope with ageing (including both problem-focused and emotion-focused strategies).Results: People in rural areas planned their ageing journey using both problem-focused and emotion-focused coping in dealing with the uncertainties of ageing. When participants could control the event, problem-focused coping strategies were used mainly seeking social support and planful problem solving. Conversely emotion focused strategies were used to deal with uncertainty and emotive issues such as health decline and the possibility of needing future care. Conclusion: There is a need for health professionals to encourage older people to consider initiating a discussion of future care needs with their social network. This is of particular importance in rural areas, which have larger numbers of older residents and limited resources to support ageing in place.

Keywords: ageing, Australia; rural; coping; family care

What is already known on this subject?

- Ageing well is associated with coping with age-related challenges, such as health decline.
- Previous studies have found that the use of coping strategies decreases with age.

What does this paper add?

- Describes the pro-active coping strategies with which older adults engage, when dealing with the uncertainties of ageing.
- Shows that older adults engage both problem -focused and emotion-focused strategies. When considering future care needs escape-avoidance may be used to maintain emotional wellbeing.
- Outlines a need for healthcare providers to support older people to use their agency to engage with and discuss strategies for coping with ageing within their social networks.

6.4.3 Introduction

Throughout the working lives of Australians, private and public agencies are exponents of planning for the future. Yet, much of this planning is based on individuals building up personal financial resources to support retirement, rather than relying on public funds (Australian Government. Department of the Treasury, 2015; Australian Parliament, 2013). After retirement, other non-financial risks such as health decline, and the availability of social support also needs to be planned for and managed (ARC Centre of Excellence in Population Ageing Research, 2014). Coping with oncoming challenges is dependent on having the resources in place to allow future planning. These resources may be financial, physical, psychological or social (Ouwehand, De Ridder, & Bensing, 2009). This is of particular relevance in rural areas where limited health services, health workforce, public transport, and family members residing at a distance, may negatively impact on available resources to support ageing (Inder et al., 2012; National Rural Health Alliance, 2011). Yet, there is a paucity of studies examining how these risks are managed in the context of the ageing Australian rural population. Given that rural populations are experiencing a greater rate of age growth, with older people forming an increasingly larger proportion of the community, these risks are of increasing importance (Davis & Bartlett, 2008).

Older people are mostly realistic about age-related challenges and in order to deal with these challenges, they need to evoke coping strategies (Ouwehand, de Ridder, & Bensing, 2007). In this way ageing well is not about having to face any losses, but how older people to cope with these losses. To explore the coping strategies used by older people across three rural settings, this study has adopted Lazarus and Folkman's Transactional Theory of Coping (Lazarus & Folkman, 1984). This framework suggests that to respond to a stressor, older people need to reflect on the implications that this stressor may have for their personal well-being, whether it will be harmful or beneficial.

Their theory identifies two distinct coping mechanisms, problem- focused and emotion-focused, along with eight coping strategies (Table 6.4).

Table 6.3 Description of the eight coping strategies in the Ways of Coping Questionnaire

General coping strategy		Description
Problem-Focused		
	Confrontive coping	*Stood my ground and fought for what I wanted*
	Seeking social support	*Talked to someone to find out more about the situation*
	Planful problem solving	*I made a plan and I followed it*
Emotion-Focused		
	Distancing	*Went on as nothing had happened*
	Self-control	*Tried to keep my feelings to myself*
	Accepting responsibility	*Criticised or lectured myself*
	Escape-avoidance	*Hoped a miracle would happen*
	Positive re-appraisal	*Changed or grew as a person in a good way*

Source: (Folkman & Lazarus, 1986)

Problem-focused coping modifies problems between the person and their environment, whilst emotion-focused coping invokes strategies to reduce or avoid distressing emotions (Lazarus & Folkman, 1984). Previous research using this theory to investigate whether coping strategies differed with age, found that older adults tend to use more emotion-focused strategies such as distancing, avoiding, and less problem-focused strategies (Chen, Peng, Xu, & O'Brien, 2018). Although this theory traditionally assesses past events and how people coped with them, this study used the framework to assess how people are coping with the on-going events of ageing.

6.4.4 Methodology

Participants were 65 years or older and living in their own homes. All participants were screened for inclusion using Lawton's Activities for Daily Living (IADL, Lawton & Brody, 1969) and the General Practitioner Assessment of Cognition (GPCOG, Brodaty et al., 2004) inclusion criteria were scores of at least 6/8 IADL and 7/10 CPGOG. This allowed the research team to select independently functioning older people who more likely to have the ability to autonomously negotiate their ageing

journey. Coping strategies and planning for ageing were analyzed by applying Folkman and Lazarus's theory as a framework (Lazarus & Folkman, 1984).

6.4.5 Results

Eleven older participants (four male, seven female) aged 71-94, were interviewed over the three rural case sites. Analysis of these interviews revealed seven themes: i) coping with physical limitations; ii) coping with possible future care needs; iii) coping with acceptance and provision of care needs; iv) coping with possible cognitive decline; v) preparation for end of life; vi) social connections and coping; and vii) faith and coping.

6.4.5.1 *Coping with physical limitations*

When discussing coping with growing older, participants used both emotion-focused coping (positive re-appraisal) and problem-focused coping (making plans). In response to questions about the ageing process, most participants were content with growing older: *"you just accept it…. it doesn't worry me"* to *"feeling blessed"*, demonstrating an emotion-focused positive re-appraisal of the ageing process.

"Every birthday is a bonus. Yeah, I can't see any problem with getting older. I think it's great because you're a long time looking at the lid. So the older you get the better. (Reg, 72)"

To overcome physical limitations, participants used problem-focused coping, exhibiting planful problem solving such as passing on the property to younger family members, when unable to manage the workload. Clare and her husband had a two year plan to sell their property, which was no longer providing a livable income. She discusses this plan below.

"[*Husband] and I have actually put the farm on the market. We've still got the [xxx] farm with our son so [son], will be kept busy, but we thought we would probably move into town when we sell. We've given it a sort of two year timeframe to sell and we would probably try and buy something or build in walking distance of town, just because of looking to long term - town and the church." Do you know what I mean? So that if something happens to one of us or we both lose our licenses, we don't want to, or [husband] particularly doesn't want me to be left out on the farm and having to do it. The kids would help, but my kids are spread all over the place."*

"It's not what we want to do, it's just being sensible and we'll still be able to go down to the [xxx] farm and he'll still have plenty to keep him occupied because he needs to be doing things."

"but it will take time to sell and we just think well you've got to think sensible about these things. It's

not what you want to do, it's accepting the facts of life. (Clare, 74)"

Despite Clare's concerns that the property would take years to sell (due to the slow rural real estate market), it sold after three months and the second interview took place in their new home (within walking distance of town).

Carrie and her husband had made the move from their rural property several years earlier, into the local rural community, due to her husband's health decline:

"[Husband] wasn't well and so yes, it was time to get out and I knew that it wouldn't work for both to be there together [husband and son]. I don't think [husband] intended to move when it was all there, he just thought he would stay on there. But then his son and daughter-in-law arrived, so he - but then he went back to [hospital] and he realised that he couldn't do it either and so that came harder to him. (Carrie, 71)"

Both of the above narratives demonstrate the passing on of property to the younger generation and the reluctance of male members to give up their lifestyle. Given that farming was such a large part of their lives, moving away from the property may have helped to adjust to this change indicating both emotional and planful coping as outlined by Folkman and Lazarus' Transactional Theory.

Others adopted planful coping by employing gardeners and cleaners to ensure their homes were maintained, supporting their ability to age in place. This involved making changes to their home in a pro-active manner, with the installation of grab rails and removal of mats, to reduce the potential for falls. Beth and Debbie also used falls alert devices (and mostly wore them), as a proactive method for their own safety.

"It should be around my neck, but the other day, I had it around my neck, and went in for a nana nap after lunch. (Beth, 82)"

"I have eh um alert alarm or whatever they call it, but I choose to have that myself. Because it was once when my daughter was away 4 months, I think overseas, and I thought well she always used to call in every day to have a cup of tea with me and she liked to do that and then she wasn't there. (Debbie 85)"

6.4.5.2 *Coping with possible future care needs*

Participants were asked if they had plans or had considered planning in anticipation of increasing health care needs. Given that this is a highly emotive area, many participants described Folkman and Lazarus' emotion-focused strategies (distancing and avoiding), with most hoping that this would never be needed, *"I'd just like to go out in my sleep one night."*

All participants framed future care needs around becoming a burden; *"that they did not want to be a burden",* whether it be on family or friends. However, most stated that their families would help them cope (seeking social support).

"You look after and support them when they're young and so they sort of look after you when you're old. (Caitlin, 82)"

Jon had plans to move in with his son if his partner died before him, but had not yet discussed this with his son. Although on the surface this is a problem-focused strategy, lack of discussion with the family would depict emotion-focused coping (Lazarus & Folkman, 1984).

"Ok, so he's in a situation where he's doing well where he is, and if [partner] goes, I could move over with him and rent the house with him, or he could move over with me, you know, so that, and he could become my carer? (Jon, 75)"

Some participants used or indicated a possible future use of home care services, to help them cope with ageing in their own homes. Eddie, who has no family in Australia, is currently weighing up his options on whether to return home to his extended family or stay in rural Australia. He discusses the possible use of local services to help him cope;

"Well if I'm going to be here I reckon it's more likely to be formal. There's no reason, if it is available, I would get in either at [two local home care services]. I'm all right at the moment. But I know they exist and I know what they do. I know [name] who runs the Meals on Wheels and he said you can have meals when you like, you know. I know they're available, but as yet I don't need them and I'm happy looking after myself. (Eddie, 74)"

For most, the use of home care services was supported. However, for some, the thought of needing residential care in the future was too hard to contemplate. Only one participant with serious health declines was considering future residential entry. A distrust and negative experiences of residential care homes, may have added to the reluctance to consider residential care homes as an option to cope with future care needs, with some participants describing negative experiences.

"nursing homes are getting out of the reach of older people and their children, one time it used to be 99% of their pension, but now it is their house and everything else and the kids have got to take out loans to get them. (Reg 72)"

Sophie's whose husband is being cared for in a local residential aged care facility (100 kilometre round trip), discusses options below:

"so the last time we were talking about relocation… and you said that, a nursing home wasn't for you with your experiences of it? (interviewer)"

"if you have to, but who wants to (Sophie)"

"you did say you had, you had visited a retirement village down south with a friend, have you, sort of, thought any more on that, or…..? (interviewer)

"Yes, I think I would go to a retirement village, but I can't do anything, at the moment, I can't take him with me and I can't leave him here. (Sophie, 73)"

Given the emotional aspect of contemplating future care, many of the coping strategies aligned with escape-avoidance(Lazarus & Folkman, 1984), with knowledge that health decline will occur, but no firm plans were made to cope.

6.4.5.3 *Coping with acceptance and provision of care needs*

Expectations of how much care and what type of care was acceptable from families and friends was very vague. Specifically the provision of personal care was often cited as being unacceptable. This was regardless of whether they had provided personal care to an older relative in the past or not.

"I don't want to be dependent on my family. It's not that I'd be uncomfortable, I expect them to keep an eye on me and look after me and keep in touch with me and ring me, but I don't want them to have to change their whole lifestyle for me. (Beth, 82)"

"Didn't mind doing it for [wife], because she lost control of her sphincters eventually and so I had to do all that, but I don't think I'd like family to have to do that. (Andy, 76)"

"[name] could come and do it, but she's my friend I have coffee with, I don't want her coming and sticking things up me. So I will be doing that myself. There are some things you just can't ask a friend to do. (Sophie, 73)"

One participant in this study had chronic health problems and was finding coping with multiple health appointments, their re-arrangement and travel to them problematic. Given that Libby could have no control over this, her responses indicated emotionally focused coping.

"And I think that the worst thing is the inconvenience that the hospital puts you through with the people you are staying with, cos you stay the night before you get to the hospital at 6 in the morning and uh then just before you are ready to go in, they tell you they can't do it and you know you been off your medication for a week where your [xxxx] specialist says 3 days is sufficient, and then you go

back on it and then they ring up and say oh we have got a spot next Thursday and you think now hang on what do I do now about medication… (Libby, 77) "

The impact of gender in aged planned coping for care was evident in this study, with three participants feeling that daughters should have the main role in caring for parents, with sons playing a lesser role. Debbie feared that her daughter carried most of the burden of caring responsibilities when compared to her siblings.

"it is always left to one person in the family to do it seems. (Debbie, 85)"

6.4.5.4 *Coping with possible cognitive decline*

Fear of loss of cognitive abilities was voiced as much as physical decline showing the importance of being in control and needing this ability to make decisions, without control coping strategies whether emotion focused or problem focused cannot be implemented. Most participants had experienced cognitive decline, either in family members or friends and the dependency that had ensued leading to them no longer being able to cope.

"he had been going downhill mentally. He was a very sharp person but I think he must have been about my age, 85 he was when he went, they went into a hostel but they didn't want to. (Debbie 85, discussing her father's decline)"

Cognitive monitoring was evident between both spouses and within families. For Libby forgetting an acquaintance's name gave her a scare.

"She was in front of us going out through the (supermarket) cash register, hello Libby, how are you? I said yeah, you smile and carry on and everything and blah, blah, blah and what do you call it and she's gone. And I said to (husband), I can't remember her name and where do I know her from and that was just a once off that really gave me a scare. (Libby, 77)"

To keep track of all their children, grandchildren's birthdays, and medical appointments Libby and her husband use a wall calendar, a planned coping strategy.

"So they're all done and I've written it down. I've got an 'alarm' so that when we come up to next year's calendar, we'll see the alarms and it will be written in red. So I think it's when you start to lose it, but then you're not aware of it. It's the other people who are worried. (Libby, 77)"

"Is that a big worry that you both have? - Interviewer"

"I think both of us to a certain degree have this, because when you can't remember what we spoke about. (Libby, 77)"

Problem-focused coping was used by other participants when considering with the possibility of cognitive decline, with participants describing their coping as being proactive by maintaining and monitoring their mental agility, by undertaking cognitive tasks such as crosswords, competitions and playing bridge.

"I test myself on the national newspaper; they have questions, because I do a crossword which is easy. (Debbie, 82)"

Involvement in social groups (clubs, church groups and Country Women's Association), was also seen as pro-actively supporting cognitive competence.

"Believe it or not. And it's good for me, they tell me I'm a good treasurer, and it's good for me, helps my marbles [Laughs]. (Caitlin, 82)"

"I help out at the school here and that's interesting, in the [name] club. So you've got to keep the brain going, nothing like a bit of pressure from various quarters. (Jon, 75)"

6.4.5.5 *Preparing for end of life*

Problem-focused coping was evident in planning for the end of life, to make things easier for partners and children. In contrast to earlier personal care discussions, participants took decisive steps to plan for their end of life. Planning included purchase of burial plots and nominating a power of attorney. Death is an expected event, which may influence the likelihood of planning in advance, in contrast with a less easily predicted decline in physical and cognitive health.

"I told my son the other day, that I want him to come with me when I go to the financial planner next time. Only because he is hasn't got a clue. (Carrie, 71)"

Jon below discusses his preparations for death,

"And you get ready for it, I mean, wills are made, and, I've even done, situation with (partner), I said, how do you, 'cos we don't family here, how do you, how do you arrange, mention your, service, you know, that you know the notice that goes out from the …. Funeral people.

You've got to put your own wording in, because they won't know.

Who my relatives are. No-one knows much about us.

Yeah, so yeah, all that sort of stuff is sorted. When I've got nothing to do, I just put it on a file there, (laughs), that someone might pick up. (Jon, 75)"

To make provision for their partner in the event of their death, two couples had sold and relocated from rural blocks to the town. Being in town would enable the surviving partner to cope with ageing by being closer to their community and family, and not reliant on non-existing public transport. In cases where one partner was living with chronic health issues, couples were proactively planning for the future eventualities. Libby, who had previously handled all the home finances, was experiencing increasing chronic health issues. She shared how she is slowly preparing her husband to take over this role.

"I'm trying to teach him because I mean, if anything happens to me, he's sort of going, you know. I sit out in the car and I said you go in there because we pay everything at the post office. (Libby, 77)"

Further problem solving coping was evident as many participants were in in the process of decluttering and cataloguing their possessions, to ease the burden for any future moves and on those left behind.

"Cleaning up, bit by bit at a time, when we're not here. (Jon, 75)"

"…. then it came to the stage where the grandson wanted the house, so three friends went out and packed the house up for her. I don't want that to happen to me. I want to get my own things so that when I move in the next move into the retirement place, that all my things will be got rid of, but you look around now and you wonder how on earth that will happen; but that's my intention. (Carrie, 71)"

6.4.5.6 *Social connections and keeping busy as a way of coping*

Participants sought social support from friends and social groups as an emotion-focused strategy to cope with the ageing process. Very few participants had children living within travelling distance. The lack of employment and education opportunities for younger people in these rural communities, had caused family members to relocate away from the older generation. The consequential increase in distance led to a growing reliance on support from non-kin, increasing the importance of friendship in rural areas as a resource for coping with ageing.

"Do you have close friends in the community? "(Interviewer)

"Yes, I do, that's what keeps me you know, I wouldn't stay here if I was totally dependent on charitable services, but I have lots of friends here who pop in and do things for me. This one particular friend, although she's a lot younger than I am, she would need to be of course to do the things she does, but she picks me up every Friday and takes me to the hairdresser and takes me shopping or takes the car to the shop and she runs in and does the messages. (Beth, 94)"

"I think if you haven't got family then you've got to make your own family. I wouldn't want to be living right in family's way, but it would be nice to be nearer, because with family you can write and phone and internet. It's not quite the same as going and meeting. (Eddie, 74)"

Friendships of the same age were highly valued as similar experiences could be shared.

"….you don't need to sit there and bottle everything yourself. If you've got friends, they've probably got similar problems. You can have a talk about it, discuss it. (Carrie, 71)"

"Probably more so, [socialise with age group] although as I said, it's getting less and less of them or fewer and fewer of them I should say. But more our age or even our son's, our kids' friends, some of them I'm quite friendly with. But I wouldn't say we're particularly friendly with anyone younger than say 40, most of them would be 50 or more. (Carrie, 71) "

Interactions with friends were highly valued and provided a lot of support for ageing from emotional support, just being there, to instrumental support such as providing transport to attend health appointments in the nearest city. One group of friends timed their health appointments in the nearest city together and made it a social outing.

"[friend one] offered the next one and there was just her and I, and those [city] shops have got so many specials. And last week was [friend two] and [friend one] and again, we stayed overnight. It gets expensive (Sophie, 73)"

Most participants (Lazarus & Folkman, 1984)were involved with volunteering and clubs, many with multiple institutions. Volunteering was a chance to socialise and a way to cope with loneliness. In this way they used problem focused strategies and sought social support within the coping transactional framework. This was particularly the case for male participants who were members of small social networks.

"every now and again I want to talk to someone, I'll go and pick up rubbish and I talk to people then, casual talk with locals on the street or on the back streets. (Jon, 75)"

Andy who describes himself as "not a particularly social person ", was introduced to the volunteer centre by his late wife, still participates and socialises with this centre.

"I'm quite happy with my own company. (Andy, 76)

if I come into town, I'll go in the Volunteer' Centre because there's always something to do up there.

Even though I'm no longer front of house, I'm the technical person there, I'm the computer head.

(Andy, 76)"

Of note is that both men felt the need to justify their socialising with positive activity, which was not in evidence with female participants.

6.4.5.7 *Faith and Coping*

Belonging to a faith community helped many of the participants in coping with illness and loss associated with ageing. This support was both spiritual (positive re-appraisal) and practical support (social support) from the church congregation(Lazarus & Folkman, 1984). Religion played a large role in the lives of the participants, with all but two networks, being involved in a formal religion. In small rural towns, the church is part of the community tradition as a gathering place and activity hub for volunteering.

"I mean I wouldn't clutch at this life if I didn't believe in a hereafter and I feel sorry for those who have no religion, because I feel comfort, I feel contentment through Christ put it that way, and I do. (Caitlin, 82)"

"God came to me one day out in the garden and sort of said you know, you've got to accept that you can't do what you're used to doing and you've got to work through that. (Carrie, 71)"

6.4.6 Discussion

This exploration of how older people cope with ageing showed evidence of both problem-focused and emotion-focused strategies in accordance with Folkman and Lazarus' transactional model. Older people in this study, used problem-focused coping to deal with challenges over which they could have control such as finances and home maintenance. In contrast emotion-focused coping strategies were employed for events that were less controllable such as future health care needs, with avoidance and positive re-appraisal being the most commonly adopted strategies (Pinquart & Sörensen, 2002a). However, for participants already experiencing loss of resources, avoidance may be working to maintain a positive emotional state and reduce anxiety, rather than being seen as a negative coping strategy (Pinquart & Sörensen, 2002b).

The majority of participants avoided planning for future care needs with only a small minority putting firm plans in place. A previous study showed that whilst almost two thirds of older people have thought about future care needs only 8%-15% actually made concrete plans (Sorensen & Zarit, 1996). In Australia the lifetime risk at age 65 of needing any formal care, is two out of three women

and one out of two men, with about one in two women and one in three men entering residential care at later in their life (ARC Centre of Excellence in Population Ageing Research, 2014). Considering these figures, a significant proportion of older Australians will require care related to ageing (be it formal or informal) at some stage. Using the emotion –focused strategy of avoidance as a coping mechanism for consideration of future care needs, may lead to a quick reactive decision where decisional control is compromised and entry into an aged care home may occur, with a resulting loss of autonomy (Jorgensen et al., 2009). Lack of access to residential care in the rural areas may have impacted on the lack of planning as seen in our data. Aged care beds are often not available within rural communities and hence not a planned for or the preferred option. The lack of aged care facilities in rural areas means that older people may also end up in a placement that is away from community and social support (Baldwin et al., 2013).

Reluctance to consider coping strategies in our data, may also be associated with their perception of low vulnerability concerning their future care needs rather than avoidance (Lindquist et al., 2016). Whether this is connected to the rural identity of self-reliance and resilience is unknown. However, it is likely that that a number of emotion-focused factors are in play depending on the life outlook of the participants in this study.

Family were given the main role in the provision of care if this was needed, but there was no agreement about what type of care would be accepted. Given that many of the younger family members are working in large cities, family members are less able or not able to provide instrumental care. The amount of informal care provided by family is dependent on their residential proximity, with close members providing more care (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). Some participants stated a preference for paid care rather than care from family members, as they did not want to be a burden. This preference has also been reported in other studies with an increase in preference for formal care over family care linked to more complex care needs (Mair, Quiñones, & Pasha, 2015).

Problem-focused coping was used with participants planning and discussing death along with making active plans for funerals and preparing partners to continue without them. In small rural communities where people are generally more widely known, losses may be more noticeable, making members more aware of their own mortality and more likely to make plans. Ideally, participants wanted to age and indeed die in their own homes and just *"drop off the twig"* one day without being a *"bother*". This is consistent with the view of rural residents identified as being stoic and able to cope with challenges, (Buys et al., 2008) which may lead to participants wanting to experience their death as a no fuss practical event. Participants accepted death and physical decline

as a natural part of ageing, whereas cognitive impairment was feared especially the development of dementia possibly associated with the loss of autonomy and sense of coping this would entail.

Seeking social support as a problem-focused coping strategy was evident, with participants accessing instrumental, informational and emotional support through their networks to help with ageing. There was also a high rate of social participation with friends and family, clubs and churches and volunteering; which has been shown to be a key indicator for successful ageing (Douglas, Georgiou, & Westbrook, 2017). Participation may also build up social cohesion within the community, further nurturing social support networks. In effect, the more individuals gave to their community, the more they feel that the community can be trusted to give them support when needed.

Social participation by those in rural areas has been shown to be higher than their urban counterparts leading to higher self-rated health (Nummela, Sulander, Rahkonen, Karisto, & Uutela, 2008). Given the high involvement in volunteering in the rural communities investigated, it could be argued that they have been pro-active in building up social capital within their rural community perhaps as part of a problem-focused coping mechanism(Lazarus & Folkman, 1984). Greengrass et al suggest that social support directly impacts pro-active coping, with the more resources, individuals have the more that they could pro-actively plan (Greenglass, Fiksenbaum, & Eaton, 2006). Given that living rurally also carries with it potential lifelong disadvantages such as lower education level and reduced job opportunities, leading to less opportunity to accumulate superannuation and increasing financial disparity, the role of social support may become more important in rural contexts. Focusing on social engagement in addition to monetary or health resources enables older adults with chronic illness and limited resources to rate themselves as ageing successfully (Depp & Jeste, 2006).

Faith and religion also played an important role in support for ageing and coping with adverse situations (Shaw, Gullifer, & Wood, 2016). Many of the participants took part in an organized religion. Having faith enabled some to evoke emotion-focused strategies and positively re-appraise and cope with the challenges of ageing, whether it was health decline of death of a loved one (Lazarus & Folkman, 1984). Emery and Pargament's work suggests this may be connected with older people finding a sense of control over their religion that brings meaning to their life (Emery & Pargament, 2004). Indeed, consistent with our data, having a faith can improve the mental well-being and satisfaction with relationships of older adults (Cohen & Koenig, 2003).

6.4.7 Conclusion

This study has shown a need for more discussions about the challenges of ageing along with the methods that older adults employ to cope with ageing within Folkman and Lazarus Transactional Theory. Although older people coped with the tangibles of life such as social participation and death, the unknown aspects of health decline and future care needs was often ignored. General practitioners, gerontologists, community nurses and allied health practitioners such has occupational therapists and social workers could be instrumental in initiating these discussions with older people about the possibility of needing care and having pro-active discussions within their social networks. Given the increasing demand for aged care services in rural areas and the lack of available services, policies must consider the broader challenges of service delivery in rural areas and engage mechanisms that incorporate coping.

6.4.8 Voices of the Network – Coping with care needs

This article on coping with ageing originally included views of the social network on how older people were coping with ageing. However on review for publication it was recommended by one reviewer that the older participants speak for themselves. In the following section I have included quotes from the network members as they also contribute to understanding how rural people cope with ageing.

“Family has to be there to support your parents when they are older” (Reg’s daughter 31, discussing her father’s future care needs)

Two participants in this study already had spouses in a carer role providing physical support. Marnie who cared for her husband stated:

“I mostly co-assist, [my husband] is very capable, that is why I don’t feel like a carer” (SNM, Reg’s wife, 57)

However, in the same interview she expresses that she is having difficulty coping with her husband’s health decline, which had also caused a move into the city to be closer to health services. This is an example of exhibiting problem-focused coping (planful problem solving and seeking social support).

“I am finding it increasingly difficult to cope with the stress of his precarious health that can see him going from being fit and well to needing an ambulance in the space of an hour or less. This has happened too often. Also, despite him thinking he is still 30, slowly it is taking him longer and giving him more pain, to do the things he always has.” (SNM Reg’s wife, 57)

Reg's daughter is supportive of this move as it allows her to help her mother to cope with her father's care.

"If he got sick it was so far to get help and then you are going into a rural hospital which they do their best they can but don't have the facilities of [regional city] hospital. Us kids couldn't lend a hand to look after dad if he was sick if mum was busy working or anything like that. Also we were not there to support mum if dad got sick she needs, she needed that a she really needs a shoulder to lean on when things are going bad." (SNM, Reg's daughter, 31)

The impact of gender in aged care was evident in two networks with three participants feeling that daughters should have the main role in caring for parents with sons playing a lesser role. Debbie feared that her daughter carried most of the burden of caring responsibilities when compared to her siblings.

"it is always left to one person in the family to do it seems."(Debbie, 85)

Her daughter (62 years) also feels that the main responsibility for her mother falls to her and 'although this is part of her life', it can be limiting when it comes to travel greater than a few weeks.

Given the importance of social networks in coping with ageing the next article moves on to discuss the role of these networks in rural communities. It explores the typology of networks and evaluates the informal social support that these networks can provide.

6.5 Publication: Should I Stay or Go: Rural Ageing, a Time for Reflection

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Geriatrics 2018 3 (49),

6.5.1 Social networks and ageing (trust)

There is an important role for social networks in supporting identity and in the provision of resources to enable older people to cope with the challenges of ageing. This paper explores the role of participants' social networks and the influence that they have on ageing in place, using data from the first interviews with the key informants and their networks.

6.5.2 Abstract

Background: Studies have shown that older people prefer to continue living in their own homes and communities as they age. However this is dependent upon available services and social support. In Australia about two thirds of people will age at home. The Australian Government provides home care packages to support ageing in place, yet in rural areas not all services are available. The lack of employment opportunities in rural areas often results in family residing at a distance, reducing available social support. This study aims to evaluate informal social support and its influence on ageing in place amongst older people in three Australian rural communities. Methods: A multiple embedded case study was undertaken in three diverse rural communities. Eleven older rural residents ageing in place aged 65+ were interviewed about their ageing experience and plans for their futures in the light of available social support, along with 15 members of their social networks. Social networks were then visually depicted with the use of ecomaps and network members were interviewed. Results show that kin and non-kin social networks support ageing in place however ageing is a time of change and reflection. Conclusion: There is a need for more discussion within these networks when it comes to future planning.

Keywords: ageing; rural; Australia; social support

6.5.3 Introduction

Ageing in place is defined as "the ability to live in one's own home and community safely, regardless of age, income, or ability level" (Simons et al., 2000). Numerous studies have shown that most people prefer to and plan to continue living in their own homes and community as they grow older

(Horner & Boldy, 2008; Löfqvist et al., 2013). In Australia the majority of older residents will age in place, with one third requiring residential care (Stones & Gullifer, 2014).

The increasing age of the population in developed countries, as well as the increasing costs of residential care, is causing governments to re-evaluate aged care policy and implement reforms on long-term care. In Australia the increasing cost of residential care was outlined in a report produced by the Australian Research Council in 2014 that estimated that the costs of residential care comprised 70 percent of total aged care expenditure (ARC Centre of Excellence in Population Ageing Research (CEPAR), 2014). In response, the Australian Government has been implementing changes to support ageing in place over the last 30 years, starting with the introduction of the "The Residential Aged Care Reform Package" in 1997, which provided Community Aged Care Packages (Australia. Parliament, 1997).

The most recent reforms outlined in the "Aged Care (Living Longer Living Better) Bill 2013" promise enhanced consumer choice for older people ageing in place, structured over a 10-year period. This new bill offers consumer-directed care, but has also introduced asset tested co-payments. In addition, it introduced the separation of the cost of care and accommodation, whilst still capping the number of home care packages and residential care places (Australian Parliament, 2013).

Older people can access home care packages after an assessment of the required level of care has been made by the Aged Care Assessment Team. Four levels of care packages are available: basic care, low-level care, intermediate care and high-level care. Services consist of personal services, diet and nutrition, continence management, mobility, nursing and allied health services, transport and skin management. These are delivered by private service providers (Australia. Myagedcare, 2018). The Government agrees the number of home care packages available yearly and how these are allocated to each State or Territory.

A recent review of home care service provision showed that there is a current unmet demand for higher-level packages with 67,000 older people on the waiting list for intermediate and high level care. Of these 35,000 are currently in receipt of basic and low level care and are waiting for a higher level to become available (Australia. Department of Health, 2017). Waiting lists and the tightening of criteria for entry to residential aged care, as well as user pays charges have moved the responsibility for aged care support from government services to individual households, with informal care provided by family and friends (Fine, 2012).

In line with the rest of the developed world, Australia's population is ageing with adults over 65 estimated to comprise of 25% of the population by 2056 (Australia. Department of Health, 2014). This age group will be over-represented in rural areas (possibly up to 36%) due to migration trends,

with younger community members relocating to urban areas for work and education opportunities. Conversely, many older migrants move to rural areas seeking a quiet retirement or for financial reasons, due to housing affordability (Heenan, 2010; Winterton & Warburton, 2011a). Much of the research on rural ageing uses a "marginalization" conceptual lens, positioning older adults in rural communities as being at risk due to lack of access to health care and resources to meet their needs. Within Australia the term rural and remote encapsulates all areas outside metropolitan areas. These areas are then further classified by distance from cities and local population size. This study uses the Modified Monash Model developed in 2015, which is used to map health care services along with health workforce models (Australia. Department of Health, 2018).

Small dispersed populations in non-metropolitan areas make the traditional healthcare workforce models difficult to implement and sustain, leading to private service providers being reluctant to move into rural service provision, due to higher running costs (Keating, 2008). The lack of available local services results in more emergency room visits, as well as more frequent inpatient stays. Due to the need to travel, rural patients often receive inpatient care for treatment that otherwise would have been provided as outpatient care (Byles et al., 2006; Davis & Bartlett, 2008; Inder et al., 2012). Lack of aged care staff is a national concern, with workforce shortages already evident in rural and remote areas. These shortages are due to lower wages and lack of training and development opportunities (National Rural Health Alliance, 2011). As younger families leave the area for work and education opportunities, local services are further impacted due to decreased demand, this also decreases the available social support (Heenan, 2010).

As the Australian Government moves towards a co-payment asset system this will disproportionally impact rural residents, as rurality is associated with lower incomes and higher rates of poverty, with rural residents having lower educational qualifications and limited employment opportunities (Glasgow & Brown, 2012; National Rural Health Alliance, 2013). This lack of opportunity carries over into old age, with lower superannuation and less savings to fund retirement (Davis & Bartlett, 2008). There may also be a reluctance to claim government support, due to stigma or lack of awareness of support available (Dwyer & Hardill, 2011). Many older rural women are more likely to live in poverty, having never worked in paid employment, but spent years raising children, working on farms and supporting families. Life and work in Australia outside larger cities can be perceived as second rate, with the erosion of infrastructure and dwindling services experienced in rural areas (Humphreys, 1999).

One million Australians currently access aged care services, however 80% of aged care support in the community is provided by partners, family, friends and neighbours (Hodgkin, 2014). Relationships are central to the ageing process and it is the friendships, both kin and non-kin that support the

ageing experience. The social relationships held within these networks can provide companionship, practical assistance and emotional support (Keating, 2008). In gerontology social networks are considered as the mechanism through which support for ageing can be delivered, as these networks contain the potential of support and care (Keating et al., 2003). Each network holds the "assets" or social capital that has been amassed over the duration of the relationship built by trust, kinship and reciprocity. However, the existence of a network tie does not guarantee support, as the decision to provide support is multifactorial (Keating & Dosman, 2009). The social networks of older people are dynamic, with losses and gains in the network throughout time: losses, such as death of a partner or siblings and gains such as consolidating new friendships (Schiamberg & McKinney, 2003).

Social networks have been studied extensively, along with the beneficial effects of social connectedness in supporting healthy ageing (Giles et al., 2004; Golden et al., 2009; Wenger, 1997; Wong & Waite, 2015). Many studies on the ageing experience have looked at social networks, showing an association between large social networks and improved health outcomes in later life (McLaughlin et al., 2010; Wenger, 1997; G. C. Wenger & Burholt, 2001). However, the complex relationship between social connectedness and health (cognitive decline and overall mortality) has been inconsistent (Green et al., 2008; Hodge et al., 2013). Nevertheless, having an active social network and sufficient social support is linked with better self-rated health and increased wellbeing (Fiori et al., 2006). Given the perceived disadvantage experienced by older rural dwellers (Erickson et al., 2012; Golant, 2008; Horner & Boldy, 2008), deciding to age in place may not be the ideal option.

Litwak's (1987) research on developmental lifespan proposed three main periods in older life when relocation is considered to support ageing. The first move is prompted by retirement and is influenced by lifestyle factors and choice. Retirees at this point are usually healthy, and may decide to move to rural or coastal areas for the quieter lifestyle. The second move may occur due to loss of a partner or the need for support for health issues. At this point health may be compromised, but can be supported by a mixture of informal and formal support. This move may be a move into town, retirement village or move to be closer to family. The third move is the move into formal care, and may occur when the informal care network can no longer cope (Litwak & Longino, 1987). Carpenter and colleagues (2007), in their study on the push factors of considering relocation in an ageing population, showed that the ability to age in place and relocation decision is influenced by three main factors. Firstly, declining health, with physical impairments resulting in the loss of independence, was the main reason for considering relocation. This was followed by financial concerns and lack of social support (Carpenter et al., 2007; Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Restricted social networks can lead older people to consider relocation in order

to move closer to family or to required support, whereas the presence of larger integrated networks may support expectations of ageing in place (Tang & Lee, 2011).

Sociologists have studied the typology of social networks of older people in order to predict the support they may be able to access or determine well-being outcome measures (Fiori et al., 2006; Litwin & Shiovitz-Ezra, 2006; Tang & Lee, 2011; Wenger, 1997). These network typologies may indicate the sources, quantity, quality, and type of available support. It is the available support in these networks that will affect the decision to stay in the same place as opposed to relocating. The aim of this paper is to evaluate informal social support and its influence on ageing in place amongst older people ageing in place in three rural communities in Australia.

6.5.4 Methods

Ecomaps were used to provide a visual representation of the social relationships and the strength of these relationships (Hartman, 1995; Ray & Street, 2005). Maps were assembled in a collaborative process with the primary participant during the interview. By firstly drafting member maps with categorization of relationship strength (by the use of multiple lines) completed towards the conclusion when the interviewee was more comfortable. (Ray & Street, 2005). These maps were then used to depict the social support available and allow classification into social support networks using Wenger's typology (Wenger, 1997).

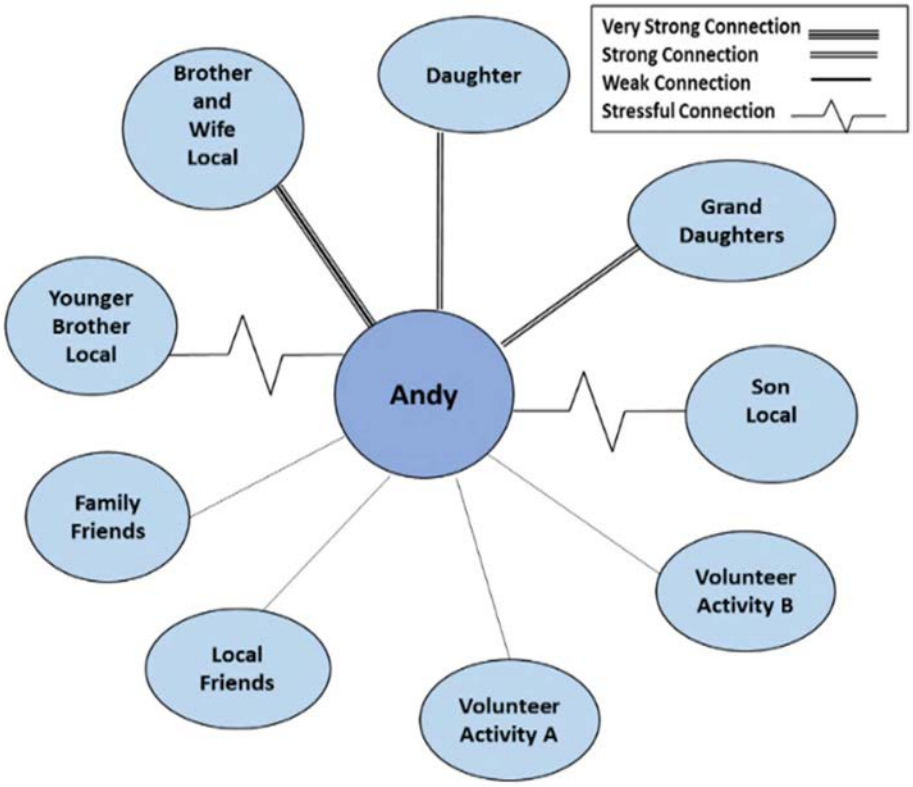
6.5.5 Results

Eleven older participants (four male, seven female) aged 71-92 were interviewed over the three sites. Additionally, 15 social network members were interviewed, including partners, family and friends aged between 26 and 80 years. Aliases are used for confidentiality. Firstly, network structures are reported, followed by the factors that impact upon relocation.

Table 6.4 Network Typologies.

Integrated Social Networks	**Characteristics**	**Embedded Cases**
Locally Integrated	Typically large social networks characterized by close connections with family, friends, neighbours and the community.	Debbie, Caitlin, Sophie
Wider Community Focused	Lack of local family members but contact with friends and neighbours. Have extensive contact with relatives who live some distance away (adult children, siblings)	Carrie, Clare, Beth, Eddie, Libby
Restricted Social Networks	**Characteristics**	**Embedded Cases**
Private Restricted	No local family, few friends and few links to community (may be married)	Jon
Family Dependent	Networks contain mostly family with only a few friends and neighbours	Reg, Andy
Local self-contained	Solitary, little contact with family or community, may receive some help from neighbours	

Figure 6.1 Andy's restricted family dependent network



6.5.5.1 *Social networks*

Network types were independent of location, with the majority being integrated networks. Within these networks, wider community focused networks were more common, due to family residing at a distance. In Cattle Town, adult children and siblings still lived rurally, yet the distance remained a limiting factor due to large dispersed cattle properties.

> *"If anything happens to one or both of us the children would have to get on a plane to come up and see what are those two up to now, you know, what have they done this time. Whereas if we're in City A or City B they've only got to hop in a car." – (James, married, Eddie's friend, Mill Town, 70)*

Interestingly, in community focused networks some network hubs had a closer connection to non-kin members. The presence of a family member within this network did not immediately correlate to the strongest connection. Studies on kin and no-kin networks have shown a more beneficial effect of networks, with non-kin resulting in decreased mortality and nursing home admissions for those with a close confidant (Giles, Glonek, Luszcz, & Andrews, 2007). Close confidants played an important role in social networks with one participant, although part of a large integrated network, confessing her

unhappiness with the lack of a close confidant. The importance of close friendships was commented on in all integrated networks, this was especially important in dealing with the loss of a partner.

> *"She was there for me when my husband died, I was there for her when hers died. – (Tessa Single, Sophie's friend, Mill Town, 65)*

The three restricted networks (one private restricted and two family dependent) had males at their centre. Although women tend to have larger social networks than men, research has shown that even after adjusting for social factors, it is unlikely that these networks are a result of gender alone (McLaughlin et al., 2010). All three of the primary network members self-identified as being a loner and preferring their own company from a younger age. Two were currently living with a female partner with most social activities and interactions taking place in the home environment, and the other had lost his partner the year before.

Cloutier-Fisher's work on small social networks discussed the importance of situating the social network in the context of the individual's life course, with small social networks not an indication of loneliness, but a function of their personality, rather than due to gender or increasing age (Cloutier-Fisher, Kobayashi, & Smith, 2011).

Jon related an incident at boarding school that he felt was the start of him withdrawing and becoming a loner. He volunteers occasionally at the local school and undertakes self-directed community services at his own pace and under his "*own terms*".

> *"I'm giving back a little but only when they ask for it. I haven't got family here, I haven't got too many friends and would rather organise ad hoc paid care than be pushed by bureaucrats [Jon discussing whether he would use government home care services]." – (Jon Partnered, Primary, Mill Town 75)*

Reg lives at home with his wife and his four children all live close by with their children. The family is very close and supportive of one another and mainly socialise together and states he is *"allergic to clubs"* and likes to do his own thing.

> *"Reg can be a bit anti-social—I don't want to go there— but if we go to a party he is the last one to leave." –(Marnie, Reg's wife, Sugar Town 57)*

In the remaining family dependent network, Andy had been widowed the previous year, close network members consisted of a daughter residing at a distance and one close kin member in the rural town who was caring for their own partner. Andy volunteered at the local library, an activity he had become involved in through his wife.

"Your wife's doing something and you just get drawn into it." – (Andy, widowed, Primary, Mill Town 76)

Whilst these relationships provided emotional support, there was not the capacity for provision of instrumental support, and he was unsure how he would cope if his health deteriorated.

Members of these networks enjoyed low levels of interactions with the community and volunteered under their own terms.

6.5.5.2 *Stay or go*

"We'll have to think about what the next stage is, unless we die first, which happens to all of us isn't it. You've got to plan unless you die first." – (James, Eddie's friend, Mill Town 70)

Within this study there were two types of relocation; proactive and reactive moves. A previous study has shown that the main push factors for considering relocation by older community residents were increasing health needs (65%) followed by finances (26%) and social isolation (6%) (Carpenter et al., 2007). Of the 11 embedded cases, two (Reg and Clare) were actively relocating, five were considering a future move, one had relocated in the last six months and three had no current plans for relocation.

Reactive relocation occurred for two participants associated with a decline in health, forcing a move to a more supportive location, due to both living both rurally and remotely. One participant stayed within the local community and another moved to the regional city. Reg had relocated to the regional city due to complex health needs and to be closer to family. He expressed regret in leaving the move too late and now being unable to cope with managing the rural property (which now had to be sold) and, although resigned to the move, was not happy in the city.

"If we get around to listing it, it is a bit of a mess it has overgrown and is going to have to be sold overgrown,—I always said I was worried we would leave it too late now we left it too late, not capable of doing it used to be able to. ...15 acres compared to this, there is no comparison, this is like going to hell without dying [Reg on now living in the city]." – (Reg, Married, Primary Sugar Town 72)

His daughter expressed family concern with the previous location and relief that they were nearer to specialized health services and that all children could now provide more support to both parents.

"…rural hospital which they do their best they can but don't have the facilities of city hospital us kids couldn't lend a hand to look after Dad if he was sick if Mum was busy working." –(Rachel, married—Reg's daughter, Sugar Town 31)

Beth had moved within the last six months from her rural property. This move was reactive, brought about by ill health and family concerns with regards to isolation of her rural property and how she would cope. Her move was organized by family and friends who packed up the house and arranged a rental property in the rural town.

"I was going through a bit of a low health period at the time and they decided I wasn't fit to live on my own and anyway, [supportive friend] had offered this house to me before, so I moved in to town." –(Beth, widowed, primary Cattle Town 94)

The most common relocation discussed in the first part of this study concerned a proactive move, in order to keep independence for longer. When deciding possible relocation from their current home, participants reflected on the difficulties of home upkeep, expectations of family care, community and availability of formal services. Participants planning to move expressed the difficulties of selling in rural areas, with properties taking a long time to sell and the difference in property values with cities having higher property values.

"Our son and his family lives in regional city that pull us to there but there are lots of problems getting there, two of which are house sales in small towns isn't too active and then the price that you get for your house compared to the price that you have to pay for some accommodation in regional city." –(Cate, married, Libby's friend, Sugar Town 75)

"We've given it a sort of two-year timeframe to sell and we would probably try and buy something or build in walking distance of town." –(Clare, married, primary, Mill Town 74)

6.5.5.3 *Home upkeep*

Although the study is based around three towns, many of the participants lived on the outskirts or satellite settlements. All participants lived on larger rural blocks or detached homes, and for some this was seen as a possible limitation for the future, whilst others were already experiencing problems.

"…so we got this block of land which has got a lot of forest around it and we're just sort of coasting along really until we get probably close to 80 when we physically won't be able to handle this place anymore and we'll have to think about what the next stage is." –(Danny, married, Eddie's friend, Milltown 70)

6.5.5.4 *Families*

Relocation was framed around future health and support needs and where would be the best place to access them. When considering a future where care may be required, an expectation of some form of family support was the norm, with most cases discussing relocation from the community moving nearer to family:

"My son thinks I should go to his town, my daughter thinks I should go to her town. While I'm as fit as I am I'll stay here but if I deteriorate, if I needed full time care, I would definitely go to his town or her town." –(Beth, widowed, primary, Cattle Town 94)

"It would be easier for my daughter when I needed her to do things for me and that. She's working so I can't drag her away from her job." –(Jess, Jon's partner, Mill Town 74)

Support expected by family varied in each case, as did acceptance of types of support financial aid and personal care. Many participants expressed the desire not to "*become a burden*" and that although they expected care that care was to be emotionally supportive to "*look out for them*", rather than look after any physical needs.

"My family gives me great support, yes, but I wouldn't live with them. We've got an aged care centre here, I would go there if I couldn't look after myself." –(Caitlin, widowed, primary, Cattle Town 82)

"…when he has been really sick he has been OK with people helping him but he is pretty quick to get back on his feet he is very proud he doesn't want someone to do something he can do himself but when he can't do something he will let someone help him." –(Rachel, Reg's daughter, Sugar Town 31)

6.5.5.5 *Home Care Services*

All participants reported knowledge of existing at-home aged care services and felt that those services would support them to remain in the community. The knowledge of and provision of home aged care packages was positive and at home services were used in all three sites.

"I'd like to stay in my own home and I know that we can get support like that [discussing at-home services]." –(Eddie, widowed, Milltown 74)

"That lady that I just spoke to on the phone, she just can't get over how wonderful HACC is here, how accommodating they are." –(Carrie, widowed, primary, Cattle Town 71)

"If I had to have someone come in to do a bit of housework or something like that I'd accept it, yeah. Because I know as I say with Mum, they were just so good and they become part of the family [Jenny on her previous interaction with at-home services, when they looked after her mother]." –(Jenny, Married, Eddie's friend, Milltown 72)

Relocation to residential aged care was judged as undesirable by the participants, with one participant describing it as the *"final punishment for being old*". Others were more pragmatic, describing residential homes as being necessary *"for people who didn't have anywhere else to go",* and *"it is a thing you need to have in mind*". In all but one case residential care was seen as the last resort. Jorgensen (2009) demonstrated that older adults had little decisional control over relocation to residential care, with the decision being made by their families and professionals (Jorgensen et al., 2009). This was alluded to in the way participants spoke about entry into residential care as being a forced move, taken out of their hands, rather than a chosen move, Debbie discussed leaving the decision about this to both her children acting on her behalf.

"I think they're great for people who want to downsize and all that sort of stuff, but for me, only if it was forced." –(Debbie, widowed, primary, Sugar Town 85)

"My sister and I talk about getting old and we hope we don't have to go to the old age home. Like maybe have a quick big heart attack and gone." –(Jess, Jon's partner, Milltown 74)

"…like Mum, she never wanted to be—and her pain, she was so sick in the end that they wanted to put her into care and thank goodness, thank the Lord she passed away [talking about her mother's illness]." – (Jenny, married, Eddie's friend, Milltown 72)

Only Libby, with compromised health, felt that residential would be suitable for her, but did not wish to leave her husband Dave, who wanted to age at home. Their current home is a small beachside settlement about twenty kilometers from the nearest rural town. They had previously tried to sell their home but had been unsuccessful.

"My husband you know he wants to stay here so…uh if I had a choice or the doctor said to me you would be better off in a home well inside I would be laughing when do we go? So I think that the government want you to stay in your home for as long as possible and there is nowhere to go, there is a waiting list, virtually someone has got to die." –(Libby, married, primary, Sugar Town 77)

In a few cases, there were differing views within the network concerning the location of ageing, with partners and children having different views and planning on ageing in different locations. In one case, the children had suggested a relocation plan without any discussion about the desires of the parent, which had caused conflict in the relationship.

"So I don't think it's in the plan of things that my family will be—they're there but they're certainly not going to be looking after me." –(Carrie, widowed, primary, Cattle Town 71)

Mismatch in expectations of relocation between a daughter and parent was shown in another case where the parent expressed a desire to move into a granny flat and the daughter would prefer assisted living accommodation. Couples also named different locations as to personal preference to age, with one partner naming one family member to relocate to and the other naming another. Both couples had partners, and, on reflection, they may have answered the question thinking about the loss of their partner and what they would do then.

"They're solid so he'd probably live there if anything happened to me but I wouldn't, I'd live here." –(Clare, married, primary, Milltown 74)

For some the rural aspect meant that they were reliant on being able to drive to stay in their current home—public transport was limited in all locations, and for those participants living on large rural blocks, non-existent. For these participants loss of their driving license was related to loss of their independence and access to local services. For Clare and her husband this prompted the move to the rural town, to continue to access services and keep connected with her social network.

"I mean you can lose your license and you can't go anywhere and he said he doesn't want to be dependent on other people. It's not what we want to do, it's just being sensible." – (Clare, married primary, Milltown 74)

For Sophie, although living in town, a lack of transport was a factor in considering future relocation to maintain independence.

"I'd just like a bus, I'd just like to be able to get out of this place without relying on somebody else … to say I'll get the bus." – (Sophie, married, primary, Milltown 73)

Throughout these interviews, reciprocity in driving was frequently seen between friends and families. Whilst the recipients were in need of these services, there was a common theme that they did not like to ask or be "*a burden*".

6.5.6 Discussion

Much of the research into social networks has been on care required and older people with chronic conditions. In contrast, this study has involved healthy community-residing individuals who form the majority of older people in Australia (Keating & Dosman, 2009). This study shows that older people are constantly reflecting on their environment and whether it is the right fit for them and their needs. It looks at the impact of social networks and local community services when considering whether to age in place. Assessment of local support that they can access and how others have managed is essential for future planning. This is in contrast to the widely held view that ageing is a time to reflect on the past, and older people have to plan for the future, which may include relocation to allow them to maintain their independence (Terrill & Gullifer, 2010).

Although social networks do not guarantee the provision of support, they are the vehicle that holds the potential of informal support for ageing in place, and this potential capital needs to be accounted for when considering a relocation (Keating & Dosman, 2009). Results show that friends provide a lot of emotional support, especially in the absence of family due to living at a distance, although strong family connections were still shown. Peer friendships, especially including a close confidant, confer a protective effect on mortality (Giles et al., 2007; Yasuda et al., 1997). However, friends and confidants in this study tended to be of a similar age, which may limit the potential of available instrumental support (Litwak & Longino, 1987).

Social networks also increased the awareness of available formal support that may influence the decision about whether or not they would be able to stay in their own homes. Knowledge and availability of home care services is a major factor when making the decision whether to stay in the community (Tang & Lee, 2011). Most participants in this study were in their late seventies and were aware of the formal local aged care support services from their peers, and discussed how these services might be relevant to help them age in place. Some participants had already accessed forms of formal support to implement modifications to their home. Monitoring how their peers coped with losses or shifts in independence also helped participants decide on what would or indeed would not be suitable for them (Carpenter et al., 2007).

Within this study there was an expectation that in the event of age-related illness or decline that family, mainly adult children, would be on hand to provide support. This is the normative expectation, with adult children continuing to be the main providers of age-related health and social support to their parents. More than half of middle aged daughters are called on to provide care for their ageing parents (Silverstein et al., 2006). However, accessing this support was not taken lightly, with many naming it as a last resort and putting limitations on the type of support they would accept from their children. No personal or financial support from children would be accepted, with the overall theme of "*not wanting to be a burden*". Whilst it was expected that the children would provide support, there was no clear concept of what that support would be. There were comments on how busy their children and grandchildren's lives were, distance as a barrier, and the fast pace that life was lived. It may be that this "generational observing" lowered their expectations of available care (Timonen, Conlon, Scharf, & Carney, 2013). Whilst the majority of adult children accept there is an obligation for them to provide support for their parents, there was no agreement on what this support should consist of (Finch & Mason, 1990).

Much of the research into rural ageing has been concerned with inferior service and delivery of health care using a marginalization lens. However, for healthy community-residing adults this does not influence their views on the suitability of their community (Boldy et al., 2011). This was consistent with the findings of this study. Suitability of the community may change in response to health declines and the need for increased use of local health services. This is the uncertainty of ageing, in that older adults most constantly reflect on what the future may hold and take action to maintain their independence. We can never know the future. It should be noted that not all older people have the resources to maintain their independence, finances to move, a social network or family to support them. Some participants in this study had no contingency plans if they were unable to manage in their own home, and expressed a desire to die in their own home. For this group the future holds uncertainty, and a dramatic increase in care requirements may force a crisis point, leading to entry into long-term residential care.

6.5.7 Conclusion

Rural communities offer social support, with many older people being part of integrated social networks. Older people with no health problems are well supported in these communities. Whilst there is an expectation on the family to provide support to allow ageing in place, there is no agreement on what form this support should take. When considering relocation, proactive moves are made with the purpose of maintaining independence, lifestyle or moving closer to family. Reactive moves occur in response to a decline in health when there is a need to relocate to access

health services and available social network support. This study shows the need to promote and facilitate conversations about care expectations of social networks at community level to allow for proactive ageing in place.

6.6 Chapter Conclusion

This chapter presented four publications analysing the core findings of this study. The first publication explored the social construction of ageing in north Queensland as portrayed in local media and its effect upon identity. Subsequent publications outlined ageing and identity, coping strategies, social networks and decision making. Although participants were aware of the negative connotations of identifying as old, they were still able to be reflexive and accept this identity. Their age identity was fluid and reflexive, which enabled them to deny the incorporation of dependency into their psyche. Self-perceived identity was negotiated through physical appearance, physical limitations and self-efficacy.

Older adults used different coping strategies for different challenges with problem-focused problem solving and seeking social support strategies used in practical matters. However, when contemplating future care needs the majority of participants evoked emotion-focused strategies including distancing, avoidance and positive re-appraisal. Social networks, both kin and non-kin, were shown to provide support to assist ageing in place. Monitoring of network peers and their use of aged care support services provided informational support when reflecting on whether the community could provide support for older residents to stay.

The next chapter will build on the concepts and understandings developed in these manuscripts and focus on how they relate to trust and risk in ageing in concordance with Giddens' Theory of Structuration.

Chapter 7 Discussion

7.1 Introduction

The previous articles have illustrated the socio-cultural experience of ageing and how older adults and members of their social networks identify and cope with the ageing process. They have shown that older people exhibit both agency and reflexivity in navigating their ageing journey.

This chapter will discuss how the drivers of modernity, increased separation of time and space along with disembedding systems, have informed ageing the post traditional world. It also explores the role that these drivers play a part in the forging of new age identities, coping with ageing and in the provision of informal support in contemporary society. In the final discussion, the roles of trust and risk will be explored in an effort to construct a conceptual framework of rural ageing based on Gidden's Theory of Structuration.

7.2 The Evolution of Risk in Rural Ageing

Risk management has become an industry in itself; the "colonization of the future", as individuals seek reassurance about and protection against possible adverse life events (Giddens, 1991, p. 111; 1999b). For older people moving towards the future, the risk of a contemporary society is that the provision of age care is now moving away from obligation and societal rules, to individualism. To navigate the future, older people need to rely on themselves and their social networks to manage the risks and the uncertainties that they face. Older people now reflect on which risks that they will take on and manage, and conversely, which risks they will choose to ignore. Although on the surface it may seem that ignoring the risk may be fatalistic, this study has shown for many older rural adults that avoidance can be a legitimate risk control strategy.

Considerable risk arises from government policies and the underlying messages that they convey to older people. Governments are mainly concerned with producing a stable economic future, which they construct by employing policies that position older adults as being a risk to society. They situate older adults as dependents and threats to future generations, requiring and using resources better utilised by younger citizens. This dependency is countered by the legitimisation of ageing through work (paid or volunteering), recognising older workers as contributors to society, along with the introduction of mandatory superannuation contributions, annuities, life insurance and raising the pension age. Likewise, it may not be financially viable for all older people to retire and many still wish to remain in the workforce. There are policies in place to promote the employment of older workers (Australian Human Rights Commission, 2012, 2013). However neoliberalist healthcare policies seek to disinvest the government of responsibilities for older Australians, moving the

economic support for aged care away from the welfare state and back to the individual and the capitalist market, causing a breakdown of trust in contemporary society (Biggs & Kimberley, 2013). National and regional media have disseminated this underlying message (of dependency) and promoted the idea that ageing itself is risky, as well as negative ageing stereotypes. The disproportionately large numbers of older people in rural areas ageing in rural towns may be perceived as a risk in itself, as evidenced by discourses in rural towns about community refreshing.

In this neoliberalist construct, older adults who have not generated enough resources to secure their future are now deemed as a risk, taking up more resources than others who better managed this risk; this in turn may lead to social censure. Conversely older people who have had earlier life advantages: education leading to a well-paid job and the building up of financial resources, are seen as successful in negating this risk (or in some media narratives as having an unfair share of resources). Financial resources can offer some protection against the risks of ageing. In this study, more resources enabled more choice in consideration of whether to use private home care services (deemed better) or public care services to support ageing. However, as discussed previously, there are more types of resources to support ageing beyond finances alone.

7.3 Trust and Risk

In a risk-aware society, individuals have to anticipate and manage risk to navigate through the life-course. In the post-traditional world this is now part of everyday life, with most risk assessment taking place in response to practical day-to-day circumstances. When driving, individuals expect others to follow the rules, driving on the correct side of the road and stopping at red lights. This allows for a cocoon of trust that is essential for maintaining our ontological security and engaging with routine life (trusting others to behave in an expected ways). However, once a risk is consciously detected, individuals need to assess this risk to decide which action to take. For example, if a car is being driven erratically it may be wise to pull over and let it pass. Human agency enables an individual to exert control over their resources within their capacity, and reject or accept society's norms and rules. It is this negotiation and reflexivity that enables the individual to undertake action in response to detected risks. An individual may suffer from declining health and worry about whether this will affect their ability to remain independent in their own home. On consideration of the local resources and social support available, the individual may decide to move closer to family (the main supporting resource) or alternatively into supported accommodation.

Older people in this study were aware of the negative dependency constructs propagated by the media. For older participants, although they were no longer in the workforce, their previous work identity still held importance. Holding on to this identity may enable them to retain their agency in

the face of a society that uses work as a legitimising norm and as a large part of a person's identity. Whilst they may not gain agency from media dependency constructs, their social networks may work together to regulate their own social construction of ageing and maintain their ontological security. Agency in ageing may be supported by the people whose views matter to older people. It is through networks composed of family and peers that older people are more able to adapt their ageing identity by becoming more aware of their unique selves and what they bring to relationships rather than previous roles (Tornstam, 2005). An older member of a network can be mentor to younger network members, passing on knowledge and technical skills. For example, ex-mechanic Reg provided technical advice to his children. People in my study reflexively adopted these unique identities and lifestyles, enabling them to fit into multiple social systems as family members, as peers and as part of larger communities (Whittington, 2015). This stable sense of self or ontological security is essential for each individual's agency and their incorporation into social systems (social structures).

Ageing in place in rural Australia can produce its own set of risks, but to older community members in this study it appears to be a worthwhile risk. Engagement with the community through membership of clubs and faith communities increases a sense of belonging. In integrated networks, reciprocity builds up trust and social capital. This engagement was evident even in restricted social networks in which low levels of participation still linked individuals to the community. While rural residents only travelled the long distances into town infrequently, they retained a sense of belonging and trust in their community. Social cohesion in these rural communities was built upon shared values and norms: history, experiences and social engagement promoting a sense of connectedness and wellbeing. Rural dwellers faced the same challenges of drought and underemployment with the support of the community coming together to cope with these challenges. This may lead to greater social trust in rural networks, increasing reliance on the social capital they engender to support older people in taking the risk to age in place.

The decision to age in place is an ongoing negotiation rather than a point in time decision. Each individual, depending on their circumstances and resources, has some capacity to be reflexive and make their own choices. Older people (particularly those with low resources) may have fewer options to manage risk when compared to their younger or better resourced counterparts, who with more financial, educational or power resources can negate this risk (Beck, 1996; Powell, 2008). Although Giddens discusses the role of resources (structures) promoting agency and action in structuration, he does not consider the impact of these resources when risks have to be managed and how resources can affect older people's agency and power to act. Individuals living in rural areas with risks such as a limited formal health services and transport, relied considerably on informal

support from their network. Individuals in these networks are aware of the lack of resources (and resultant risks), but may trust that the social capital held within that network will help them overcome these deficits and provide support.

In an attempt to reduce health care expenditure, the political discourse on ageing tends to suggest that health and functional status are under the control of the individual, putting the responsibility onto older people (Katz, 2013). Again, these views are developed based upon the expectation of older people being self-responsible actors undertaking rational actions, which may not always be the case. This ongoing discussion around successful ageing further puts the onus back to the individuals, with success in ageing comprising of avoidance of disease, maintenance of physical and cognitive functions and active engagement in life (Bowling & Dieppe, 2005). In addition this individualistic approach in public policy is in direct contrast to communitarian belief systems, such as those found in Indigenous and some immigrant communities. This promotes a limiting and limited view on ageing. Older people are a heterogeneous group, and are all undertaking their own journey. Rural participants engaged in many ways to age successfully. To older people, ageing is a subjective concept. Some individuals with age-related health decline saw this as a natural part of ageing, whilst others viewed this as a failure. Staying in the community, and coping with disability, having choices and living their own lives may be more important to older people than being expertly cared for in an aged care residential home with no control. This decision to age in place may be viewed by family members, friends and health professionals as an irrational and risky choice in the face of possible health related decline. However given the heterogeneity of older people it may be impossible to predict who will age successfully just by accounting for the resources, rather, it depends on the individual and their agency to control and draw on these resources.

Individuals in this study exchanged resources and social capital within the community and with their families. Families and friends provided emotional support as well as practical help, such as shopping and transport. Although much of the literature rates large integrated networks as the most advantageous to ageing successfully, this study suggests that family restricted networks may also provide support, but that this can come at a cost (Anderson, Larkins, Beaney, & Ray, 2018). Closed family networks played a protective and supportive role, enabling older people to age successfully. However, when adverse life events caused stress this was experienced and internalised by all the family members, sometimes leading to a breakdown in coping (Wenger, 1997). Integrated networks were more diverse, consisting of both kin and peers, which allowed for more emotional distance. These larger diverse networks may spread provision of care needs across multiple members leading to less of an impact when coping with adverse events. In this study integrated social networks

provided bridging capital that facilitated personal connection to services to enable them to stay in the community.

Despite the social fragmentation described in this post traditional era, participants still expressed trust in the social capital held in the family unit, as well as trust in the social capital held in non-kin relationships. All older people in my study had expectations that family would provide support to cope with ageing across all network types, suggesting that family units were still strong. This was evident regardless of the distance from family at which the ageing member was living. In rural areas, in the absence of younger family members, non-kin can become more important in terms of supporting the ageing journey and may replace the role of family, with peer social engagement becoming stronger due to shared experiences. It was clear that family care may be accepted, but what type of care would be acceptable to older people was yet to be negotiated (for example many did not want close personal care from family), and this enabled them to exercise their agency. Although on the surface this expectation would support the traditional norm of children providing care for their parents, this was not the case, with participants limiting the type of care they would accept from family, along with observations about the type and amount of care family members could provide. Rather than sitting back and being dependent on family, older people's expectations of care were reflexive and constantly changing depending on information received (Hodgkin, 2014; Timonen et al., 2013).

7.3.1 Negotiated Care - Families

This increase in democracy (giving each family member agency), supports a negotiation of the care model with the new intergenerational contract being a fluid agreement no longer dependent on tradition, with care mostly given out of love rather than duty. Negotiation enables each party to consider and decide what support is available and what support would be acceptable. The decision of the family to provide care, or conversely the decision of the older person to receive care is based on rules and norms built up over a generation of family relationships and interaction. Network members reflect upon the social norms and traditions and act accordingly if they can legitimize the action through their belief system or within their capacity to provide this care. Tronto's 1993 description of "family care as a naturalized activity in which no consideration of the terms and conditions of the work are required, voices are silenced, and power and obligation structure its provision" (Tronto, 1993 p. 66), is no longer the case for ageing in this rural study. Negotiated trust now replaces obligation. The risk in this model is a mismatch in beliefs and expectations resulting in feelings of guilt and resentment, as evidenced in two networks in this study. In the traditional model

of care, older parents often moved into the family home, and where this option is expected (based on previous norms), but not offered due to changing intergenerational norms, conflict may result.

However, tradition still plays a part in the consideration of provision of future care for ageing in rural Australia, with existing expectations voiced in this study. Women were expected to be the main care providers, and expectations on males to provide support for ageing were lower. It was unclear whether this was a push effect (from the social network) or a pull effect on females to care. Silverstein's study on intergenerational support reported a stronger pull effect on females to care based on their normative beliefs and obligations than the pull effect on adult males, so both these factors may have been in evidence (Silverstein et al., 2006). However, higher expectations on provision of care by female network members suggests that gender democracy has not yet been achieved.

7.3.2 Care and Trust in Abstract Systems

Post-traditional societies have moved from traditional drivers of trust: kinship, community, religion and tradition, to that of negotiated trust. When Giddens discusses trust in post-traditional society he claims that the norms and beliefs that previously created trust are now undermined, and that all individuals need to actively work to gain trust (Giddens, 1990, 1991). Participants in this study employed two types of trust as proposed by Giddens: "facework commitments", which exist in direct interactions of a daughter caring for her ageing parent or the receptionist at the local general practitioner, or "faceless commitments", trust in abstract systems such as social welfare. The individual perception of trust is then embedded in the level and quality of the individual's interaction, with their daughter or welfare system and their perceptions of reliability and trustworthiness. Both types of trust are essential in order to function in contemporary society. Trust is the link between social networks on one hand, and the individual on the other. In contrast to Giddens post-traditional world, kinship, community and religion were still very prominent in rural social networks. Participants described a sense of community, with many taking part in volunteer organisations that provided support for their peers, as well as strong participation in organized religion. However, whether this community involvement was in response to reduced services, was unclear, and this increased level of engagement with the community may be a risk management strategy to increase the likelihood of reciprocal support given back if required. Regardless, the continued involvement by participants in facework commitments (traditional drivers of trust), may then translate to high levels of trust within their community.

Giddens argues that, in a post-traditional society there is no place for trust in religion, rather life is shaped by man through science, technology and the economy. Yet this was not the case in these

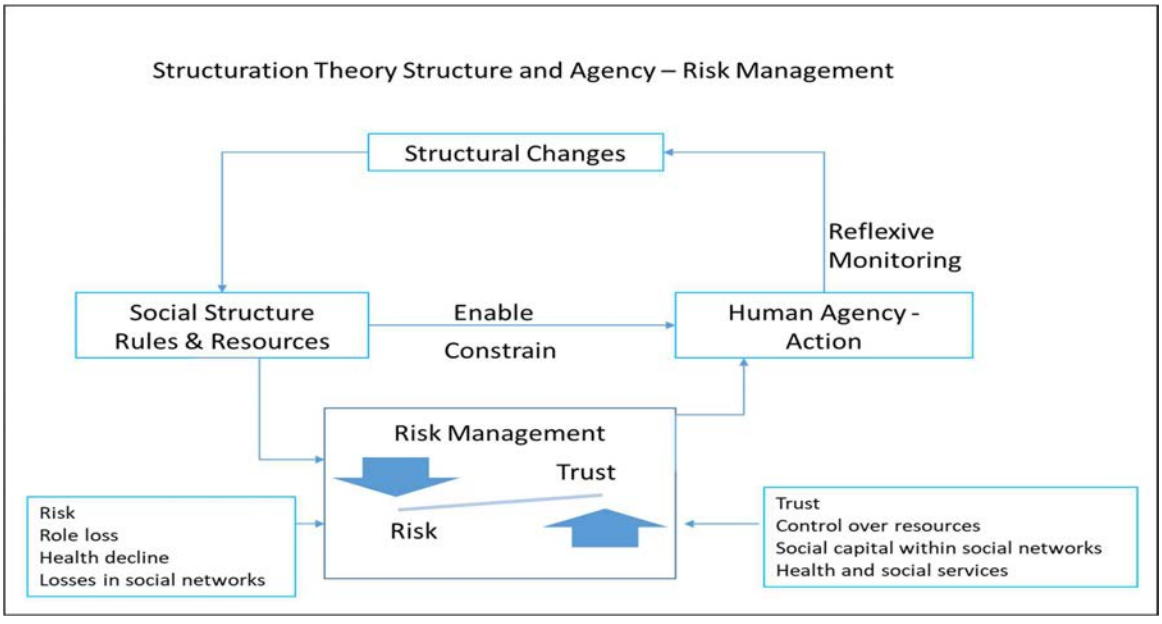
rural communities, where faith still played prominent role in supporting the ageing process, both in helping people cope with challenges and providing connectedness within the community.

7.4 The Structuration Model of Rural Ageing (Risk Management)

In Structuration Theory both trust and risk both play an essential role in the ageing process. To trust in an action, we need to have awareness of the risk that taking this action incurs. Both, therefore, need to be considered and interlinked with structures, resources and human agency before action occurs. Every action that older people consider: be it staying in their rural community or leaving, is an example of reflexive thinking and risk management.

Figure 7.1 demonstrates the interplay between trust and risk in ageing in rural communities. It shows that older people undertake constant and renegotiated risk management between the risks that they face in ageing (health decline, financial risk and role loss), against trust in their resources (financial, social or informational). It is through this reflection on their available resources along with the trust that each individual has that these resources will enable them to cope with the prevailing risks, that an individual decides whether or not to take action. In this way, trust promotes both agency and independence. When family lives in the local community, there may be trust that they will provide care based on family norms allowing for ageing in place. However, in contemporary society others in the network also have the agency to change the system, based on their hierarchy of risk management. Hence there is always the risk that expected care will not be forthcoming or acceptable.

Figure 7.1 The interaction between trust and risk



7.5 Strengths and Limitations

Study strengths were a clear documentation of the conduct of the research study, as well as member checking and consideration of researcher reflextivity throughout the whole project. In addition I stayed in these communities, ate in the local cafes and soaked up the context of the participants experiences.

Several limitations should however be noted in the conduct of this study. For example, the recruitment method used in this study: through clubs, churches, general practitioners and community organisations, might have selected for more socially engaged people. Although participants were screened for inclusion, there was still an evident difference in physical abilities, in that although everyone could perform most of the independent activities of daily life, it was easier for some than others, and depended on the outlook of the individual. The study included a small number of participants and members of their social networks from three rural and remote communities in north Queensland, and may not be transferable to other rural and remote areas. Although given the variability and diversity in the sites chosen transferability may be higher than expected. In addition, having the interviews approximately a year apart may not have allowed for enough time for changes to occur, and perhaps a longer time frame would have captured more changes although not feasible within my PhD timeframe.

This study did include Indigenous groups by chance, but due to the small numbers, ethnicity-based differences and the cultural aspects of ageing were not explored in any depth. Finally, in Australia there is a strong rural identity based around independence and resilience, hence these results may not be transferable to urban populations, nor was this the intent.

7.6 Conclusion

This study used Gidden's theories and ethnography to explore ageing in rural communities, as described by 11 participants and their social networks from three rural and remote towns in north Queensland. Older community dwellers shared their experiences of ageing in place, and revealed what their community meant to them, along with their plans for the future. Community engagement through clubs, volunteering and friendship groups supported their identity and provided emotional and informational support. Family was still trusted to take a role in providing future health care needs if required, but plans for the future were not always discussed with family. The importance of friendship networks in rural areas where family resided at a distance showed that non-kin support may be of great importance in these rural areas. Ageing peers also provided assistance for ageing in

place by raising awareness of services that were available and by sharing their experiences. This enabled other network members to include these services when considering future needs.

7.7 Implications for Policy

New forms of ageing require new forms of policy. Governments need to move away from trying to legitimize older people through paid work. However, they have introduced new policies to support employers to employ older workers, stating that they are a lost resource. Although an older worker is classified as a worker aged 55 years or older, ageism is still apparent in many workplaces. Many policies involve the monetarisation of ageing, and frame older people's contributions including informal care using dollar values. In this way those that are not directly earning or saving the economy money are seen as non-contributors and their many family and social contributions are devalued. These policies are heavily dependent on older people in the professional economy and are based on a workforce that values cognitive labour rather than manual labour or family. However, as shown in this thesis, manual labour is still in evidence and rural economies work differently, based on family succession and dictated by the seasons. We need to identity these rural challenges along with supporting and acknowledging the positive contribution that older people bring to their communities. It is only by doing this that we can change the negative social construction of ageing.

Given that informal care is the cornerstone of all care, there is a need to understand the ever-changing dynamic of the family to ensure that our older population can receive care at home and not rely on traditional gendered obligations that may no longer by available. Given the increasing demand for aged care services in rural areas, policies must consider the challenges of service delivery in rural areas and mechanisms to incorporate coping strategies. Government should promote socially connected communities enabling older people to age in place.

7.8 Implications for Practice

This study demonstrated that there is a need to promote the discussion of possible future care needs within families. Individuals may not recognize or be willing to recognize their need to plan. In addition, adult children need to accept that their parents are ageing and may need care. There may be a role for health professionals to prompt this discussion with older individuals, particularly those who are frail or have chronic health conditions empowering them with strategies to start this conversation. Funding could be provided to community workers to implement community-based activities that promote social engagement in older people in order to facilitate the build-up of social resources. Awareness of non-fiscal planning for ageing should be given more attention, as well as more education based on a strengths-based supportive approach.

7.9 Future Research

Given the increased national and international mobility of younger family members for career and lifestyle opportunities, there is a need for further longitudinal studies into how care in ageing is negotiated, especially in rural areas when the family lives at a distance. It is clear that there is still a role for the family in the ageing process, and consideration about how family can best provide care and support at a distance is required.

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Appendix One – Ethics and Consent

1.1 Ethical Approvals

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1.2 Information Leaflet

"Youth is the gift of nature but age is a work of art"

Stanislaw Jerzy Lee

To arrange an interview time or for further information please contact:
Emma Anderson
Phone: 07 4781 5107
Email: emma.anderson1@jcu.edu.au

Supervisor:
Dr Robin Ray,
Senior Lecturer
College of Medicine & Dentistry
James Cook University
Phone: 07 4781 5835
Email: robin.ray@jcu.edu.au

Ethical Approval

This study has been approved by the James Cook University Ethics Committee, if you have any concerns please contact: Phone: 07 4781 5011
Email: ethics@jcu.edu.au
Approval Number H6262

Taking part in this study is completely voluntary participation and participants can withdraw from the study at any time without explanation or prejudice.

JAMES COOK UNIVERSITY AUSTRALIA

Social Networks and ageing at home in rural north Queensland.

Research Project Information

Project Title

Social networks and ageing at home in rural north Queensland

What is a Social Network?

A social nework is the group of family, friends, neighbours and accquaintances that we interact with. It is used to identify relationships and structure within social groups.

Research Aims

My research aim is to investigate the informal support given between family and friends to support healthy ageing in rural north Queensland.

Research Objectives

What are the challenges and expectations of ageing in rural north Queensland?

Are the challenges and expectations of ageing the same within social networks?

What plans do older Australians and their social networks have in place to address these challenges?

Why I am doing this study?

I have a special interest in ageing; the challenges faced living in rural environments and the support provided to and given by informal social networks. This study will be the basis of my research degree. I hope that the results of this study may inform upon future rural aged care policies.

How to get involved

If you are aged over 65 and live in your own home in Town 1, Town 2 or Town 3 I would like to invite you to be interviewed. Interviews will be audio-recorded and arranged at a time and place to suit your needs. The interviews will take about 40 minutes.

I would like to hear your views on ageing, your home and social support provided by and given to friends, family and neighbours. You will be asked to participate in two interviews with about an 18 month interval in between (this can be longer if required).

In a similar way I would also like to interview friends and/or family in your social network. This includes anyone that you socially interact with and that you are happy to nominate. These interviews will be conducted at a venue of your contact's choice and can also be done by telephone.

While we do need to collect your interview responses and your contact details (so that I can contact you again in about 18 months' time) all information you give me will be strictly confidential.

1.3 Information Sheet – Primary Network Member

Views of older residents in rural north Queensland and their social networks about their planned approach to healthy ageing in place: a series of case studies.

You are invited to take part in a research project to gather you and your social networks views on ageing in rural Australia. The study is being conducted by (myself) Ms Emma Anderson under the supervision of Dr Robin Ray, Professor Sarah Larkins and Dr Sarah Beaney.
I have a special interest in ageing; the challenges faced in living in rural environments and the support provided to and given by informal social networks of friends, neighbours and family. This study will be the basis of my research degree.

If you agree to be involved in the study, you will be invited to be interviewed at a time and place to suit to your needs. This can be in your home or any place that you feel comfortable. The interview, with your consent, will be audio-recorded, and should take about 40 minutes of your time. The first interview will involve completion of two short screening tools to determine your eligibility for inclusion in this study so may take a bit longer. I would like to interview you twice with about an 18 month interval in between interviews (this can be longer if you require). In between these interviews I will provide a newsletter on my studies progress.

In a similar way I would also like to interview friends and/or family in your social network. This includes anyone that you socially interact with and that you are happy to nominate to be interviewed. These interviews will be conducted face to face at a venue of your contact's choice or by telephone.
Taking part in this study is completely voluntary and participants can withdraw from the study at any time without explanation or prejudice. You may also withdraw any unprocessed data from the study.

While we do need to collect your interview responses and your contact details (so that I can contact you again in about 18 months' time) all information you give me will be strictly confidential. Only de-identified and aggregated data from the study will be used in my thesis, research publications and conference presentations. You will not be identified in any way in these publications.

Participants will receive a $10 gift voucher at each interview as a small thank you for your time.

If you have any questions about the study, I am happy to be contacted – Emma Anderson.

Some people may find talking about ageing upsetting. If you need support as a result of this interview, please contact a Lifeline counsellor on 131114

Principal Investigator:
Emma Anderson
College of Medicine & Dentistry
James Cook University
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Email: emma.anderson1@jcu.edu.au

Supervisor:
Dr Robin Ray, Senior Lecturer
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Email: robin.ray@jcu.edu.au

This study has been approved by the James Cook University Human Research Ethics Committee

If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 ethics@jcu.edu.au

1.4 Information Sheet Social Network Member

Views of older residents in rural north Queensland and their social networks about their planned approach to healthy ageing in place: a series of case studies.

XXXX has suggested that as a member of their social network you may be interested in taking part in a research project that gathers older Australians and their social networks views about ageing in rural Australia.
The study is being conducted by (myself) Ms Emma Anderson under the supervision of Dr Robin Ray, Professor Sarah Larkins and Dr Sarah Beaney. I have a special interest in ageing; the challenges faced in living in rural environments and the support provided to and given by informal social networks of friends, neighbours and family. This study will be the basis of my research degree.

If you agree to be involved in the study, you will be invited to be interviewed at a time and place to suit to your needs. This can be in your home or any place that you feel comfortable. Interviews can also be conducted over the telephone. The interview, with your consent, will be audio-recorded, and should take about 40 minutes of your time. I would like to interview you twice with about an 18 month interval in between interviews (this can be longer if you require).

Taking part in this study is completely voluntary and participants can withdraw from the study at any time without explanation or prejudice. You may also withdraw any unprocessed data from the study.

While we do need to collect your interview responses and your contact details (so that I can contact you again in about 18 months' time) all information you give me will be strictly confidential. Only de-identified and aggregated data from the study will be used in my thesis, research publications and conference presentations. You will not be identified in any way in these publications.

Participants will receive a $10 gift voucher at each interview as a small thank you for your time.

If you have any questions about the study, I am happy to be contacted – Thank you, Emma Anderson.

Some people may find talking about ageing upsetting. If you need support as a result of this interview, please contact a Lifeline counsellor on 131114

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Phone: (07) 4781 5011 (ethics@jcu.edu.au)

1.5 Consent Form – Primary Network Member

1.6 Consent Form – Social Network

1.7 Newsletters

Social Networks and ageing at home in rural north Queensland

Newsletter February 2017

Research Update

Firstly thank you to everyone who has given up their time and taking part in this project - your help is very much appreciated and without you there would be no project!

Research Update

Just a quick update I am now recruiting in Town 2 and hope to start recruitment in Town 3 and Town 4 this year. For everyone in Town 1 who has helped out I will be in contact for a follow-up interview in the next 6 months and look forward to seeing you all again.

One thing coming from all my interviews is the large amount of care and support out in the community that you give each other. I have some good news in that I was successful in gaining an Australian Government Research Scholarship which will allow me to work on my studies full-time for the next two years!

Research Presentations

In 2015 I met a wonderful lady Madge Sceriha who gave me advice on my research and with her enthusiasm and guidance joined the organizing committee for The Ageing in North Queensland Symposium 2016. The Symposium was organised by the Townsville Region Committee on the Ageing (TRCOTA) in collaboration with James Cook University and was held in late November 2016. The Symposium brought together a diverse range of speakers and included lively panel discussions with community members and government groups from Mackay to Cairns and Charters Tower. This event aimed to ensure that not only do we advance the rights of older people in North Queensland, but we examine the issues, barriers and challenges they face. Keynote addresses were given by Dr Robin Ray from JCU College of Medicine and Dentistry and Mr. Mark Tucker Evans from Council of The Ageing QLD. I also presented on the importance of social networks and rural ageing.

We were lucky enough to have Seniors for Change entertain us all with their wonderful singing

Upcoming Presentations

The National Rural Health Conference is taking place in April in Cairns and I have been lucky enough to be selected to give a presentation. I will be giving a short talk on "Media reporting on ageing in rural and north Queensland" which critically looks at negative stereotyping of older people in the media as a significant social issue. If you would like further information please let me know and I can send you the full article. Details about the conference can be found at www.ruralhealth.org.au/14nrhc/
If you have any questions or need to update your details please contact me emma.anderson1@my.jcu.edu or 4781 5107

Social Networks and Ageing at home in north Queensland

Newsletter January 2018

QUICK FACTS

The Economic Value of Informal Care in Australia

Older Australians currently provide $40 billion dollars in unpaid care per year looking after family and friends. This care is the cornerstone of current Government aged care policies promoting ageing at home.

Australian Research Council
Population Ageing Research

Research Update

Firstly - I hope that everyone had a happy and social Christmas with all your family and friends and wish you all every happiness and health for 2018!

Thank you again for giving up your precious time and agreeing to be interviewed it is much appreciated.

The research project has now entered its second year and soon I will be in contact with the participants in Town 2 and Town 3 for the second interview. I look forward to seeing you all.

I hope to complete all the interviews by the end of April and concentrate on finalizing my PhD in 2019. Again, this would not be possible without you all giving up your time.

Research Presentations

I will be presenting some of the results from your first interviews at the International Ageing and Society Conference in Tokyo this year. This presentation will discuss rural residents and their choices for ageing in place.

The Ageing and Society Abstract

Should I Stay or Go? Rural Aging a Time for Reflection

Studies have shown that older people prefer to continue living in their own home and community as they age; however, this is dependent upon available services and social support. In Australia about two thirds of people will age at home. The Australian government provides home care packages to provide support to age in place however in rural areas not all services are available. The lack of employment opportunities in rural areas often results in family residing at a distance reducing available social support.

A multiple embedded case study was undertaken in three diverse rural communities. Older rural residents aging in place were interviewed about their aging experience and plans for their future when they review available social support. Social networks were then visually depicted with the use of ecomaps and network members were then interviewed. Results show that aging is a time of change and reflection and there is a need for more discussion within these networks when it comes to future planning. It is hoped that results will inform policies that help support aging in place for rural residents.

1.8 Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

Developed from:
Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	EA Pages 61-62
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	BSc Page 145
3. Occupation	What was their occupation at the time of the study?	Research Support Page ii
4. Gender	Was the researcher male or female?	Female Page vi
5. Experience and training	What experience or training did the researcher have?	Researcher was supervised by experienced researchers in this methodology including a geriatrician. EA has done a previous qualitative research project and attended workshops and training.
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	No participants were unknown to the researcher prior to interviews. Page 61.
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Information leaflet Page 201
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Pages vi and 68
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory,	Pages 3, 54-57

	discourse analysis, ethnography, phenomenology, content analysis	
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Page 61
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Page 61
12. Sample size	How many participants were in the study?	Page 70
13. Non-participation	How many people refused to participate or dropped out? Reasons?	Page 62
Setting		
14. Setting of data collection	Where were the data collected? e.g. home, clinic, workplace	Page 63
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Page 63
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Pages 57-59, 62
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Pages 60 & 64
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	Yes two interviews. Page 62 and throughout results and discussion
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Audio recording Page 64
20. Field notes	Were field notes made during and/or after the interview or focus group?	After interview Page 62
21. Duration	What was the duration of the interviews or focus group?	30-60 mins Page 64
22. Data saturation	Was data saturation discussed?	Not relevant in case study design.
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	No - but were discussed at second interview page 66.
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	2 Data Coders Page 67
25. Description of the coding tree	Did authors provide a description of the coding tree?	Page 125
26. Derivation of themes	Were themes identified in advance or derived from the data?	Derived from the data. Page 66
27. Software	What software, if applicable, was used to manage the data?	NVivo Page 66
28. Participant checking	Did participants provide feedback on the findings?	Page 67
Reporting		

29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Quotations used throughout results section. Aliases were used.
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Chapter 6. All analysis is supported by data quotes.
31. Clarity of major themes	Were major themes clearly presented in the findings?	Chapter 6 presents the four main themes
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Minor or diverse themes are discussed in chapter six.