Understanding ageing well in Australian rural and regional settings: Applying an age-friendly lens

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Abstract
Objective: This study investigates 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.

Design: Data were gathered through open-ended response postcards distributed using a whole-of-community approach.

Setting: The Rural City of Wangaratta, a rural local government area located in north-east Victoria.

Participants: 262 postcards were returned by rural older adults, carers and family members.

Main outcome measure: 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?

Results: Even though all eight age-friendly domains were identified as important for health and wellbeing, community and health services was the most frequently discussed domain, followed by transportation and access to outdoor spaces and buildings. However, individual-level factors, inclusive of personal activities, attitudes and capacities, were also identified as important to rural older adults.

Conclusion: Findings support the use of the World Health Organization’s age-friendly city framework in assessing what is important to rural older adults’ health and wellbeing, with the community and health services domain most salient. However, individual-level activities, attitudes and capacities must also be considered.

KEYWORDS
age-friendly, ageing well, community services, older age, rural

1 | INTRODUCTION

In Australia, the proportion of people over the age of 65 years has increased from 12% to 15.3% in the past two decades and is expected to increase to 22% by 2061. A higher proportion of older adults reside in rural areas, and the proportional growth of older adults in these regions is projected to be twice that of metropolitan areas by 2021. This trend is due to age-specific migration flows, including youth outmigration to metropolitan areas and immigration of older people for lifestyle reasons. The rural residents experience higher rates of chronic disease, injury-related deaths
and depression compared with their metropolitan counterparts, and rural population ageing is expected to increase the rates of chronic disease and mental ill health.

In alleviating the purported economic implications associated with population ageing, and enhancing the quality of life for older adults, governments have developed policies encouraging active, healthy ageing. One approach is the World Health Organisation (WHO)’s Global Age-Friendly Cities and Communities framework. An age-friendly community (AFC) is one that enhances the older people’s quality of life by providing opportunities for health, participation and security, and the WHO framework has identified eight community domains that contribute to age-friendliness: outdoor spaces and buildings; transportation; housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community and health services. Similarly, the Canadian Age-friendly Rural and Remote Communities guide identified the same eight domains, although it had also included features and barriers, specific to rural settings, within each domain.

Rural communities encounter additional challenges to age-friendliness that are not prevalent in urban communities. For example, they often possess a limited infrastructure, limited transport options, reduced opportunities for social participation, fewer social and health services, and difficulty in retaining health care professionals. Yet, there are benefits often associated with rural communities, including increased levels of volunteering and social capital. However, the current literature on the age-friendliness of rural Australian communities is limited and primarily addresses the challenges faced by stakeholders, rather than the older people’s experiences. Further, international empirical studies looking at rural age-friendliness have deductively explored the eight domains, assigning an equal value to each. This is not conducive to identifying priority domains that are relevant to rural older adults’ health and well-being, which is critical given the current environment of rural fiscal restraint. Thus, the current study aimed to determine how the rural community-dwelling older adults’ views of what is important for health and well-being align with the eight WHO age-friendly domains, and which domains are the most salient. This was achieved by using the eight WHO AFC domains to thematically analyse open-ended responses to a postcard survey that was conducted within one regional Australian setting.

2 METHODS

2.1 Research setting

Data were collected as part of the first stage of the Well Ageing Vision and Engagement (WAVE) study, which was conducted in the Rural City of Wangaratta (RCOW), a regional local government area in north-east Victoria. The RCOW is largely comprised of agricultural land, with significant residential areas located in Wangaratta, its rural city and over 50 small townships and localities. In 2016, its population was 28 310, with 22.5% of its residents aged over 65 years, which is above the state average of 15.6%.

What is already known on this subject:
- In Australia, population ageing is more pronounced in rural areas.
- Age-friendly communities enhance the older people’s quality of life by providing opportunities for health, participation and security.
- Rural communities experience challenges to becoming age-friendly, including limited infrastructure, limited transportation and few social and health services.

What this study adds:
- Though all age-friendly domains were discussed by rural older adults within this study, some domains were discussed more frequently than others.
- “Community and health services” was the domain most pertinent to the health and well-being of the rural older adults in this study.
- Along with the eight World Health Organisation domains, individual-level activities and capacities were also identified as important to remaining healthy and well.

2.2 Research design

From November 2016 to March 2017, data were gathered through open-ended response postcards, which asked older adults (OP), and family members or carers (FMC) to write a free-text response to the following question: What is important to you as you grow older (or to your loved one), in terms of keeping healthy and well? This question was piloted with the project reference group (comprised of local health care professionals) and older adults themselves. Convenience sampling was used, where postcards were placed in local institutions (e.g. hospitals, libraries), circulated to community organisations and hand-delivered by health workers and volunteers (to access less socially connected participants). A reply-paid envelope was attached to the postcard, with an online version also available. Within
smaller townships, community leaders assisted with circulation of postcards to older residents. A statement was included on the postcard, stating that researchers from a local university would be analysing the results, with the aim of identifying strategies to support rural older adults better.

2.3 Analysis

A realist thematic analysis, which sought to report the experiences and realities of participants, was conducted. As per Braun and Clarke’s framework, responses were imported into a qualitative data analysis program (QSR-NVivo 11; QSR International, Melbourne, Vic., Australia) and reviewed to ensure familiarity and generate coding ideas (phase 1). Initial codes were generated using a data-driven approach (phase 2), which grouped the factors that enabled older people to remain healthy and well. Data were coded by the third author and checked by the second author. Both coders are women, have PhDs in different fields with qualitative expertise and are employed as university researchers. Here, an alignment of codes with the WHO AFC framework was noted, and consequently at phase 3 (searching for themes), a theory-driven approach was used, with codes grouped using the eight AFC domains as themes. These themes reflected opportunities, afforded by the community setting, which were related to the eight domains. Themes and their codes were then reviewed (phase 4), with a series of codes that did not fit the eight domains identified. These codes reflected individual-level factors, including personal capacities and attitudes, and activities conducted within micro-level environments (home, interaction with family and friends), as opposed to the community factors represented within the AFC domains. Consequently, an additional, data-driven theme was added. The full dataset was then reviewed by both coders to ensure that all data had been represented, with the final nine themes and their subthemes then further refined (phase 5), to ensure distinctiveness. Results were also presented at two community forums (n = 60), which were attended by the study participants for verification, with no additional information generated during these forums.

2.4 Ethics approval

Ethical approval was obtained from the La Trobe University Human Research Ethics Committee (HREC S16-051).

3 RESULTS

Two-hundred and sixty-two postcards were returned (Table 1). When the data were analysed against the age-friendly domains (Table 2), participants considered all eight domains to be important. However, as Figure 1 indicates, some domains were discussed more frequently than others. “Community and health services” was the most frequently mentioned domain, with almost half the sample discussing it. Although some participants expressed satisfaction with the existing service provision, many participants highlighted the need for a more adequate range of health and community services. Lack of equity of service provision between rural and metropolitan areas was frequently stated as a barrier, with one participant requesting “access to the same health services that people in Melbourne have” (FMC29). Participants wanted health services, including specialist services, to be locally available, as expressed by one participant, “best services for our bodies, top specialists available” (OP224).

Transport was the second-most frequently discussed domain. Many participants reported a lack of transport options, which restricted their ability to get to appointments and activities. As one participant suggested: “I live alone. When I have to give up [my] driver’s license, how am I to get to important appointments?… My daughter lives out of town and [is] very busy” (OP159). Consequently, accessibility of outdoor spaces and buildings was the third-most frequently discussed domain. Older people valued walking within the community for fun and fitness, and attending activities and appointments. However, more accessible walking paths were needed, as suggested below: “more pavements (instead of grass or gravel) particularly in streets close to city centre” (OP196). Another participant suggested “implement [a] footpath policy in the CBD [Central Business District]. At the moment it is chaotic and congested and too many tables and racks used by the traders” (OP162).

Social participation was the fourth-most prominent domain, with older people suggesting that the “opportunity to get out and socialise [is] very important” (OP196). A

<table>
<thead>
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<th>TABLE 1</th>
<th>Participant characteristics (n = 262)</th>
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<td>Age of the respondent (y)</td>
<td>Percentage</td>
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<tr>
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<tr>
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<tr>
<td>Older person</td>
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<td>Carer/family member</td>
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range of suggestions were made, with participants requesting “a place in the community where older people can go and participate in activities” (OP173), and highlighting the importance of formal, structured activities such as “church, choir, dancing, CWA [Country Women's Association]” (OP232). Participants suggested that it was important to “be useful, able to do things for myself and others” (OP12) and that “to be stimulated, have things to do and activities to keep you occupied” (OP165). However, more information was needed about the availability and accessibility of services and activities, with some participants suggesting “a booklet listing and detailing all services available for older people as they age, would be of great help” (OP121).

Housing, civic participation/employment and respect/social inclusion did not feature as prominently as preceding topics. Some participants wanted to be able to access affordable long-term rental options, and greater diversity in housing stock, such as “more options for that in-between stage [of living]” (FMC26). A small number of participants stated the importance of “the opportunity to work - available jobs” (OP189) and volunteer activities such as “cooking for hospital” (OP30). In regard to respect and social inclusion, participants highlighted the importance of intergenerational activity, as one participant noted: “opportunities for contact at a community level with a range of age groups. I have no family so am isolated” (OP143). Access to delivery services from local stores, particularly in relation to food, pharmacy and small hardware items, was also important.

In addition to these domains of community life, individual factors were also important (Figure 2), which are defined here as elements associated with personal attitudes and capacities, and activities conducted within micro-level environments (home, family and friends). Within this domain of individual factors, five subthemes were identified, with the maintenance of physical health being the most prevalent subtheme. Participants highlighted the importance of “eating good fresh food” (OP169), “keeping fit” (OP70) and “sleeping” (OP98). The maintenance of personal independence was also important, described as “doing everything myself” (OP169). This was expressed through the ability to continue to “care for myself in my own home” (OP187), “still being able to drive my own car” (OP56) and being “financially secure” (OP5). Many participants also recognised the need to prioritise relationships, through “keeping in touch with growing family” (OP219) and “having people I can talk to about anything” (OP12). Other themes included prioritising mental stimulation, through “keeping my brain active and stimulated” (OP223) and “doing jigsaw puzzles” (OP21).
FIGURE 2 Frequency of responses associated with individual factors (n = 262)

Some participants also mentioned the importance of attitudinal and emotional equanimity, by means of “dealing with situations as they present and move on” (OP188) and “keep (ing) happy” (OP212).

4 | DISCUSSION

This research adds an invaluable contextual understanding to the Australian rural age-friendly literature. It provides insight into which domains resonate most strongly with older adults living in rural Australia, in terms of their impact on health and well-being, and by extension how age-friendly their rural environments are. Although some of the issues discussed reflect those highlighted within the international rural age-friendly literature, we have extended this by determining which domains are most salient to the Australian rural older people. The findings highlight that community and health services are most significant to older adults’ perceptions of what is needed to keep them well, with almost half of the sample highlighting this aspect. Although this point might reflect a perceived deficiency in access and equity principles, it nevertheless highlights the importance of these forms of rural infrastructure. This suggests that for rural communities, identifying specific community and health services that are critical to age-friendliness is a priority, particularly in the context of continued service centralisation and withdrawal. However, given the interconnectivity of age-friendly domains, facilitating better access through attention to other domains (e.g. better communication and information around available services and supports, transport to access services and supports) might be beneficial. Even though the factors related to respect/social inclusion and civic participation did not feature as prominently as expected, given the importance of these concepts to supporting older people in rural communities, this might reflect the taken-for-granted nature of the rural social capital, or the emphasis on health within the data collection tool. However, our broad approach to data collection, where we did not explicitly ask about the AFC domains, enabled the identification of individual-level factors that are important. These factors will be critical in measuring the impact of age-friendly approaches on rural older adults, and age-friendly approaches should therefore consider how these individual-level attitudes, activities and capacities can be fostered.

4.1 | Limitations

The qualitative findings, discussed here, are subject to a certain amount of interpretation, based on the researcher’s positioning and experience, which is supported by an existing level of familiarity with, and previous application of, the WHO AFC framework. However, we have attempted to increase the objectivity by using two coders, employing an existing framework with defined parameters for analysis and undertaking a multilevel analytical process with a clear audit trail. Additionally, this research was limited to only one Australian region, and considering the diversity of rural places, these results are not generalisable. Further, we did not have the capacity to differentiate between those living in larger and smaller townships, which would yield more nuanced results. The use of postcards for data collection also meant that we were unable to gather in-depth responses, which would have yielded more insight into this subject. Although we did not specifically enquire about the age-friendly domains, this can be construed as a strength, given that we were able to inductively discern these factors by asking a broader question. Finally, our findings do not differentiate between what the rural older people value and the barriers they experience, and future research should delineate these two perspectives in exploring age-friendly priorities. Given Australia’s increasing rural ageing population, it is crucial to understand how diverse rural environments facilitate the health and well-being of diverse older adults, and what this might look like. This will alleviate pressure on health services and improve population health outcomes.

5 | CONCLUSION

These findings provide support for using the WHO AFC framework as a deductive analytical framework to identify the priorities of community-dwelling rural older adults, while simultaneously highlighting the need to consider individual-level activities, attitudes and capacities. Specifically, determining how health and community services can be more accessible and affordable is essential in addressing the age-friendliness of rural communities.
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AUTHORS’ CONTRIBUTION

All authors made a contribution to the development of the manuscript.

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