Independence: support for the elderly in their communities

HACC Consumer Consultation Report

2009

Dr Carol Patterson

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Dr Carol Patterson
Author

Tasmanian Council of Social Service
PO Box 1126
Sandy Bay TAS 7006

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Executive summary

The Home and Community Care HACC Independence Project (2009) has provided an invaluable opportunity to research the ways that elderly people maintain personal health and well-being across key elements of independence, with a particular focus on the functionally disabled. These are: mobility and access to services; health; financial security; capacity to undertake self-care; family support and connections; and community engagement and networks. These elements are the basis of *ageing-specific* initiatives addressing the health care needs of elderly people, which, the project finds, are largely embodied in Home and Community Care (HACC) policy and programs. The project does not encompass a review of customised packages of care such as Community Aged Care Packages (CACP) and Extended Aged Care at Home (EACH) packages. HACC aims also meet the guidelines for international policy action on ageing expressed in the United Nations' Madrid International Plan of Action on Ageing.

In researching independence in the elderly, a complex relationship between dependence and independence was revealed. Care and need, dependence and independence were demonstrated in finely-balanced relationships between social networks, family members, care givers and recipients. In reality, a mix of dependence and independence characterised the daily lives of the elderly in this project. This mix was determined by personal circumstances, living situations and life stories, as well as values and preferences. The interactions of older people in their reciprocal social and familial relationships demonstrated, in fact, their *interdependence.* For instance, rather than being passive recipients of care, many elderly people did their best to give and to be valued as volunteers, child minders, family supporters, community support workers, and friends, while many also participated in a range of physical, social and cultural activities.

In order to explore the nexus between HACC services directed towards supporting the identified elements of independence for the functionally disabled, and the lived reality of the elderly, qualitative data were gathered. Evidence comprised open-ended interviews with 35 elderly respondents; interviews with 10 key informants; the

construction of 7 community case studies; three focus groups of HACC service providers conducted in the north, north-west and south of Tasmania provided a service provider point of view; and an extensive literature review provided a sound theoretical basis to the project.

Major conclusions were drawn from this information-rich material. While each individual was unique, the capacity to age successfully in terms of the preferred health and well-being determinants on which government policy is based, was not unique, but largely an outcome of maintaining the daily routines and active pursuits of a lifetime. It was clear in this project that the individual's 'lifecourse' - the health habits of a lifetime - were significant factors in creating well-being in old age. In a very real sense this operated as a form of health capital or insurance accumulated over a lifetime. Indeed, in describing their lives in terms of the spectrum of dependence, independence and interdependence the participants themselves judged their capacity to continue with their preferred activities as indicative of good health, rather than their personal health profile, good or bad. HACC services, when supporting *in these terms* the capacity of elderly individuals to maintain healthy living in their homes increased individual empowerment, as it represented the positive intersection of a government program with individual needs. Therefore relationships, interactions and activities within their communities were also crucial for independence and better health and well-being.

Case studies of seven communities, although not exhaustive due to time constraints, found that each community was unique in character, culture, history, and in its formal and informal services, including resources such as medical and transport services, and social and cultural foci. These factors, in turn, contributed to the patterns of service delivery locally and regionally; and contributed to elderly people's engagement with the community, with positive consequences for their health and independence where these resources were present.

The elderly participants in this project were embedded in their communities in relationships of dependence, independence and interdependence to service provision, formal and informal. In some communities, informal care provided by a neighbour

was essential for the elderly to maintain themselves in their homes. Taking part in local events, participating in club activities and volunteering expressed engagement with their community for other elderly participants. For them, opportunities to contribute were created, reinforcing their value to the community while maintaining their rights, dignity and choice to age in place. Transport, on which rural people are so dependent, was of course a key issue in facilitating ageing in place, affected by the sparsity of public and private transport, and limited community transport options in rural communities. In other households, HACC services were essential in helping individuals to both remain living at home, and to maintain their connection with the community. Communication by telephone was the main form of contact with family and friends; yet the potential for email and internet use in support and service provision for the elderly is apparent in overcoming barriers of distance and isolation.

Key informants and the focus group participants provided an overview of participant needs and current service provision within communities. They provided critical analysis of the allocation of HACC services in terms of perceived needs, emerging trends and gaps in service provision. These findings informed the multi-dimensional character of 'ageing-in-place,' while revealing similar concerns and issues in all community contexts.

In terms of the results, lack of equity was apparent in some Home and Community Care service delivery. It did not appear to have a basis in policy decisions about the deployment of these services but possibly was the result of history and of perceptions of local levels of demand for services. For instance one community appeared to receive minimal services for the elderly from a principal service provider. Elderly members of other communities did not appear to access a particular service such as the HACC counselling service. Within communities, there were differences in the services accessed by functionally disabled elderly men and women respectively; differences in services addressing the particular needs of the very elderly, especially dependent women; and a lack of service reach to elderly people in isolated rural areas.

Regular consumer and community consultation would significantly assist in reducing inequity in service delivery and achieve the effective targeting of resources where

they are most needed by the elderly. A framework of consumer and community consultation such as the draft policy of the Tasmanian Department of Health and Human Services, entitled *Your Care, Your Say: Consumer and Community Engagement Strategic Framework and Action Plan* (2009), can be utilised, as it sets out the following consultative processes:

- initiate and encourage needs-based planning for health promotion, to ensure that programs and activities address the identified health issues in the specific communities;
- involve community and consumer participation in identifying health needs and issues and in the planning and evaluation of health promotion programs;
- assist individuals and groups to identify their own needs and find solutions to socially-based problems; and
- work with community groups to strengthen community action in identifying and promoting health and healthy lifestyles across generations.

Using these initiatives, HACC policy would better maximise service provision to support communities and their elderly members. A number of service providers stood out in fostering independence programs with their elderly consumers, particularly those recently discharged from hospital. They achieved results by encouraging consumers to undertake daily tasks and routines in a goal-oriented, staged process and thus to achieve their own independent functioning.

The results demonstrate that independence, in terms of its constituent elements, is essential for the ongoing health of the elderly, with interdependence the optimum, and that lack of support for independent living potentially may result in their institutionalised aged care, as is demonstrated in Figure 1, below.

Recommendations – HACC 2010 Independence Project

1. *Support social interaction*

   Encourage partnerships between HACC service providers and other agencies to enable increased opportunities for social interaction for HACC clients and in particular for geographically and socially isolated groups.

   Such collaborations might include Eating with Friends type activities, the Men's Shed movement, living libraries, chat hotlines, walk groups, improved transport options and contributions to policy making and local planning through groups such as local council positive ageing committees.

2. *Promote best practice in supporting independence*

   Promote best practice in supporting independence in the elderly by extending care-worker training such as that used in the HACC Home – based Independence Program (HHIP) Program.

3. *Provide better access to information about HACC services*

   - Review how information about HACC services is disseminated to its target groups, such as on discharge from hospital, in general practices and in government agencies.
   - Use local media (radio) to publicise HACC services and service providers to communities and regions.

4. *Facilitate access to technology*

   Support computer training for the elderly to help them to access services. This initiative would support social interaction and might be approached in collaboration with Centrelink who have a similar program.

5. *Further explore the role of informal support*

   Conduct research that examines the nature and role of informal support provided to HACC clients, focusing on:

- the geographically isolated who may not be using HACC services ; and the socially isolated which includes elderly people living in suburban and urban areas who appear not to be accessing HACC services;
- the role that HACC programs can play in enhancing levels of informal support, as well as formal services, to these groups.

6. *Extend services to under-serviced groups and communities*

   Better enable access to HACC services such as respite and transport by under-serviced groups and communities. Under-serviced groups vary according to area, but include the isolated frail elderly, single men and single women.

7. *Review HACC transport options*

   Review HACC transport options, specifically those catering for participation in social events by elderly people with a functional disability no longer able to drive or who have recently lost their licence, and might not have sufficient access or finances for use of private transport.

8. *Improve the provision of allied health services*

   Access to allied health services, particularly occupational therapists to better facilitate hospital to home care is a high priority if independence models are to succeed, so therefore improve access for the elderly.

1. Introduction

1.1 HACC Independence Project

The Home and Community Care Program (HACC) is a key provider of community care to the frail aged, and younger people with a disability and their carers. The overall objective of the HACC program is to enhance the independence of these groups, and to avoid or delay their premature admission to long term residential care, including institutionalisation. The HACC program seeks to achieve these outcomes through the provision of basic maintenance and support services, and by programs of assistance developed and implemented by HACC service providers (National Program Guidelines for the Home and Community Care Program 2007: 4).

Although research into the concept of independence is vast, particularly for the frail elderly, none has been undertaken with the HACC population in Tasmania under the current policy conditions, and in light of the growth of the consumer populations for HACC services. It is timely that, with this project, HACC consumers are consulted as to what *they* think is independence, and how it manifests in their daily lives, at home and in the community, particularly in terms of social inclusion.

The research aims for the HACC Independence Project are, therefore to:

1. Investigate understandings of what independence means amongst HACC eligible consumers.
2. Investigate understandings of what independence means amongst HACC eligible consumers who are not accessing these services.
3. Review the notion of independence as it is experienced by service providers in the field.
4. Explore the relationships between consumer understandings and experiences of independence and the current policy and practice direction of the HACC Program.

The decision has been made not to include young people living with a disability in this project. While sharing many of the needs of the aged – including elderly people with a functional disability – the profile and needs of this group are found to be so distinct that they deserve a project devoted exclusively to them.

1.2 Home and Community Care in Tasmania

In Tasmania the Home and Community Care (HACC) Program is jointly funded by the Australian and Tasmanian Governments. HACC provides funding to both the government and non-government sectors for the delivery of a range of community care services. Most people value living in their own home but some frail older people with a disability and their carers may find this difficult without assistance. Although help may be provided by relatives and friends, support is also provided by formal community care services in the home and in the local community. HACC services may be provided by service providers such as community houses and local councils and include:

1. Centre-Based Day Care which provides group recreational and social activities.
2. Home Help/Home Care/Domestic Services which undertakes domestic chores.
3. Personal Care which provides assistance for daily self-care such as eating, bathing, shopping and bill-paying.
4. Home Maintenance which provides assistance with home and garden maintenance and repair.
5. Home Modification refers to changes in the home to improve safety such as rails and ramps, and emergency alarms.
6. Transport which helps people to get about for appointments or shopping.
7. Food services such as Meals on Wheels.
8. Community Nursing by a qualified nurse for any needed care.
9. Allied Health Services which include podiatry, physiotherapy, speech therapy and occupational therapy.
10. Advocacy Services which provide advice about rights and responsibilities when receiving services, and in dealing with service providers and other organisations.
11. Social Support includes services for people who need help with shopping, banking, paying bills or for company and social interaction.

Support for carers of the aged and people with a disability includes respite through Respite Care Centres. Carer Resource Centres in each capital city provide information and advice to carers, including at Commonwealth Carelink. There are also a number of carer support organisations such as Carers' Association and Alzheimers Australia. Financial support through a carer's allowance and carer payment is available to carers.

The range of services provided by HACC is directed towards maintaining living at home safely and independently for the elderly with a functional disability, in helping with routines and everyday tasks. HACC services are augmented by other Australian Government initiatives such as the Dementia Behaviour Management Advisory Services for those with more complex needs.

The HACC program operates within a regional framework with the purpose of improving responsiveness and equitable access to its services. Service providers funded by the HACC program are part of a wider care network in which an organisation's service may be one of several services a person receives. Therefore, cooperative and coordinated working arrangements between service providers are essential for the people they serve (National Program Guidelines for the Home and Community Care Program 2007: 4). This project, with its focus on the activities of HACC service providers, does not review the nature and efficacy of the relationships between these and other service providers. However, the HACC Home-Based Independence Program (HHIP) is a model of best practice that has been adapted by other HACC service providers, and is similar to approaches used in other HACC programs throughout the state.

In summary, the HACC Home-Based Independence Program is a 1 to 12 week program designed to improve a person's overall health, independence and social interaction, particularly those post-operative, but including elderly people referred to it. The program is conducted by a multi-disciplinary team of health professionals – including registered nurses, an exercise physiologist coordinator, and occupational therapists. The individual is given a comprehensive health assessment in the home, following which goals are negotiated to help them achieve independent living. The goals are attained through:

- a plan of care with services to improve abilities to carry out daily activities;
- an individualised exercise program to improve the person's strength, balance and to reduce risk of falls;
- education about managing health needs on a daily basis; and
- information to improve medication management.

The program incorporates a home safety assessment with advice and demonstration on equipment to assist the individual to be independent. An in-service session provides training to the support or care workers about the goals and aims of the HACC Home-Based Independence Program.

2. Project design

2.1 Aims

The project aims were to explore the relationship of independence to both formal and informal assistance, as experienced by HACC consumers and non consumers; and to ascertain the implications of consumers' experiences and understanding of independence on future HACC policy and service delivery. This is a descriptive project with a qualitative, multi-stage explorative approach comprising:

- in-depth interviews with members of the target group;
- key informant interviews;
- focus groups with service providers to identify and explore the issues; and
- consultation with HACC officers.

The major parameters of independence were identified as:

- personal mobility, and access to services;
- health;
- financial security;
- capacity to undertake self-care;
- family support, and
- community membership and networks of social engagement.

These parameters formed the basis of the measurement tool, an open-ended questionnaire. The characteristics of the elderly – personal frailty, impairment, differing levels of literacy such as are found in the population as a whole – militated against a large-scale quantitative research approach.

Researched were the lived experiences and associated meanings that older people place on aspects of their social world as they negotiate their way in this world. Emphasis was placed on the words people used to describe the every day experiences and emotions of their social worlds.

2.2 Study groups

At the core of the HACC Independence Project were study groups comprising consumers or potential consumers of HACC services. These were the aged and frail aged. The age ranges were 'pre-elderly' (50-64), 'young-elderly' (65-74); 'old-elderly', (75-84) and 'old-old' (85+). These categories are used generally in the literature, and conform to ABS 2006 Census of Population and Housing age categories. Income, geographical dispersion, health profiles, and therefore personal use of HACC and other support services vary, but in general are similarly diverse. Family support, social connections and degrees of community engagement are also heterogeneous. For this reason, sampling for participants in the project was guided by demographic variables to attain a range of responses and thus profiles of experience, rather than statistical representation. These variables were:

- Couples;
- Singles;
- Tasmanian regions: S, N and NW
- rural/urban/suburban;
- Young elderly (50-75);
- Old-elderly (75+);
- Male/female; and
- Disabled – older.

*Recently, on a Friday night. **'Bridget'**, aged 75, had an adverse reaction to medication. The after-hours medical service took her through the symptoms and they lessened. She was advised to go to the doctor on Saturday morning, but there was no local clinic, and she couldn't go to the hospital as the community car was not available. There was a local ambulance but Bridget was afraid of requesting it in case she was taking it from someone in more urgent need. Finally, she went to the local doctor on the following Monday.*

Thirty-five people were interviewed in all, providing profiles of a range of HACC consumers and non-consumers. Participants were referred by services providers, community and neighbourhood house staff, members of the HACC service provider forums and members of organisations such as Council of Ageing Tasmania.

2.3 Participant interviews

Participants were interviewed according to the parameters of independence, identified as their experiences of personal and social mobility, financial security; health status and medication; capacity to undertake self-care; HACC service use; family contact and support; community membership and social networks; physical security; and help

given to others through an organisation or personally, to measure reciprocity. Participants were also asked to assess their own levels of dependence-interdependence-independence in the questioning, and by identifying their place on a dependence-independence continuum ranging from 0-10. Finally, they were asked what might help them to be more independent in their daily lives.

The interviews took place in the person's home and were preceded by an information-consent form to be read and signed. The transcript of the interview was returned to the interviewees to read, edit, add to it and provide comment if they wished. In this way, the participants made a valued contribution to the project. A thank-you gift of two Myer-Coles gift vouchers worth $40 were provided to each participant.

The project gained a sense of personal capacity, and how the elderly were able to manage their lives; attitudes towards physical limitations and impairment; daily routines and activities, and rich insights into the meanings associated with independence. The gathering of information rich data gave an 'insider view' of the project group's experiences, issues and their management, behaviours and capabilities, social and familial interactions and events over time.

2.4 Key informant interviews

Ten key informant interviews were conducted with people concerned with aged care, either directly in service provision or general practice, or in associated activities within, for instance community or neighbourhood houses. Initiatives supporting the independence of the aged have been undertaken by HACC service providers.

Key aspects of services supporting independence in consumers have informed the recommendations of this report and are referred to in the text where appropriate.

2.5 Community case studies

In support of the aims of the HACC Independence Project, social mapping by community identified the character of its age cohorts, support needs and current

service provision, issues, gaps and emerging trends. Australian Bureau of Statistics Census Data 2001 and 2006 are used to identify trends in population growth and ratios of elderly to other age groups, compared to national figures. Indicators of socio-economic status used in the project report are individual median weekly incomes, and percentage of welfare housing per community. Home and Community Care data analysis for 2008 – 2009 identifies services delivered and patterns of use for elderly men and women in the communities.

Communities were selected according to socio-economic status, size and location, by region.

- in the south, these were Geeveston, Kingston/Kingston Beach and Risdon Vale;
- in the north, this was Newnham;
- in the north-west, these were Devonport and Sheffield; and
- A snapshot of 'inner-city' (Hobart).

***'Grace'**, aged 80, lives on the widow's pension. She states that this is not enough to give anyone 'a good time' and if 'you can't go out a bit, life isn't worth living.' She has to be careful, because this month, for instance there is the 'light bill, phone bill and rates,' although she had managed alright when her husband was alive. Grace owns her own home, and yes, she has financial worries, there is not a lot in the bank.*

It is important to emphasise that the case studies were not an exhaustive review of all health services in an area or community but HACC service provision. However, each case study produced suggestions and approaches for HACC services for the elderly in their communities.

2.6 Focus groups

HACC service providers and HACC government officers took part in focus groups conducted in the south, north and north-west of the state. Discussion encompassed the elements of dependence, independence and interdependence; and effective service provision, and concluded with a one-page feedback form completed by the participants. The forms were collated and analysed. Whiteboard notes made by a scribe were also transcribed and analysed, and recorded transcript analysed. A description of the focus groups' feedback is located in the Appendices. This material has been incorporated in the report where appropriate.

3. Literature review

The United Nations' Madrid International Plan of Action on Ageing (Sidorenko and Walker, 2004: 147) is a guide for international policy action on ageing through the twenty-first century. Its global goal is to improve the quality of life of older people on the basis of their security, dignity and participation, while sustaining supportive formal (eg health care and social security) and informal (eg family, neighbourhood and community) supports to well-being. It seeks to implement policy actions described as *ageing-mainstream*, which are designed to integrate ageing issues into all major national policy domains (development, planning, finance, employment, education and health), focusing on poverty-eradication and national development frameworks; and implement policy actions described as *ageing-specific* – policies and programs specifically addressing the needs of older people such as pensions, long-term care and health-care services. Implicit in both foci is a major goal, the independence of the elderly in society. Independence is seen to ensure greater well-being. Yet, what constitutes the notions of dependence and independence for the elderly and how do they experience these concepts in their daily lives?

3.1 Notions of independence

The problems of defining the notion of independence for the elderly are illustrated in the following meanings encapsulated in government ageing policy (Plath 2002: 45):

- not living in an institution;
- quality of life and well-being;
- valued and active contribution to the community;
- able to access community services and facilities;
- not using community services and facilities; and
- not relying on aged pension in retirement.

Complex and contradictory as Plath's elements appear, all are aspects of living in society for the elderly, even though people have their own individual and situational constructions of the notion of independence, whatever their living circumstances. These constructions are the outcomes of experiences influenced by personal mobility,

physical and mental health, financial means, living mode and by social and family circumstances.

Independence in the elderly is not simply the opposite of dependence. Heuvel (1976: 165, see also Dant 1988) finds that dependence as a state always has reference to a social relationship, as indeed does independence. It occurs in the personal interaction between individual and significant other such as a carer, who may impose, through their role, a negative self-perception. The individual then defines his or her situation as dependent (helpless, powerless), a situation which may or may not match reality. Further, dependence can also arise when the social and physical environment defines the individual negatively as being dependent. This occurs through treatment given such as health or welfare services, and the individual may then accept this categorisation and become dependent (White and Groves 1997: 83).

Boyle (2008: 302) finds that, socially, old age *per se* is equated with dependence related to physical impairment, and hence with vulnerability, passivity and a loss of autonomy. Younger people living with a disability are seen as being dependent on others and older people living with a disability are seen as objects of care. Both states indicate perceptions of a loss of autonomy and therefore of personal independence in these people. Most vulnerable (Boyle 2008) are the elderly living in long-term care, where they may lose control over important aspects of their daily lives such as when to get up, have meals and see friends. Indeed, some research has found that a main reason for people's reluctance to enter residential care is fear of loss of independence, expressed as the loss of 'rights, dignity and choice' (Bland 1999: 539).

Conversely, the prioritising of personal and social independence (however this notion is determined) reflects the 'dominant belief system of the wider community in Western societies' (Brotherhood of St Laurence 2003: 3) as individualistic. In this social context, 'older members of the society will attempt to define their situation as independent and therefore refuse to access support services' (White and Groves 1997: 83). The result for ageing individuals, particularly the retired who have permanently withdrawn from the workforce (Scharf and Smith, 2004) is often social and physical isolation which has negative consequences for physical and emotional health. Low

income elderly people who qualified to receive HACC services often felt that such services were only to be used when 'you are no longer able to look after yourself' (Brotherhood of St Laurence 2003: 4). Unfortunately, this was an expression of resistance and independence with negative consequences in the daily lives of these people. In contrast, the importance of family networks for 'material, practical and emotional assistance' (Schröder-Butterfill and Marianti: 2006) – which the isolated and marginalised often lack – cannot be over-emphasised.

As the notion of independence operates in the psychological, economic, physical and social arenas (Plath 2002: 40), its meaning for people in the community is complex, and differs in a number of key respects from that of government policy with its aim of encouraging independence to avoid the costs of institutionalisation for the disabled and frail elderly. These differences are explored in the following sections.

3.2 Government policy

Apparent in government policy on ageing are two 'prominent intellectual frameworks' (Brotherhood of St Laurence 2003: 3) which are distinct, but linked. These are: quality of life-based policies promoting healthy, active, productive and therefore successful lifestyles for the elderly; and the burden of future health and welfare expenditures that the growth in numbers of the ageing will place on the community. Government quality of life policies addressing growth of the ageing segment of the population are validated by data contained in reports such as that of the Productivity Commission (2005: xii), *Economic Implications of an Ageing Australia.* This report concludes that population ageing, through the combined effects of loss of productive input and the growth of service demand 'will give rise to economic and fiscal impacts that pose significant policy challenges.' However, this finding is challenged by Monash University's Centre for Health Economics working paper 150 (Richardson 2004: 5; see also Mullan, 2000), which concludes that 'the impact of ageing per se upon health costs, i.e. when every other variable is held constant, is likely to be very small.'

The Brotherhood of St Laurence project (2003) finds that, because policy is focused both on longer term savings by diverting people from institutional care, and promoting the prevention of problems leading to institutional care, there is a mix of economic and social imperatives directed towards two different audiences that creates unresolved tension and practical dilemmas for those responsible for service delivery. Noted with concern (Brotherhood of St Laurence project 2003), is the fact that rising costs of providing for the health needs of an ageing population has resulted in policy emphasising user-pays, targeting and the rationing of services. Major policy drivers in the approaches to care for the elderly and disabled have been identified in a Canadian project (Woodward, C. et al. 2004: 178) as: hospitals facing financial constraints leading to shorter stays; changes in demography meaning that more frail elderly people need ongoing health services and support to remain in their homes; and a growing segment of the population with chronic illnesses and physical disabilities also needing health services and support in their homes. Implied is a considerable extension of policy and resources to meet the needs of the elderly in the face of these demands.

In Tasmania, the state government has adopted a public education campaign promoting healthy ageing policies, directed towards supporting the goal of independence for the elderly. This and other policies reflect government response to the fact that, as at June 2006, Tasmania had the second highest proportion of people aged 65 years and over of any Australian state or territory (ABS 2006). This situation was paralleled by generally lower socio-economic status than other Australian states, with a concomitant higher incidence of preventable diseases.

The goal of independence as policy is expressed in the 2007 *Tasmanian Plan for Positive Ageing* (the cover of which is adorned with photos of healthy, happy, active and culturally engaged elderly people) and in the major planning document *Tasmania's Health Plan* (2007: 35). In the latter policy document, it is specified that the state's Home and Community Care Program 'will actively develop and implement services, which prevent or delay decline, and promote consumer independence'. The Home and Community Care website states: 'The overall objective of the HACC

Program is to enhance the independence of people in these groups and to avoid their premature admission to long term residential care.'

Similar programs are pursued in other Australian states. An enhanced quality of life for the elderly is specified in Victoria's *Positive Ageing* policy: 'Victorians today are living longer and healthier lives than previous generations. There are real opportunities for current and future seniors to enjoy an improved quality of life. Senior Victorians should be welcomed to participate in cultural activities and community life.' The New South Wales government's *Policy on Ageing* (2007) states that it is 'committed to creating a society where people of all ages are valued and independent, and which fully uses the skills, experience and wisdom that come with maturity'.

Nationally, this approach is reflected in the information literature promoting Commonwealth government policy, such as the introduction of the Seniors' card and Seniors' Week's promotion of healthy lifestyles. The notion of independence has also become linked over time with Commonwealth government policies promoting financial self-provision through personal and employer-funded superannuation and tax incentives (*Recognising Older Australians* 1996). Although dependence on the aged pension is still estimated to be eighty per cent of all elderly (Borowski et al. 2007: 209), the message is clearly conveyed: you can't be financially independent by relying on the aged pension. This assumption may be monetarily correct, given the expenditure that continues from status as a wage-earner to status as a retiree (with or without independent income). It does not, however, recognise the substantial contribution of older people to the community through their activities as volunteers, child carers, community support workers, and in providing personal support as carers. Many older people also continue working, even if on a part-time basis. Their financial contribution needs to be recognised in policy, and in public acceptance as an important dimension of ageing.

Positive policy and public recognition would go some way towards supporting the elderly, and in countering negative perceptions of ageing. Sidorenko and Walker, (2004: 147) identify these aspects of ageing in terms of the 'personal reserves' of the

elderly as they age which influence their continuing health and well-being. Personal reserves are also identified as 'material resources, family, friends and social ties, care when needed, health, opportunities for autonomy and self-actualisation' (Grundy 2006: 107). A strategic framework and action plan incorporating policy and service development across a range of portfolio areas, as has resulted from the New Zealand Government's Positive Ageing Strategy (2001), would address the risk of social exclusion for the frail elderly and disabled in Australian communities.

The aged pursuing well-being through healthy lifestyles as far as they are able, are achieving personal control through their life choices. This pursuit, embodied in day-by-day social and cultural activities and events, is empowering. But does it constitute independence or interdependence, and how possible is it for elderly people, particularly those with a disability, to achieve? The creation of the new image of healthy lifestyles and well-being in theory allows older people to reject conventional views of illness and decline in ageing with its concomitant 'dependence'. But the attempt to adopt new lifestyles or maintain previous lifestyles without modifying them to match personal capacity may constitute a source of stress in itself.

The push for health and well-being in the elderly and those with a disability is a reflection of what Rudman (2006: 183) describes as a change in the idea or construction of retirement – and hence old age – over the last fifty years. The change is from the representation of retirement as a time of 'social isolation, structured dependency, lack of roles and passivity, to opportunity, continued productivity, self fulfilment and self-reliance,' in effect a new life in ageing rather than resignation to old age. For older people, Godfrey and Randall (2003) find, ill health and disability in themselves do not present a threat to healthy or 'successful' ageing per se, but certainly can limit their ability to achieve health and well-being in their own lives. Godfrey and Randall also explore the concepts of social networks and social support, making a useful distinction between the two: 'Social network means the structure of the relationships (density, homogeneity and range), social support refers to the kind of help received by individuals within the network.' (2003: 28). Thus, social support is a function of networks, which define the outer boundaries of support upon which an individual can draw.

Hilary Graham (2002: 2011) finds that health in old age is dependent on individual life choices or decisions which constitute the 'lifecourse', but these choices and decisions are also influenced by social factors beyond individual control. These factors include social instability and economic insecurity resulting from changes in the economic basis of society. Factors such as family wealth and education are also critical, from childhood upward, in influencing life chances through employment opportunities, quality of life, housing, access to health services to name a few, and hence adult health into old age. Graham has found 'a polarisation of life chances and living standards' in modern post-industrial society, resulting in two groups, the privileged and the poor, who experience unequal access to education, to safe, well-paid work, and therefore to equality in life chances.

The 'polarisation of life chances and living standards' is exacerbated by insufficient wealth distribution, (Wilkinson and Pickett,: 2009). The wider the gap between rich and poor, the wider the gap between health and well-being, despite the compensatory provision of welfare and services by government.

3.3 The role of the community

Informal care for the elderly is an outcome of their social membership of the community, and is most often found in small, close and/or rural communities. Activities that support the well-being and therefore independence of the elderly range from 'looking out' for elderly neighbours, to helping with shopping, cleaning and gardening. Do family and neighbourly support activities risk being undercut by government policies, in that they may negatively influence community attitudes towards the elderly? Formal services may result in 'crowding out' of the informal support from the family (Motel-Klingebiel et al. 2005: 863), and also from friends and neighbours. A further risk therefore could be that government services may be cut-back, leaving the elderly with no support at all. However, 'crowding in' (Motel-Klingebiel et al. 2005: 864) by the presence of formal services can also optimise informal support from the family by establishing a framework in which both familial and formal services best meet the older person's needs. If formal support is not

available, or is insufficient in the type of service provided, the family is the major resource for the elderly, and carries the burden of care.

Motel-Klingebiel et al. identify other factors, principally personal and household, influencing the support given to the elderly in a range of communities which are apposite to this study. They include partnership status, health status, number of children in the family and normative beliefs (Motel-Klingebiel et al. 2005: 876). In that formal service provision is found to encourage familial support and is positively correlated with the total amount of help, the concept of 'crowding in' is endorsed as an effective framework for service delivery. Godfrey (2003) goes further, prescribing a locality-based model addressing independent ageing within a framework that explores approaches other than those based on the family. These include befriending services to reduce loneliness, and support to informal care-givers provided in the context of people's social, cultural, and economic environments.

In general, the lives of the elderly are closely bound to place, and become more so with their declining mobility. Space is further implicated in health status, with greater distance from kin related to less interaction and therefore support (Andrews et al. 2007). Indeed, the extent to which the social interactions and relationships of the elderly are fostered with others 'in place' can be considered an indicator of community health. For 'it is impossible to imagine a healthy community that does not create varied and ample opportunities for its citizens to meet and interact in formal and informal settings' (Baum et al. 2000).

The social and physical structure of a locality has the potential to support well-being by sustaining healthy living. Such support takes the forms of increased mobility through pedestrian access to local shops and services; traffic and pollution control; and a range of transport options. It should also encourage social engagement through fostering inter-generational neighbourly ties, and sustaining culture by supporting local activities, and participation in clubs and organisations. The social fabric of localities provides a context for group and personal identity, validating the individual's role in and contribution to their community. This has been recognised by Tasmania's Social Inclusion Unit which states that 'a socially inclusive community

removes the barriers that stop Tasmanians from participating in society. It makes sure that community assets and the services people need are available to everyone.' (Adams 2009: 32).

Health and healthy ageing policy should encompass the accessible and supportive environment, built and natural (Bartlett and Peel 2005: 98). Such an approach should result in 'age-friendly services and facilities' such as banking, transport, government procedures and businesses to reduce the risk of individuals being isolated, marginalised, living in poverty and being stigmatised (Plath 2002: 46).

Against this background, a strategy or model of action to promote independence and to optimise successful ageing within the community would result from partnerships between service providers, including Home and Community Care and local council positive ageing committees, by taking the following steps:

1. Mobilise a coalition of local people, service providers, agencies and organisations within the community to identify local risks and resources.
2. Select a number of priority risks for action.
3. Develop and implement an action plan with community participation, identify interventions, with resources and personnel; include extending services, establishing new services, education and preventive health promotion.
4. Monitor over a specified time period with feedback and evaluation from all participants.

Meanwhile, studies (Brotherhood of St Laurence 2003; Plath 2002) continue to explore the personal experiences of the aged living in society. They have found the isolated and marginalised – of particular concern are the 'extreme elderly' – living on their own with minimal family links and community networks, who may be in need of help but are reluctant to access services. Feelings of pride in their personal independence, a fear of bureaucracy and rejection of what they see as charity intervene between need and help.

Although this group of older, single people are asserting personal power through denial, they are suffering for it in an actual lack of control over their circumstances and is likely to result in their early admission to institutions.

3.4 Conclusions of the literature review

Implicit in these discussions of the notions of dependence and independence are socially endorsed attitudes towards health, and responsibility for good health. As Crawford (2006: 402) finds, personal responsibility for health is widely considered to be integral to 'individual autonomy and good citizenship.' In a culture that values health, people define themselves in part by how well they succeed or fail in attaining good health through their own practices. In this scenario, the aged as a group are handicapped by the inherent health problems which they acquire and the limitations these place on personal efficacy. Hence, their identity as healthy persons and their ability to demonstrate agency (Crawford 2006: 403), and thus independence – in these terms – are compromised. As a group, the aged and frail aged counter by modifying their personal and social activities to suit their capacities, as does any group in society.

People have individual and situational understandings of the notion of independence, often at variance with the structural and systemic approaches of policy makers. These understandings are the outcomes of personal and social experiences, both in the past and continuing into the future. Ageing in place sees the elderly utilising the resources and services of their local communities and service hubs to the best of their ability.

Harbison and Morrow (1998: 693) draw a useful distinction in the perceptions of independence in the elderly over the age of 75 or 80 who have 'a tenuous relationship with the idea of the state being responsible for their welfare', as a result of their experiences of war and the Great Depression before the coming of the welfare state. They are compared with those aged between 65 and 75 who accept welfare support almost as a right, and don't see it as compromising their independence. The aged still express and act on values of self reliance, frugality and hardiness, while those in the 60 to 75 age group take for granted the involvement of the state in education, health

and social service provision, unemployment benefits and pensions. These services have not been equally positive for all groups, for there are those who remain under-serviced, evidenced by those living in poverty such as members of indigenous groups, the unemployed and women. However, 'baby-boomers' are proving to be more resilient, displaying considerable independence in determining how they will age, which services they want and how they will use them.

The message underlying current health promotion for the elderly, in which personal independence is expressed as participation in active, healthy retirement lifestyles assumes each has the capacity to re-make self and the world in these images, as well as the financial means to do so. In this view of independence the emphasis is on individual efficacy, even though the elderly are addressed as a homogeneous group in government policy-making and program implementation. Thus, responsibility for health care and costs are shifted to the elderly as individuals, an approach fuelled by views of the size of the ageing population – seen as alarmist by some – (Jolanki 2008: 61), and predictions of a future financial burden on society. There is little acknowledgement of the unpaid contribution of the elderly to the community, identified by Plath (2002), or conversely that the traditional perceptions of old age which is a reality for many are derived from experiences of decline, dependency, poverty and powerlessness.

Godfrey et al. (2004: 1) have found that 'the essence of "ageing well" is the ability to sustain inter-dependent lives and relationships that meet needs for intimacy, comfort, support, companionship and fun,' ideally within the localities where the elderly and their families live. How male and female 'lifecourses' differ needs to be acknowledged and incorporated in appropriate strategies. As people age, the private sphere of socially informal networks, friends, and associations becomes dominant. For women, there are continuities in interests, activities and social participation that are less apparent for men, who have retired from their dominant sphere of activity, the public realm of work. Single men, whether widowed or alone, have greater difficulties in coping with ageing, particularly if they have not had the opportunity in a lifetime of work to develop interests to carry into retirement and old age. Andrews et al. (2007) recommend the creation of 'inclusionary spaces' where the elderly feel safe,

welcomed and cared for, and which may take a number of forms – neighbourhood or community houses, day centres, clubs, regular bus trips, even theatre.

Care and need, dependence and independence are facets of daily life which shift to accommodate finely-balanced relationships between social networks, family, care givers and recipients, influenced by personal health and the health of others. Heuvel (1976: 167) sees dependence and independence as asymmetric realities, as most relationships are, in fact, interdependent and are expressed within social norms through activities, obligations and duties. To Mary Godfrey (University of Leeds), dependence and independence are fluid and multi-faceted, very much determined by personal circumstances, values and preferences. Indeed, the interactions of older people in their reciprocal social and familial relationships are by nature interdependent and manifest in one way as the substantial contributions made by older people – particularly those in the 60 to 80 age group – to family and community as volunteers, child carers, community support workers, friends, and through their participation in a range of physical, social and cultural activities, clubs and organisations.

Within the home setting, collaboration between the elderly suffering illness and disability, and family members as carers, and health officers and others providing support is characterised by a mix of privacy and professionalism (Efraimsson et al. 2001: 815), of richness of relationships and interplays of helplessness and self-efficacy. Furthermore, the boundaries are challenged between care service providers (formal and informal) and recipients, when this relationship is perceived as one of inequality or powerlessness (Fine and Glendinning 2005).

Grundy's (2006) identification of the personal reserves required in order to enable the elderly to maintain the capacity to cope with the challenges which they face is an approach confirmed in policy such as the New Zealand *Positive Ageing Strategy* (2001: 9). It asserts the reciprocal nature of personal reserves, as the elderly:

> have skills, knowledge and experience to contribute to society, and the expected growth in the proportion of older people during the coming decades will provide New Zealand with a valuable resource.

Promoting the skills, knowledge and experience of the elderly as valued resources for society, utilised within their capacities and desire to contribute, provides a positive role model for youth (*Positive Ageing Strategy* 2001: 11), and is a valued outcome for society. For those who will experience difficulty in attaining these heights of self-determination such as the frail, marginalised and isolated, support from government services within their social networks and in supportive living environments within their communities presents a key approach for future policy development and programs. This is the case if social inclusion – and thus independence through interdependence – for the frail elderly and the disabled, and their carers is to be achieved.

4. Results

4.1 Analysis of participant interviews

The following information is collated from participant responses. It includes demographic data and a review of the factors supporting (or otherwise) independence in the daily lives of the elderly participants.

In terms of the ages of the participants, there were 7 pre-elderly: 50-64; 10 young-old 65-75; 13 old-elderly aged 76 to 85; and there were 5 old-olds, who were aged over 86.

There were 11 men in the sample, 6 of whom were single, and 5 of whom were in long-term relationships. There were 25 women in the sample, of whom 20 were single and 5 were in long-term relationships. The majority saw friends and neighbours regularly (25) but 10 did not socialise with friends or neighbours, although only two women did not take part in any activities: one was voluntarily house-bound and the other had major eyesight loss. The majority of participants maintained close connections with family members (28), but 7 did not, either because their children lived too far away, or because they did not have a positive relationship with them.

Most participants (20) lived in a community where they had either always, or mostly as adults, lived. Eight participants did not come from the community where they now lived, and 7 did not provide this information. Financially, only 5 participants were self-funded, that is, not receiving a government pension of any sort. The remainder (21 participants) received a single or couple's aged pension, a disability pension or Veteran Affairs pension. Eight participants lived on a mix of pension and income from superannuation or investment.

Assessment of personal levels of independence was revealing, as 29 participants scored 6 or above on the Independence scale, with 10 clustering at 8 and 4 scoring themselves 10 out of 10. In this latter group were 3 respondents in their nineties, who were amongst the most active of the group.

Considering the role of communications technology in the lives of the elderly in this project, all but one participant used the telephone as their primary form of communication; and the one-non user did not use any form of technological communication. Fourteen participants used the mobile phone, 8 used the internet and 9 still wrote letters. All of the internet users also used the telephone, and 7 of these also used the mobile phone. Therefore, a high level of use of technology was demonstrated by only 7 elderly participants – 4 men and 3 women. The 9 project participants who wrote letters qualified this use by describing it as 'occasional' only, such as cards at Christmas.

In terms of Home and Community Care service provision to communities, imbalances in services delivered to men and women were identified in four communities; the needs of the isolated elderly were identified in three communities; transport needs were expressed by residents in four communities; need for a day centre or a similar space was apparent in two communities; and a review of allied health provision was needed in two communities. Under-delivered services included nursing and personal counselling, carer counselling and respite and social support, particularly for men. Entirely new services required were programs of chronic pain management, an after-hours service to the elderly and a voucher system or subsidy to the elderly to encourage their ongoing physical and social engagement in the community.

The following section analyses the responses of the elderly participants by the major parameters of independence:

- personal mobility, and access to services;
- health;
- financial security;
- capacity to undertake self-care;
- family support, and
- community membership and networks of social engagement.

Personal mobility, and access to services

For the participants, personal mobility was highly valued, but was limited by poor health and disability. Except for those with a restricted licence (1), older people and those with a disability had similar levels of mobility as the young-old. Those with particular mobility restrictions found that HACC services enabled them to manage in the home, through providing home modifications, maintenance and regular domestic support.

Transport availability and affordability were has critical factors in the ability of the elderly to access services and to participate in the community. As social and physical boundaries narrowed, the elderly became dependent on others such as adult children and friends when moving outside of these boundaries.

In these communities, mixtures of public transport, HACC buses and Community Transport addressed to some extent the transport needs of the elderly. Loss of a car licence had a significant impact on elderly people's abilities to choose how they spent their time, such as going to concerts, meeting friends, helping the family or volunteering. For instance, Ian and his wife were no longer able to spend holidays on Bruny Island as Ian's licence was restricted.

Remaining an active community member was dependent on personal mobility, and couples were better off than singles socially. Women who had relied on their husbands for transport experienced mobility problems as widows, especially if they were unused to using public transport. The young-elderly were most able to drive and maintain their community connections.

Elderly rural, suburban and city dwellers all experienced limitations on their mobility. Those in rural areas were most seriously affected by inadequate transport because of the greater distances. They therefore suffered more from lack of access to services and daily support, increasing the risk of institutionalisation for them.

Mobility is a key indicator of people's health and independence and, through enabling their social engagement and connections, interdependence.

Health

Health status ranged from good to poor, and participants, in listing their health issues, indirectly judged how limiting they were in terms of independence in their daily lives. Poor health restricted a number of participants in living as they wished, particularly in undertaking daily tasks. It restricted their mobility and capacity to engage in social activities. Thus, there was a correlation between health and capacity to exercise independent choice. However, rather than giving activities up completely, participants modified them to suit their health circumstances. Anne, unable to cope with a large garden, grows plants in pots and hanging baskets; Alice (2) walks to the shops with a walker, leaving the big shopping for her son; Grace's daughter helps with vacuuming, washing and cleaning. Unable to drive due to his amputation, Arthur sold his home to move closer to public transport so that he can still attend hospital, and go out socially.

In other patterns of activity modification, some elderly people reduced their activities over time to match their dwindling physical capacity. John used to play a lot of sport; he gave this up to coach football, then attended his sons' football games, and now watches footie on the television – a residual interest resulting from his personal history and declining capacity. Lorraine lives in the house were she was born, enjoys social activities such as the local walks group but is very reluctant to cross the river to Hobart for any reason.

In cases where the elderly experienced bad health or disability, carers, whether live-in or visiting, were essential for them to live comfortably in their own homes and communities. These people mostly were supported by HACC services. When these services were delivered by best practice service providers, consumers were supported to undertake household duties, their own self-care, and manage medication independently.

Given their high self-rating on the Independence scale, poor health was discounted by the participants as affecting personal independence. People measured health by their ability to continue to do the things they wanted to do, and to engage meaningfully with daily life, even when these activities were modified by age and/or disability.

Health impacts on quality of life and therefore personal independence for the elderly.

Financial security

The majority of participants (22) as a group lived on the single or couple aged pension, including a disability pension (5 participants), and a Veteran Affairs pension (2 participants). Five participants were self funded, and 8 had additional income which came from superannuation or a small investment. Most participants owned their own homes, although five participants rented from a family member, either paying a small rent or no rent at all. Only one participant rented welfare housing and was happy with this situation. One participant lived in an independent living centre and one had a sizeable mortgage which she was paying out of her single aged pension.

Most participants (25) reported managing quite well on their incomes. But 8 participants (almost a quarter) worried over finances, even though they managed to 'get by.' Many participants reduced costs, for instance by growing vegetables (Ian, John, Emily); not taking out household insurance (Susie); not smoking, drinking or gambling (Jean); some had children who helped out by paying bills and rates (Dawn, Joan); or bought only frozen vegetables because 'you don't waste them', and little meat (Joan). While estimable, extreme frugality equates with dependence as it reduces elderly people's choice and decision-making in their daily lives, all the more so if ill-health and lack of mobility (personal and public) are also experienced.

The small amount that the 8 participants earned from additional income allowed them to 'do a little extra' like going to the theatre, attending concerts, and having a coffee, or a counter meal with friends - important activities with social groups in the community. For Garry who lived with a disability, quality of life would be improved with subsidised heating and equipment to improve mobility in the home, and funding for a care attendant for a few hours a week. Susie, similarly living with a disability, limited her social outings to once a week because of lack of money. Lack of income for the elderly compounds a negative social image of being 'needy,' and dependent, contributing to loss of self-esteem, vulnerability, passivity and loss of personal autonomy. This can be counter-acted personally and socially by even a small amount of disposable income.

Financial security is a key indicator of independence, through enabling people to have mobility, choice, social connections, self-esteem and agency, and thus interdependence.

Capacity to undertake self-care

Participants mostly were able to care for themselves, including showering, cooking their own meals and dressing, including putting on shoes. They undertook their own toileting, and care for nails, hair and feet, with many taking regular visits to a podiatrist. They managed taking their medication, and completing tasks such as bed-making, and putting away clothes. Help was received from family members and HACC for vacuuming, and hanging out and bringing in the washing.

Some elderly participants maintained that they were perfectly capable of looking after themselves, but HACC home help was essential for 3 receiving personal care and 2 receiving home nursing. Other participants received varying degrees of help, particularly those living alone. Rosie's daughters monitor her showering and dressing, and Mary's daughter helps her with her nails. Women liked to get their hair done regularly at the hairdresser.

Betsy appreciated HACC home help when she had a broken femur, for vacuuming, cleaning the toilet and bathroom, washing the floors and hanging out the washing. Val shares with her HACC domestic help 'a keen sense of hygiene, the rightness of things, and order.' Others were helped by family members who did home handyman tasks like changing light globes, and helping maintain the garden. Grace's grand-daughter comes every Wednesday to hang out and bring in the washing.

Carers looking after their partners full time appreciated support from HACC services such as domestic help and respite care. Valik who is sight impaired receives help to shower from a HACC carer three mornings a week, otherwise performing all care tasks himself, including cooking. Podiatry was the most widely used of the allied health services by these participants. A mix of care both formal and informal in the home helped the elderly to remain mobile and to maintain not only health and hygiene, but their dignity, self-esteem and confidence in negotiating their world.

A mix of support to the elderly for their care helps them to maintain daily routines and activities; it helps them to engage socially, and thus enhances well-being and self-esteem.

Family support and connections

In the sample most people (28) – whether alone or as part of a couple – received support from family members in different ways, which they appreciated and relied upon. The participants also described how they reciprocated to family members. Family support was both practical and social, and its lack can be viewed as indicating social isolation. There appeared to be little difference between rural, urban and suburban situations for the elderly. Many had children living outside of Tasmania, but only one couple had all of their children living outside of Tasmania.

Susie's father, whom she calls 'the small grey one' visits her regularly and they usually go out for dinner. Rosie lives in a granny flat and is looked after by her daughter. Vincent lives in a house owned by his daughter whom he visits for tea, and goes to another daughter's for tea on other week days. Doug and Anne take their nieces swimming, pick them up and drop them off at home. Alice (2)'s son rings her every evening and calls in regularly, as does her grandson. Val's son works nearby and calls in regularly as does Eve's – her daughter-in-law takes her super-market shopping. Valik's cousin helps him with gardening, shopping, paying bills and doing odd jobs; Ken's daughter lives next door and keeps an eye on him. Five members of couples were carers for their partners.

There were varied reasons why some people did not receive family support. Jeanette's children live interstate; Margaret J has only a niece living in Penguin who is bedridden and she is unable to travel to see her; Arthur has no family in Tasmania; Fiona and Robert have no family; Lily's children live in nearby towns but have very little contact with her. In these examples, the presence and absence of family both demonstrate and validate the importance of family networks in providing material, social and emotional support to the elderly.

Family support helps the elderly to be independent and, through companionship and socialising, provides opportunities to reciprocate.

Community engagement and networks

Community membership and ongoing social engagement were experienced by the majority of participants. Elderly people told stories describing past times and life experiences which had affected their health, and through their social activities and connections, their well-being. They belonged to organisations such as Probus and Rotary, educational groups such as School for Seniors and University of the Third age, sports clubs such as the Wilmot Bowls Club, Huon Yacht Club and the Hobart Walking Club, and cultural groups such as Geeveston Archives and History Centre, and Friends of the Tasmanian Symphony Orchestra. Many had let their membership of charities and clubs lapse, while others had newly joined groups, or run groups themselves.

In their daily lives, social activities were important for the participants, such as attendance at day centres, walk clubs, darts, HACC bus trips and outings, lunches and counter meals. Most had a small group of friends which augmented their family relationships. For others, friends were the most important social elements in their lives.

For a number of the participants social activities were limited by their finances, for others by ill health or disability, but they adjusted as far as they could. Similarly, activities at home were adapted to suit personal capacities, such as gardening, crafts and hobbies. Others enjoyed informal interaction with neighbours in sharing tools, gardening, swapping videos, helping out with renovating, and holding morning teas and even dinner parties.

To reiterate, participants adapted to changed circumstances financially and physically to best maintain their social connections as they aged. Twenty of the 35 participants were living where they always had lived, while others had moved into these communities. Work had been a key element of their community membership. For instance Ian, an orchardist with health problems resulting from this work still enjoyed social activities in a farming community.

Community membership and networks of social engagement validate people's lives, and both express and foster health and interdependence for the elderly.

4.2 Community case studies

Each case study is comprised of the following types of information:

- a short description of the community;
- a summary of the 2001 and 2006 ABS Census data identifying trends in the demographic data, including population numbers, and the social indicators of median weekly individual income and percentage of welfare housing in the community;
- interviews with local elderly people;
- key informant interviews of local service providers – medical and non-medical, such as social and cultural activities;
- summary of Home and Community Care service use;
- excerpts from the interviews which provide a picture of how people live with varying degrees of independence in these communities, and which give a voice to the people interviewed; and
- the recommendations for each community which identify how services can better support local elderly people in their daily lives, and highlight service gaps, trends and emerging needs.

Geeveston

Geeveston is a small rural town in the Huon Valley, south of Hobart. It has a township population of 761 with a broader rural population of 1585. It is a culturally active community, focused around the Geeveston Community Centre and the Southern Design Centre, a popular centre for the arts and crafts. Notable in this community is the strong local ethos of self help, and the willingness of the young to 'look out for' the elderly, an attitude which is carried through the generations. The social strength of the community is evidenced in community activities, volunteerism, and participation in groups such as the local walk club, the University of the Third Age, sports, water-based activities and cultural groups. In many ways, locals contribute to a healthy community where help and support is informally provided, and this is a strength which needs to be recognised and supported.

Demographically, the total population of the Geeveston region decreased from 821 to 761 between 2001 and 2006. However:

- It increased by 3 per cent for persons aged 55 to 64 years
- and saw a reduction of persons aged 65 years and over of 2 per cent to 12 per cent – still 1 per cent higher than the national figure of 11 per cent.

Therefore, the young-aged group as a percentage of the population is increasing over time.

- Male-female percentages were almost even, at 49.1 per cent male and 50.9 per cent female.
- In 2006, welfare housing accounted for 28.6 per cent of tenure type compared to a national 14.9 per cent;
- Median weekly individual income was $320 compared to $466 nationally.

Home and Community Care data for 2008 - 2009 indicate HACC services to be thinly spread for this town and its immediate region. There is no respite care based in Geeveston itself, although respite care is provided by SE Respite Services. There is no counselling, or carer counselling recorded in the data – though outreach is available from Huonville. There is no centre-based care provided in Geeveston. No social support was recorded.

- 2 men received 4 hours each of personal care compared to 8 women who received 20 hours of personal care.

However,

- 23 women received 13 hours of domestic assistance while 7 men received 14 hours each;
- 14 women received 26 hours of home maintenance compared to 5 men who received 32 hours of home maintenance;
- 6 women received 1.5 hours of counselling, but only 1 man received 1 hour of counselling;

In terms of access to transport, 15 women made HACC transport trips 8 times, and men made HACC transport trips 7 times.

Participants have identified particular needs: for a community day centre to provide respite for carers and for additional home maintenance and personal care. They were concerned about safety on local roads for the elderly, and found it difficult to get to hospital appointments in Hobart. Transport was a concern, as elderly persons faced licence restrictions or loss of licence. There was little use of HACC services by these participants, and often little knowledge of what was available.

Key informants identified the dwindling local population as threatening the social fabric, as people are less able to look after each other, and children move away for further education or work. As a consequence volunteerism is hard to maintain and local sports teams are no longer viable, all of which threaten the lifestyle, economy and social viability of this town.

Also identified were: the expected growth in patients with dependence issues in the next few years and the paucity of services in Geeveston needing be addressed – particularly when compared to service provision in other regions; elderly singles living in remote farmhouses who are not regularly monitored, evidenced in the small number of the elderly helped by the Huonville Health Centre nurses; the complexity of managing health needs of home-bound patients with severe health problems whose dependence on help from neighbours and/or family is welcomed but insufficient; depression and anxiety are problems in this region, but there is no outlet or service where locals can receive counselling, except from a visiting service in Huonville.

Programs such as health promotion and chronic disease management were not present.

Suggestions and approaches arising from this overview were:

- more HACC service provision in general to Geeveston and surrounds;
- a nurse to help implement general practice management plans for the over 65's with severe health problems, to help them to remain independent in their homes;
- establish a day centre in Geeveston to provide respite to carers, social support for other functionally disabled elderly people and for health and well-being activities;
- encourage elderly people living on their own in isolated farmhouses to take part in social activities, providing an opportunity for health and welfare monitoring;
- provide additional HACC home maintenance and home safety services to functionally disabled locals;
- promote HACC personal care services to men;
- review mental health counselling services in Geeveston, including those provided from Huonville, Dover and Franklin.

Kingston/Kingston Beach

Kingston is a suburban outgrowth of the older suburb of Kingston Beach, and both are in the Local Government Area of Kingborough, south of Hobart. Spread along the beaches of the Derwent Estuary, the suburb enjoys lovely views and a holiday ambience. Kingston has a township population of 8538, and Kingston Beach has a static population of 2025**.** The combined population for Kingston and Kingston Beach was 10 563 in 2006. Kingston is a fast growing community and is a service hub for the rural regions and small urban centres south, extending down the D'Entrecasteaux Channel area which have implications for outreach to these areas.

In terms of demographic data, this area is notable for a slight rise in the numbers of the aged in a growing community in Kingston – an additional 1.5 per cent over the period 2001 to 2006, and increasing numbers aged 65 and over in the population of Kingston Beach, from almost 15 per cent in 2001 to 18.7 per cent in 2006. Additionally:

- In Kingston, welfare housing comprised 26.1 per cent of tenure types in 2006 compared to a national average of 14.9 per cent, indicating service needs for the disadvantaged elderly.
- For Kingston Beach, welfare housing comprised 6.8 per cent of this tenure in 2006.
- High socio-economic status of the Kingston area is evident in income – in 2006 this comprised weekly median individual income of $446, and in Kingston Beach comprised $496 compared to the weekly median individual income nationally of $466.

A mixed picture in which high average incomes contrast with high levels of welfare housing in Kingston indicates the range of services which should be provided for the increasing numbers of the cash-strapped aged.

Home and Community Care data for 2008 – 2009 indicate in that in Kingston more women receive services than men but that they receive roughly equal hours, for instance:

- 188 women received 15 hours of domestic assistance compared to 56 men who received 14 hours of domestic assistance;
- 53 women received 4 hours each of home maintenance compared to 20 men receiving 4.5 hours.

However;

- 36 women received 31 hours of personal care over this period, but 12 men only received 7 hours of personal care.
- 7 women received 61 hours of respite care, but 5 men received 51 hours of this service;
- 59 women received 5.5 hours of counselling compared to 20 men who received 3 hours of this service.
- In terms of social support, 37 women received 47 hours while 14 men received 22 hours of this service;
- 93 women used HACC transport trips 26 times each over this period;
- 32 men used HACC transport trips 27 times each over this period

In Kingston Beach, the figures were much the same except for the following:

- men were less likely to receive domestic assistance (10 hours each), did not receive personal care or social support, and only 1 man received respite care;
- 3 women received 41 hours each of personal care, and 5 women received 83 hours of personal care.
- No women received respite care, but 3 women received 10 hours of centre-based care
- 4 women used HACC transport trips 26 times each over this period;
- But 2 men only used HACC transport trips once each.

Participants' concerns were principally to do with personal mobility and transport. Deficiencies in the built environment raised concerns about consideration of the elderly when Council road and footpath maintenance is taking place. Reaching public transport is difficult for those living in rural areas, worsening their social isolation. The needs of the isolated elderly living in the rural areas of Kingborough – dating from prior to suburban expansion - are not to be overlooked.

One key informant (local doctor) identified more extensive use of Home and Community Care services such as help with shopping for the elderly as a need and that services should be provided to help maintain independence before situations become too drastic or reach breaking point. A need for more respite care was identified, as the Manor Gardens Club is good but too small to cater for a present and growing population of the elderly. It was suggested that financial support given in the form of a fund to the elderly to undertake exercise should be a part of the HACC wellbeing program.

Informants felt that there was a need for more assisted living for the elderly; another issue was the problem of care for the elderly after-hours, with after-hours visits an expressed need in the Kingborough area. This service has been reduced because of the amalgamation of medical practices, a point also made by one of the participants. The key informant concurred with participants in identifying transport as an issue. Although the bus service to Hobart is adequate, there is a problem with taxis and taxi vouchers which are difficult for frail elderly people to deal with.

Another service needed in Kingborough is a program for chronic pain management which would benefit the local elderly, but it is uncertain who would take charge of this project: the Community Health Centre in Kingston, the key informant said, is 'overwhelmed with demand.'

Groups with special needs were identified by the key informant as people with little money who live alone and lack personal and social mobility.

Suggestions and approaches arising from this overview were:

- provide extra funding support to the Manor Gardens Club (day centre) or establish another centre to increase respite for carers and social support for the frail elderly, particularly in Kingston Beach where the numbers of the elderly are increasing;
- identify elderly people living on their own, particularly in rural areas of Kingborough, and encourage them to come into a central location for regular health and welfare monitoring and to increase their participation in social activities, possibly in partnership with Kingborough Council;

- consider ways to fund a local after-hours medical service to cater specifically for elderly people with a functional disability in health care programs;
- promote HACC home nursing, social support and counselling for men;
- promote health and wellbeing as part of HACC programs, and a program of chronic pain management for the elderly in Kingborough, possibly in partnership with local medical practices.

Sheffield

Sheffield is a small rural town located 30km from Devonport and 93km west of Launceston where major health services are located. Sheffield experienced a period of rapid growth with the commencement of the Hydro Electric Commission's Mersey-Forth Power Development Scheme. On completion in 1963, the town's population declined, but is now static. Today, Sheffield is the centre of the Kentish Local Government Area and is well-known for its murals, an indication of community vibrancy.

According to ABS data for 2001 and 2006, there has been an increase in population from 990 to 1034 over this time period. Additionally:

- The percentage of the population aged 65 and over increased by 8 per cent to 20 per cent in 2006. Of these, there was a higher ratio than average of women, 52.3 per cent compared to 47.7 per cent men.
- Welfare housing was 20.5 per cent in 2006 compared to 14.9 per cent nationally.
- Weekly median individual income was $327 compared to $466 nationally.

The pattern of services supporting independence of the elderly in this community and its surrounding districts is revealed in the HACC data for 2008 – 2009, with more men being supported by HACC services:

- 7 men received 27 hours of domestic assistance each, compared to 23 women who received 17 hours each;
- Very little home maintenance was provided – only 7 consumers, 2 men and 5 women – received this service;
- Notably, 6 men received 80 hours of personal care each compared to 9 women who received 13 hours of personal care each;
- No social support was recorded as being received by men, while 21 women received 17 hours each;
- Very little counselling was delivered, to only 6 consumers: 2 men and 6 women.
- Women were more likely to receive centre-based care (day centre), 24 women receiving 107 hours each, compared to 1 man receiving 48 hours of centre-based care.

- More women (45) made trips using HACC transport (1180), than men (13) who made 154 trips, an indicator of women's isolation due to being unable or unwilling to drive as they age and/or became widowed.

Participants identified transport to and from Devonport and Launceston for medical appointments or for visiting relatives in care particularly on the weekend, as an area of need, because of the lack of transport, and the expense of private transport. Distance exacerbated feelings of dependence, as a number of participants expressed loneliness and vulnerability due to either receiving no support from family members living elsewhere, or being too distant from them even when they were willing to help. Social isolation was thus experienced by some participants.

The key informant described the issue of unknown numbers of frail elderly people living on their own in rural areas who might benefit from support, and again the need for transport on the weekend, particularly for those visiting relatives in care.

Suggestions and approaches arising from this overview were:

- the needs of elderly people, particularly women with a functional disability living on their own in the Kentish LGA who might benefit from regularly coming into Sheffield for social activities, and health checks;
- review the provision of allied health services in consultation with Tandara Lodge Community Care and the Sheffield Medical Centre;
- consider instituting a chat hot line for those who feel (or are perceived to be) insecure, isolated or in need and would appreciate this service;
- promote HACC nursing and personal counselling services, given the small numbers who appear to be accessing these services;
- promote the Eating with Friends program currently operating in Sheffield to extend it to outlying areas such as Wilmot and Barrington.

Risdon Vale

Risdon Vale has a population of 2868 (ABS Census data 2006). It is a self-contained suburb surrounded by forested hills, and has a rural feel; although close to population centres including Hobart where the major hospital and health services are situated, geographically it is cut off. Risdon Vale has an Indigenous Protected Area (IPA) an important cultural and spiritual site at Risdon Cove, managed by the Tasmanian Aboriginal Centre. Although Risdon Vale started out as purpose-built welfare housing forty years ago, many of the houses have been bought, often by members of the families who grew up there. Stability of home ownership and family links are features of this suburb.

Demographic data indicate that there has been an increase in population from 2671 to 2868 over the period of 6 years. Additionally:

- In the population, there has been an increase of persons aged 65 and over from 12.0% to 12.6% over this time period.
- Welfare housing comprised 51.6 per cent in 2006 compared to 14.9 per cent nationally.
- Median weekly individual income was $319 compared to $466 nationally.

Home and Community Care data for 2008 - 2009 reveal that elderly men were under-serviced. They received fewer hours per person than women in services including domestic assistance, personal care, social support, and counselling for this period.

- In domestic assistance, the same number of men and women (24) received 13 hours each and 16 hours respectively.
- In personal care, 3 men received 60 hours each compared to 8 women who received 89 hours each.
- However, for home nursing, 13 men received 22 hours of nursing each, while 13 women received only 10 hours each.
- Women received 16.5 hours each of social support compared to 6 men who received 2.6 hours each.
- Only women (2) received respite care.

- HACC transport was equally accessed by men and women, with 47 trips each over this period.

The participants were concerned about the costs of rates, energy and transport. One participant was concerned about changes in appointment times at the Royal Hobart Hospital which meant long waiting times for frail people needing medical care.

Key informants stated that Risdon Vale Community House plays a key role in helping the aged and fostering community engagement in Risdon Vale. It provides five community lunches a year for the elderly with payment a gold coin, as the elderly don't like 'charity.' The Community House works hard to facilitate help across generations: young school refusers help by serving tea to the elderly and playing cards with them. A walking group leaves from the Risdon Vale shops every Wednesday. Friday is set aside for the aged care program, which is advertised as the 'Aged Care Fun Club.'

The Risdon Vale Community House is funded one day per week by HACC to provide the day respite centre. There is a HACC-funded bus that only holds 10 and some residents are not able to go on trips.

Key informants felt that the community needed more transport options and fare subsidies, as there was a problem with mobility for the aged. Some living in distant parts of Risdon Vale had difficulty getting to the doctor if they had to walk. Residents – whether renting or owning – wanted to remain living in their own community. As two aged care facilities, a retirement village and an aged care facility providing dependent and semi-dependent care are planned, remaining in contact with the community should be facilitated for the elderly. This would provide a good solution for couples and singles planning to down-size to a retirement village.

Suggestions arising from this overview were:

- promote HACC services to elderly men in Risdon Vale, particularly domestic assistance, home maintenance, meals, personal care and counselling;

- replace the current HACC-funded bus which has seating capacity for 10 with a larger bus with more seating capacity for the functionally disabled;
- encourage elderly men's participation in HACC funded social support activities and promote Risdon Vale 50's and Over Club, and the Aged Care Fun Club;
- fund the establishment of a Men's Shed in Risdon Vale, in partnership with Clarence City Council.

Devonport

Devonport is a coastal city of 25,000 people situated in the centre of Tasmania's north coast. It is a hub for health services in the region, which includes the North-West Regional Hospital situated in Latrobe.

Demographic data indicated that Devonport's population in 2006 of 22 978 showed an increase of 1033 from 2001. Additionally:

- The percentages of those aged 65 and over increased by 2 per cent to 17.6%. Combined percentages of the population over 55 in 2006 were 29.6 per cent or almost one third.
- Welfare housing comprised 33.3 per cent in 2006 compared nationally to 14.9 per cent.
- Median weekly individual income for 2006 was $368 compared to $466 nationally.

Home and Community Care data indicate greater delivery of services to elderly women than men in Devonport, although the hours received per head were largely comparable. For example:

- 1340 men received domestic assistance compared to 4968 women, equalling 16.1 hours each for both men and women.
- Home maintenance was also delivered to more women than men: 77 men received 4 hours each, while 253 women each received 5.9 hours.
- In terms of personal care, 171 women received 42 hours in this period, while 87 men received 50 hours of personal care.
- 18 women received 52.5 hours of respite care, while 15 men received 79 hours of respite care.
- Social support: 292 women each received 29.4 hours of social support, while 76 men received 40 hours of social support.
- 107 men received 2.7 hours of counselling each, while 433 women each received 1.2 hours of counselling

- 54 men received more centre-based care (day centre) each than women, that is 192.3 hours compared to 148.3 hours each for 73 women.
- Transport trips: 575 women made 19.2 trips each, compared to 247 men who made 29.6 trips each.

The participants expressed financial needs such as purchasing extra carer help for the elderly disabled, mobility equipment in the home, and extra heating. One or two elderly singles had concerns about paying bills; another regretted not having enough money to be able to socialise more. Most had family help in their day-to-day living which alleviated mobility and care needs; they also had support from neighbours, and support from local service providers.

A key informant, a manager of a large care association, with volunteers as the basis of service provision and over 1 000 consumers stated that demand for its services is increasing, as there is no comparable service in Burnie or Devonport. Their area of operations extends as far as Cradle Valley to the west and Port Sorell to the north – a growth area for the elderly – and the service makes 1200 trips for medical purposes alone per month.

Key informants find that a major problem is transport, with illness and lack of money negatively influencing elderly people's access to services. If individuals have to travel to Hobart or Launceston to attend specialist appointments, then travel is an issue. Community cars may not be available, and if they still have their licence, the elderly may not be able to drive these distances. There is not good public transport in Devonport.

Another common situation is lack of information about the services which are available for the elderly. It is a problem getting information to them, given often low literacy rates, so pamphlets and newspaper advertisements don't reach them, and they may not watch community announcements on television. Radio is the best, a key informant has found, for those who listen to metropolitan ABC, but not for those who listen to other stations. She finds that the best way of communicating this information

is directly, through speakers and contacts at community service organisation meetings.

The young-elderly (age 55-65) fare better and access services more, and are out and about more. People become more isolated, the key informants find, as they get older and are more vulnerable due to ill-health. Females as a target group have needs which are addressed such as with health screening, and men need to be targeted more. The Pit Stop program promotes men's health screening in small communities such as Penguin, Forth, and Ulverstone, including at workplaces for 55-65 year olds. This has been promoted as part of Rural Health Week.

Suggestions and approaches arising from this overview:

- with a large and increasing population of the elderly in Devonport, provide extra support to organisations providing HACC services to the functionally disabled elderly;
- extra support should be considered for non-ambulatory HACC clients to cover heating costs, and a review of equipment provision to improve their mobility in the home;
- provide extra day HACC care for elderly women as they appear to be under-represented;
- promote HACC services for elderly men including counselling, domestic assistance and social support.

Newnham

Newnham is a northern suburb of Tasmania's second city of Launceston. Newnham has older, working class housing stock with more recent residential development in areas of new housing. Because of Newnham's proximity to central Launceston, locals access its medical services, such as those located at Launceston General Hospital.

Newnham's population increased by only 100 over the period 2001 to 2006, with males comprising 48.5 per cent of the population and females comprising 51.5 per cent. Additionally:

- Those aged 55 to 65, and 65 and over were under-represented in 2001 data, but by 2006 conformed to national ratios.
- Welfare rental was 17.3 per cent in 2006, compared to 14.9 per cent nationally.
- In 2006, median weekly individual income was $355 compared to $466 nationally.

Home and Community Care data for 2008 - 2009 shows fewer men receiving more hours of most services than women. For instance:

- 30 men received 22 hours each of domestic assistance over this period compared to 79 women who each received 25hours;
- 9 men received 3.8 hours of home maintenance compared to 22 women who each received 6.5 hours;
- 33 women received 55 hours of personal care, compared to 12 men who received 80 hours of personal care;
- Also, 5 men each received 119 hours of respite care compared to 5 women who each received 21 hours of respite care; and 8 men received 282 hours of centre-based care compared to15 women received 74.8 hours of centre-based care;
- 11 men received 41 hours of social support, and 14 women received 37 hours of this support;
- Men were more likely to use community transport, with 42 trips per person (22 men) in this time period compared to women (30 women) who each made 27 trips.

Participants expressed financial stress due to meeting medical costs arising from ill health, such as the gap between specialist costs and health insurance reimbursement. Some were immobilised and confined to home by health problems. More information on HACC services and subsidies was felt to be needed. Dependence on a visiting or live in carer to help with daily self-care routines was expressed. In terms of transport, the costs of getting about when you have to pay for a taxi were a concern. Getting about in Launceston either by car or walking was a difficulty, and public transport for the elderly living in outlying suburbs was non-existent.

Key informants at the Northern Suburbs Community Centre (NSCC) emphasised the Centre's importance in providing social support, offering a range of activities, groups, outings and events in Newnham and the surrounding suburbs of Rocherlea, Mayfield and Mowbray. As well, NSCC provides support to other organisations, with both the local Community Health Centre and the local doctor requesting help with services for older members of the community and their families. These activities are publicised through organisations including Women Tasmania, and through the social work team at Launceston General Hospital who are picking up on this support and help in local communities

NSCC undertakes community consultation to identify needs and addresses these needs with programs. Because of these initiatives, a greater demand for services is generated. Groups at the Community Centre provide opportunities to socialise and have become embedded in this community.

The biggest local problem is transport and getting around, including personal mobility for those using walking frames and scooters. There are problems of access to and use of equipment to help with mobility. Information about services for the elderly is erratic. NSCC gives advice when needed. There is growing need in the northern suburbs for support to the elderly. Aldersgate Aged Care Facility in Newnham would like to be more involved with NSCC activities, but people can't walk from there to the Centre and there is no transport – there should be a HACC bus to service this need. Older people should be encouraged to be active, such as taking part in managing the community garden at NSCC, but again there is no vehicle to transport them.

In the northern suburbs, the main trend is people living longer. In Mowbray and Mayfield – suburbs close to Newnham – there are a lot of older people who have lived there for years. They receive limited family support and a growing trend is to give support to those identified by the NSCC Family Support Team with food on site which is stocked in collaboration with Church groups, especially for the elderly at Christmas. Links to informal support networks, such as neighbours, helps identify and meet the needs of the elderly.

A marked trend is grandparents looking after grandchildren. Although they have a self-help organisation, Grandparents Raising Grandchildren, they need substantial support. If elderly grandparents don't have good health, they need a respite service. The NSCC has provided places for grand children at Li Lea Pad child care centre.

A key informant at Family Based Care (North) sees a needs trend in the growth of the bereaved as a group. It is difficult for widows who have been dependent on their husbands to undertake tasks such as paying bills, and they become socially isolated, particularly if they don't have family support. Their own lack of mobility and transport limits family access and community engagement. Lack of contact with people then negatively affects nutrition and total well-being.

Suggestions and approaches arising from this overview were:

- promote HACC services to functionally disabled women in Newnham;
- promote HACC subsidies towards improving access and mobility in the home and community, possibly through the Northern Suburbs Community Centre;
- improve HACC transport service options in this and adjacent communities to improve the elderly residents' community engagement activities;
- encourage exercise and social interaction in the elderly, possibly through a voucher system;
- support elderly widows in Newnham and adjacent suburbs who seem less able to cope with daily living with HACC services as appropriate, and social engagement initiatives.

Inner city Hobart

Australian Bureau of Statistics demographic data show a small increase in the population of the Hobart Local Government Area between 2001 and 2006, of little more than 1 000. However, these were mostly males, and those aged 55-64 years. Male-female ratios for 2006 indicated slightly more women than men, compared to national averages. Median weekly individual income was $526 compared to $466 nationally and welfare rental comprised 10.2 per cent of household tenure.

HACC data reveal that more women than men received domestic assistance but the hours of help received for 2008 - 2009 was comparable for both, at 6 to 7 hours per person. Similar patterns of use are apparent for home maintenance, meals delivered, personal care, respite care, nursing, social support, allied health care, assessment, counselling, centre-based care and trips made with HACC transport.

Participants expressed financial stress due to meeting medical and dental costs, and concern at the long waiting lists for treatment. Financial stress was also expressed about home maintenance and bill-paying. One participant experienced security problems due to the illegal actions of a neighbour, while others had excellent relations with neighbours, expressing reciprocity through helping each other out. A participant who voluntarily stayed at home produced a large amount of crafts and foodstuffs which she regularly gave away. Hardship was also expressed in terms of lack of money to socialise. Mobility within the community was dependent on personal health.

Suggestions and approaches arising from this overview were:

- publicise and promote local chat hot-lines (e.g. Lifeline) to support those functionally disabled people confined to the home;
- publicise and promote safety in the home with an emphasis on cords and leads, particularly through service providers and carers;
- support elderly widows who seem less able to cope with daily living with HACC services as appropriate, and social engagement initiatives.

5. Conclusions

A qualitative approach to the Home and Community Care HACC Independence Project has enabled the thirty-five elderly participants – HACC users and non-HACC users – to identify what they think is independence in terms not only of the key elements of independence identified in Figure 1: mobility, financial security, capacity to undertake self-care, health status, family support and connections, community engagement and social networks, but to describe how it manifests in their daily lives, at home and in their communities. The conclusion is drawn that, of these three states, interdependence is the optimum and is to be supported by services for the elderly.

Figure 1 highlights the associations between levels of dependence, interdependence and independence, and degrees of social and physical isolation of the individual elderly person. Using this evidence, the levels of services required to maintain interdependence by fulfilling social as well as health needs were also identified.

5.1 Personal experiences of independence

The HACC Independence Project has validated the personal quality of life and well-being of the elderly, their valued and active contribution to the community, and capacity to access services and facilities, which is best described as interdependence. The elderly individual defines his or her own levels of independence, as is clear in this project where, despite their health status, the majority of the elderly viewed themselves as being very independent across the age ranges.

Perceptions of independence were not linked to age, nor to biomedical or policy formulations of ageing. Neither were they linked to physical competence, as the five participants with a disability gave themselves very high scores on the Independence scale. Those with serious, incapacitating illness requiring constant care were most likely to score low on the Independence scale. For the elderly, loss in terms of ill health and disability did not in itself constitute a threat to successful ageing. Health was expressed not simply as the absence of disease or disability, but the capacity to

engage with society in meaningful activity, and to take part in a social life with family and friends. Only two participants did not engage in regular social activities, and two-thirds saw friends and/or neighbours regularly. Of further importance for personal health was retaining a strong sense of self identity and purpose, through participation in social and community life, attributes which then overrode the debilitating and limiting effects of illness and disability. The individual defines her or his relationships with friends, family and neighbours in terms of needs and wishes; the relationships of the elderly individual to care givers should similarly be defined.

Given the focus of policy which seeks to manage growth in the ageing sector of society by providing support in the home in supporting independence for the elderly and those with a disability, relationships with friends, family and neighbours are key to effective and compassionate care-giving and receiving. A major finding differentiating government policy initiatives from the reality of lives of the elderly is that family and community engagement, rather than being an outcome of health and well-being promotion, results from people's life stories – the way they have lived their lives, and the ways they have now adapted to current circumstances. Health and well-being are contingent upon these life stories, or the individual's 'life course': the two groups that managed their health and well-being best in the project being those who had kept up their personal interests throughout their lives and into old age, and those who were socially embedded in their communities. Adapting to the effects of ageing, life interests were tailored to personal capacity. Participants most able to maintain their well being and therefore independence were those continuing activities which were a habit of a lifetime. These included two participants over the age of ninety, one of whom still bushwalked and another, an elderly woman, still stacked ten tonnes of wood every winter. Other couples still sailed and belonged to sports clubs, or contributed to the community through church and club membership.

In keeping up productive activities, routines and hobbies at home, often resulting in ongoing social contact, elderly people maintained their identity and sense of being useful members of the community, and through the interdependent character of these activities, their independence. These activities included gardening, cooking, wood-turning, wood collecting for the fire, tapestry, knitting, raising chooks and breeding cattle many of which helped supplement income to a small degree. In other examples,

elderly people maintained residual activities. An example was that of elderly men progressing over the years from active sports participation, to coaching, to watching children and grandchildren play sports, to finally watching sports on television. Another situation was that of people who had spent their lives working in a particular area such as orchards, farming or forestry maintaining physical activity such as collecting timber from the bush, walking to the top of the hill to bring in the cows, and cultural interests such as working in the community archives and heritage centre. Neighbourhood or community houses were important foci for community engagement, through activities such as walk clubs, talks, morning teas, Tai Chi, bus trips, and charity events. The activity Eating With Friends was also important in encouraging people to meet regularly with friends outside of the home to share food, and to interact with volunteers, and young people from local schools who helped prepare and serve the meals. Through these activities, the elderly resisted social isolation, structured dependency, passivity and powerlessness.

5.2 Self reliance

There are two facets of independence in the lives of elderly people classified as young elderly (55 to 65). On the one hand they take services for granted, as they are used to receiving support throughout their lives such as social services, educational benefits, and pension payments which are viewed as a right. On the other hand, the health and well-being culture of the 'baby-boomers' has been observed by service providers as giving them a level of self-determination in living independently that will carry them positively into old age. To this extent they have determined their lifecourse early in life and built up health capital or insurance as a way of life much as they might have accumulated financial capital. In their later years this manifests as better health and continued social engagement, which supports them as their capacities inevitably diminish.

For example, a third of the participants did not use HACC services at all. Most of them were self-funded retirees (5), demonstrating that the possession of financial resources helps mitigate the affects of ageing. The second group were elderly people healthy enough not to need help in living independently in their homes. Both groups included very elderly people who expressed their independence by not using HACC

services. This attitude was born of socio-economic circumstances and had stood them in good stead in lives experiencing major social and economic downturns. Where they do receive government services such as a pension, they are grateful but this does not mean that they view access to other services such as HACC services as a right. They prefer to rely on themselves to undertake tasks such as painting the house, or by going without, particularly if they do not have family support. In this way, their independence is asserted, but also compromised as they grow older and less capable of maintaining themselves in the home. Public education programs and positive, locally based programs should promote services to these people.

5.3 Ageing in place

For elderly people, whether living in rural, suburban or urban situations, social networks define the outer boundaries within which they draw for support. These spatial and temporal boundaries overlap with but are not necessarily contingent to geographical boundaries. Local networks and informal support within these boundaries may substitute for formal service provision. Likewise formal support services can mitigate the effect of geographical and social boundaries in the daily lives of the elderly by increasing personal and group mobility, levels of social engagement and communication within and outside the home and the community.

Place affects people's health through the proximity or otherwise of family, kin, health services and other forms of support. In terms of health and other support in the home, the elderly living in rural areas are doubly disadvantaged. Distance from health and support services combined with reduced mobility if a licence is cancelled, is exacerbated by a history of lack of local public transport which has forced dependence on the car in the past. This situation is not easily overcome in rural areas, but community cars and buses provided by the Red Cross, Home and Community Care and the state government's Patient Transport Service and Medical Retrieval service address this need.

Culturally, 'ageing in place' in terms of home, place attachment and identity support independence in the elderly. People who have lived in a small community (rural or otherwise) all their lives are empowered in old age when their stories are collected for

the local archive; they are further empowered when their expertise is utilised locally, demonstrated in this project where elderly people are volunteer guides at the local heritage centre, run a crafts workshop, markets, make jams and cakes and take part in cultural activities at the local library. Others living in small communities experience loss and isolation when their partners die, or their children move away or cease contact with them. Further, elderly people have different experiences of place if they are residents who have moved away and then returned, or if they are new to the area.

To be noted is the extent to which technology can reduce the impact of boundaries in the social lives of the elderly. Enhanced access to information and services ultimately supports independent living. In this study, the principal form of communication was the telephone. The flexibility of mobile telephone use was not recognised, as the majority of participants who used the mobile phone only used it 'rarely.' Similarly the potential of internet use to reduce social and geographical boundaries and enhance personal independence was not realised by the elderly in this study, as it was used only by one fifth of the participants.

Ageing in place is a complex process, which, in the face of ongoing personal, social and technological change requires older people to reintegrate with home and community, to adapt their role, and to use their own resources to maintain their independence as they age. Many participants in the project demonstrated their engagement with this process. They gave concrete examples of their adaptability and creativity in the face of reduced income, health and mobility.

5.4 Types of services best supporting independence

Care and support service delivery for the elderly in the community is complicated by the individuality of their profiles of need, indicated in a summary of the project data. The participants ranged in age, from 50 to 92, with 10 men and 25 women, 5 of whom were couples. The majority received the aged income or a mixture of personal income and the aged pension. Five were self funded retirees. Home location varied, with participants living in rural, urban, suburban areas, and in the three regions of Tasmania, south, north and north-west. Home location had little influence on self-

perceptions of independence. Elderly urban dwellers scored high, but there was little difference in the high average scores between elderly rural and suburban dwellers.

Participants' health status was extremely varied and it is best at this point to simply describe the types of HACC services used by the participants. Most service use was attendance at day centres, followed by domestic help and home maintenance. Transport was an important support to the elderly, with 10 participants using the HACC funded bus, and another 4 using community transport and taxis. The allied health services most used by this group of participants was podiatry. A small number also were helped with community nursing and personal care.

Maintaining good health and dignity through support in caring for themselves was important for the participants who received HACC care, particularly if they had a serious health condition. An array of help was provided by HACC carers, while allowing the elderly to undertake tasks within their capacity to do so, such as showering, cooking meals, dressing, including putting on their own shoes and socks, toileting, taking medication, and caring for nails, hair and feet. They were mostly able to undertake small chores about the house, including making the bed, putting away clothes, hanging out the washing and bringing it in. Vacuuming and handling washing – hanging out and bringing it in – were difficult for a number of elderly people.

5.5 Barriers to independence

In the HACC project, barriers to greater independence were identified as financial constraints, reduced mobility because of poor health, the physical strain of maintaining the home, and lack of transport. Those identifying transport services as limiting their mobility in rural areas specified the long distances to health and other services located in rural and urban centres; and in suburban and urban areas it was lack of adequate regular transport services to and from the city. The negative effect of the loss of a licence was felt by participants wherever they lived, as it reduced the ability to make choices such as whether to take part in community activities.

Financial constraints restricted the ability of the elderly to make choices to engage in the community and thus contribute to their own health and independence. A small

amount of disposable income enabled them to attend cultural events, go shopping for more than the necessities, take part in organised activities that required a monetary contribution and increased their mobility by allowing them to hire taxis and take bus trips more frequently. Project results indicate that a high income was a factor in helping the elderly to remain independent as it was an additional resource enabling them to continue their activities, and helped them with mobility and access to services.

It is argued that elderly women cope better with the ageing process than men because of the lifetime social networks which they are able to call upon. Yet, in this sample, some women experienced physical and social isolation when their husbands died, having been dependent on them for mobility, undertaking tasks such as paying bills, and maintaining the physical home. While some seemed to be physically isolated, they were not necessarily socially isolated. For instance Dawn, an elderly woman who, with the death of her husband never left her home, did all of her shopping by telephone, minded her school aged grandchildren after school, had a son living with her who paid the bills and gave her company, was always being visited and spent her time making crafts for charity.

5.6 Family support in overcoming barriers

In this project, incidental family support was important in surmounting the barriers to independence with family members meeting elderly members' unavoidable needs such as shopping, bill paying, house maintenance and spring cleaning, and by providing social structure and opportunities to contribute. Although family support varied greatly across the participants, most did receive support when it was needed, and were able to reciprocate by helping their children and other family members through baby-sitting or child-minding, housework and handing out 'loans.' Socialising and celebrating important occasions with family members were important dimensions of their lives for the elderly, and many travelled considerable distances to attend these gatherings, including inter-state. The importance of the family was validated. Empowering activities were reinforced by positive valuing, and stereo-typed representations of ageing were broken down.

A problem in rural communities was that of elderly people living in remote areas whose well-being was uncertain due to their physical isolation. While their health and well-being would be reviewed if and when they attended the local medical practice, the haphazard nature of this interaction was a concern to local service providers. In a number of the communities, social networks of family, friends and neighbours in the wider community buffered losses incurred as locals aged. Creating inclusionary spaces – whether in the form of an information bus such as the ManVan, a health day centre, walk or other activities and club, or a regular market, would encompass the health and social needs of the elderly and their independence. A program of consultation should focus on those elderly people who are isolated physically and emotionally, such as newly widowed men and women, those without family support, and grandparents bringing up grandchildren.

5.7 Communities

Each of the seven communities presented a different profile of support for independence in the elderly both formal and informal, that is support provided by formal health and medical services, and support provided by friends, neighbours and family. ABS demographic data, Home and Community Care data and interviews served to identify local needs and gaps in health service provision, health service uptake and emerging trends which indicate how needs are currently met, and how they might be better met to support independent living in the daily lives of members of these communities. This casts light on the social fabric of each society, its adaptability to change, and amenability to catering for the needs of the elderly.

As noted, for older people in these communities, illness or disability per se did not constitute a threat to healthy ageing, as long as people were able to retain the capacity to engage meaningfully with daily life and continue their preferred activities. This understanding was evidenced in this project in two ways: individuals' nominated measurement of independence on the Independence scale; and the ways in which individuals have modified their activities to match their capabilities, without giving them up, often with the support of HACC services. Thus, healthy ageing clearly has two dimensions where HACC services are deployed most effectively outside the home: meaningful, community-based activity such as is provided in day centres and

programs such as Eating with Friends, and services which support contact with family and friends, such as transport subsidies which allow elderly individuals to pursue their own interests (not forgetting home support which potentially frees up the elderly to spend more time outside of the home). Such support counters any perception that HACC services are only for the frail and needy, and by implication those who are dependent and disempowered.

A creative focus on services delivered through community-based organisations would facilitate connectedness, engagement and support within each community, linking with current community organisations, such as with arts, history and heritage organisations, as has happened in Geeveston, and with initiatives undertaken by councils through their positive ageing committees, such as at Kingston.

Ideally, such programs would encourage people when they are healthy and able to develop interests and continue them as they age, and should be adaptable for those who are limited by poor health, mobility and restricted finances.

On this basis, the recommendations for each of the communities also can be viewed through a creative lens in which activities such as theatre, art, book club, craft, music and choir, exercise and sport facilitate social inclusion. Such an approach promises the following outcomes:

- initiating and supporting current lifecourse activities, so that social inclusiveness is maintained as the individual continues to age;
- supporting personal worth and self-image through ageing, retirement and as health deteriorates;
- initiating and supporting activities which are inclusive of generations rather than those which isolate the elderly from the community; and
- initiating and supporting activities which are inclusive of families, friends, neighbours, places and institutions.

Creating *inclusionary spaces* within the boundaries of support upon which the elderly and those with a disability can draw should also extend to include those lacking

family and social networks such as the rural isolated. Ideally, inclusionary spaces should comprise a mix of formal and informal services and support.

5.8 Government services: local, state and federal

As is clear from the results, not only are all the elderly as individuals unique, but so are their communities: even the two rural communities in the project are dissimilar. Communities are dynamic, change can be predicted and data illustrates changing trends across gender and age groups. Health service provision, specifically for this project HACC services, are shown to be important elements in supporting independence in the elderly in these communities. Yet, equity of delivery is not apparent, and the community case studies show that some communities lack services, some groups are under-serviced, and some services such as respite are thin on the ground. Ongoing monitoring of needs, gaps and emerging trends at community level is required for the effective and efficient delivery of services, and this can best be structured through a HACC consumer and community consultation process. Just such a consumer consultation process is currently being developed for HACC, and also DHHS which could be utilised for these ends.

A number of linkages have been identified which, in partnership with HACC, would provide a strategy or model of action to promote independence and optimise safe and successful ageing within the community, and which would augment community-wide consultation processes. Positive Ageing Committees in the councils of each local government area would be appropriate partners and could incorporate the following steps:

1. Mobilise a coalition of local people, service providers, agencies and organisations within the community to identify local risks and resources.
2. Select a number of priority risks for action.
3. Develop and implement an action plan with community participation, identify interventions, with resources and personnel; include extending services, establishing new services, education and preventive health promotion.
4. Monitor over a specified time period with feedback and evaluation from all participants.

Appendices

6.1 Issues identified by the focus groups

Focus groups were held in the south, north and north-west. Summarised below are the main points made by the focus group participants about independence for the elderly, in the words of the participants. The focus group participants were care-workers and administrators delivering the broad range of Home and Community Care services to functionally disabled elderly people living in rural, suburban and urban communities in these regions. Their responses are clustered and presented in terms of the spheres of home, community and government agency.

The *home* includes the immediate environment which can be modified to support independent living; it is where, at best, elderly individuals manage their domestic surroundings in acts of independence, and also are able to provide support and help to others. It is where support to the elderly individual is provided by the carer, close neighbour and/or family member. It is where HACC services such as home maintenance, home modifications, domestic help, and home nursing are delivered to the elderly person in the home, as well as follow-up support for post-operative hospital discharges.

The *community* is the broader locus of connection and engagement, of extended family support, as well as formal health support and activities, and those provided informally by the community, as well as organisations such as clubs and local council activities. The community is the source of social involvement for the individual or couple. Many HACC services are located in the community: centre care; respite care; community transport; personal counselling and carer counselling; allied health care, and social support which are directed to supporting the elderly in living independently at home.

Government programs for the elderly (federal, state and local) provide aged benefits and subsidies; health service provision such as hospital and medical services; HACC

services such as respite and day centres; care homes and assisted living; and other services which impact on the individual such as licensing laws, transport provision, and services such as power, water and sewerage, all of which should contribute to independence for the elderly.

In the home

1. When asked to define independence, focus group members responded as follows:
    - independence for individuals is seen as maintaining their own home in the ways they are accustomed to – keeping what is familiar and manageable;
    - dependence is not always a negative condition, but is part of the spectrum of independence, and links with interdependence;
    - the meaning of independence is having support systems to enable the elderly to stay in their own home;
    - for others it may mean only some support services, or it may mean respite care, for instance, for them or for their partner;
    - it is a healthy living rather than a frail ageing model; and
    - it means being able to make your own decisions, to be allowed to decide for yourself, as opposed to family members making the decisions on their behalf.

2. Focus group participants also commented:
    - Sedentary lifestyle is a problem – we set up the environment to allow us to do as little as possible, and bring everything closer, requiring less mobility, less exercise and then services are needed for tasks which demand exercise, such as vacuuming, looking after yourself; society must seek to avoid the need for services to address shortcomings due to lack of activity, such as overweight and obesity, diabetes, heart conditions.

3. In terms of HACC best practice service provision:
    - volunteers and carers should continue to be trained and then supported to work *with* the consumer rather than *for* the consumer, helping them to do their own shopping, prepare food and other tasks for themselves, to maintain consumer's independence;

- even people with chronic conditions, especially those receiving HACC services should be supported with the focus on attaining independence in their daily tasks and routines;
- helping too much leads to individual's dependence rather than independence;
- the consumer must assert their independence, rather than thinking they deserve help as they are now old; and
- home modifications are necessary for people to be able to live in their own homes and in enabling the elderly to manage and do tasks on their own; bathroom renovations, new non-slip floors, equipment, plumbing; there is a huge need.

4. Examples of people living independently were given as:
    - independent retirees, those in a higher socio-economic situation and healthier background;
    - baby boomers, especially the young-olds of 55 and upwards, but even capable 80 year olds are 'out there doing it'; they know how to solve problems and will fix things themselves; and
    - similarly, HACC consumers need to be empowered and need to feel in control of their lives.

5. Issues surrounding dependence-independence were identified as:
    - the importance of food and good nutrition which is wrapped up in independence, personally, for the family, and socially; food *is* independence;
    - mobility: physically, access is often an issue with walking frames, wheelchairs indicating a need for more ramps; level access showers prevents many falls and enables some to shower for the first time in a long while;
    - information about appropriate services is necessary to facilitate independent decision-making, as there is a multitude of services such as home care services and the consumer needs to be helped to decide who and what services to utilise; and
    - communication between hospital and the community in support of the frail elderly patient is essential.

6. Focus group participants also commented:
    - the focus should be on whole of life – building up personal strengths; use wellness rather than dependence language when interacting with consumers; and preventative services should be more available to consumers; and
    - ability to manage is not age related but an outcome of a supportive environment, strength of mind, circumstances, personality, etc.;

In the community

Focus group participants defined independence socially as the ability to do things in the community, and maintain community access and connections.

Factors supporting independence in the community were:

1. Public transport, particularly in isolated communities, as it supports social contact and engagement, and produces incidental exercise which keeps consumers more independent. Further:
    - adequate transport also promotes interdependence for the elderly through productive relationships between people and generations;
    - loss of ability to drive is very significant in relation to independence: if the consumer can't drive, it is devastating – the losses experienced are access to life style – shopping, shops, and other activities; and
    - people have to wait on other people for lifts, they can't walk to the bus and back and this equals loss of independence.

2. Participants commented that up to 40 per cent of neighbours help the elderly in some parts of Tasmania, sometimes more so than family members, and in some areas respite is provided to the neighbour(s). This is informal support within the community, and is a key indicator of interdependence.

3. Communication between services and service providers to establish consensus on service provision to support independence is essential, and getting the appropriate service to the consumer with better discharge planning and communication to new and existing consumers should be a regular part of service provision.

- good communication between hospital and community is a necessity, although Commonwealth Carelink Centres for older people, people with disabilities, and those who provide care and services are helpful for information; and

- communication with the aged consumer needs to be addressed: overcoming language barriers and cultural issues in terms of cultural background but also wider, as in terms of age, gender, and between communities, and in respecting consumer rights and choices. Some don't know where to turn – aim is to get people to access services and look after themselves, and thus gain confidence.

4. Education for care workers needs to focus on approaches to encourage consumers to continue 'doing'; and being involved, without services 'taking over'; services need to be consumer-centred to meet individual needs, and services care workers need to implement this training early, so consumers can be empowered to self manage their lives.

Government – state, local and federal policies

1. Focus group participants identified the necessity to adjust funding guidelines / programs to meet evaluated community and / or consumer needs.

2. They also found that financial security is an issue, as many consumers on disability support or aged pensions have little or no savings – for instance it would be far more economical to modify a person's home than provide institutional care – if the government helped more they could save approximately $100k per person over a 5 year period; there is a huge waiting list for home modifications, more than current funding allows.

3. Aged care, and HACC, needs service co-ordination, case management, development and use of a self-management model with the consumer at the centre.

4. Participants commented that whole of sector, i.e. government policy, focuses on a dependency model, and this is clear in the language used to describe 'care';

independence needs communicating differently by taking into account culture, language, hearing ability.

In each sphere of activity, focus group input demonstrates the complexity of providing support to the elderly. People have different abilities to cope, abilities conditioned not only by their personal health profile and life course experience, but also by income, age and degree of ageing, gender, community location and community engagement, and family support and status such as whether single or a couple. Policy implications arise from this diversity of factors that directly impact on each elderly person's place on the dependence-interdependence-independence continuum.

6.2 Linkages

Utilising initiatives in the wider community would enhance HACC service provision in areas of need, particularly those identified by the focus groups through a structure facilitating cross sectional engagement. These include:

1. The restructured Patient Transport Service and Medical Retrieval service which addresses transport and accommodation needs at community level.

2. Key strategies in Tasmania's Health Plan such as the emphasis on the importance of community organisations developing trust between themselves and others; learning to work together.

3. Social inclusion initiatives by the Tasmanian Social Inclusion Unit aimed at developing social capital such as community transport, also have the potential to foster elderly people's engagement in the community. This initiative is funded to $1.5 million for the purchase of vehicles by partners such as Rotary and community/neighbourhood houses in rural and outlying areas.

4. Each community has a Community Health Centre delivering a wide range of DHHS services to local communities, some of which overlap with Home and Community Care services. Other services such as allied health care meet local needs, particularly in communities not comprehensively serviced by HACC.

5. Local municipal councils have Positive Ageing Committees whose membership includes elderly people and stakeholders. The Positive Ageing Committees are facilitated by a community development officer to develop a positive ageing plan. The local community is consulted, and principals and activities suited to the needs of locals are designed and implemented. In Kingborough, for example, its positive ageing plan – based on consultation with its communities through a survey and workshops – includes a set of principles: access and participation, consultation, inclusiveness, building on diversity, equity, respect, communication,

responsiveness, effectiveness, efficiency, building community capacity, confidentiality and accountability.

6. The Patient Travel Assistance and Patient Retrieval Scheme, as noted, is a statewide non-emergency transport policy developed by DHHS on the basis of the Banscott review. Its Health Communications Centre is located within the Tasmanian Ambulance Service. It is designed to address widespread transport and accommodation disadvantage, including for the elderly.

6.3 References

Adams, D (2009)., *A Social Inclusion Strategy for Australia*. Government of Tasmania, Hobart.

Andrews, GJ, Cutchin, M, McCracken, K, Phillips, DR and Wiles, J (2007). Geographical gerontology: The constitution of a discipline, *Social Science and Medicine,* Vol. 65, Issue 1, 151-168.

Australian Bureau of Statistics (2006) *Australian Demographic Statistics,* Catalogue no. 3201.0. Government of Australia, Canberra.

Australian Bureau of Statistics (2006) *Census of Population and Housing, Core Activity need for Assistance by Age and Sex,* Catalogue no. 2068.0. Government of Australia, Canberra.

Australian Bureau of Statistics (2008) *Tasmanian State and Regional Indicators, Ageing in Tasmania, 2006.* Catalogue no. 1307.6. Government of Australia, Canberra.

Bartlett, H and Peel, N (2005). Healthy ageing in the community, *Ageing and Place*, Garvin, JA and Phillips, DR (eds), Routledge, London and New York, 98-109.

Baum, F, Palmer, C, Modra, C, Murray, C and Bush, R (2000). Families, social capital and health. Winter, J and Lyons, M (eds), *Social Capital and Public Policy in Australia,* Australian Institute of Family Studies, Melbourne, 250-275.

Bland, R (1999). Independence, privacy and risk: two contrasting approaches to residential care for older people, *Ageing and Society,* 19, 539-560.

Borowski, A, Encel, S and Ozanne, E (eds) (2007). *Longevity and Social Change in Australia,* University of New South Wales Press, Sydney, Australia.

Brotherhood of St Laurence, November 2003. Report *What Value Independence?* 1-44.

Boyle, G (2008). Autonomy in long-term care: a need, a right or a luxury? *Disability and Society*, 23:4, 299-310.

Cattan, M, White, M, Bond, J, Learmouth, A (2005). Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions, *Ageing and Society*, 25/1, 41-67.

Cork, S, (ed) (2009) Brighter Prospects: Enhancing the Resilience of Australia, Australia 21: Shaping the Future, 1-84.

Crawford, W (2006), Health as meaningful social practice. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*. Vol 10 (4), 401-420.

Dant, T (1988). Dependency and old age: theoretical accounts and practical understandings, *Ageing and Society* 8, 171-188.

Davis, MW, Trim, G, Buchanan, J, Le Couteur, DG, Rubenach, S, McLean, AJ (1999). Older people in hospital, *Australasian Journal on Ageing*, vol.18, number 3, supplement, 26-31.

Efraimsson, E, Hoglund, I and PO Sandman (2001). 'The everlasting trial of strength and patience': transitions in home care nursing as narrated by patients and family members. *Journal of Clinical Nursing*, 10, 813-819.

Findlay, RA (2003). Interventions to reduce social isolation amongst older people: where is the evidence? *Ageing and Society* 23, 647-658.

Fine M, Glendinning, C (2005). Dependence, independence or inter-dependence? Revisiting the concepts of 'care' and 'dependency'. *Ageing and Society* 25, 601-621.

Futurehealth: Tasmania's Health Plan (2007). *Department of Health and Human Services*, Government of Tasmania, 1-67.

Graham, H (2002), Building an interdisciplinary science of health inequalities: the example of lifecourse research. *Social Science and Medicine*, 2005-2016.

Godfrey, M and Randall, T (2003), Developing a locality-based approach to prevention with older people. *Nuffield Institute for Health*, University of Leeds, Britain, 1-67.

Godfrey, M, Townsend, J and Denby, T (2004), Report: Building a good life for older people in local communities: the experience of ageing in time and place. *Joseph Rowntree Foundation.* http://www.jrf.org.uk. Accessed 7 July 2009.

Grenier, A (2007). Constructions of frailty in the English language, care practice and the lived experience. *Ageing and Society* 27, 425-445.

Grundy, E (2006). Ageing and vulnerable elderly people: European perspectives, *Ageing and Society* 26, 105-134.

Harbison, Joan and Morrow, M. (1998). Re-examining the social construction of 'elder abuse and neglect': a Canadian perspective, *Ageing and Society* 18, 691-711.

Heuvel, Wim van den (1976). The meaning of dependency. In Munnichs, MA and van den Heuvel, WJA (eds) *Dependency or Interdependency in Old Age.* Martinus Nijhoff, the Hague, 162-173.

Jackson, N (2002). When the population clock stops ticking: an indicative study of population ageing in Tasmania, *Australasian Journal of Regional Studies* Vol. 8 No. 1, 3-19.

Johnson, M (1976). That was your life: a biographical approach to later life. Munnichs, MA and van den Heuvel, WJA (eds) *Dependency or Interdependency in Old Age.* Martinus Nijhoff, the Hague, 147-161.

Jolanki, O (2008), Discussing responsibility and ways of influencing health. *International Journal of Ageing and Later Life* 3 (1), 45-76.

Mullan, P (2000). *The Imaginary Time Bomb*: *Why an Ageing Population Is Not A Social Problem*. I. B. Tauris, London, New York.

Paillat, P (1976). Criteria of independent (autonomous) life in old age. Munnichs, MA and van den Heuvel, WJA (eds) *Dependency or Interdependency in Old Age.* Martinus Nijhoff, the Hague, 35-41.

Motel-Klingebiel, A, Tesch-Roemer, C and H-J Kondratowitz von (2005), Welfare states do not crowd out the family: evidence for mixed responsibility from comparative analyses. *Ageing and Society*, 25, 863 – 882.

Plath, D (2002), Independence in Old Age: Shifting Meanings in Australian Social Policy. *Just Policy* No 26, May 2002, 42-47.

Report on Government Services (2006). *Productivity Commission*, Government of Australia http://www.pc.gov.au/gsp/reports/rogs/2005/index.html/

Richardson, J (2004). Ageing and Health Care: Inexorable costs versus modest adaptation, *Centre for Health Economics working paper 150*, Monash University, Melbourne, Australia, 1-16.

Rudman, DL (2006). Shaping the active, autonomous and responsible modern retiree: an analysis of discursive technologies and their links with neo-liberal political rationality. *Ageing and Society* 26, 181-201.

Scharf, T and Smith, AE (2004). Older people in urban neighbourhoods: addressing the risk of social exclusion in later life, Phillipson, C, Allan, G and Morgan, D (eds) *Social Networks and Social Exclusion*, Ashgate, UK, 162-179.

Sidorenko, A, Walker, A (2004), The Madrid International Plan of Action on Ageing: from conception to implementation. *Ageing and Society* 24, 147-165.

Schröder-Butterfill, E and Marianti, R (2006). A framework for understanding old-age vulnerabilities, *Ageing and Society*, Vol 26, part 1, 9-35.

Tasmanian Plan for Positive Ageing Second Five-Year Plan (2007). *Department of Health and Human Services*, Government of Tasmania. http://www.dpac.tas.gov.au/divisions/seniors/positive_ageing/html_version/

Taylor R, Ford, G (1981). Lifestyle and Ageing: Three Traditions in Lifestyle Research. *Ageing and Society*, Vol. 1 Issue 03, 329-345.

The New Zealand Positive Ageing Strategy, *Ministry of Social Policy*, Government of New Zealand, Wellington, New Zealand 1-33.

Townsend, P (1981). The structured dependency of the elderly: a creation of social policy in the twentieth century, *Ageing and Society* 1, 15-28.

Wilkinson, R and Pickett, K (2009). *The Spirit Level.* Penguin. London. UK.
White AM, Groves, MA (1997) Interdependence and the Aged Stereotype. *Australian Journal on Ageing* Vol. 16 No. 2, 83-89.

Woodward, CA, Abelson, J, Tedford, S and Hutchison, B (2004). What is important to continuity in home care? Perspectives of key stakeholders, *Social Science and Medicine* 58, 177-192.

6.4 Interview schedule

HACC Independence Project TasCOSS 2009

Code_____

Would you like someone to help you with answering these questions? Is this private enough for you or would you like to sit somewhere more private?

First of all, some questions about yourself:

Age
(decade)_____Sex_____Region_____Rural/urban_____
_

1. Are you:

Couple ☐ **(***Describe***)** _____

Single ☐ **(***Describe***)**_____

Other ☐ **(***Describe***)**_____

2. Could you tell me about your health?

(*Describe***)**_____

3. What might be your income per fortnight:

0=no regular income; 1=less than regular minimum pension (approx. $580 per fortnight for singles; $880 for couples)); 2=OAP or the same as the pension; 3=an amount more than pension (but less than twice); 4=twice the pension or more.

4. Is it enough to see you through to the end of a fortnight? ☐1 **yes** ☐ **no**

(*Describe***)**_____

5. In your home, do you:

Rent ☐ _____

Own (1**)** ☐ _____

Pay mortgage ☐ _____

Other (*Describe***)** ☐ _____

6. Do you have any financial worries about your living situation? ☐yes ☐ no

(*Describe***)**———————————————————————————

Now I am going to ask you some questions about dependence and independence in your daily life.

7. When going out, how many trips or outings would you make in a week?

0=none or less than 1 outing; 1 outing; 2 outings; 3 outings; 4 outings or more.

8. How do you mostly get about the place?

- ☐ Walking
- ☐ Bus
- ☐ Taxi
- ☐ Car
- ☐ Motorised scooter
- ☐ Wheelchair
- ☐ Other

9. Who do you go to see mostly, when you go out?

- ☐ Doctor
- ☐ Hospital
- ☐ Bank
- ☐ Post Office
- ☐ Service Tasmania
- ☐ Shopping
- ☐ Specialist
- ☐ Chemist
- ☐ Day centre
- ☐ Friend(s)
- ☐ Family member(s)
- ☐ Clubs or social groups
- ☐ Church
- ☐ Outings
- ☐ Other

10. Are you always able to get to these places when you need to? ☐1 yes ☐no

(*Describe*) ———————————————————————————

11. About local services (shop, chemist), are you're able to get to them?
☐1 yes ☐ no

(*Describe*) ———————————————————————————

12. If you want to contact people, how do you do that, mostly?

- ☐ Telephone
- ☐ Mobile phone

- Internet
- Letter
- Face to face chat

13. Are you always able to contact people when you need to? ☐1 **yes** ☐ **no**
(*Describe*) _____

14. Each week, how often do you enjoy leisure activities outside the home of one hour or more?
0=no activities; 1=activity; 2=activities; 3=activities; 4=activities of 1 hour or more
(*Describe*) _____

15. Are there any activities which you do at home, weekly?
0=no activities; 1=activity; 2=activities; 3=activities; 4=activities of 1 hour or more
(*Describe*) _____

16. How much time would you spend on your own, each week?_____

17. Are you happy with this amount of time? ☐ 1 **yes** ☐ **no**

18. About your family, do you see someone regularly? ☐ 1 **yes** ☐ **no**

How often? 0=no contacts; 1=contact; 2=contacts; 3=contacts; 4=contacts or more.

(*Describe*) _____

19. Relationship to you: do you look forward to seeing them? ☐ 1 **yes** ☐ **no**

20. In your social life, how often would you see friends/neighbours each week?
0=no contacts; 1=contact; 2=contacts; 3=contacts; 4=contacts or more.
(*Describe*) _____

21. Do you belong to a club, society, or cultural group? ☐ 1 **yes** ☐ **no**

(*Describe***)** _____

22. In general, are you happy with your social life? ☐1 **yes** ☐ **no**

(*Describe*) _____

23. Do you look after yourself each day, in your daily care? ☐1 **yes** ☐ **no**

- Showering
- Cooking meals
- Dressing, shoes
- Toileting

- Taking medication
- Caring for nails
- Caring for hair
- Caring for feet
- Small chores about the house (making bed, putting away clothes, hanging out washing)
- Other _____

0=1 care activity a day; 2 care activities a day; 3 care activities a day; 4 or more care activities a day.

24. Do you receive help from any of the following: ☐1 **yes** ☐ **no**

- Gardener
- Home handyman
- Cleaning lady
- Family member

25. Do you receive any HACC services? ☐ **yes** ☐ **no**

- Home help/Home Care/Domestic Services for domestic chores;

_____

- Personal Care – help with daily self-care - eating, bathing, shopping and bill-paying;

_____

- Home Maintenance - help with home and garden maintenance and repair;

_____

- Home Modification to improve safety such as rails and ramps and emergency alarms;

_____

- Transport for appointments or shopping;

_____

- Food such as Meals on Wheels;

_____

- Community Nursing;

_____

- Allied Health Services which include podiatry, physiotherapy, speech therapy and occupational therapy;

_____

- Advocacy Services, that is advice about your rights and responsibilities when dealing with people providing services and organisations;

_____

- Social Support includes services for people who need help with shopping, banking, paying bills or just company;

_____

26. Do you receive help from any other groups or organisations? ☐ **yes** ☐ **no**
(Such as Community Based Services; Polish, Italian, Greek (or other nationality) Club; Respite care, Australian Red Cross meals, Community Transport Services)

(*Describe***)**_____

27. In general, does the support you receive in your daily life help you to be/feel dependent (0) or independent (1)?

28. Can you tell me about aspects of your daily life where you might feel dependent?

(*Describe*) _____

29. Can you tell me about aspects of your daily life where you might feel independent?

(*Describe*) _____

30. Are you active in an organisation that gives help to people? ☐ **1 yes** ☐ **no**
(*Describe***)**_____

31. Do you help anyone out personally with support? ☐ **1 yes** ☐ **no**

(*Describe***)**_____

32. Do you actively look after your own health and well-being, as far as you are able?

☐ **1 yes** ☐ **no**
(*Describe***)**_____

33. Do you feel secure in your home and daily life? ☐ **1 yes** ☐ **no**

(*Describe***)**_____

34. Generally, do you feel independent in the way you live? ☐ **1 yes** ☐ **no**

(*Describe***)**_____

On this scale of dependence and independence, where would you place yourself?

35. Can you think of anything at all that could help you to be more independent in your daily life?

(*Describe***)** _____

Thank you for your help

7. Figures