Wellbeing among older Australians in rural areas

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Overview

- Rural ageing – why is it significant?
- Some implications for wellbeing
- Need to consider individual / community context – potential for double jeopardy
- But challenge to deficit narrative
- Vulnerabilities
- ...and capabilities / assets
Rural population ageing trends

• Older people more likely to live in rural areas across world
• In Victoria, concurrent trends, older people both long term rural residents and retirement migrants (Hugo)
  – Tendency for young to move away for education and employment
  – Retirement migrants move to (scenic) Murray Darling region – cheaper housing
• Overall about 25% of those aged 65+ live outside cities / large towns
• but variation across places - some regions 40% aged 65+ (Salt)
• - eg Towong shire median age over 50
What is rural?

• Rural is very hard to define.... Often defined as outside major metropolitan areas but is more nuanced
  – Some commonalities of rural living eg geography, economy, climate
  – but also differences eg mining, farming, remote Indigenous.
• Our lit review (Winterton et al. *Journal of Rural Studies* in press) identifies 3 spatial characteristics of particular significance to o/p’s wellbeing –
  – degree of remoteness,
  – population density, and
  – distribution of communities within a geographic area (eg closeness to service centre)
Place is important as we age

• Critical importance of place / local environment as we age (eg Gong et al 2014). Affects our mobility, independence and Quol.

• Yet does not remain static - hence can change as people get older - what suits us in our 60s may not be appropriate in our 80s.
  – Place relationship w housing... May move for cheap housing but far from family if need support
  – May become geographically and socially isolated when age eg causing issues eg carers
A complex story

• Diversity across communities, individuals and groups – some do well, others not (Keating, *Rural Ageing: A good place to grow old?*, 2008)

• Communities can have multiple impacts eg Beechworth, interspersed - mixture of high and low wellbeing. Others highly disadvantaged

• Need to avoid trend towards homogenising – differences by groups eg older Indigenous, low income women, farmers

• ALSO... much attention to disadvantages assoc w rural ageing and poor health outcomes, yet many rural o/p report high QuoL (Winterton & Warburton 2011)
Complex and multifaceted

• Vulnerability to multidimensional risk of social exclusion as we age (Lui et al., 2011).

• Further, we argue that socio-spatial dimension ignored, yet rural is a risk laden environment in which to age (Warburton et al., in press)

• Need to recognise multifaceted and diverse... BUT also need to move beyond deficit narrative (Bourke et al., 2014)

• Look at vulnerabilities (risk) but also capabilities (assets)
Vulnerabilities and capabilities

- Rural presents complex and diverse environments.
- Tendency to focus on risks or assets - not interaction and how it impacts on wellbeing.
- Below have separated the two to get a broad sense of issues associated with rural ageing - but they interact.
- We are looking at these issues in relation to the concept of wellness in rural ageing (Warburton et al., ARC project).
- Wellness is similar to wellbeing, defined as a multidimensional/dynamic concept reflecting the optimal state of health of individuals and groups (WHO).
Vulnerabilities (individuals)

- **poor health outcomes**
  - "vulnerable people in vulnerable places" (Joseph 2005); shorter lifespans
  - eg Hume health profile - high prevalence of comorbidities, lack of good diet, high obesity and smoking levels

- **distance and travel**
  - from family, medical facilities, low digital literacy

- **transport** is a major consideration.
  - Reliance on car
  - In our work, those who can't drive or lose their ability to drive (eg widows) are increasingly at risk

- **rural culture** can be problematic.
  - Resilience, self reliant, stoicism can (perversely) reduce help seeking behaviours. Eg high rates of farmer suicides.
  - Stigma associated w services.
Vulnerabilities (communities / services)

• structural disadvantage
  – rural poverty, lack of services, often disadvantaged areas – rural sites vulnerable to major structural change eg globalisation, service rationalisation. Retreat of state intervention through neoliberal policy frameworks
  – lack of services - not just health but also everyday services eg PO, shops, places to meet

• Lack of services
  – tyranny of distance, transport, spreads resources thinly
  – poor technological interface (eg telehealth)

• difficulties of recruitment and retention of health workforce in rural areas
  – shortages, ageing of workforce
Capabilities (social environment)

- **Strong local support with capacity to counter lack of services**
  - place is important but individuals are social animals
  - rural environments are noted for their high levels of social involvement
  - strong social networking, civic participation and strong neighbourhood connections
  - “it’s like the saying that it takes a community to rear a child. I suppose it takes a community to look after the old as well” (Warburton et al., *Sociologia Ruralis*, 2016).
  - Easier to get involved

- **But overall, large somewhat idealised literature – can be problematic**
  - May be high community expectations
  - “everyone knows everyone” or “everyone knows your business”... but "people can't care if they don't know about you"
  - individualised solution – it’s “their fault”; people “want to be left alone” or “they want to be isolated”- yet is complex, depends on community
Capabilities (volunteering)

• **Higher levels of volunteering in rural than urban areas.**
  – Varies by remoteness (Winterton, 2014) eg 31% major city, 39% regional and 41.5% rural. (ABS 2007). Also volunteer more time.

• **Multiple assets – for communities / individuals**
  – Rural communities are rich in volunteering / social capital
  – Individually, volunteering is related to improved health and wellbeing in later life.

• But reliance on volunteers can be problematic for rural communities:
  – Greater responsibility has passed to rural communities to develop their own solutions to service provision (Winterton, 2014)
  – But is it “the community has to be resourceful, because there is nothing else”? Or “the voluntary groups are coming in and doing a huge amount of work that I suppose... should be done by a state agency” (Warburton et al., 2016).
  – With population ageing, finding sufficient volunteers may be a challenge.

• And possibly problematic for individuals:
  – High level of expectation - "anyone w a pulse has to do something for the community" (Warburton et al., 2016). May not suit all.
Conclusions

• Findings across studies show that wellbeing depends on both the individual and the nature of the rural community.

• Place is important in later life – but people and places are diverse - wellbeing is complex, multifaceted

• Community disadvantage impacts on wellbeing eg remote poor communities increased risk of poor health and reduced wellbeing.

• Yet in our research we are finding that those who can take advantage of the social environment do well eg can drive, have enough $$s, not FT carer etc

• In contrast, social isolation and loneliness are major challenges to rural wellbeing - partic as there are fewer services (eg community development, mental health) to step in.

• But again, it depends on personal expectations & preferences (ie is it loneliness or social isolation? Is it choice?)
Thank you
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