Chapter 2
The Research Approach

This research reflects the view that 'it is important ... that health professionals must solidify their efforts both in doing research and in applying research findings to practice', and that 'applied research seeks to solve the problem which has direct and immediate implications for practice' (Axford, Minichiello, Coulson & O'Brien 1999:3–4). In respect to the classification of this research, it is descriptive in describing existing practice and attempts to shed knowledge on the relationships between the needs of an ageing population in the context of rural communities and the delivery of a range of human services in that context. Therefore, this research 'involves the development of discipline-specific knowledge ... and knowledge about healthcare practice' (Axford et al. 1999:7).

In conceptualising this research, it is suggested that of the four types of theory, *empirical generalisations, causal models, middle range theories* and *conceptual frameworks*, as espoused by Turner (1985) and Denzin (1988) and cited in Gerber (1999:20, 21). The *empirical generalisations* type is applicable in that it 'involves contrasting the results from [the] study with the related literature review to develop new generalisations'. In so doing, the study also draws on '*conceptual frameworks*' that consist of 'descriptive categories which are placed within a broad structure of both explicit and assumed propositions' about how best we organise and deliver aged, disability and health care in rural settings.

The processes that occurred in attempting to conceptualise and focus the research in this study very much reflects the framework for research as described by Gerber (1999). This process involves the identification of a broad topic of interest, the 'clouding' phase, initial conceptualisation, evaluation/ reconceptualisation and final conceptualisation of the research study.

In this context the initial area of interest was older people and ageing in rural communities. The study of the sociology of ageing, together with the literature review in this area, led to a degree of commonality in research findings and sociological perspectives between ageing, disability and rural health and community dynamics. This finding led to a shift of focus for the research from that purely concerned with the needs of older people to one that also focused on disability, rural health and community dynamics.

Sociological orientation

As previously described, this research has a major focus on older people in rural communities and, to a large extent, depends on research and theory associated with the sociology of ageing. In this context, Minichiello and Walker (1996:1) suggest that 'the sociology of ageing is a constantly evolving enterprise' where early research focused on a functional perspective involving role and activity theory and disengagement theory portraying old age as a social problem. They further contend that while the focus on the problems of ageing occurred, 'the relationship between ageing and socio-economic structure was largely ignored'.

The universal theory of functionalism was subsequently challenged by 'new approaches ... to contextualise old age, both in terms of individual biographies and wider economic and political processes'. Subsequently, they proposed that 'the political economy of ageing sought to develop a critical understanding of the role and status of older people in advanced industrial societies'. This approach suggests that 'economic political social factors are often at the centre of this perspective rather than older people per se', drawing attention to 'social divisions between different groups of older people, based especially on class, gender, race and age' (Minichiello & Walker 1996:1–2).

Important to this research are the five main emerging issues identified as contemporary developments in the sociology of ageing (Minichiello & Walker 1996:2–3). These emerging issues provide much of the framework for this research because 'in the political economy mould' contemporary research looks at the impact of 'changing employment and retirement patterns and the role of the State as a mediator between age and the labour market' and this very much reflects contemporary Australian policy and legislation. Moody (1993) suggests that critical gerontology is concerned with the problem of emancipation of older people from all forms of domination. This study attempts to look at models of care that reflect the desires of older people to live normal integrated lives in their own communities.

The third emerging issue takes a life course perspective that Featherstone and Hepworth (1989, 1991) and Kohli (1988) suggest 'explores ageing as an important dimension of cultural change' (Minichiello & Walker 1996:3) and this perspective is important in the context of this study as lifestyle, leisure, employment and social support structures are all considered.

Again, in the emancipatory or empowerment approach, the fourth emerging approach, Minichiello and Walker (1996:3) suggest that 'older people themselves

are becoming more active political agents' and, citing Moody (1993), 'that older people will increasingly advocate on their own behalf'.

In many rural communities, older people now represent the largest sector of the community and are already in a position to exercise power and advocate at the community and local government level and, at the wider level, through representative community-based organisations. Advocacy organisations already exist in the form of grey power, pensioner and self-funded retiree associations (Myers 1997).

The fifth emerging issue discussed by Minichiello and Walker (1996:3) studies relations between generations and contends 'that socio-demographic changes are having a profound impact on the duration and intensity of intergenerational relations between kin and, at a macro level, fiscal austerity is raising questions about the social contract between generations which underpins all welfare states'. Intergenerational relations are important in the rural context with the loss of younger family members from rural communities. While rural communities have larger proportions of children and higher fertility rates than metropolitan areas, the established pattern of young adults leaving country areas and migrating to more urban areas is reflected in lower proportions of 15–29 year olds in 'small rural centres' (AIHW 1998). In disability services, many parents/carers are also entering the older older cohort and the disabled themselves are ageing and also losing family support structures. The Australian Bureau of Statistics 1993 survey of Disability, Ageing and Carers found that 20% of principal carers are over 65 (Yeatman 1996).

Myers (1996:2) suggests that while 'some of the common theories of the past still provide a basis for organising points in reviewing research findings', the major research orientations in the field are mainly problem-driven rather than theory-driven. While the challenges of an ageing population are increasingly recognised, the responses have essentially led to 'problematizing old age' (Achenbaum 1996:145).

Therefore, Myers (1996:3) suggests that social science 'has come to be viewed as addressing major issues of ageing societies and the aged that have high national policy and program relevance' and that 'this problematizing perspective often leads to the development of crisis orientation in which research focuses on problems associated with issues such as health care reform'. The noting of the problem-driven perspective by Myers is not to question its legitimacy 'but rather to recognise its pre-eminent role in framing research agendas'.

Myers goes on to suggest that social scientists often adopt advocacy positions for older people where there is an implicit rationale of self choice (autonomy) for a particular position. However, he is of the view that the 'empirical study of the values, attitudes, and preferences of older persons has received insufficient research attention'.

Important in the context of this research is the challenge proposed by Minichiello and Walker (1996:5) of 'how to conceptualise the links between macro and micro levels of analysis, between social hierarchy and human agency'. In this context it is suggested by Minichiello and Walker (1996:5) that:

> there can be little doubt that dominant Western culture and its institutional arrangements have conspired against older people ... [through] the social and political exclusion processes by which older people had withdrawn from paid employment ... the absence of older people in popular culture ... the low status of aged care as a specialty ... the labelling of population ageing as a social burden by policy advisors, the devaluing of the ageing body, and the invisibility of the work of informal caregivers.

These assumptions are all important elements of the framework for this study because they reflect the real difficulties inherent in existing aged and health care policy, planning, operational structures and service delivery. An understanding that these sociological perspectives operate against the successful implementation of models of care that reflect the wishes of older people and communities is important if appropriate models are to be developed and implemented.

Importantly, in the context of public policy and its implementation, it is suggested by Minichiello and Walker (1996:6) that:

> the relationship between policy and its implementation cannot be taken for granted, and age care policies are no exception [and that the political implementation of policy] frequently operate in ways which create or transform or subvert what might have been regarded as the policies handed down to them.

Rural health and community development

In addition to the sociology of ageing, this research needs to take into consideration the context of older people in rural communities and how the range of health and community services are delivered to those communities. Humphreys (2000:5) asserts that 'the significance of a considerable social and geographical diversity of rural Australia is now fully recognised'.

Strasser and Bryant (1999:10) further assert that in respect to rural and remote

health services:

> a sustainable models approach to the development of health services needs to be developed community by community. It will include specific components for the type of sustainable model but also take into account the specific needs of that individual community.

As suggested by Best (1999:2), 'solutions to rural health concerns must be tailor–made to the existing situation — a simple nostrum but one which can be lost in a policy framework which tries to impose a "one-fits-all" philosophy'.

Mooney and Aldrich (2001:161–165) argue that:

> the agenda for health service reform must start with the values of the communities that these health services are there to serve (recognising that different communities will bring different values to the process). Once we know what the community values are we can begin to garner the evidence to allow us to pursue more efficient and more equitable health services ... reform is best done under the umbrella of health services as a social organisation with respect to which the community ought to set the agenda.

These perspectives bring into play the 'contribution of social capital to the health of rural Australians'. Baum (2000:1) argues that 'a crucial aspect of the creation of healthy communities lies in achieving a balance between economic and social factors in public policy'. Cox (cited in Strasser, Worley, Hays & Togno 2000:1) describes social capital as 'a social fabric or glue which binds us together to facilitate co-operation for mutual benefit'.

Dempsey (1990 cited in Strasser et al. 2000:1) is quoted as saying that 'often the restructuring of health services is centrally determined and occurs in a way which reinforces negative stereotypes in the rural culture of the city and government being distant and antagonistic.' Baum (2000) suggests that the importance of social capital, therefore is in 'how can governments support, enhance and extend "good" social capital ... and ... form effective partnerships with Non Government Organizations (NGOs) and through them with grassroots organizations?'

Community involvement in health development is often seen as an appropriate approach in developing countries and for marginalised and at-risk groups. They seem to be not properly valued approaches in developed health systems and communities, despite the potential they possess in this context. Nonetheless, the poorer health status of rural communities in Australia, the poor health status of Indigenous communities and the economic survival threat to these communities suggest that the community development/action research approaches might be as

relevant as those suggested for developing countries.

'Development is a multisectoral process. The different sectors ... are all interrelated, and changes in thinking and practice in one sector are likely to affect the others' (Kahssay & Oakley 1999:3). While this quote focuses on broader sectors, it is nonetheless relevant to older people and rural communities. The sectors of health, disability, aged care, housing, leisure and recreation, education, tourism and lifestyle are becoming increasingly interdependent sectors and future policy should be shaped with this inter-dependence in mind.

Kahssay and Oakley (1999:3–4) go on to suggest that community development has moved to a newer approach of 'participatory development'. They say that this approach is based on two premises that '... it is important to develop people's ability to change these conditions' (economic and political). Secondly, that 'development programmes and projects have largely bypassed the vast majority of people' and development interventions need to be rethought to 'give the excluded majority a chance to benefit from development initiatives'. They further state that 'this approach to development intervention was seen as the antithesis of what was generally referred to as "top-down" development'.

This participatory approach calls for a more 'people-centred approach to development intervention' and this implies empowerment and participation as both a means and an end. Kahssay and Oakley (1999:9) refer to the Brioni interregional meeting of the World Health Organization on community involvement in health held in 1985 where the essential principles of health development were summarised as:

> Community involvement in health is a basic right of all people ... Many health services depend on limited resources ... and ... community involvement can ... help make available health resources more responsive to the basic needs of people ... community involvement in health increases the possibility that health programmes and projects will be appropriate and successful ... and ... community development in health breaks the bond of dependence.

Rifkin (1996, cited in Kahssay & Oakley 1999:9) suggests that the benefits of community participation are that people make better use of existing health services, that they can also contribute to scarce resources and that 'people would change their poor health behaviour if they have been involved in exploring its consequences'. Rifkin (1996, cited in Kahassay & Oakley 1999:10) also suggests that:

> people would gain experience and information which would help

> them to gain control of their own lives and thus challenge the existing social, political and economic system which had deprived them of this control.

The World Health Organization Study Group on Community Involvement in Health suggests that the contextual factors for success in this area include political commitment, the reorientation of the formal health and other (development) organisations, the economic situation and the level of development of local structures and organisations (Kahssay & Oakley 1999:12). Ironically, their discussion surrounding these contextual factors suggests that community involvement, while taking time and resources to implement, is actually meant to deliver better resource use locally but that that is an objective difficult to achieve in national health services where health care is privatised and/or the State's role is reduced to a minimum.

Turning community involvement into action together with formal health services, according to Kahssay and Oakley (1999:16, 17), requires commonality of purpose, sharing of knowledge, agreement on common goals and objectives, training and political support. They further suggest that the implicit assumptions underlying community action in health are that 'communities best know their own health needs', that they have 'the skills and knowledge to play an effective role' and that 'there is a genuine commitment on the part of health service staff ...'. Therefore, they note that all community-based initiatives to promote health development have one or more objectives of increased community participation in decision making, increased accountability of health services, providing assistance with community education and awareness and to strengthen local action to promote health development.

Community health in action has the potential to provide some methodology in which care providers and small rural communities might come together to develop both sustainable services and the social capacity to provide a continuing worthwhile environment in which to meet the needs of a predominantly older population. Kahssay and Oakley (1999:133) identified that key elements in the process are to develop leadership, enhance commitment, build on people's capacities, build networks and create a critical mass.

Kahssay and Oakley (1999:137) state that tools for participatory community involvement 'rely increasingly on qualitative rather than quantitative research methods' because it provides an emphasis on why the problem exists rather than how many have the problem. They suggest that qualitative methods are becoming

increasingly prominent in the 'planning and management of health care'. They also suggest that 'qualitative methods are people-orientated methods ... they are used to examine the depth of the problem rather than its breadth', and that qualitative methods use in the health field has been recognised 'because of the need for planners to understand how cultures, societies and people view health itself and any interventions which are being applied'.

Importantly, Kahssay and Oakley (1999:138) suggest that scientific rigour and validity of qualitative methods 'rests on the concept of triangulation'. They define triangulation as 'data collected from one source is validated or rejected by checking with at least two other sources or methods'.

This research follows the triangulation approach in that the results of the household survey are compared with the focus interviews of aged care providers and local government in rural areas, the findings of other studies reported in the literature and the results of a similar but statewide study of NSW Health, entitled *New South Wales Older People's Health Survey, 1999* (NSW Health 2000). In addition, the concepts and possible models from this research were indirectly tested at industry forums conducted by Aged Care and Community Services Association 'Think Tanks' at Dubbo in 2000 and Tamworth in 2001.

Finally, it is hoped that policy makers, community care providers and rural communities might consider the discussion, outcomes and models of care proposed by this research for implementation as pilots that might be evaluated, developed and implemented through the use of community development and action research approaches. Chenoweth, Owens and Stein (1999:248) suggest that:

> the increasing acceptance of action research is in no small way attributable to the growing popularity of approaches which have their origin based in the philosophy that is rooted in the ideals of empowerment and egalitarianism, and the need to move from segmented thinking to viewing problems and people in a holistic way.

Research objectives

This study has three key objectives:

i. to review the contemporary literature as it refers to the ageing population, particularly in the context of rural communities and their access to health services

ii. to gain knowledge and an understanding of the ageing population and the

issues surrounding the delivery of community care to that population in a rural context

iii. to determine and develop models of care that might address the issues and needs detected in the literature and through this research.

Research propositions

A number of propositions form the basis of this research. These propositions either reflect a personal view and/or understanding of health care needs of rural communities or reflect contemporary views within the general community and within the health care industry about issues of ageing, rural communities and the management and organisation of health care services. These propositions include:

i. The older population is increasing rapidly and will place a disproportionate burden on health and aged care services.

ii. Health services to rural communities are in danger of becoming non-viable because of the economic decline of rural communities and the impact of globalisation and the economic rationalist approach to the delivery of health care.

iii. Older people and rural communities are entitled to fair and equitable access to the full range of health and community care services in accordance with the principles of our universal health care system.

iv. Current organisational structures, delivery systems and divisions of responsibility and control of health and community care services are no longer appropriate.

v. Appropriate solutions, particularly for rural communities, require the active participation of the community together with providers in the planning, delivery and management of health and community services.

Research design

This is a descriptive empirical study which documents 'the outputs from related studies' with the aim that it may 'raise questions for new studies' and allow 'contrasting of results, from the study with the related literature review to develop the new generalisations' (Gerber 1999:20). A multi-method approach was used with a household survey of a rural based older person cohort and focus interviews of aged care providers and local government located in rural communities. The validity of the research and findings is supported by the review of other data,

industry focus interviews and the review of national and international literature.

The research stages of the study are described in Table 2.1. Stage one involved a review of the literature that initially focused on the sociology of ageing and subsequently included rural health, disability and the organisational structure of healthcare and community care delivery. This literature review revealed many common issues, themes and delivery methods between different sectors of health and community services and the needs of rural communities. This reinforced the need to work towards common integrated solutions.

Stage two involved aged and disability care industry and local government consultation with a view to establishing the issues that they identify as confronting their industries. Local government and residential aged care providers in the New England region were formally advised in writing of the study and invited to contact the researcher if they wished to participate. Face-to-face interviews were conducted with those who responded to the invitation and a summary of the results of interviews was recorded for each interview. This period of the research was also used to consult the aged care industry representatives on what information they consider valuable in obtaining from the local older people in their communities that would assist them and support the purposes of this research. This process helped in developing the household survey tool and at the same time assisted in its validation. In terms of the survey sample, an accidental non-random/probability sampling design was utilised as the opportunity was provided to distribute the survey by mail to ratepayers in selected local government areas with electricity rate notices from the local power supply authority.

Stage 3 involved the input of data from the returned completed household surveys into a database for subsequent analysis using the SPSS 10.1 statistical package, the results of which are documented in the next chapter.

Stage 4 involved the drawing of comparisons with the results of the *New South Wales Older People's Health Survey 1999.*

Stage 5 involved a reflective consideration of the analysis of the data in light of the previous literature review that required a further literature review to explore issues and themes arising from the previous stages and to test the findings at aged industry forums.

Stage 6 provided the opportunity to develop proposed models of care that reflected contemporary research directions as evidenced by the literature, the

needs, intentions, attitudes and priorities of older people resident in rural communities as reflected by the household survey and what might be possible within the constraints of public policy within Australia.

Working definition and inclusion criteria

As the purpose of this research was to question current policy, views and beliefs about the older population, ageing and the wider ambit of community care delivery and to 'develop new generalisations' (Gerber 1999:20), it was important to avoid narrow definitions that might lead to the reinforcement of existing constructs.

Table 2.1: Six stage process of the research project

Stage 1	Literature review
Stage 2	Development of draft household survey tool, conduct of local government, aged care industry focus surveys, validation of survey tool.
Stage 3	Development of database. Conduct of household survey, data input and analysis utilising SPSS 10.1 statistical package.
Stage 4	Comparison of results with the *New South Wales Older People's Health Survey 1999.*
Stage 5	Reflective consideration of the literature and the analysed data. Testing of findings at aged care industry forums. Further literature review.
Stage 6	Development of models of care concepts and research outcomes.

As an example, the literature on ageing (Myers 1997; AIHW 1998:64–65; Cooper 2000; Mulley 1997) refers to different age cohorts, generally from age 60 onwards to discussion about the older old. The household survey did not discriminate between age cohorts. It was decided to include data from those households with residents 50 years of age onwards as that data would reflect the views and details of both the existing older and those moving into that group within the next decade.

Likewise, in the contemporary literature and public policy approaches, there are definitional and classification systems for what constitutes rurality and the categorisation of different sized rural and remote communities. Again, these classification systems and definitions were not invoked in this study because the

purpose was not to differentiate between the rural communities but to seek outcomes and solutions that would suit a range of rural communities. In fact, the outcomes and models may have an application wider than the rural context.

As this study has a focus on the needs of rural communities, it is important that the wider context of health and community care delivery is included within the general definition of the study. Therefore, in addition to acute health care, aged care services, areas of disability service and general community service delivery are included.

Ethical considerations

The University of New England has established a Human Research Ethics Committee responsible for considering and, where appropriate, approving all research projects conducted by staff and students of the University. At the commencement of this project, a Non-invasive Procedures Form A was completed (see Appendix A), together with the development of a Plain Language Statement and Consent Form (see Appendices B & C). These were forwarded to the Human Research Ethics Committee who reviewed the material and subsequently gave approval for the project to proceed.

Data collection

The opportunity to undertake both the focus interviews and the household survey aspects of this research arose from two concurrent events. A local not-for-profit disability service provider sought the services of the researcher in an honorary capacity to provide advice to that organisation about its future strategic direction. At the same time, the researcher was engaged to undertake a consultancy by the New England North West Area Consultative Committee, funded by the Commonwealth Department of Employment, Workplace Relations and Small Business. The purpose of the consultancy was to examine the growing proportion of older people in rural communities and to look for the potential this might provide to create and increase employment in those communities.

While neither event proposed or provided the resources so that a household survey could be undertaken, the two organisations agreed to a proposal to support a household survey. From its resources, the disability provider printed the household survey tool and met the cost of the reply paid postage and envelope circulated with the survey. The disability provider was also instrumental in convincing the local electricity provider, NorthPower, to distribute the survey tool with electricity rate notices as well as providing media releases and televised community service announcements to encourage the completion of the survey.

The survey population was the 21,686 people aged 50 years and over resident in the eight rural local government areas of Barraba, Gunnedah, Manilla, Nundle, Parry, Quirindi, Tamworth and Walcha. To reach this population, an accidental non-random sampling design was used by distributing the survey questionnaire to all the households with the electricity rate notices in those local government areas. The response produced a sample of 2,058 households or 4,284 household members, of which 2,599 (60.7%) members were of aged 50 years and over. This represents a response rate of nearly 12% of the survey population of 21,686 who were aged 50 and over.

The variables included in the survey tool provided information on household numbers, age, income source and ranges, housing, disability, carers and health community service use. It also included retirement intentions and aged care accommodation preferences. The views of respondents were also sought as to whom they thought was responsible for providing aged care.

The parameters of the household survey included a double-sided single sheet survey tool, and a 50 years of age and over potential survey group of 21,686 residents, with 4,284 responding from 2,058 households in eight local government areas located in rural New South Wales. The *New South Wales Older People's Health Survey 1999* was state-wide, conducted by telephone within a population aged 60 years and over of 818,900, where 9,418 interviews from 14,455 telephone calls were accomplished. The parameters of both studies are more fully described in Table 2.2 below.

Limitations of study

The household survey was opportunistic, provided by the resources of interested industry participants without which it would have been impossible to achieve within the resources of this study. The questionnaire survey instrument is found at Appendix D. The constraints of its design were that it had to meet the physical limitations imposed by the electricity provider, NorthPower, who was offering free distribution with electricity accounts, that being, a single page printed on both sides. The second constraint was that the questions asked had to attempt to meet the information needs of the interested industry participants and the purpose of this study.

The outcomes of these constraints were that, firstly, the questions were broad and specific issues could not be addressed in any great depth. Secondly, the survey tool had to be distributed to all households within the designated local government areas, when the intention was to seek the views of those in the 50

years and over age group. As expected, the overall return rate was low, given that the survey tool was not relevant or of interest to a great proportion of those who received it. The return rate of 12% of the 50+ population in the study group also reflects these limitations

Table 2.2: Comparative survey details

	Thesis household survey	**New South Wales Older People's Health Survey 1999**	**Thesis focus interviews with aged care providers and local government**
Type of survey	Mailed single sheet, double sided questionnaire to all households in eight rural local government areas of Barraba, Gunnedah, Manilla, Nundle, Parry, Quirindi, Tamworth, Walcha	Telephone survey of randomly selected households in New South Wales	Focus interviews of representatives of 11 organisations
Population	74,959 total population, 21,686 of population aged 50+	1.05 million of NSW population, 818,900 aged 60+, excluding those living in institutions	7 local government representatives 4 Directors of aged care providers 9 Managers of aged care services 1 CEO of training company 2 senior managers of a disability provider
Sample size	2,058 household responses of 4,284 household members	73,468 telephone numbers called, with 14,455 calls (20%) yielding an eligible household	As above
Proportion of older people	1,654 households had at least one member aged 50+ (80.3%) 2,599 or 50.7% of the 4,284 household members were 50+ 2,599 of the 50+ population of 21,686 represents 11.98% of that population	A total of 9,418 interviews were completed (including proxy interviews), while 3,906 interviews or selected respondents refused to participate, a 70.7% response rate	

A further minor constraint was that the distribution was by postcode that reflected, but did not exactly match, the local government areas included. Where this disparity was obvious, completed returned questionnaire forms were excluded. On the positive side, every effort was made to increase community awareness of the survey and its purpose through extensive community service announcements in all forms of media during the six week distribution cycle of electricity accounts by NorthPower.

Kumar (1999) suggests that the advantages of questionnaires are that they are less expensive and that they offer greater anonymity. In terms of disadvantages, he suggests that they have limited application because of the variable literacy level of the population, a potential low response rate and the self selecting bias within that response rate may mean that the findings of the study may not be representative of the total study population. He further suggests that this approach limits the lack of opportunity to clarify issues and does not provide for spontaneous responses. However, the main findings of the survey did in fact reflect those of the *NSW Older People's Health Survey 1999* (NSW Health 2000) and were consistent with those reported in the literature.