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Jonathan Georgiou
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**Developing New and Alternative Quality of Life Indicators for Older People:
A Case Study from Community Vision and a Cohort of their Aged Clients in
Perth, WA**

Jonathan Georgiou

Student Number: 100 219 33

**A thesis submitted in fulfilment of the requirements for the
Award of Honours Degree (Bachelor of Social Science) at the
Faculty of Health and Computer Sciences
Edith Cowan University**

Supervisor

Dr Peter Hancock

Date of Submission

October 2008

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Abstract

This Honours thesis explored the highly debated construct of Quality of Life and in particular, how this concept was perceived amongst a small cohort of aged clients from *Community Vision*, a peak Non-Government Organisation operating in the northern suburbs of Perth, WA. The Analytical Framework utilised in this Honours study consisted of two phases; an analysis of existing academic literature and the development of a new qualitative inquiry. Semi-structured interviews and electronic surveys were conducted with a group of aged clients, staff and managers from *Community Vision* and key informants representing three peak WA aged care service providers. This Honours research was comprised of three main components.

The first component was a review of the seminal and current academic literature outlining relevant gerontological, sociological and Quality of Life paradigms. Existing Quality of Life indicators and Frameworks were reviewed and several major themes were identified as a result of this secondary analysis. As evidenced in the literature, there was no clear definition of Quality of Life *per se*. A variety of Frameworks were identified as being multi-dimensional constructs that encompassed both objective and subjective indicators of Quality of Life. There appeared to be a strong interrelationship between these objective and subjective dimensions and it was found that interpretations of tangible constructs do impact on an individual's Quality of Life. The secondary data indicated that there was strong support for the individuation of Quality of Life Frameworks and in allowing respondents to nominate themes that were personally significant to them.

The second component of this study involved using qualitative approaches to determine how a sample of respondents (identified above) perceived the concept of Quality of Life amongst older people. As in the literature review, the primary data pointed to a significant interrelationship between objective and subjective dimensions of Quality of Life. Respondents indicated that older people were heterogeneous and one's contextual situation and personality were important factors in identifying interventions that would improve their Quality of Life. A recurrent theme throughout the primary and secondary data was that 'methods of best practice' should be based on individuating services and encouraging older people to actively participate in decisions relating to their care. Evidence from secondary sources was also used to support data obtained through this primary inquiry. As such, new or alternative Quality of Life indicators identified as part of the Analytical Framework were used in discussion pertaining to the

strengths and weaknesses evident in the *Referral and Assessment Form*, the current Quality of Life indicator used by *Community Vision*.

The third component of this Honours study was an evaluation of the global phenomenon identified as a rapidly ageing population. In light of the data obtained as part of the literature review and qualitative inquiry, it was found that a rapidly ageing society had implications for the future Quality of Life of older Australians. It was established that due to a lack of government financial input and poor recruitment rates in the human services, the scope of aged care policy development and practice would become severely limited and the Quality of Life of older people would diminish. It was argued that governments, academics and policy-makers could employ collaborative, preventative strategies aimed at reducing this decline in service delivery. The Wellness approach and the technique of reminiscence were presented as avenues that would promote the individuation of care and ensure there was an egalitarian relationship between aged clients and service providers in the future.

Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

- i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;
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I would first like to acknowledge *Community Vision*. Thank you to all of those at *Community Vision* who inspired and helped me to complete this thesis. I will continue to value my time as a volunteer and cherish all of the wonderful connections I have made over the past year.

I would also like to thank all of the key informants who took the time to pass on their collective wisdom, helping to create a piece of work based on collaboration and understanding. It is my hope that what I have achieved in this thesis will strengthen the value that is placed on the lives of older people in Australia and encourage others to continue striving to maximise the quality of life of all people.

Thank you to all teaching and support staff at ECU who have guided me over the past four years. A special thanks to Justine Dandy and Carole Gamsby for their advice and guidance over the past year.

Sincere thanks to my Supervisor Dr Peter Hancock, who endeavoured to keep me on the right track with both words of criticism and encouragement, for which I am most grateful. Thank you for your support, patience and for taking time out of your own research to assist me. I hope to take on board all that I have learned from this journey and move forward with confidence and continued success.

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Key Terms of Reference and Abbreviations

ABS: The Australian Bureau of Statistics.

Acceptance: A natural process where a person adapts to a situation willingly.

Adaptation / Adaptability: Refers to the process of adjusting oneself to fit a situation or environment (Atchley & Barusch, 2004, p. 551).

(Adjective) Ageing: In the process of becoming old. Does not imply the person is old (Atchley & Barusch, 2004, p. 551).

(Noun) Ageing: Physical, psychological and social processes that occur over time, causing changes in a person's functional capacities and also influencing social definitions (Atchley & Barusch, 2004, p. 551).

Ageing Society: In Australia, the ageing of the society has been attributed to "decreasing birth rates and longer life expectancy" (Australian Government Dept of Health and Ageing, 2006, p.2).

Attitude: Refers to an individual's intrinsic beliefs or personality.

Autonomy of Choice: Refers to the options available to an individual and that person's ability to choose from this selection.

Client: Refers to aged clients from the *Community Vision Adult Day Centre* in Woodvale, Perth WA (sampled as part of this Honours research).

Cohort: An aggregation of people having a common characteristic, usually the time period in which they were born (Atchley & Barusch, 2004, p. 552).

Coping: Contending with or attempting to overcome everyday problems (Atchley & Barusch, 2004, p. 552).

CVI: Community Vision Incorporated.

Dependency: The condition of receiving assistance from others for the necessities of life (Atchley & Barusch, 2004, p. 552).

Disability: A condition that restricts a person's physical or mental capacity to engage in desired or expected roles or activities (Atchley & Barusch, 2004, p. 552).

Eclectic / Eclecticism: An approach that acknowledges the potential value of a wide range of alternatives (Milller & Hester, 2001).

ECU: Edith Cowan University.

Functionalism: Functionalism is tied to positivist approaches and is concerned with the structure of society as a whole (Bowling, 1999).

HACC: The Health and Community Care Project.

Independence: Maintaining control in one's life with minimal to no reliance on other people or services – the opposite of dependency.

Intellectual: Refers to cognitive functionality or attitudinal processes.

Isolation: Refers to a process whereby an individual no longer actively functions as part of society.

Key Informant: Refers to representatives from peak WA Aged Care Service Providers (sampled as part of this Honours research).

Managers: Refers to managers from *Community Vision's* Administrative Offices in Joondalup, Perth WA (sampled as part of this Honours research).

NGO: Non-Government Organisation.

NHMRC: The National Health and Medical Research Council.

Objective Indicators: Individual measures of QOL including tangible objects such as finances, employment, place of residence (home ownership), education levels and one's social or physical environment (Bowling, 2005).

Old Age: A stage of the life course socially defined or typified by increasing frailty and disability, much introspection and concern over the meaning of life, distinct awareness of approaching death, and financial and physical dependency (Atchley & Barusch, 2004, p. 553).

Older People: People who are 65 or older (Atchley & Barusch, 2004, p. 553).

Pension: A periodic payment to a person or the person's family, given as a result of previous job service (Atchley & Barusch, 2004, p. 553).

Phenomenology: A qualitative discipline centred on the notion that what we know as life, is a social construct created by humans (Bowling, 1999).

Physical Wellbeing: Refers to the actual physiological health of the individual (based on mobility or presence of a disease or disability).

Positivism: A quantitative discipline based on the numerical measurement of society and deeply connected to the natural sciences (Bowling, 1999).

QOC: Quality of Care

QOL: Quality of Life

QOL Frameworks: A theoretical model that measures the construct, Quality of Life.

QOL Indicators: A single measure of the construct, Quality of Life.

Qualitative: Refers to data presented in a numerical form (Kreiken, Smith, Habibis, Mc Donald, Haralambos & Holburn, 2000, p. 594).

Quantitative: Refers to data presented as words (Kreiken, Smith, Habibis, Mc Donald, Haralambos & Holburn, 2000, p. 594).

Reminiscence: In addition to remembering events, it is a portrayal an individual's life experiences from a highly subjective perspective (Tilki, 2000).

Resignation: Where an individual grudgingly adapts to a situation because of its inevitability.

Resilience: Refers to the means to counteract adverse encounters.

Resistance: Refers to the rejection of an intervention or attempts made by others to assist an individual.

Retirement: The period following a career of job holding, in which job responsibilities and often opportunities are minimised and economic support comes by virtue of having held a job for a minimum length of time in the past (Atchley & Barusch, 2004, p. 554).

Sensory: Refers to one's sight and hearing.

Social: Refers to a variety of societal constructs such as friends, family, community and infrastructure.

Staff: Refers to members of staff from the *Community Vision Adult Day Centre* in Woodvale, Perth WA (sampled as part of this Honours research).

Subjective Indicators: Individual measures of QOL including one's contextual understanding of QOL based on personal history, future prospects and attitudes (Bowling, 2005).

Wisdom: Refers to the wealth of prior experiences accumulated over the course of a lifetime that can be passed onto others in the form of knowledge.

WHO: The World Health Organisation.

Chapter One

1.0 Introduction

This Honours thesis explored what constituted Quality of Life (QOL) amongst a small cohort of older people in Australia. The primary research conducted to support the thesis was qualitative and sampled clients and staff from the *Community Vision* (CVI) *Adult Day Centre* in Woodvale, Perth, Western Australia. CVI is a peak Non-Government Organisation (NGO) operating throughout the northern suburbs of Perth. The agency provides various community, care and support services to older people and people with disabilities. Managers from CVI's Administrative Offices in Joondalup were also interviewed as part of this study, as were key informants from three peak WA aged care service providers. Through an analysis of literature and qualitative evidence, the Honours candidate has examined how participants perceived QOL amongst older people in an Australian context. This examination has been combined with relevant literature to provide further understanding of QOL among older people and of QOL Frameworks themselves.

Primary and secondary data was collected and analysed to explore the argument made by many academics and policy-makers (see Literature Review), that in light of Australia's ageing population, the QOL needs of older people will change significantly and further attention should be focused on this issue. However, due to the small sample size used in this thesis, results will not be generalised to the greater Australian population *per se*. However, the data gathered during the study will enhance the body of knowledge concerning what increases or diminishes QOL amongst the sample group and perhaps provide indicative results for other researchers and policy-makers. This may also provide new impetus for others to focus on the growing problem of QOL among those who make up ageing populations such as in Australia.

1.1 Background

As part of a practicum unit in 2007¹, the Honours candidate was placed at CVI to enhance his knowledge about working with human service agencies and with older people. During the 200 hour placement the Honours candidate worked on an *Elder Home-Based Care Pilot Project* and also volunteered at the *Woodvale Adult Day Centre* both of which were co-ordinated by CVI. Subsequent to the completion of his practical work, the Honours candidate has continued to volunteer at the centre.

During his practicum and over the course of the *Elder Home-Based Care Pilot Project*, the Honours candidate was exposed to a variety of aged clients, service providers and academics. CVI was working collaboratively with other aged service providers and a WA Tertiary Institution. This partnership was the initial point of inspiration for this Honours thesis - to develop theoretical frameworks or methods of best practice *vis-à-vis* QOL for older people, by primarily consulting with older people and avoiding a top-down approach and homogenisation. CVI valued the voices of older people as having the same importance as the expert opinions of academics. The Honours candidate felt this was an important factor in the empowerment of older people.

The level of heterogeneity amongst older people became apparent to the Honours candidate through his contact with them in CVI and the general community. This fact became further impetus for this Honours thesis. Through informal discussions with staff and managers at CVI, it was evident that older people had individual personalities, carried out different activities and had intrinsically determined wants and desires, which were also influenced by their contextual situation. As such, any further research into improving aged care services or the lives of older people needed to consider the subjective variances that existed amongst them.

Throughout the Honours candidate's practicum placements and his undergraduate degree, it became evident that human service workers and academics had conflicting perspectives on aged care and QOL indicators. It appeared that field workers preferred a more direct, immediate approach to aged service delivery. Their focus was on meeting individual client needs and working out methods of 'best practice' through 'considered' trial and error. Conversely, academics appeared to adopt a more measured and utilitarian approach to aged service delivery. They placed confidence in research and strived to provide methods of best practice that were

¹ In 2007 the Honours candidate was completing a Bachelor of Social Science at Edith Cowan University with a Double Major in Community Studies and Welfare and Community Work. Practicums were an essential part of this degree.

supported in academic literature. By being both a volunteer and tertiary student, the Honours candidate was able to identify with each point of view and planned to utilise both perspectives and frame these within an Honours thesis, primarily through the development of a theoretical framework that encouraged the need to individuate the care older people receive whilst still adhering to methods of research and field 'best practice' in the literature (see Literature Review and Findings and Discussion chapters).

Based on these sources of inspiration and after discussing possible research topic areas with the Honours candidate's Supervisor, it was determined that the thesis would focus on the 'QOL of older people'. The Manager of Community Aged Care Services at CVI agreed to support the study and CVI generally was willing to take part in this Honours study. After provisionally agreeing to allow interviews to be conducted with CVI clients, staff and managers, the Honours candidate was required to submit a Thesis Proposal to the CVI Board of Executives. The Board of Executives agreed to provide the Honours candidate with clearance, provided he received support from the Ethics Committee at Edith Cowan University (ECU). Ethics clearance was granted by both CVI and ECU in June 2008.

1.2 Statement of purpose

The purpose of the study was to determine whether The *Referral and Assessment Form* used by CVI to assess client's QOL (see Appendix H), could be enhanced. This enhancement would come from the analysing of components from other QOL indicators identified in the literature review and primary data. The *Referral and Assessment Form* is the current QOL indicator used by CVI to assess aged clients needs and determined the level of care individuals required (Aged Care Team Leader, 2007). This study was not an evaluation of CVI instruments and practices. The CVI QOL indicator was used as a theoretical basis for the comparison and discussion of new and alternative indicators that could be used in the development a new QOL Framework.

The research was also designed to establish whether other existing indicators identified during the research should be applied by CVI and other similar NGO's in the form of a new QOL Framework, thereby enhancing the QOL for aged clients. The study explored the validity of the CVI QOL indicator in a real world setting through the use of interviews with clients, Day Centre staff, CVI management and key informants from other peak WA aged service providers. The scope of the primary and secondary data collection was expanded to investigate expected QOL changes that may occur as

part of an ageing society. This encompassed discussions pertaining to service delivery and the future requirements of older people in Australia.

1.3 Significance of the Study

This study was a collaborative effort between older people (clients), service providers (staff, managers and key informants) and the Honours candidate. In listening to the voices of aged clients the Honours candidate has considered what QOL means to them and therefore, what is important for improving the lives of this cohort. Similarly the Honours candidate has collaborated with aged service workers in a study that affects their work in the field and also identified QOL issues that they believe to be significant to future practice. Participants displayed an interest and enthusiasm to see the final findings of the Honours study, thereby illustrating that participants believed they were actively involved in finding answers to issues that were significant and important.

The primary and secondary data collated in this study will specifically inform CVI about new or alternative QOL indicators that may enhance the QOL of their aged clients. Issues, analysis and recommendations developed in this study could also be used as indicative data in similar NGO settings, thereby improving their initiatives and future programs resulting in wide-reaching benefits for older people in general. Old age is a universal phenomenon and as such the QOL of older people should form the basis of further research. It is a concept that will eventually affect every Australian.

1.4 Research Questions

- How does a small cohort of aged clients, staff members and managers from CVI and key informants representing peak WA aged services, perceive QOL amongst older people?
- To what extent is the current QOL indicator used by CVI, the *Referral and Assessment Form*, applicable to the group being studied?
- Does the QOL indicator used by CVI need to be refined and further developed to incorporate additional QOL indicators?
- How can the results of this project be used to better inform policy-makers and service delivery practices related to aged care?
- In light of Australia's rapidly 'ageing society', will older people require greater input from policy-makers and service providers to ensure their QOL is considered, debated and maintained?

1.5 Thesis Structure

Chapter One introduced the broad area of 'QOL amongst older people'. It also provided background information about the Honours research and listed the objectives of the study. Chapter two will provide a thorough review of the seminal and current academic literature surrounding gerontology, sociology and QOL paradigms. This review will form the theoretical basis of QOL indicators identified during the collection of primary data. This chapter will also provide the reader with Australian statistical knowledge about shifting demographics in an ageing society.

Chapter Three will outline the research design and describe the Analytical Framework employed in this study, as well as discussing the strengths and limitations of the study. A brief discussion about the QOL themes identified through the data analyses will lead onto Chapter Four. This chapter will discuss in greater detail the findings of the primary and secondary data which have been divided into two important categories - objective and subjective QOL indicators. Chapter Five will explore the advantages of old age identified in the primary data; whether there should be development of a new or alternative QOL Framework; and discuss and analyse the implications of a rapidly ageing society upon service delivery organisations and older people themselves in an Australian-context. This chapter will also cover any unexpected outcomes of the research and future directions further QOL research may take.

Chapter Six will provide concluding statements summarising the overall study and outline the final conclusions which will be based on the analysis of primary and secondary data collected. Recommendations will be made about the relevance of the *Referral and Assessment Form* and whether the CVI QOL indicator should be amended to include new or alternative QOL indicators. Final recommendations provided in this chapter will relate to the generic problem of a rapidly ageing society and how service providers might improve the future QOL of older people in an Australian-context.

Chapter Two

2.0 Overview: Literature Review

This chapter provides a review of secondary sources from seminal and current academic literature. The broad areas of old age, an ageing society, gerontology, sociology and QOL Frameworks have been discussed below. Additional literature is also presented as part of the 'Findings and Discussion' section of this Honours thesis (see Chapters Four and Five).

Journal articles and text books were obtained through the Edith Cowan University (ECU) library catalogue, local libraries and reputable internet search engines such as Google Scholar. Key words and phrases used to navigate these databases included generic search terms such as 'QOL', 'older people' and 'gerontology'. However as volumes of research became available, more specific search terms relating to individual QOL Frameworks and other dimensions of QOL were included to expand these search parameters such as 'Lawton's Model' and 'Social Production's Function Theory' (SPF Theory).

Current affairs and news articles documenting recent events surrounding older people in Australia were also collated as part of the literature review process. Articles were sourced from news sources such as *The West Australian Newspaper* and *The Senior* – a newspaper targeted at informing older people in the Perth community. News sites such as *Ninemsn* and *ABC News* were also utilised as sources of information about current events surrounding older people. The bulk of these secondary sources were utilised in the 'Findings and Discussion' section of this thesis.

Bibliographical information was also taken from on-line or hard-copy publications produced by Australian human service organisations and government bodies. These sources provided general background information about the contextual situation of older people in Australia and detailed the services available to older people in WA. Much of this data was utilised to provide background information and was not used to inform the analysis in this thesis as the information provided by these organisations did not relate specifically to the measurement of QOL amongst older people, which was the main focus of this study.

2.1 Defining Older People

James, Graycar and Mayhen (2003) defined older people in Australia to be individuals aged 65 years and older. Atchley and Barusch (2004) further divided the category of older people into three separate age-defined subsections. These included the “young-old”, the “middle old” and the “old-old” (Atchley & Barusch, 2004, p. 31). Respectively these categories encompassed those aged 65 -74, individuals who were 75 to 84 and older people 85 years and beyond.

Maddox (2000) stated that there was much variation amongst older people as a population. His research suggested that in old age, people did not automatically become a homogenous group. Maddox (2000) also found that there were measurable differences between individuals that formed part of the same cohort. Although the heterogeneity between and within aged populations has been recognised in this Honours thesis, for the purposes of this study, older people will be classified using James *et. al's* (2003) Australian definition. It was beyond the scope of this study to differentiate between the QOL of differently aged older people within the aged client cohort from CVI.

2.2 Australia in Context: An Ageing Society

As stipulated by Atchley and Barusch (2004), there are two interconnected reasons for the recent phenomena of ageing societies. The first being that advances in modern medicine and hygiene practices reduced mortality rates, therefore more people reached old age. The second cause is linked to economic theory, whereby the devaluation of money and the enhancement of costs associated with caring for children resulted in a decrease in births. In Australia, the ageing of the society has been attributed to “decreasing birth rates and longer life expectancy” (Australian Government Dept of Health and Ageing, 2006, p.2).

Over the past decade, various authors have purported that Australia “is an ageing society” (Borowski, Encel & Ozanne 1997; James et al., 2003; Jamrozik, 2005, p. 102). There has been an exponential increase in the number of older people in the past thirty years. Demographic statistics show that 8.5% of Australian's were 65 years or older in 1966 and that this climbed to 12.6% by 2001 (Jamrozik, 2005).

The ABS (2008) has predicted that 26% of the Australian population will be 65 years and older by 2050; this is compared to only 15% between the ages of 0 and 14 years by the same year. In 2005 there were 312 000 individuals above the age of 85, amounting to 1.6% of the Australian population, which will rise to 1.6 million or 6%, by

2005 (Australian Government Department of Health and Ageing, 2006). Furthermore, there will be 2.9 million individuals over the age of 80, comprising more than 10% of the Australian population (Australian Government Department of Health and Ageing, 2006).

According to Atchley and Barusch (2003, p. 31) older people as a “*population is already very diverse and becoming more so over time*”. Therefore, in an ageing society like Australia, sustaining the choices available to older people would be of significant importance to legislators. As such, Australian Federal government planning for aged care services is largely based on ageing society forecasts and is focused on maintaining a variety of care options for older people (Australian Government Department of Health and Ageing, 2006).

The ‘ageing society’ appears to be a global phenomenon with a number of European nations and the USA also showing a high percentage of older people in 2001 (Atchley & Barusch, 2004). This ageing trend appears to be continuing into the new century. In the year 1950, there were 200 million older people in the world; this will rise to 1.2 billion people over the age of 60 by 2025 (Atchley & Barusch, 2004). 12% of the overall population of Developing Nations and 20% of the total population of Industrial Nations will be 60 years or over. However, 70% of the global number of aged individuals will be in developing countries. “The social, economic, and health systems of most countries of the world will be profoundly affected by the growth in the older population over the coming decades” (Atchley & Barusch, 2004 p. 31). The impacts of an ageing society both in terms of population growth and resource distribution apply to Australia purely because it is part of the Industrial world.

Maddox (2000) stipulated that the distribution of social and economic resources can be altered to suit the needs of older people. As further discussed below (see section 2.3), Maddox (2000) recommended a return to the interventionist style of gerontology where social scientists advocated for changes related to aged welfare provisions, Medicare and housing assistance. However, Maddox (2000) suggested that academics do not share their knowledge with politicians and therefore cannot illicit societal change in terms of enhancing aged care provisions. There may need to be greater collaboration between academic institutions and legislators in order to produce ‘methods of best practice’ and meet the future QOL needs of older people in Australia.

It was the opinion of Maddox (2000) that if access to social resources was altered, then this would impact on longevity and the QOL of older people. As further purported below, there should be a shift from viewing older populations from a

biological perspective to one where older people are perceived as a contextually diverse group in society; by changing the delivery of social and financial resources, older people's futures would also change (Maddox, 2000). Morgan (1992, p. 11) argued that "the practical and intellectual issues provoked by an ageing society have become the priorities of gerontological research". The heterogeneity of older people in Australia and the subsequent variety of individual and societal issues they may encounter in an ageing society is likely to impact heavily on their QOL. This was the main focus of the primary data in this Honours thesis, where it was argued that financial and industry constraints would most likely diminish the overall QOL of older people in the future (see Chapters Four and Five).

2.3 Theoretical Frameworks: A Brief Overview of Gerontology

In his seminal text, Tibbits (1960) discussed gerontological research prior to the 1960s. It was his belief that up until the publication of his work, the majority of research conducted with older people had been focused on the 'individual', including the biological process of ageing and modifying the "circumstances of older people" (Tibbit's, 1960, p. 6). He stipulated that there had also been increased attention to the personalities of older people and how shifts in one's character related to their contextual situation.

Maddox (2000) reported that the focus of gerontology in the middle of the 20th Century was on the interaction between individual older people and their environments. It was believed that the experiences of older people and subsequent behaviours could be changed by altering their social environments. During the 1970s, research into older people was fundamentally quantitative in nature. Older people were viewed as homogenous and passive and at the time, gerontologists did not take into account the subjective contexts of individuals (Maddox, 2000). Adopting the 'individual' focus of biology as described by Tibits (1960), in the 1970s, gerontologists viewed the ageing process solely from a genetic perspective and not in conjunction with societal influences (Maddox, 2000). In the 1980s, aged people were de-individuated and research was conducted without personal contact with older people (Maddox, 2000).

In the 1990s, Maddox (2000) suggested that there was a desire to return to a focus on older people as individuals. He stipulated that social gerontology was evolving and should no longer be limited by the use of solely quantitative research methods. This was supported by Morgan (1992, p. 11) who suggested that the early 90s signalled a retreat from "functionalist theory towards a more practical involvement in

the social ecology” of older people. Maddox (2000) posited that social gerontology would return to collaborating with older people in research and again, take into account their social situations. Maddox (2000) advocated for a pluralistic approach to gerontology research, whereby a mix of statistical analyses could be used in conjunction with qualitative approaches (see sections 2.4 and 2.5 for further discussion about quantitative and qualitative approaches). This was an approach adopted in this study, whereby statistical and theoretical sources relating to an ageing society were used in conjunction with information gathered from qualitative inquiry (see Chapter Five).

2.4 Theoretical Frameworks: Positivism and Phenomenology

Positivistic approaches are based on the numerical measurement of society and deeply connected to the natural sciences (Bowling, 1999). Sociological disciplines have evolved alongside the natural sciences and as such have adopted various quantitative research techniques such as surveys, experimental designs and statistical analyses (Bowling, 1999). Bowling (1999, p. 175) stipulated that in traditional disciplines, both societal norms and structures were thought to be determined by quantifiable rules – “explained in terms of cause and effect relationships” – and therefore, sociology should only investigate tangible phenomena using rigid, quantitative research methods to develop theory. This traditional approach was not considered, nor did it inform this study, however it did lead the candidate to the theoretical framework of phenomenology.

Phenomenology is a qualitative discipline centred on the notion that what we know as life, is a social construct created by humans (Bowling, 1999). It has been posited that qualitative techniques, such as unstructured or narrative interviews and observation are more effective measures of society and behaviour than approaches used in the quantitative research styles described above (Bowling, 1999). Bowling (1999) stated that sociological approaches should disregard paradigms related to the natural sciences because they dispassionately measure aspects of life without looking at the personal and symbolic meanings behind constructs. Rubinstein (2002, p.143) stipulated that “the ‘scientific paradigm’ privileges researcher’s interests”; conversely he argued that “qualitative interviewing will always follow informants’ leads and issues of interest, for they are at the heart of an informant’s personal-meaning system”. This theoretical orientation is in line with the research design applied in this Honours study (see Chapter Three).

Rubinstein (2002) defined meaning in several ways. These encompassed environmental attachment, strategies for living, adaptation, emotions, the management of life-course events, daily activities as well as semantic meanings (Rubinstein, 2002). He further explored three kinds of meaning in more detail; these were ‘interpretation’, ‘personal meaning systems’ and ‘cultural meaning’.

‘Interpretation’ was defined as the re-assessment of one’s prior experiences and cultural values. According to Rubinstein (2002), ‘personal meaning systems’ are personalised structures of an individual’s prior experiences (prior events, one’s life’s story, cultural influences and past behaviours). He further argued that older people assess prior and present experiences based on their contextual understanding of meaning. Contextual dimensions affect an individual’s outlook and the subsequent meaning they place on certain phenomena (Rubinstein, 2002). An objective event can hold a certain degree of worth to an individual, based on its subjective significance to their lives (Rubinstein, 2002). Rubinstein (2002) purported that, ‘cultural meaning’ involved community-based values that are carried out as part of tradition. They can be desirable forms of communal behaviour that in reality, are not necessarily strictly adhered to.

The qualitative approaches described above resonated with the research design and analytical inquiry utilised for this study. The fundamental purpose of this Honours thesis was to ascertain what QOL meant to a small cohort of Australian participants. The interviews conducted were one-on-one and asked respondents to provide open-ended answers based on their understanding of QOL and related paradigms. Therefore, establishing ‘meaning’ was an important part of this highly subjective process. The research design and Analytical Framework utilised in this Honours thesis are further outlined in Chapter Three.

2.5 QOL Paradigms: Functionalist and Phenomenological QOL Frameworks

Functionalism is tied to positivist approaches (Bowling, 1999). It is concerned with the structure of society as a whole. Functionalist measures of physical functioning and subdivisions such as health status and QOL are centred around “the performance of activities of daily living” and “role functioning” (Bowling, 1999, p. 175). The first is concerned with hygiene, house-keeping and one’s physical ability. The latter is related to one’s place at work, society, their friends and familial contacts and monetary resources available to them.

Furthermore, Bowling (1999, p. 175) suggested that functionalist measures of ill health are determined by “consequences”; consequences of poor health on one’s “immediate” (family) and “wider social systems”. The latter encompassed “the wider socialisation and nurturing functions of families upon which law, order and stability in society are dependent”. Also considered was the level of “employment” and the state of the “economy” (Bowling, 1999, p. 175). In functionalism, if these consequences impact negatively on the structure of society they are deemed “dysfunctional”; if they improve society, then they are considered “functional” (Bowling, 1999, p. 175).

Bowling (1999) also discussed the qualitative approach to evaluating health-related QOL. One’s contextual understanding and perception of QOL would be of concern to a phenomenologist. QOL instruments with standardised measures may not include indicators that are personally significant to an individual and therefore not qualitatively measure one’s wellbeing (Bowling, 1999). Of significant importance to this Honours study is the subjective meaning QOL has for the cohort under investigation. The semi-structured interview process utilised in this study was flexible and thus allowed respondents to discuss matters of intrinsic importance to their QOL, rather than purely answer pre-constructed questions. This technique will better inform the development of a new QOL Framework, as it will incorporate constructs defined by aged clients and not solely rely on standardised measures of QOL.

2.6 QOL Paradigms: Narrow and Broad QOL Frameworks

QOL Frameworks have generally been constructed with either a narrow focus or based on a broader understanding of an individual’s well-being (Gerritsen, Steverink, Ooms & Ribbe, 2004). According to Gerritsen *et al.* (2004), models based on health-related QOL fall into the first category. According to Hunt (1999) health-related QOL may be regarded as synonymous with one’s ‘physical functioning’. Opponents of such a view have argued that a person with physical debility may be limited in their mobility, however this does not necessarily demonstrate that a person with a disability has a poorer QOL than a physically healthy individual (Hunt, 1999). It was suggested that such a “narrow” correlation discriminated against older people, people with disabilities and those with long term diseases and therefore, was not applied in this Honours study (Hunt, 1999, p. 229).

It would appear that health-related QOL can also be separated into “holistic” measures (such as “social, emotional and physical well-being”) or more limited definitions that focus on a person’s life in general (Carr, Gibson and Robinson, 2001, p.

1240). Hunt posited (1999) that QOL should not be evaluated purely on the individual's health. In order to maximise one's life status, societal, monetary cultural dimensions of wellbeing need to be addressed in conjunction with a person's physical state. Coming from a health-related background, Lacasse, Wong and Guyatt (1999) stipulated that QOL is commonly comprised of four recurring themes. These included 'bodily functioning', 'psychological wellbeing', 'socialisation' and 'physical sensation'.

Community indicators of QOL have also been divided into narrow and broad categories, ranging from countrywide measures to local service delivery and individual QOL (Zagon & Shookner, 2002). Bowling (2005) argued that there are fundamental QOL indicators that permeate the greater population. These included 'mental', 'physiological' and 'emotional' health (Bowling, 2005). Also important were social and familial networks, civic participation, as well as maintaining physical and financial security (Bowling, 2005). Bowling (2005) also described 'autonomy' as a distinct measure of QOL. This eclectic approach to measuring QOL was closely related to the multi-dimensional *Referral and Assessment Form* utilised by CVI and used as the theoretical foundation of this Honours study (Aged Care Team Leader, 2007) (see section 2.14 below).

2.7 QOL Paradigms: Objective and Subjective Dimensions of QOL

According to Lebowitz (2000) QOL is an extensive topic. There is little agreement as to its theoretical foundations, what indicators exist or how QOL frameworks should be utilised (Lebowitz, 2000). Although there appears to be no universal definition of the concept of QOL, it is usually measured in terms of 'objective' and 'subjective' indicators. "Quality of Life is both objective and subjective, so its measurement should include how people think about their lives" (Eckersley, 1999, p. ix).

Objective indicators involve tangible objects such as finances, employment, place of residence (home ownership), education levels and one's social or physical environment (Bowling, 2005). Subjective indicators include one's contextual understanding of QOL based on personal history, future prospects and attitudes (Bowling, 2005). According to Roche (1990), QOL is subjectively measured by personal opinion and objectively defined in terms of standardised measures. These objective and subjective indicators appear to be interlinked.

QOL is based on highly fluid and contextual indicators (Bowling, 2005). These include an individual's prior life experiences, their emotional wellbeing, their current

living status (including factors such as physical wellbeing) and personality type. QOL can also be affected by cross-comparison to other people's living standards and personal assessments of their own life (Bowling, 2005). It has been argued that such measures of QOL cannot be readily transferable to populations outside of the group being studied and therefore not generalisable to the greater society (Bowling, 2005).

As outlined by Bowling (2005, p. 148) conventional QOL measurement devices have been "*ad hoc*", with no uniform structure. Although QOL itself has no agreed upon classification (Bowling, 2005), the importance of perception and one's outlook on life have been recognised and there has been a recent trend to add subjective dimensions to pre-existing, traditional objective QOL Frameworks to enhance the scope of QOL inquiry (Bowling, 2005). This approach was utilised as part of this Honours study in order to re-define or further develop the CVI QOL indicator, the *Referral and Assessment Form* (Aged Care Team Leader, 2007).

2.8 QOL Paradigms: Objective QOL Indicators

Based on Bowling's (2005) interpretation, 'financial', 'residential', 'social' and 'physical wellbeing' were classified as objective indicators of QOL. However other sources suggested that these so-called objective indicators, also had subjective dimensions. These objective QOL themes and objective-subjective interrelationships will be described below.

Gnich and Gilhooly (2000, p. 17), endeavoured to explore "why, the financial needs of older individuals impact on quality of life". According to these authors, financial wellbeing can be gauged through the utility of objective and subjective means. The first requires an assessment of the tangible worth of individuals based on their available monetary resources (Gnich & Gilhooly, 2000). The latter is a personal assessment of one's feelings towards their own economic situation. Gnich and Gilhooly (2000) found that financial contentment has a greater influence on a person's perceptions on life overall, than does the reality of one's economic status.

It was found that older people who had financially prepared for their retirement were more likely to experience a positive sense of wellbeing in old age (Gnich & Gilhooly, 2000). Educating one's self about retirement or being informed of options through television and radio media were also found to enhance one's perceived QOL (Gnich & Gilhooly, 2000). It was also determined that financial planning should occur through an individual's life in order improve their experiences in old age (Gnich &

Gilhooly, 2000). Having a positive attitude was also thought to determine one's participation in retirement planning (Gnich & Gilhooly, 2000).

The next theme described will be residential indicators of QOL. In their discussion concerning old age and environment, Weisman, Chaundhury and Moore (2000) described several places that older people live. These included private residences, day centres, retirement villages, nursing homes and special care units. It was their opinion that "place" was more appropriate a term than traditional titles such as "building" or "setting" that denoted only the physical dimensions of such old age environments (Weisman et al., 2000, p. 3). The authors felt place better reflected the mental, societal, structural and physical dimensions of old people's environments.

Generally speaking, there were three facets of place defined by Weisman *et al.*, (2000); 'subjective', 'objective' and 'consensual'. 'Subjective' indicators of place are the personal interpretations individuals hold concerning their environments. 'Objective' indicators are the contextual influences that shape environment. 'Consensual' indicators involve societal limitations imposed by community values and expectations. Therefore the latter constitute options that are available or acceptable to an individual operating within an environment, thereby determining their actions or overall perception (Weisman et al., 2000).

Roche (1990) portrayed QOL as a multi-dimensional concept that is viewed and measured in different ways. Roche (1990) identified many societal facets of QOL, including age, culture, ethnicity, politics, economy and the current trends in human service delivery. The latter facet is discussed further below in terms of quality of care (QOC), particularly in terms of residential aged care facilities.

At the time of Roche's study, the Australian government focused on only eight paradigms which centred on maximising the effectiveness of services for older people (Roche, 1990). The quality measures were used to evaluate care standards across various departments and community agencies (Roche, 1990). These included 'health care', 'social independence', 'freedom of choice', 'individual rights'; 'provision of a home-like environment', 'variety of experience', 'privacy and dignity' and 'safety' (Roche, 1990). These indicators were seen as universal needs and designed to be individualised for clients based on their care requirements (Roche, 1990). It was Roche's opinion that aged individuals in nursing homes, hostels and residential care may not be receiving optimum services, with many of these measures not being recognised as relevant to older people.

Furthermore, Giltin (2000) discussed the concept of designing an age-friendly residence through home modification.

We must be able to identify characteristics of homes that are desirable, or that maximise independence, individual choice, and autonomy. Also, we must develop a measurement approach that is reliable and ecologically valid, e.g., one that accounts for the person as a contextual factor. These represent difficult methodological tasks, given the extreme variation in the physical arrangements of homes, the differentiated relationship between persons and household characteristics, and the highly individualized needs and task preferences demonstrated by older adults. (Gilton, 2000, p. 48).

A global project conducted by the World Health Organisation (WHO, 2007) discussed the greater concept of age-friendly cities. Spanning 33 nations, the study explored the opinions of older people, care-givers and service providers through qualitative inquiry. It was argued that age-friendly cities supported the three pillars of ‘active ageing’ (health, participation and security) and therefore ensured a high degree of QOL amongst older people. In essence, “an age- friendly city adapts it’s structures and services to be accessible to and inclusive of older people with varying needs and capabilities” (WHO, 2007, p. 1).

A universal group of social QOL indicators, prominent in importance to older people included areas such as socialisation and social engagement (Bowling, 2005). In respect to wellbeing, “lack of social support, participation and contact” can be correlated with diminished physical and mental functioning – even death (Bowling, 2005, p. 101). Bowling (2005) identifies networking and support as two main social indicators crucial to any QOL indicator. Networks are a source for new and pre-existing social connections – this may be in the form of tangible resources (such as financial welfare) or emotional care (Bowling, 2005). Social supports may be obtained through one’s connections – again, these are actual forms of monetary or personal care as well as one’s perception that they are being cared for (Bowling, 2005).

The last objective indicator of QOL described here will be ‘physical wellbeing’. As posited by Atchley and Barusch (2004), older people can expect longer, healthier lives due to new medical interventions. However, this may result in more citizens requiring home-based care, as compared to the relatively autonomous old age population that makes up today’s society and hence ironically reduce QOL.

Hickey, O’Boyle, McGee and Joyce (1999), discussed the formation of the WHO and it’s initial definition of health in the 1940’s. WHO defined health as a

multifaceted concept, related to social indicators, overall wellbeing and personal affect (Hickey et al., 1999). Specifically health was viewed as the “complete physical, social and emotional wellbeing, and not simply the absence of disease or infirmity” (Hickey et al., 1999, p. 119).

Hickey *et al.*'s (1999) research pointed to two factors in QOL measurement. In their longitudinal study of healthy older people, it was found that indicators of QOL were not static. Over the period of a year “social and leisure activities” decreased in significance, whilst “finances” rose in significance to QOL (Hickey et al, 1999). Second of all, this older sample was comparatively higher in their evaluation of their QOL than a healthy younger cohort (Hickey et al, 1999). If a researcher was using a narrow, health-related QOL Framework, they might predict that younger people would report a higher QOL because their general health may be better than that of older people. In light of Hickey *et al.*'s (1999) findings, this may point to the subjective nature of QOL (one's perception of their reality) being highly influential in assessing one's QOL in old age.

2.9 QOL Paradigms: Subjective QOL Indicators

According to Bowling (2005) subjective indicators of wellbeing are contextual in nature. Such measures are influenced by one's perception of self and the world around them (Bowling, 2005). In this literature review subjective indicators will encompass concepts related to ‘subjective wellbeing’, in addition to this were the issues of ‘depression’, ‘anxiety’, ‘bereavement’, ‘adaptability’ and ‘reminiscence’. Conversely, objective indicators are dimensions that exist in physical reality and can be tangibly measured. The separate subjective measures of QOL are discussed in greater detail below.

Subjective wellbeing is highly personal and requires understanding an individual's state of mind, their prior experiences, their future expectations and what that person deems important to their continued existence (Bowling, 2005). There are several elements to subjective wellbeing including; ‘happiness’, ‘life satisfaction’, ‘morale’, ‘self esteem’ and ‘self concept and sense of coherence’ (Bowling, 2005). ‘Happiness’ is defined by Bowling (2005) as how positively or negatively an individual defines their immediate QOL (this is based on both perception and tangible objects) and is therefore not a static indicator. ‘Life satisfaction’ refers to the cognitive dissonance between one's reality and their goals. The greater the gap between one's actual situation and their life's desires, the lower their satisfaction rates become. This can

involve an individual comparing themselves to other people or to different times in their life (Bowling, 2005). Similar to Hickey *et al.*'s (1999) findings above, Bowling (2005) suggested that studies into old age have shown that older people express higher levels of contentment than their younger counterparts.

'Morale' is linked to subjective wellbeing. There are micro, macro and cognitive dimensions that comprise the concept of morale (Glicksman, 2000) - an individual's self-perception and self-worth, their place in society (passive or dynamic) and one's outlook on life (dissonance between one's actual wellbeing and their perceived status) (Glicksman, 2000). As already purported, morale is related to one's states of affect and their perception of themselves or their status in the greater society. It also relates to coping skills and handling or approaching daily tasks (Bowling, 2005).

'Self-esteem' and 'self-concept' are interlinked. Self-esteem, is being aware of one's capabilities and understanding their value as an individual (Bowling, 2005). Self-concept is formed by how one views and assesses one's self. An individual's self belief in their personal abilities is determined by their self perception (Bowling, 2005). Generally, older people are less likely to have high self esteems due to their inability to "negotiate" life as compared to younger generations (Bowling, 2005, p. 128).

Bowling (2005) stipulated that there are three factors related to one's 'sense of coherence'. These were 'comprehensibility', 'manageability' and 'meaningfulness'. Comprehensibility was described as interpreting events that happen throughout life as reasonable and not unexpected (Bowling, 2005). Manageability was one's ability to endure these phenomena (Bowling, 2005). Meaningfulness was concerned with using these life experiences as something valuable to engage in and learn from (Bowling, 2005).

Subjective wellbeing, as defined by Glicksman (2000) is related to positive feelings and mental states. According to Bowling (2005) QOL is synonymous with how positive one's life is. Subjective wellbeing is an assessment of an individual's mental, physical, economic and social status (Glicksman, 2000). It involves a comparison between one's current life and their prior experiences (Glicksman, 2000). Subjective wellbeing is further influenced by events in one's life and how one reacts to such happenings. This can be determined by collectively held values and societal norms (Glicksman, 2000). Bowling (2005) argued that subjective gauges help facilitate human services and social administrators to meet the individual expectations of clients. This supposition resonated with the findings of this Honours study that subjective

dimensions should be included in QOL Frameworks in order to individuate care amongst older people.

A further subjective QOL indicator identified in the literature was depression. Universally, the largest sources of depression amongst older people are consequences of physical disorders, pain, loss and diminished social support (Richardson & Barusch, 2006). Hereditary influences are also thought to impact negatively on a person's affective state; as do people's perceptions, their adaptability and socio-economic situation. According to Richardson and Barusch (2006) the 'nature and nurture' factors stated above, may be interlinked. Katz (2000) suggested that depression is a disorder heavily influenced by events in one's past and their level of functioning.

In older people, depression is more likely related to a lack of positive feelings as opposed to an increase in new concerns impacting negatively on them (Katz, 2000). Katz (2000) found that older people do not experience positive feelings as frequently, even when they are in a positive situation. In addition, older people appeared to be more passive and not easily stimulated into action (Katz, 2000).

Anxiety was another subjective indicator identified in the literature. As conveyed by Richardson and Barusch (2006), the contextual history of older people can influence personal experiences of anxiety. Some individuals may have had life long anxiety issues. Richardson and Barusch (2006) further suggested that individuals exposed to negative situations out of their control, often developed feelings of helplessness and anxiousness, for example the recent loss of a spouse. Similar negative feelings may also occur for people with sick family members and friends (Richardson & Barusch, 2006). Secondary data indicated that older people may also develop anxiety due to a lack of financial funds; however this was not strongly supported in the primary data of this Honours thesis (see Chapter Four).

As stipulated by Richardson and Barush (2006), older people try to maximise their wellbeing and as such, develop different behaviours in order to cope with age-related physical debility. In this way, people maintain their access to daily tasks and routines. If older people cannot adapt to such changes, then they may experience anxiety, depression and poor mental health (Richardson and Barusch, 2006). Due to the fact that older people develop more efficient ways to "experience and express their negative emotions over time, they often experience multiple feelings simultaneously. "The co-occurrence of anxiety and depression is more common in later life than among younger people" (Richardson & Barusch, 2006, p. 96).

The subjective indicator of bereavement was related to anxiety and depression. Richardson and Barusch (2006, p. 265) argued that older individuals tend to cope more successfully with “loss” than younger people. The authors stipulated that as older people have had a greater prior life understanding of loss, they do not evoke strong emotions when a death occurs and have usually had time to prepare for the passing of a loved one (Richardson & Barusch, 2006).

According to Nahemow (2000, p. 22) “adaptability” is a significant feature of growing older. In order to achieve an optimal level of QOL, individuals learn to “adapt” to their environment so that they no longer experience discomfort (Nahemow, 2000, p. 23). According to the author, reaching this comfortable state of being is influenced by one’s level of competence (ability to carry out tasks) and older people may be lacking in this.

The final subjective indicator reviewed is Reminiscence. Reminiscing is not solely about remembering events, but portraying one’s life experiences from a highly subjective perspective (Tilki, 2000). According to Tilki (2000), older people should have the opportunity to reminisce in both formal and informal environments. “Reminiscence affords a rich seam of information which has the potential to enhance the quality of life for older people by enabling professionals to listen to the real needs of clients” (Tilki, 2000 p. 107).

Reminiscence through social contact allows older people to engage in reflexive activities (Schaie and Willis, 2000). One has the opportunity to re-assess actions and learn from prior experiences, particularly if reminiscence is undertaken with someone familiar to the individual. Knowledge of an older person’s history can help an individual shape how aged people perceive their lives (Schaie and Willis, 2000).

Subjective indicators of QOL are wide-reaching and influenced by many intrinsic, cognitive, emotional and contextual factors. In addition to the substantive themes discussed here, subjective dimensions can also be interrelated with objective indicators of QOL (see section 2.8 above). The indicators identified in the literature correlate with those recognised in the primary data of this Honours study and will be discussed in detail in later chapters (see Chapter Four).

2.10 QOL Paradigms: Individual QOL Frameworks

Bowling (2005) also discussed *Individualised Measures* of QOL. These measure significant issues as experienced by the individual, either in relation to their overall lives or by any debility they might have. Joyce, O'Boyle and McGee (1999) advocated for the individuation of QOL measures. The authors argued that traditional measures neglected the subjectivity of QOL and focused on evaluating a person's QOL from an objective position (tangible measures of wellbeing such as the presence of debility).

QOL was also believed to be synonymous with concepts such as attitude, personality characteristics, one's reactions, cognitive or affective wellbeing and reasoning (Bullinger, 1999). Joyce *et al.* (1999) suggested that QOL should be measured and defined from the individual's perspective rather than based on the "expert" assumptions of aged care officials using standardised QOL frameworks (Joyce *et al.*, 1999, p. 4). Bullinger (1999) further argued that QOL was a dimension of individuals. Lacasse (1999) also suggested that individual QOL was influenced by one's perception of their QOL after accessing interventions that are meant to enhance wellbeing.

2.11 Individual QOL Frameworks: Trait, Cognitive and Interactionist Theories

Trait theories suggest that certain personality characteristics are collectively shared by all individuals (Bullinger, 1999). What differs is the magnitude of these characteristics in select people. Bullinger (1999) believed that trait theories were related to the construction of group-based QOL frameworks. For example, international measures of QOL (that utilise the same QOL indicators for each respondent), such as the *WHOQOL* framework (see section 2.13) are relevant to different cultural groups (Bullinger, 1999). If certain indicators are shared in all people, regardless of their background, then group measures could also be applied to individual QOL assessment (Bullinger, 1999).

Cognitive theories ascertain that one's conduct is related to how one perceives their situation (Bullinger, 1999). In short, individuals interpret settings differently and have various ways of acting based on their subjective world view. A person's outlook on life can affect how they behave, rather than their actual needs determining their actions (Bullinger, 1999). Bullinger (1999) believed that cognitive models of personality were related to the construction of individual measures of QOL. Indicators of QOL are defined by the client and their level of QOL is measured over the course of

an intervention. Generally, a person's QOL is often identified as optimal if there is minimal difference between one's perceptions and their actual state of being (Bullinger, 1999). Similarly, Lacasse (1999) discussed the definition of individual QOL measures as assessing conflict between one's actual and ideal level of capability.

The interactionist theory is based on the foundation that an individual, their situation and prior experience determine individual actions (Bullinger, 1999). There are two general dimensions to selecting behaviour; one being that individual actions are selected based on previous events in one's life. An individual re-evaluates past actions and then acts based on their perceived ability to overcome the latest hurdle (Bullinger, 1999). The second issue is that decision making is also impacted on by one's capacity to fulfil certain tasks, as well as their subjective perspectives and expectations. The more challenging an environment, the more likely people will act in the same manner (Bullinger, 1999). Bullinger (1999) tied interactionist theory to QOL measures. The author recommended that QOL frameworks incorporate general and individual indicators; measure QOL using wide parameters (indicative of all people), whilst also encouraging respondents to put forward their personal opinions (Bullinger, 1999). This recommendation was deemed highly relevant to the discussion pertaining to further development of the *Referral and Assessment Form* in this Honours thesis. The objective indicators of the CVI indicator were found to be universally significant to measuring QOL, however subjective dimensions were found to be equally important.

2.12 Individual QOL Frameworks: A Review of Existing Models

In Bowling's (2005) review of Individual QOL Frameworks she discussed the *Schedule for the Evaluation of Individual QOL*. The schedule requires older people to describe five issues that are personally significant to their own wellbeing (Bowling, 2005). Participants further describe how severely these factors impact on their lives and overall QOL (Bowling, 2005). Their responses are then displayed as a pie chart illustrating how significantly each facet is an indication of that person's QOL (Bowling, 2005). Arguably, a limitation of such an individualised approach has been the onus it places on respondents (Bowling, 2005). Although a strength may be, that the participant is able to more easily identify issues appropriate to their needs (Bowling, 2005).

The *Quality of Life Index* is a tool for self-assessment (Browne, 1999). As in the schedule discussed above, individuals using this index elect QOL indicators that they feel are significant to their personal wellbeing. They then relay whether they have

positive life experiences in each of these indicators (Browne, 1999). A similar procedure was used in this Honours study, where participants were asked to define what QOL meant to them, as well as describe any issues or advantages that they or older people in general experienced in relation to QOL.

According to Browne's (1999) *Goal Attainment Measures* employ the concept that QOL is determined by comparing one's actual state of being, with what they desire for themselves. Aiming for desired outcomes and actually attaining these goals are related to positive experiences of QOL (Browne, 1999). Such measures are subjectively individualised and not subject to standardisation – desires being highly personal in nature (Browne, 1999).

Another Individualised Framework discussed by Browne (1999), was the *Subjective QOL Profile*. This model encompassed four indicators of QOL. The first indicator includes physical, physiological, psychological and sexual ability under the banner of 'functional life'. The next objective indicator, 'social life', is comprised of networks, social engagement and participation. Monetary and housing concerns come under the objective indicator 'material life'. The last is the subjective indicator 'spiritual life' which involves religious views, faith and personal activities such as "reflection" "reading" or "meditation" (Browne, 1999, p. 165). The inclusion of an open question allowed respondents to put forward another indicator that they feel is significant to their personal QOL.

The *Subjective QOL Profile* is based on the notion that individuals are the experts in measuring subjective QOL (Browne, 1999). Again, as with previous models, this instrument evaluates the personal significance of QOL indicators and measures the difference between what an individual desires and their actual state of being (Browne, 1999). However it also gauges how efficiently an individual adapts to this dissonance by altering their perception on what constitutes significant outcomes (Browne, 1999). The *Subjective QOL Profile* allows the individual to assess areas of importance to their personal wellbeing and also ascertains how much discrepancy exists between one's ideal perception on life and actual reality (Browne, 1999). It also assesses how an individual adopts strategies to overcome this dissonance, such as changing how they feel about certain goals (Browne, 1999).

Browne (1999) discussed *Content Analysis* as another QOL instrument related to individual QOL frameworks. *Content Analysis* refers to a procedure where an interviewer elicits written or verbal or visual responses from an individual concerning QOL ("what is your life like at the moment") (Browne, 1999, p. 153). The researcher

then categorises the information, thereby conducting a thematic review of the data. This is a methodology closely related to the primary data collection and analysis phase of this Honours study (see Chapters Three, Four and Five).

The theoretical underpinnings of Individual QOL Frameworks are strongly linked to the desired focus of this Honours thesis. This study's purpose was to determine what QOL meant to a group of older people and service providers. By recognising that situations are highly contextual and promoting the subjective nature of people, individualised measures of QOL allow for flexibility and the collation of highly personalised information.

2.13 QOL Frameworks: A Review of Additional Models

The World Health Organisation (WHO) developed the *WHOQOL-100* and the *WHOQOL-BREF* frameworks, recognising that QOL was related to both objective (such as lack of debility) and subjective indicators (such as cultural values) of wellbeing (Bowling, 2005). The *WHOQOL-100* framework includes four main themes. These consist of 'physical' (a dual measure that includes the related theme of level of independence), 'psychological' (a dual measure that includes the related theme of spirituality/religion/personal beliefs), 'social relationships' and 'environment indicators' (Bowling, 2005).

The *WHO* frameworks function as a series of questions, with response times taking 10-20 minutes (Bowling, 2005). The *WHOQOL-100* questionnaire requires an interviewer and the *WHOQOL-BREF* utilises self-assessment, with all answers gauged using an ordinal scale consisting of five choices (Bowling, 2005). Both models cater to specific demographic and cultural groups (such as older people or those with a specific disease). The four main QOL themes are further broken down into 24 subsections. With a total of 100 questions, there are four items per subsection with an additional four that query an individual's overall objective and subjective QOL. *WHO-BREF* utilises one item from each of the 24 subsections and only two queries about overall QOL (Bowling, 2005).

The *LEIPAD* questionnaire also included both objective and subjective indicators of QOL (Bowling, 2005). The European office of *WHO* suggested that holistic measures of wellbeing become more salient as people age. Many facets of life become interlinked as debilitating events recur in old age (Bowling, 2005).

In this model, questions related to QOL reflected physical capacity, self care, experiences of depression or anxiety, mental functioning, socialisation, sexual prowess

and life satisfaction. In order to expose value judgements and reduce personal bias, queries were made about respondent's self-perception about their physical state, whether they were experiencing volatile feelings about their situation, their levels of social desirability, spirituality and self-esteem. The first set of questions allowed for a 3 gauged ordinal response, while the latter required nominal responses (Bowling, 2005) with the self assessment taking between 15 and 20 minutes.

The *CASP-19* model encapsulated four indicators of QOL important to old age. The first was 'control' of one's physical surroundings. The second, 'autonomy' relates to the level of independence an older person has in respect to making their own decisions. The final two were 'self realisation' and 'pleasure' which are indicative of one's actions and learning processes. The model was based on Maslow's hierarchy of needs thereby inferring a correlation between one's needs and subsequent experiences of QOL (Bowling, 2005).

Gerritsen *et al.* (2004) posited that valid QOL Frameworks consisted of three paradigms. The first paradigm advocated for the use of a broadly conceptualised QOL model; an instrument that measured the QOL of all people (not simply old people or individuals receiving high care programs). The framework should also consider both the limitations and strengths of an individual in determining QOL (For example, evaluating both the negative impact of poor vision on a person's QOL whilst viewing that person's ability to read brail as a positive indicator of QOL (Gerritsen *et al.*, (2001)).

The second paradigm involved isolating the value of individual QOL indicators. Gerritsen *et al.*, (2004, p. 612) stated:

For instance, if QOL is considered to consist of a physical, a psychological and a social dimension, it should be clear whether each dimension contributes to QOL to the same extent, or if...the physical dimension is more important than the other two dimensions.

Furthermore, as QOL is not necessarily static, frameworks should also link QOL constructs by measuring how shifts in one indicator can impact on the others as well as how individuals cope with this in-balance (Gerritsen *et al.*, 2004).

The final paradigm of a well designed QOL Framework, was described as the ability to measure the subjective nature of QOL (Gerritsen *et al.*, 2004). They denounced a one-size-fits-all approach to maintaining QOL. As opined by Gerritsen *et al.* (2004), a general indicator of QOL may be social well-being; however individuals may have varying expectations on what constitutes QOL and as such, one individual

may benefit from social contact whereas another individual might feel social contact is unnecessary for maintaining their wellbeing.

The authors argued that the *Social Production's Function Theory* (SPF Theory) incorporated all of these paradigms (Gerritsen et al., 2004). This Framework was designed for use by all people and operates on the basis that all QOL indicators are interlinked. An individual using the model would theoretically use personal resources to complete tasks in order to ensure physical and social wellbeing. They would ultimately attain a state of wellbeing that was subjective to their needs (thereby maximising their QOL) (Gerritsen et al., 2004).

Bowling advocated the use of a one-dimensional model, a *self-rating global QoL uniscale* as conceived by Beckie and Hayduk (1997 as cited in Bowling, 2005). The underlying principle of this framework was that QOL should be viewed as a single paradigm. QOL is influenced by a multitude of sources (such as physical, mental and social wellbeing) but QOL itself should be measured using a single rating mechanism that encompasses all aspects of an individual's life – the uniscale and items such as “How do you feel about your life as a whole” (Bowling, 2005, p. 7).

According to Perkinson (2000) *Lawton's QOL* model is centred on how one interprets their surroundings and experiences. Lawton believed that QOL is a multifaceted paradigm where different themes are interlinked and affect one another (Lebowitz, 2000). The main idea behind Lawton's QOL model was “the good life” (Weisman et al., 2000, p. 5) and particularly one's relationship with their environment. An individual is shaped by their environment but their personal view of the world is also determined by their own values (Weisman, 2003). QOL was measured using the personal values and social values of the individual, based on the relationship between the individual and their environment (Richardson & Barusch, 2006).

Lawton's model consisted of four paradigms, ‘behavioural competence’, ‘perceived QOL’, ‘objective environment’ and ‘psychological wellbeing’ (Weisman, Chaundhury and Moore 2000). The first indicator, behavioural competence, is an assessment (based on social norms) of the tangible facets of life, such as physical, mental and social wellbeing as well as time (Perkinson, 2000). The second indicator, perceived QOL, is also an assessment of these objective facets influenced by personal measures of wellbeing (Perkinson, 2000). The quality of objective (external) environments is the penultimate indicator of QOL and can encompass private, communal and societal situations (Perkinson, 2000). The final indicator is psychological wellbeing and is determined by one's ability to navigate through life

(extrapolated from behavioural competence and perceived wellbeing) (Perkinson, 2000).

An example of Lawton's QOL framework was described using individuals with dementia. Lawton would have focused on what the individual was capable of, rather than how they were limited by, their psychological disorder (Richardson & Barusch, 2006). Objective indicators of QOL would have included the personalisation of care and environmental facets, such as the number of staff to clients, on the job training opportunities and the aesthetic qualities of the place of living (Richardson & Barusch, 2006). Subjective indicators would have encompassed the perceptions and feelings of the individuals with dementia (Richardson & Barusch, 2006).

It would appear that the bulk of QOL Frameworks are broad, multi-dimensional concepts that include both objective and subjective indicators of QOL. Also evident is the relationship between separate indicators of QOL that may overlap and influence one another. There also appear to be fundamental, universal indicators of QOL that are present regardless of parameters such as age or nationality, however how these affect individuals is determined by one's interpretation of objective events.

2.14 CVI QOL Indicator: The Referral and Assessment Form

The conceptual framework of this study was based around the QOL indicator used by CVI; the *Referral and Assessment Form* (Aged Care Team Leader, 2007). The four main QOL indicators outlined in this document were 'physical', 'sensory' 'intellectual', and 'social' measures. The physical indicator was further broken down into mobility, personal hygiene, medical conditions and an older person's living environment. The sensory and intellectual indicators encompassed an older person's ability to communicate, the level of assistance required to fulfil routine tasks, financial matters, their mental capacity and hearing or sight loss. The social indicator determined an individual's level of socialisation and social engagement. These indicators have been used by CVI to assess the QOL of older clients and to ascertain the type of care or services they required to maximise their independence.

Based on the findings of the literature review some preliminary analysis of the *Referral and Assessment Form* may be made. The QOL indicator used by CVI could be interpreted as being a broad model. It also includes multi-dimensional, interrelated QOL concepts akin to those used in Lawton's QOL model (Lebowitz, 2000). However, the model used by CVI is largely restricted to measuring only objective indicators of QOL. The CVI forms are standardised using nominal and ordinal questions and

although containing some space for extra comments, opportunities for open-ended responses were minimal. In light of the arguments made by Joyce *et al.* (1999), the CVI indicator model could be viewed as lacking in subjective measures of QOL and therefore may miss crucial components in determining the level of care or type of service a client may benefit from. The addition of new or alternative QOL indicators to the CVI model, are discussed further in Chapter Five.

2.15 Summary: Literature Review

As evidenced in the literature review, Australia is an ageing society and it would appear that the demands of the future will require more far-reaching and individualised care than is currently provided. In order to sustain the QOL of older people, the distribution of social, economic and health services to a growing number of older people worldwide, will need to be altered. In addition, pluralistic approaches will need to be employed that consider older people not only from the perspective of a collective group but also as individuals.

It would seem that while there is no agreed upon definition of QOL, QOL paradigms can be narrow or broad. The vast majority of QOL indicators are multi-dimensional concepts that employ both objective indicators and subjective indicators. There was considerable overlap between these indicators, whereby an individual's interpretation of a situation can influence their QOL. There has been strong momentum in the QOL debate for the individuation of QOL Frameworks, thereby encouraging respondents to identify themes they perceive as personally significant to the measurement of QOL. The *Referral and Assessment Form* used by CVI appears to meet some of these criteria; however this form may need to have new or alternative QOL indicators added to its structure to best benefit its future clients.

Chapter Three

3.0 Overview: Research Design

The previous chapter discussed various facets of sociological and gerontology practice and thereby illustrated the theoretical underpinnings of this Honours research as a qualitative study. Arguments surrounding some divisive issues regarding QOL were discussed in detail and although no specific definition of the concept was made, several QOL paradigms were identified in the seminal and current literature. QOL was positioned as a multi-faceted construct in which an interrelationship existed between objective and subjective QOL indicators. As this was a recurring theme in many current QOL Frameworks, it was suggested that any theoretical framework constructed as part of this thesis, would need to acknowledge this relationship. The notion that Australia was an ageing society was also discussed and it was argued that the QOL needs of older people were of great concern to policy makers and NGO's alike.

A substantial amount of sources have been drawn from secondary data in the previous literature review in order to create a theoretical framework. However, primary data was also collected in this thesis, using a qualitative research design. The complex steps involved in collecting and analysing this data will be discussed in this chapter, as will the ways in which the literature reviewed in chapter two was used to inform the thesis research design. Other issues such as the ethical consideration, recruitment of participants and sampling frames, interview techniques, data analysis frameworks and strengths and limitations of the research design will also be discussed in this chapter.

3.1 Ethical Considerations

A brief proposal outlining the purpose and ethical considerations of this study was submitted to CVI's Board of Executives. This Honours candidate assured CVI that he would be working to stringent Edith Cowan University (ECU) research guidelines and that the primary data collection would not commence until National Health and Medical Research Council (NHMRC) ethics approval was obtained from ECU. CVI provisionally accepted the research proposal, provided that it received said ECU ethics approval.

Key informants were approached after ECU ethics clearance had been granted. As such, the key informants were contacted informally and asked whether they would be willing to participate in the study. Again it was assured that the Honours candidate would be working to ECU research guidelines and that further interviews could not be

conducted until additional NHMRC ethics approval was obtained. The key informants provisionally agreed to participate, pending ECU ethics approval. The amendments to widen the scope of the research population were approved by the ECU ethics committee.

The Honours candidate prepared *Information Letters* and *Ethics Consent Forms* based on ECU and NHMRC guidelines (see Appendices A - G). Due to ECU ethical guidelines, the *Information Letter* and *Ethics Consent* forms needed to be disseminated as hard copy documents with the University's Banner included in the letter head. These were distributed to participants taking part in the face-to-face interviews, but were also dictated by the Honours candidate where a client's vision prevented them from reading. The documents outlined the purpose of this study; explained what was required of the clients and service providers and highlighted the rights and responsibilities of all parties involved.

Informal discussions about the study took place with prospective clients and staff prior to the formal face-to-face interviews taking place. In the case of management undertaking the electronic surveys, the *Information Letter* and *Ethics Consent* forms were given to them in a hard copy bundle pack. This process addressed any queries or concerns that emerged. Consent was obtained in writing prior to the formal interviews taking place. An additional information sheet was provided that outlined the process by which the *Ethics Consent* form and the survey needed to be completed and returned to the Honours candidate. This document was the equivalent of carrying out an informal discussion prior to the survey being filled.

The face-to-face interviews with client and staff participants from CVI took place at the Woodvale Community Centre in the northern suburbs of Perth. It was a secure setting that both the Honours candidate and participants were familiar and comfortable with. The interviews were conducted in a private room that was air conditioned and had suitable furniture for sitting and talking. Formerly a podiatrist's room, it is now used for activities (such as quizzes and discussions about current affairs) and as a leisure room for staff on break. Each interview was conducted individually; ensuring full confidentiality.

All respondents were encouraged to select a pseudonym thereby keeping their identity anonymous. Not only did this involve the participants in the decision-making process, but many also viewed it as an opportunity to 're-invent' themselves and took joy from the activity. Verbatim quotes and general information cited by individuals in

the primary data collection phase were referenced throughout the thesis by using these pseudonyms.

In respect to the key informants, although they were also given the opportunity to choose a pseudonym, it was made clear that their occupational rank may be included as part of this study to indicate to readers that the key informants were experts in the human services field. To maintain anonymity, the names of the peak organisation, agencies and departments that the key informants represented are not referred to in this research. In addition to this, key informant responses have been paraphrased or quotes have been omitted that could indicate the organisation they worked for.

Each participant had access to their personal audio recordings and transcripts. The information collected during interviews formed part of the findings for this research but personal accounts are not attributable to individual participants. All recordings were transferred to audio files on the Honours candidate's Personal Computer (PC) at his home. All field notes were placed onto *NVivo* and all interview transcripts and survey documents remained on Microsoft Word.

All data concerning the study was also printed and saved to disk or other external devices for back-up purposes. Only the Honours candidate and his Supervisor have access to this data. Upon the completion, submission and grading of this thesis report, all hard copy primary data will be kept under lock and key in the Supervisor's office on ECU Joondalup Campus and subsequently destroyed in line with NHMRC guidelines.

3.2 Recruiting Participants and Sampling Frames

Case studies involved clients, staff and managers from CVI and key informants from peak WA aged service delivery agencies. The process of recruitment was non-random and therefore a true generalisation to the greater population of older people outside the Day Centre was not feasible (Walliman, 2004). However, the study was able to draw indicative and valid conclusions that could inform policy and research. The Honours candidate employed a combination of Theoretical Sampling, Convenience Sampling and the Snowball Technique sampling technique to recruit participants (Walliman, 2004).

Theoretical Sampling was described by Walliman (2004) as the utilisation of individuals who have first hand knowledge of a topic. The Honours candidate determined that clients from an *Adult Day Centre* - operated by CVI in Woodvale, a suburb of Perth - had direct knowledge concerning old age and could comment on what

constitutes QOL for older people. Similarly, the service providers were able to act as expert sources. Staff members were recruited from the CVI *Adult Day Centre*, managers were recruited from the CVI Administrative Offices in Joondalup and key informants represented three peak WA aged service delivery agencies. The role of staff, management and the key informants was to provide professional perspectives on the QOL of aged clients and the QOL experiences of older people in general.

Walliman (2004, p. 163) defined Convenience Sampling as the use of “what is immediately available”. At the time of the study the Honours candidate was volunteering at the *Adult Day Centre* on a weekly basis, thus it was a sample that he had access to and was familiar with (Walliman, 2004). Similarly, key informants were already known to the researcher as a result of prior experience with the peak organisations. The Snowball Technique was purported by Walliman (2004, p. 164) to be when a researcher makes contact with “a small number of members from the target population” and encourages “them to introduce you to others”. In this Honours study, the managerial staff were made available to the Honours candidate by the Manager of Community Aged Care Services; this was the Honours candidate’s main point of contact at CVI’s Administrative Offices in Joondalup.

There were approximately 20 older people attending the centre on a daily basis when data was collected in July 2008. Therefore, an ideal sample size of clients was 50% ($n = 10$). The Honours candidate addressed members of staff and clients as a group, discussed the rationale of the study, the ethical obligations of all parties and disseminated the *Information Letters*. The Honours candidate then informally approached individuals and asked prospective participants if they would agree to be interviewed. As there were three male clients in the Thursday group (the CVI client cohort used in this study), it was desirable that all males participated. The remaining female clients were also given the opportunity to participate in the study. The numbers of staff and volunteers available on a daily basis were not constant; the numbers generally being between five and ten. Therefore all available members of staff were approached to participate in the interviews. Managers were also targeted as a ‘total population’. The Manager of Community Aged Care Services was asked to disseminate the survey bundle packs and electronic surveys to managerial staff.

However, despite the manager’s co-operation there was a low recruitment rate from managers at CVI and some client participants chose to leave the study; as such, another recruitment process was then utilised which can be likened to a technique described by Bell (2005). An Opportunity Sample is usually implemented by a

researcher who is unable to ascertain a random sample in a “small study” and therefore they use as many compliant individuals from the “total population” as possible (Bell, 2005, p. 146). As such, the Honours candidate respectfully re-approached all prospective participants (clients and staff) from the *Adult Day Centre* that had not made clear their decision to participate in the study. The Honours candidate also made repeated requests to the Manager of Community Aged Care Services to communicate with managers and ask that they consider volunteering their time for this study.

In order to expand the scope of the sample population, the Honours candidate widened the participant base to include key informants from aged care agencies outside CVI. Four Peak human service delivery and policy agencies were approached to participate in face-to-face interviews. One key informant from each organisation or department was contacted using telephone and e-mail communication.

The total number of participants recruited for this study was sixteen. Eleven participants (clients and staff) were chosen from the CVI *Adult Day Centre*. The client portion of this sample included six individuals above the age of 65. The majority were female and of British-Australian descent. The five staff members that formed the second part of this group from the CVI *Adult Day Centre* were all female and also of British-Australian descent. Two managerial staff members were selected from the CVI Administrative Offices. This sample group were also female and of British-Australian descent. Three key informants from separate peak WA aged service delivery organisations were also recruited. Two were female and all individuals were of British-Australian descent.

3.3 Research Methods: Semi-Structured and Survey Interviews

The Honours candidate conducted interviews and personally sent survey interviews via e-mail. The semi-structured interview process was face-to-face. The questions directed to CVI clients, CVI staff and the key informants were verbal in nature and open-ended. A digital audio recorder was used to document the face-to-face interviews. The Honours candidate also took notes during and after the interviews. These field notes indicated points of interest and themes for further questioning or analysis. As purported by Bell (2005), the use of open-ended questions allowed respondents to not only answer the prescribed questions but talk about matters significant or unique to them.

The structured interviews were presented to CVI managerial staff in the form of surveys. Rather than conduct face-to-face interviews, due to the time constraints related

to their work, managers were given a choice of completing either one of two survey formats. Managers had the option of completing electronic surveys or filling in hard-copy versions of the same survey provided to them in a bundle pack that also included the *Information Letters* and *Ethics Consent Forms*. These surveys included a list of open-ended questions that were similar in content to the face-to-face interviews. Once the respondents completed the surveys the electronic documents were returned to the Honours candidate's personal e-mail account.

Unlike the quantification of interview responses that takes place in traditional experimental research designs, the questions used as part of this research focused on the respondents' personal and professional views on QOL amongst older people. In quantitative research designs, set answers are assigned a pre-determined value and the "meaning" behind what is said is only considered after an analysis of the content (Rubinstein, 2002, p. 137). Conversely, interviews used as part of qualitative research design (such as in this study) encourage respondents to provide an in-depth account of their personal experiences; thereby establishing the meaning behind one's responses (Rubinstein, 2002).

After an examination of Gray 1998 (as cited in Bell, 2005) and her discussion on narrative inquiry and its connection to open-ended interview techniques, it was expected that respondents in face-to-face interviews would provide a narrative account of their views on QOL amongst older people. In line with Bell (2005) and Walliman's (2004) suggestions, it was the Honours candidate's role as interviewer not to lead the respondents but to direct the focus of the conversation through use of neutral language and generic questions.

The research completed for this thesis used active listening techniques. Flick (2006, p. 178) defined active listening as "signalling interest without intervention" and maintaining the "relationship with the interviewee". Rubinstein posited that by using active listening techniques, interviewers probe further by asking exploratory questions or move onto other facets of the interview.

In this study, the Honours candidate provided respondents with affirmative vocal and visual prompts, thereby encouraging them to continue speaking or to move on. To give the impression that the interviewee was interested in what was being elicited, eye contact was maintained with individuals and the interviewer turned respondent's answers back into questions, asking them to further explain a subject of importance. When theoretical saturation was reached (a participant began reiterating the same point) the interviewer asked respondents if they felt it was time to move on to another subject

of interest. Similarly, if a respondent had already provided a full answer to a question further down the item list, the interviewer did not present respondents with the question. If a respondent had only partially touched on a subject related to a future question, the interviewee was encouraged to elaborate on prior information given.

By using a semi-structured instrument, the interviewer was in a position to ask respondents to expand on matters of interest or concern to the study; according to Bell (2005) this is a strength of qualitative research. Rubinstein (2002) discussed a process by which the interviewer and participant work together to manufacture meaning - an interviewer facilitates the participant to explore previously, undiscussed topic areas (Rubinstein, 2002). In line with this discussion, many participants in this study had not considered the topic under question prior to the formal interview taking place (Rubinstein, 2002). Responses that were relevant to the topic and which illustrated what a certain indicator meant to an individual were sometimes raised after discussing unrelated topics. During the course of the interviews, participants also went back over previous questions once they had a grasp on what they were trying to say or had developed a better understanding of what QOL meant to them. This flexibility may also be attributed to the use of a semi-structured interview.

Rubinstein (2002) suggested that generally, interviewers do not follow-up a statement made by a participant by providing their own opinion on what was stated. Despite this, he further posited that personal value judgements may be made, depending on the nature of the research design. This appeared to be the case in this study, where respondents (particularly aged clients) required a specific example of the meaning behind a question, or where an item needed re-wording. Some respondents were more prepared to divulge information once the interviewer had provided an anecdote based on personal experience. In this way, interviews became more like conversations that promoted familiarity and trust between the interviewer and participants.

3.4 Analytical Framework

The Analytical Framework involved identifying QOL indicators through the literature review and interview processes. The first phase, the literature review, listed several existing QOL Frameworks and QOL indicators currently being used in Australia and other developed nations. Also included was demographic information concerning ageing populations and possible modifications to resource distribution as a result of this phenomenon. One of the aims of this review was to establish whether the *CVI Referral and Assessment Form* required amendments (Aged Care Leader, 2007). Another aim was to establish what changes might occur as part of an ageing society and how this could impact on the QOL of older people in Australia.

The CVI QOL indicator also formed the basis of the second phase of the Analytical Framework, the interview process. The four main themes identified in the *CVI Referral and Assessment Form* included; 'physical', 'intellectual', 'sensory' and 'social' indicators of QOL (Aged Care Team Leader, 2007). The questions developed for the interviews and survey interviews were based around these four themes of the CVI indicator. As in the literature review, a purpose of the interviews was to assess whether these themes were adequate measures of QOL amongst older people or if the instrument should be further developed to include new or alternative QOL indicators. The interviews also aimed to ascertain other pertinent information about the QOL of older people in an ageing society and how aged service delivery may evolve to meet the demands of an ageing population.

Probing questions were initially used to ascertain the subjective perspectives respondents held about QOL. The question guide for clients followed on from this, with items relating to the four main themes identified from the *CVI Referral and Assessment Form* (Aged Team Leader, 2007). The majority of questions relating to the four themes were asked of all participants and these universal questions were modified to suit the separate sample groups and individuals therein. As stipulated by DETWA (2004) the questions were shaped to cater to the individual participant giving their response. For example -

"In your opinion, do older people..." – for staff

"In your experience, do you ever..." – for clients

Some questions were relevant only to clients, staff, managers or key informants as they were specific to these respondents' subjective opinions or expertise.

In recognition of the valuable experience and knowledge held by participants working in service delivery or policy development, the question list was expanded to

include items relating to an ‘ageing society’ and ‘service delivery’. The interviews closed with an open-ended question that allowed all respondents to discuss matters significant to them. The questions were not prescriptive and conversations were flexible. The list of questions was an indication of how the Honours candidate could conduct the interviews and was modified to suit the situation. All items were used to gather primary data that will further understanding of QOL issues and explore ways in which to develop new or alternate indicators.

According to Rubinstein (2002, p. 149) “listening” is an essential component of data analysis. In addition to ‘listening’ during the initial interview process, Rubinstein (2002) stipulated that listening also involved assessing audio or transcript sources. In this study, audio recordings were transferred to the Honours candidate’s PC onto the audio program *Olympus Digital Wave Player*. Subsequent to this, all interview conversations were transcribed to the Honours candidate’s PC onto *Microsoft Word* documents. Hand written field notes were also taken during the initial interviews and subsequently transcribed onto *Microsoft Word*.

Historically, ‘themes’ have been described as recurrent subject areas that are identified by participants as areas of great significance to their lives. As purported by Rubinstein (2000), in this study, themes were interpreted during interview’s (detailed in the field notes) and again as part of the analysis process. *NVivo Version 8*, a post-positivist software tool for qualitative analysis, was used for content analysis purposes. The researcher input field notes and survey interview data into *NVivo*.

The Honours candidate then placed verbatim quotes from the field notes and survey data into separate thematic nodes. *NVivo* was used to develop substantive codes and nodes; from this it was determined what initial themes appeared to be emerging from the primary data relating to old age and QOL indicators. Using these substantive codes as a foundation, further data analysis involved the categorisation of full interview and survey content by constructing themed tables on *Microsoft Word*. These themes and quotes were then used as part of the thesis findings and were used to explore and discuss any new or alternative QOL indicators.

In the final analytical process, comparisons were made between select QOL Frameworks collated in the literature review, the indicators identified through an analysis of the participant data and the QOL indicator currently being used by CVI, the *Referral and Assessment Form* (Aged Care Team Leader, 2007). The research has been able to identify strengths and weaknesses of the current CVI and other QOL indicators.

This has contributed to the discussion of QOL issues for older people in an Australian context which is presented in following chapters.

3.5 Data Analysis

As already stipulated in the above section, data analysis initially began in the literature review, during the interviews (albeit informally) and throughout the thematic analysis phase – using *NVivo* and tables produced on *Microsoft Word*. It was evident from the secondary sources listed in the literature review, that QOL was a multi-dimensional concept. Existing frameworks generally included universal indicators of QOL such as the objective measures of physical wellbeing and one's environment. Also considered in many models was the subjective dimension of QOL, the individual perspective of the person and how this related to the way objective indicators impact on QOL.

Throughout the interview process it became apparent that respondents interpreted the concept of QOL using similar objective-subjective parameters. Certain tangible indicators were identified to be universally important in predicting whether an older person's QOL was positive. However, it was widely posited that the intrinsic nature of older people also influenced an individual's level of QOL. The objective and subjective indicators of QOL have been visually represented in Table 3.1. Many of the themes listed in the table below resonate with QOL indicators described in the literature review.

The indicators were interrelated and could be broken down further into sub-themes or other QOL indicators. For example, the objective indicator 'physical wellbeing' was further subdivided into 'daily tasks and routines' and 'personal hygiene'. The objective indicator 'sensory' referred to 'hearing' and 'sight'. 'Intellectual' indicators were measured in terms of 'cognitive functioning' and 'attitude' (a subjective QOL indicator). The objective indicator, 'technological aids and human support' was highly influenced by the subjective indicators 'resistance' and 'adaptability' (also subjective indicators).

The objective theme 'service delivery' was broken down into 'care and support services' and 'medical services'. 'Residential' indicators of QOL were subdivided into 'place', 'in-home care' and 'age-friendly cities'. The objective indicator 'financial' was measured in terms of 'government pension' and how one perceives 'third party assistance'. The broad area of 'social' was related to 'service delivery', one's ability to 'communicate', feelings of 'isolation' or 'depression' and 'one's autonomy of choice'.

Other ‘social’ dimensions related to ‘transport’ and ‘age-friendly cities’. The subjective indicator ‘anxiety’ was strongly related with ‘bereavement’ and feelings of ‘loss’. The subjective theme of ‘reminiscence’ was also related to ‘loss’.

Table 3.1 QOL Indicators Identified in the Primary Data

Objective Indicators of QOL	Subjective Indicators of QOL
<ul style="list-style-type: none">• ‘Financial’• ‘Intellectual’• ‘Physical Wellbeing’• ‘Residential’• ‘Sensory’• ‘Service Delivery’• ‘Social’• ‘Technological Aids and Human Support’	<ul style="list-style-type: none">• ‘Adaptability’• ‘Anxiety’• ‘Attitude’• ‘Autonomy of Choice’• ‘Bereavement’• ‘Depression’• ‘Loss’• ‘Reminiscence’• ‘Resilience’• ‘Resistance’• ‘Wisdom’

3.6 Strengths and Limitations of this Research

Rubinstein (2002) described power relationships that can exist between the interviewer and the participant. He identified a correlation between the length of an interview and the nature of the interviewer-participant relationship. According to Rubinstein (2002), structured interviews that are usually shorter, afford greater authority to the interviewer due to the narrow, pre-determined content. Therefore, brief interviews may be limited as tools for data collection because the items may not be personally relevant to the participant.

As such, Rubinstein (2002) advocated for longer interviews as a means of fostering familiarity between the participant and the interviewer - ultimately diminishing the imbalance in power. Arguably, a strength of this Honours study was that the majority of semi-structured interviews were conducted between 15 and 50 minutes in length. Using Rubinstein's reasoning, this suggests that participants were encouraged to talk freely and without a perception of time constraint.

A possible limitation of power-relationships was that the interviewer (in a position of authority) can be viewed by participants as the 'question-master' (Rubinstein, 2002). Participants in this honours study did sometimes refer to the researcher as a 'question-master' and apologised for breaching the item parameters. However, overall, the power-relationship was minimal and a strength of this study was that respondents felt comfortable enough to provide free flowing responses and were encouraged to talk about matters significant to them.

In most research designs, questionnaires are usually applied to small cross-sections of a population and results are not easily generalised to the greater global community. A small sample group was a possible limitation of such research designs. In this Honours study, a small sample was utilised for interviews and surveys, however the information was never intended to be generalised to the greater population and therefore not a weakness of this thesis.

Hunt (1999) further stipulated that data acquired through research using a cross-section of a population is generally presented as indicative of other populations and situations. Again, this was the purpose of this Honours study, to convey the interview data as indicative of other aged clients in similar NGO settings. However a possible limitation of this Honours study was that conclusions derived from such data can be erroneous, in that there are extreme variations between separate demographic populations based on culture, ethnicity, gender, social status and nationality (Hunt, 1999).

Rubinstein (2002, p. 145) identified a dichotomous relationship between the “individual” and “collective” natures of responses obtained as part of the interview process. Rubinstein (2002) suggested that individual participants are usually encouraged to provide responses based on their subjective experiences, the responses of all participants are then investigated as a group and recurring themes are identified. This format is similar to the data collection and analysis phase of this honours study.

As such, this research may be limited, as Rubinstein argued that although shared experiences may become apparent to a researcher the history of individuals is highly personal. Therefore, the experiences of ‘one’ cannot be directly generalised to other people. He further stipulated that analysts usually present an individual response as indicative of the sample population’s experiences (Rubinstein, 2002). Again, this may be a limitation of this study. Verbatim responses were analysed, compared and quotes deemed the best examples of a particular theme, were used as representative of recurrent themes in the data. Despite this, many quotes from individual cases were also used to depict separate sub-themes that were personally significant to only one participant.

3.7 Summary: Research Design

In summation, the research design was made up of a series of semi-structured interviews and survey interviews. A small cohort of older people from the *CVI Adult Day Centre* were the central focus of this study. In addition, staff members from the *CVI Adult Day Centre*, managers from the *CVI Administrative Offices* and key informants from three peak WA aged service providers were also interviewed. Both the limitations and strengths of this Honours thesis were identified as being related to the power-relationships forged between the Honours candidate and the respondents and the small scale of this Honours study.

Interviews were transcribed and the content was reviewed using thematic analysis techniques, whereby verbatim quotes were grouped into themed categories. As part of this research, interviews have been used to add context to the secondary data and responses concerning QOL have been utilised in the development of a new or alternative QOL indicator. Data has also been applied to discussions about an ageing society and how the QOL needs of older people may change in Australia.

Chapter Four

4.0 Overview: Findings and Discussion

The previous chapter outlined the various components of the research design used in this Honours thesis. At the end of Chapter Three, the major QOL themes identified in the primary data were briefly discussed. These QOL indicators were grouped into two important groups – ‘objective’ and ‘subjective’. The objective indicators were tangible measures of QOL that exist in reality – ‘physical wellbeing’; ‘sensory’; ‘intellectual’; ‘technological aids and human support’; ‘service delivery’; ‘residential’; ‘financial’; and ‘social’. The subjective indicators were intrinsic constructs that measured QOL from the perspective of the individual - ‘autonomy of choice’; ‘attitude’; ‘resistance’; ‘adaptability’; ‘resilience’; ‘depression’; ‘anxiety’; ‘bereavement’; ‘loss’; ‘reminiscence’ and ‘wisdom’. Analysis of the primary data indicated that the majority of these objective and subjective indicators of QOL overlapped and influenced one another. As such, the indicators have been listed as separate major QOL themes and the subsequent interrelationships between these QOL indicators have been discussed under each themed category.

The sample population used to inform the Analytical Framework consisted of four separate groups. These included a cohort of six aged clients from the CVI *Adult Day Centre*; five members of staff from the CVI *Adult Day Centre*; two managers from CVI’s Administrative Offices; and three key informants from peak WA Aged service delivery organisations. All participants selected a pseudonym to ensure their anonymity should their responses be used as personal communications in this Honours thesis. Each participant has been categorised according to their sample group in Table 4.1 below.

Table 4.1 Participants’ Sample Groups and Pseudonyms

CVI Client Sample	Day Care Staff Sample	Manager Sample	Key Informant Sample
Ben	Andy	Anne	Danni
Drew	Dorothy	Fay	Nirva
Jane-Davies	Joan		Eddie
Jasmine-Rose	Margo		
Mary-Jones	Regina		
Matilda			

4.1 The Meaning of QOL - Objective and Subjective Indicators

QOL is both subjective and objective. There are things “out there” such as housing, getting food, the weather, all sorts of quite objective things, which of course, affect how I feel, but how I choose to respond is up to me

- Eddie, Key Informant from a Peak WA Aged Service Delivery Organisation

The responses made by respondents concerning what constitutes QOL amongst older people varied significantly. However, there were some significant themes throughout all interview groups once the primary data was analysed. Objective indicators were deemed central to an individual's QOL and encompassed areas such as physical and mental wellbeing, access to adequate financial resources, physical security (place of residence) and the weather (this latter objective indicator is discussed further in Chapter Five). In addition to this, was one's status in society and the maintenance of social contacts. More specifically, it was found that in old age, QOL meant having access to emotional support and services delivered by centre-based care organisations where social participation was facilitated (Jane-Davies, personal communication, July 31, 2008).

There appeared to be a strong relationship between objective indicators of QOL and how these personally impacted on the individual, thus indicating a subjective dimension to QOL. For example, it was suggested by several respondents and supported in the secondary data that it was not enough to just have social contact, but that older people needed to value that contact in order for it to benefit one's QOL (see Gerritsen et al., 2004). Furthermore, the key informants stipulated that individuals evaluated their lives along a continuum that consisted of positive, negative, objective and subjective dimensions.

One of the clients stated, that *“as long as you still enjoy life, it's good enough”* (Mary-Jones, personal communication, July 24, 2008). This sentiment was shared among all sample groups and so, it can be inferred that experiences of a positive QOL was strongly linked with feelings of happiness and life satisfaction in old age. This point was reiterated by Bowling (2005) who stipulated that happiness and life satisfaction were essential components of subjective wellbeing.

Older people's perceptions of QOL were deemed as important in determining one's choice for sustaining life – *“I don't consider that anybody that's got anything really badly wrong with them should... I think they should have the choice... anyone who's got cancer or anything like that and they want to take a pill or whatever”* (Mary-Jones personal communication, July 24, 2008). This was a single example of the

greater theme autonomy of choice, which was widely regarded throughout the primary and was supported secondary data as a major subjective indicator of QOL amongst older people (see Bowling, 2005; Gitlin, 2000).

4.2 Physical Wellbeing: Daily Tasks and Personal Hygiene

So, you've got your health, that's a big deal. That's one of the big things
– Drew, Client from the CVI Day Centre

A number of clients disclosed that they were suffering from a wide variety of physical conditions. It was suggested by a CVI manager that *“physical mobility plays an important part in a person's life – the more restricted they become, the more difficulties in completing tasks – this would affect a person's QOL”* (Fay, personal communication, July 28, 2008). CVI client Ben, supported this belief, stating that his physical limitations restricted his capacity to fulfil daily tasks that were of intrinsic importance to him, *“Well, other than the fact that you can't do the things that you'd like to do. I like gardening, I like making things; I'm pretty handy with my hands... But you can't do it because you can't see”* (personal communication, July 10, 2008). As was hypothesised in the interactionist theory, the inability to complete certain tasks restricted the number of options available to him (Bullinger, 1999).

The intrinsic effects of not being able to undertake particular tasks were highly contextual – *“It would depend on how you've done it all throughout your life... if you've been a clean person having your shower everyday, it would be very frustrating waiting for someone to come in and do it for you”* (Joan, personal communication, July 24, 2008). Again, as suggested in the interactionist theory, individuals overcome new problems by reflecting on prior courses of action and by assessing their current level of capability (Bullinger, 1999). Although people who are traditionally ‘hygienic’ would prefer to continue personal care activities, physical debility may prevent them from doing so. However, cognitive theory demonstrated that one's interpretation of phenomena also determines how they behave (Bullinger, 1999). Client Jasmine-Rose stipulated that although she was physically capable of undertaking daily tasks such as domestic duties, she did not enjoy doing them and thus, it was not in her nature to complete them (personal communication, July 10, 2008). This was further evidence of a clear objective-subjective link in the theme of physical wellbeing.

Clients and staff viewed personal hygiene to be of great significance to QOL and stated that older people's lives would be diminished if they could no longer care for themselves – *“I would hate it... I'm very thankful at my age I am still able to do it and*

I'm just praying it'll continue" (Jane-Davies, personal communication, July 31, 2008). Client Matilda strongly valued her independence and elected not to employ a carer. Instead, she and her husband were able to work together and continue to fulfil number of personally significant domestic duties and physical exercise – *"I'm very what you'd call hygienic... we both are, my husband and I – we prefer a clean home"* (personal communication, July 24, 2008).

Staff member Regina (personal communication, July 31, 2008) stated that the inability to care for one's self was an indication that their QOL was poor because of its psychological affect on older people's subjective wellbeing. Similarly, Margo (personal communication, July 15, 2008) stated that *"it's very degrading to them"* to have personal care managed by another. Most staff believed that although older people would feel frustrated at having to ask for help, after having been mobile and independent all their lives, without assistance they may become isolated, vegetate and eventually deteriorate; care was perceived as beneficial to older people's subjective and social wellbeing in the long term.

Fay stipulated that the ability of older people to adapt to physical debility was influenced by one's *"attitude"* and therefore highly individualistic – *"Some people find it difficult to accept that they need assistance and can become quite depressed – others will make the most of the situation and look forward to the support workers visit"* (personal communication, July 28, 2008). In terms of evaluating her overall physical wellbeing, Drew engaged in downward comparison – *"Oh well, I mustn't grumble. I can get around and I can do things and there are some of them who can't"* (personal communication, July 31, 2008). Jane-Davies and Matilda put their capacity to care for themselves, down to *"luck"*, however the clients both shared mobility issues and had adaptive strategies in place so that it would not impact negatively on their ability to fulfil daily activities (Jane Davies, personal communication, July 28, 2008; Matilda, personal communication, July 24, 2008).

One key informant stipulated that if older people didn't have access to transport *"then often they can't participate"* in society (Nirva, personal communication, August 27, 2008). An issue for Matilda was public transport due her physical limitations - *"I can hobble down to the bus, if I have to... but it's when I'm coming home, I'm just about pooped!"* (personal communication, July 24, 2008). Matilda adapted to this by having her husband provide her with transport. However, without her husband's ability to drive a car she would be *"quite housebound"*. According to CVI manager Anne,

isolation as a result of physical debility and an inability to travel is a serious issue for older people (personal communication, July 25, 2008).

Similarly, Jane-Davies expressed that she lacked confidence in her ability to keep her balance when utilising bus services. This was another issue raised by Anne (personal communication, July 28, 2008) where an older person's "mobility is affected" by having a fall and there is a subsequent loss in "*confidence and independence*", leading to a "*downhill spiral*". However in this case, Jane-Davies adapted to her fear by organising alternative transport, either by using taxi's or relying on friends and family, thereby maintaining her participation in society. It would appear that Matilda and Jane-Davies would benefit from age-friendly transport initiatives being provided in Perth (this concept is discussed in further detail in section 4.15 below).

Although physical wellbeing is primarily an objective indicator of QOL, it is clearly influenced by various subjective dimensions. A poor physical state does not necessarily imply that an older person has a diminished QOL, however it is a strong predictor that an older person may experience limitations related to their autonomy of choice. As such, care services may be seen as a further threat to an older person's already diminished independence. The measurement of QOL appears to be highly dependent on how one perceives their physical wellbeing, based on their attitude, their contextual understanding of the situation and their ability to adapt.

4.3 Sensory: Importance of the Senses

Not to be able to read, not to be able to see, I think it's worse than being in a wheelchair

– Jane-Davies, Client from the CVI Day Centre

A consensus was reached amongst all participants that vision and hearing were essential to one's objective and subjective dimensions of QOL. A recurring theme amongst clients was the subjective value placed on vision, particularly reading, as an indicator of one's QOL - "*I really think that I would be absolutely devastated if I couldn't read, sew and knit and do those things*" (Matilda, personal communication, July 24, 2008). Fay suggested that those with "*sight impairment*" and "*people with hearing difficulties, find it hard to be in group situations*" as they can feel excluded from conversations (personal communication, August 28, 2008). As purported by Hickey *et al.* (1999) health should be measured as a holistic phenomenon (emotional, social and physical), rather than just the absence of a physical disorder. As suggested above, older people may experience a poor QOL not only because of their inability to

see but because of what this represents. In the case of Matilda, a loss of intrinsic pleasure and a negative emotional state due to poor eyesight would diminish her QOL (personal communication, July 24, 2008). Similarly, CVI Manager Fay thought sensory limitations would lead to diminished social contact and therefore a low QOL (personal communication, July 28, 2008).

According to CVI staff and managers, good hearing and vision generally indicated that the older person had a high level of physical and social functioning – they were usually healthy and able to engage with others on a personal level. Conversely, poor eyesight and hearing was seen as detrimental to an older person's ability to participate in society or conduct everyday tasks. Low sensory functioning was viewed as a multi-dimensional issue – *“Independence would be affected in every aspect of life... driving, preparing meals, shopping, cleaning, personal care, socialising, watching TV or movies, eating, safety and using technology”* (Anne, personal communication, August 25, 2008). One staff member stated that older people with sensory disabilities either needed assistance or to adopt coping strategies; failing that, they simply needed to accept their situation (Joan, personal communication, July 24, 2008).

Although sensory issues were an important objective indicator of QOL respondents did not discuss the subject at length. It was perhaps viewed as a fundamental part of life that needed little or no explanation. Much of the discussion collated from question about sensory indicators of QOL was more closely related to the objective indicator identified as technological aids and human support (see section 4.5 below). From the brief statements given by respondents, it was clear that sensory indicators were of subjective importance to individuals in terms of the importance they placed in their ability to read or to see in order to conduct everyday activities.

4.4 Intellectual: Cognitive Functioning and Attitude

It seems as though when you get older, all the energy either goes to your brain or your body. So something seems to wear out; you either wear out mentally first or physically first. So, getting older, I mean some of our clients, they're elderly - they can hardly walk but they're still very switched on... it might take them a little longer to think about things, but they'll know far more than I'll ever know

- Dorothy, Staff member from the CVI Day Centre

The above quote illustrated two opposing points of view. The first being, that there was a general consensus amongst the participants that older people's mental abilities do eventually deteriorate, coinciding "*with slow reaction times*" and thereby affecting "*activities such as driving, reading, shopping, understanding and communicating*" (Anne, personal communication, August 25, 2008). All sample groups nominated memory loss as a significant issue that impinges on the QOL of many older people.

The second point was that age was deemed largely irrelevant in predicting an individual's mental capacity. Many respondents felt that growing older could not be used as a measure for mental acuity because individual experiences were contextual and there was much variability between older people - "*we cannot discriminate about age, certainly things happen as we age, but they're not inevitable*" (Eddie, personal communication, August 28, 2008).

Throughout the interviews, it was apparent that mental wellbeing was thought to be related to objective indicators of QOL. These included one's physical wellbeing and the nature of their social contact - "*Once again, it all depends on how fit they are and mobile... coming here (the CVI Day Centre) is good, it's good therapy for everybody. It gets you out. You mix with people*" (Margo, personal communication, July 15, 2008). Key informant Eddie agreed that physical activity could negate mental decline and help individuals cope with potential threats to their physical wellbeing (personal communication, August 28, 2008). Margo opined that if an individual had "*a good state of mind, then they can cope with everything*" (personal communication, July 15, 2008). This was further supported by key informant Fay, who stated that older people "*who remain mentally alert and engaged would tend to retain a better QOL*" (Fay, personal communication, August 28, 2008).

Again, the affect older people's cognitive functioning had on their QOL was considered to be highly contextual - "*some people remain mentally alert and engaged in what is happening in their community and the world in general... others lose interest*

or become disengaged” (Fay, personal communication, August 28, 2008). A staff member argued that one’s attitude changes as people grow older and begin to physiologically wind down -

your priorities become different as you get older; when you’re young you’re more ambitious... you’re all, ‘ok let’s get on with life’ and as you get older you realise that you can’t beat the clock – you’re getting older and there’s nothing you can do about it. So you have to try and do the best you can with what you’ve got (Dorothy, personal communication, July 16, 2008).

A study reviewed by Gnich and Gilhooly (2000, p. 23) found that older individuals appeared to “lower their aspirations”. As Dorothy suggested, Gnich and Gilhooly (2000) found that younger generations focus on climbing the social and occupational ladders whereas older individuals aim to preserve their current level of being.

Overall, intellectual measures of QOL appeared to be strongly related to other objective themes in the primary data such as physical wellbeing and various social indicators. The subjective indicator of attitude was also thought to change in old age. Although old age was correlated with a decrease in mental activity, socialisation skills and intrinsic motivation, this view was not supported by all respondents. The level of intellectual prowess retained in old age was conveyed as being highly relative to an older person’s situation.

4.5 Technological Aids and Human Support: Resistance and Adaptability

I probably wouldn’t like it, but it’s like glasses; if you don’t wear glasses then you don’t see. You accept the things you can’t change. Well, I mean if you have a walking stick to get along, well if you want get along, then you get a walking stick, don’t you?...There’s nothing else to do... I mean, you don’t just throw in the towel because you have someone come in to help

– Mary Jones, Client from the CVI Day Centre

Although primarily an objective indicator of QOL, there was a strong subjective dimension to technological aids and human support. Although the objective importance of technological aids such as canes, glasses or hearing aids were recognised – *“I have been tested for my hearing but I probably would be better if I had a hearing aid”* (Drew, personal communication, July 31, 2008) - throughout the study it was evident that the attitudes of individuals can compound their situation. Many clients viewed technological aides negatively and therefore, did not use them – *“In environments I don’t wear it I should put it on, but I can’t be bothered”* (Jane-Davies, personal communication, 31 July, 2008). Some clients and staff viewed hearing aids as useless

apparatus' and therefore not beneficial to QOL – *“people say to me, ‘well, hearing aids are not much good’, half the people that have got one, don’t use them”* (Drew, personal communication, 31 July, 2008). One staff member posited that *“We always have problems with hearing aides here... it causes stress... so the whole situation probably isn’t very pleasant but people try to do the best that they can”* (Dorothy, personal communication, July 17, 2008).

According to CVI staff and managers, the decision to procure technological aids was considered highly dependent on the subjective beliefs of individuals and often fraught with resistance – *“It all depends on the person... It’s just the initial thing. Admitting to yourself, you’re getting old... it comes down to dignity and pride”* (Margo, personal communication, July 15, 2008). One client suggested that she might resist attempts to assist her, her independence being threatened – *“Oh, I’d feel useless. I’ve done everything for people you know... it’s just a part of my life. So for me to get help, I’d probably be a bitch!”* (Jasmine-Rose, personal communication, July 10, 2008). Glicksman (2000) posited that subjective wellbeing is influenced by how one perceives their mental, physical, economic and social status; an individual compares their present status with past experiences. Similarly, CVI manager Anne believed that current older people facing the use of aids and support, may suffer from *“feelings of inadequacy”*, because they have *“always been very independent”*, being *“the generation who fought for our Country”*. As purported by Glicksman (2000), subjective wellbeing is linked to events in one’s life and how individuals reacts to problems that arise. Anne suggested that older people can resist assistance, finding it a challenge *“to rely on another person”* and they can reject technology. It was opined that they may *“refuse to accept the assistance and battle on”* – their QOL being adversely affected in the long term (personal communication, August 25, 2008).

From discussions with other clients, it was clear that should an older person require assistance, their personal concerns might eventually be outweighed by the necessity of the aid or service – *“At first it was the pride thingy... but once you know you have to use it – it’s a different matter... I wouldn’t feel embarrassed... better to have it”* (Matilda, personal communication, July 24, 2008). However, there was a sense that although people might agree to using aids or accept support, they would continue to perceive it as unpleasant – *“Well, I would have to go along with it wouldn’t I? It’s for my benefit so... nobody likes substitutes... they’re crutches”* (Drew, personal communication, July 31, 2008).

It was evident that functional debility in old age was perceived by some as an ongoing process of loss - *“going down the slippery slope”* (Matilda, personal communication, July 24, 2008). Despite this, it was also opined that people could adapt and find new ways to cope - *“you can’t just vanish it all with one stroke... it’s the things that make up for it”* (Drew, personal communication, July 24, 2008). As such, the subjective QOL indicator of adaptability, particularly acceptance, was a significant theme identified in discussions about technological aids and human support. Furthermore, members of the staff and managerial sample posited that over time, older people might view the aid or support as beneficial to their objective and subjective QOL - *“I think that they would actually come to enjoy it because it’s (a carer) company as well... if they’ve got a hearing aide then they can hear what’s going on around them”* (Regina, personal communication, July 31, 2008).

The primary data suggested that technological aids and human support could indicate a high level of QOL for older people by assisting them to mix socially. Although aids and support were viewed as potentially beneficial to one’s objective wellbeing, it was posited that they did not always improve an older person’s sensory condition. Subjective indicators such as levels of resistance (pride), adaptability (acceptance) and perceptions of loss were identified as factors involved in an older person’s decision to use assistance. Many clients and staff perceived devices negatively, suggesting that substitutes were not appreciated or necessarily useful.

4.6 Service Delivery: Care and Support

Just because you have a carer come, it doesn’t mean to say that you’re a dead loss or you don’t have any QOL

– Dorothy, Staff Member from the CVI Day Centre

Clients utilised carer and support workers for a range of duties including domestic work, hygiene, shopping, cooking and library services. CVI staff and management suggested that generally, carers provided services to older people with physical disabilities and mental health issues who needed assistance meeting their basic needs. There were clear objective and subjective dimensions to care and support services as an indicator of QOL. Ben (personal communication, July 10, 2008) disclosed that having permanent assistance would improve his QOL, however he also suggested that it was the social contact he required most, not necessarily the physical support. Similarly, staff member Margo was adamant that a carer enhanced one’s QOL by providing physical assistance and as a point of social contact - *“It does help if they*

have a carer coming in. It helps with the housework, they've got somebody to talk to. Even though she's got work to do, she'll still talk to them" (personal communication, July 15, 2008).

Respondents from the client, manager and key informant populations suggested that interventionist human support has a negative impact on older people's subjective QOL. It was suggested that long term care would affect older people's independence – *"It would have an impact on their lives – the more help they require, the more dependent they become"* (Fay, personal communication, August 28, 2008). Despite many clients stating that they would consider employing a carer if they recognised the physical need for one, they felt their QOL would be diminished due to a loss of independence – *"I would hate it... causing people to wait on me hand and foot. Its ok if you've got to, you've got to"* (Jasmine-Rose, personal communication, July 10, 2008). Key informant Danni believed a solution to this would be increasing older people's awareness of alternative technological aids that they could purchase themselves, therefore postponing the need for a support worker and maintaining *"control"* (personal communication, September 4, 2008).

Overall, there were clearly opposing views about carers and the impact support services have on older people's QOL. Some respondents viewed care as an opportunity for older people to socialise, whilst others perceived support services as representing a loss in independence. Independence is related to the major subjective indicator autonomy of choice (Bowling; Gitlin, 2000). Autonomy was a recurring theme throughout the primary and secondary data in discussion pertaining to separate areas of QOL thereby illustrating the theoretical importance of independence as construct in maintaining one's QOL.

4.7 Service Delivery: Medical Services

In most instances, a healthy relationship with a GP assists their QOL

- Anne, Manager from CVI Administrative Offices

The actual process of taking medications and seeking medical support was deemed intrinsically detrimental to individuals – *“the fact that you have to take tablets and things is quite depressing and some of the elderly clients become besotted with going to the doctor and getting tablets and I mean it’s probably, pretty scary”* (Dorothy, personal communication, July 15, 2008). Furthermore, objective issues such as the accessibility of health services, the failing memory of older people the possible side effects of some medicines and the actual medical concern were also thought to compound the situation – *“There may be an impact on the person’s QOL, dependent upon the seriousness of the health issue”* (Fay, personal communication, August 28, 2008).

Interview data with participants revealed that the relationship between medical services and impact on QOL was deemed highly subjective to the individual – *“This will depend upon the individual... Many people need medication to keep them in optimum health – it does not necessarily mean that they need assistance in other ways”* (Fay, personal communication, July 28, 2008). Hunt (1999) stated that health professionals and pharmaceutical companies have very little bearing on overall QOL because physical health does not strongly indicate one’s overall wellbeing. Hunt (1999) suggested that the medical profession’s narrow focus on physical health does not address other subjective facets of an individual’s life (such as one’s ability to cope, religious beliefs and perspectives on living and dying).

Members of the manager and key informant population suggested that an older person’s medical experience was affected by whether the consultation process was collaborative – *“health care and medication can either be positive or negative, it depends on the delivery of the service and your own involvement, control and being seen as valuable in that process... that then affects your QOL”* (Danni, personal communication, September 4, 2008). As argued by Hunt (1999), health workers should provide clinical care and enhance QOL by providing services that are conducive to a person’s contextual situation and are collaborative. Participants viewed total reliance on a medical professional as being potentially detrimental to their subjective QOL. A professional who assesses an older person as being incapable of remaining in their home, may force them to relocate to residential care resulting in a loss of independence (Anne, personal communication, July 25, 2008).

Hunt (1999) stipulated that ultimately, medical interventions are not always successful in enhancing the QOL of individuals and posited that medicines should not be viewed as panaceas for poor QOL. Despite this, overall, participants believed that medication and health services improved older people's QOL in regard to objective dimensions such as physical wellbeing. This appeared to outweigh the possible, subjective negatives of the clinical experience – *"The assistance of a health professional would indicate that the person is being looked after in the best way possible to enable them to maintain a QOL"* (Fay, personal communication, July 28, 2008). Similar to this Honours study, Roche (1990) found that respondents in four aged care residential facilities (including clients, care-giver staff and supervisors), selected health care services as the most significant positive determinant of QOL.

4.8 Residential: Private Residences and Villages

I think that all depends on the person. I think you may find somebody who finds it incredibly lonely who would actually benefit from a hostel type of residence. Most of the population I feel, would think they are losing their freedom

– Regina, Staff Member from the CVI Day Centre

Respondents reported that generally, older people lived in two kinds of environments; private residences and residential care facilities such as retirement villages or nursing homes. Most respondents viewed private living as an indicator that an older person's subjective QOL was high – *"I think if you're living in your own home you've got all your memories around you, you've got everything you've built up throughout your life"* (Joan, personal communication, July 24, 2007). In the literature, "continuance of self" was thought to be a determinant of QOL in old age (Gitlin, 2000). Specifically, it was argued that remaining in one's own residence represented safety, familiarity and relative independence for an older person experiencing functional debility. In short, private homes are environments that foster adaptability in old age (Gitlin, 2000).

It was also opined by a member of staff that granny flats were advantageous to one's QOL (Dorothy, personal communication, July 16, 2008). One client resided in a granny-flat, attached to her son's private property. She considered herself to be "lucky" and described various in-home conveniences that allowed her to remain relatively independent (Mary-Jones, personal communication, July 24, 2008).

However, living privately also appeared to have a potentially negative impact on objective and subjective QOL – *"a lot of people might live in a private big old house,*

but they can be very lonely... We've had cases where they've actually fallen and nobody's found them (Dorothy, personal communication, July 16, 2008). Therefore, it was suggested that having support staff on call was an objective benefit of residential accommodation. Some respondents maintained that older people living in “*residences or retirement villages have got a very good QOL. They're kept warm, there's food, they do activities and that with them*” (Dorothy, personal communication, July 16, 2008).

Members of staff and management suggested that moving into a retirement village meant older people lost independence and were giving up a ‘place’ that held intrinsic value. Relocation to residential care was widely perceived as an indication that an older person’s QOL was depreciating -

Our client base has shown that remaining as independent as possible in their own home or retirement village has a positive effect on their quality of life.... In most of the circumstances we have seen, entering permanent care is usually a necessity due to the client becoming a danger to themselves by living in their own home (Anne, personal communication, August 25, 2008).

In terms of maintaining an older person’s independence, Roche (1990) found that permanent care often resulted in a reduced freedom of choice for older people. This was despite facilities usually maintaining one’s objective QOL. This was perceived to be a result of a lack of collaboration between staff and clients in terms of decision-making (Roche, 1990). Privacy was thought to be best maintained by giving clients their own living spaces (including personal hygiene facilities); however, Roche (1990) argued that this was not feasible in all institutions (sometimes for the protection of clients).

In respect to losing items of intrinsic value, Roche (1990) argued that facilities could be made more ‘homely’ by allowing aged clients to keep their material possessions (Roche, 1990). In addition, that by modifying the structure and shape of residential care buildings to appear more like a house and allowing clients to have opportunities to prepare meals, also fostered feelings likened to a continuance of self amongst older people. Similarly, Roche (1990) found that an older person’s perception of social independence was sustained if one’s social connections outside the care facility were maintained – thereby also enhancing overall QOL of older people. Client Jane-Davies suggested that when she entered care, she experienced social marginalisation – “*we do have a hall in our village, which I don't go to because I feel shut out*” (personal communication, July 31, 2008).

Staff and managers also suggested that social advantages and disadvantages of residential care are influenced by the subjective nature and experiences of individuals - *“Everybody’s different, a lot of people go and live in these places because it’s company for them and they want to interact with other people and they’ve got the time because they’re retired”* (Margo, personal communication, July 15, 2008). Conversely, one manager suggested that on the whole – *“from the many clients we have seen enter permanent care, it is rarely a positive experience for either the client or their family”* (Anne, personal communication, July 25, 2008).

Autonomy of choice was a strong predictive factor in determining the level of QOL experienced by older people in any residence –

Depends on the individual. Many people prefer to live at home, even if it poses difficulties for them... If a person is living in a place where they do not wish to be, then this will have a negative impact of their QOL (Fay, personal communication, July 28, 2005).

Weisman et al. (2000) identified subjective and objective as two indicators related to place. From the primary data, it would appear that an older person’s subjective perception of their place of residence played a larger role in indicating their QOL than the actual objective physical benefits of the environment they were living in.

4.9 Residential: In-home Care and Age Friendly Cities

These services are in place to keep them as independent as possible in their own home... Some require a little assistance and some a bit more. These people, without the assistance, would either be struggling terribly or end up in permanent care... QOL is improved

– Anne, Manager from CVI Administrative Offices

Both CVI managers believed that access to in-home care was essential to the QOL of older people - particularly in residential care facilities. It was argued that older people required greater support to remain living independently in their own private residences and without the need for permanent care (Fay, personal communication, August 28, 2008). Maintaining one’s autonomy has been described as a universal desire – as such, Australian community care services are centred on sustaining older people’s independence and remaining private residences (Australian Government Department of Health and Ageing, 2006).

Despite this, Anne suggested that West Australian *“personal care services only provide for a fraction of what is needed”* and that *“if the situation becomes unhygienic, it usually ends up with the client entering permanent care as in-home services won’t*

assist due to OHS issues” – thereby forcing that older person to relinquish their independence (personal communication, August 25, 2008). It was posited that in-home services needed to be individualised to meet client’s needs and not based solely on governmental standards of care (Anne, personal communication, August 25, 2008).

A number of staff stated that the QOL of older people living in old age homes was poor. Participants from the staff population suggested that individuals can become totally dependent on support workers, because in some residential care facilities, such services are available at all times (Joan, personal communication, July 24, 2008). This was seen as detrimental to older people’s QOL because it indicated that the older person had developed a high degree of dependence on support services. In addition to this, it was stipulated that the QOC in many institutions was inadequate and therefore identified as an undesirable places to live in now or in the future (Andy, personal communication, July 16, 2008).

A 2008 news article, supported much of the fears expressed by the participants by outlining recent negative events surrounding an eastern states residential care facility in Australia (ABC, 2008a). According to the source, a great number of older residents were adversely affected by a stomach virus in a short period of time. A representative from *Aged and Community Services Australia* was quoted as saying - “things that would make a younger, fitter person unwell for a couple of days can be terminal for older people in residential care” (ABC, 2008a, p. 1). At the time of the article, the facility was being investigated and there was a proposal that all aged care settings be evaluated for poor QOC.

In light of the possible benefits of staying at home (rather than entering into poor quality care facilities) the concept of universal design was considered by key informants. In both the primary and secondary data it was found that older people’s QOL would objectively benefit from more age-friendly residential designs (WHO, 2007). These included; doorways being made accessible to people with wheelchairs or walking frames; whether the bathroom or toilet was easily accessible; the inclusion of floor surfaces or hand rails that limited one’s propensity to fall; and whether the garden was modifiable to suit the changing needs or limitations of an older person.

The WHO’s (2007, p. 32) global study into age-friendly cities found that in Melbourne, Australia - “assistance equipment is not used because it does not fit into the home and many care-givers are unable to afford the necessary renovations”. Key informant Eddie (personal communication, August 28, 2008), argued that if it became normal practice to include settings for hand rails, or if door frames were made larger,

modifications could be completed quickly and inexpensively and stigma would be reduced. Eddie suggested that there was a subjective dimension to the concept of age-friendly design – *“people are very short-sighted about their future needs”* (personal communication, August 28, 2008). He stipulated that many retirement villages do not include such technology as standard when marketing to buyers, as older people do not believe they are warranted.

It would appear that autonomy of choice was viewed as an important aspect of residential indicators of QOL. The subjective theme of independence is an important facet of QOL for older people. As supported in the primary data, they may maintain this independence by remaining at home. However if inadequate in-home services take this control out of their hands, older people may be forced to relocate to a poor quality residential care facility and become increasingly dependent on aged services. Age-friendly designs were believed to enhance the level of subjective and objective control experienced by older people in both the home and in residential care.

4.10 Financial: Government Pension Rates

Well, I would say that on an average, they're just existing. There's no quality to it. I'd say I'm lucky, but lots of people are not

– Ben, Client from the CVI Day Centre

Financial security was considered central to one's objective QOL – *“I think enough to live pretty well on or live every day without worry or if something crops up – it always does”* (Jasmine-Rose, July 10, 2008). In Gnich and Gilhooly's study, there was a weak link between objective and subjective economic indicators amongst older people. Having a low level of objective wealth, did not necessarily mean an older person experienced a poor QOL. In their own review of the literature, Gnich and Gilhooly (2000) suggested that older people resigned themselves to having less money in the long term (for example being on the aged pension) and adjusted to this reality by “lowering” their subjective expectations on life (Gnich & Gilhooly, 2000, p. 21). Similarly, it was stated in the primary data, that older people adjusted to their lack of income and continued to do so throughout their old age (Nirva, personal communication, August 27, 2008).

According to Gnich and Gilhooly (2000) older people appeared to measure their wellbeing by comparing themselves to people with a lower economic status, thereby maximising their view that they were financially content (Gnich & Gilhooly, 2000). A common thread in the primary data was that older people engaged in downward

comparison. It was stipulated by a key informant that many older people believed *“there’s someone worse off than me”*, despite the objective truth that they were economically bereft (Nirva, personal communication, August 27, 2008).

It was clear that government welfare was a key indicator of one’s objective wellbeing - *“Well, it’s a living isn’t it? (laughs)...I mean how could you live without a pension really?”* (Matilda, personal communication July 24, 2008). Gnich and Gilhooly (2000) suggested that older people might experience a diminished QOL due to long term dependence on a static form of income (financial aid or some form of savings). According to Gnich and Gilhooly (2000), older people have a reduced chance of overcoming economic hardship, having no viable means of accumulating extra wealth. As a consequence of this loss of control, older people could suffer negatively and develop psychological issues (Gnich & Gilhooly, 2000). However, Jasmine-Rose viewed government aid as a means to remain somewhat independent and not reliant on one’s family – *“so, I’m very grateful to Centrelink”* (personal communication, July 10, 2008). *The Combined Pensioners and Superannuants Association* spokeswoman, Charmaine Crowe posited that the pension had both an objective and subjective function for older people. She argued that, *“the pension was put in place to give people support and dignity”* (ABC, 2008d, p. 2).

A few clients also had privately funded sources of income, such as *“superannuation”* and *“investments”* (Ben, personal communication, July 10, 2008). Mary-Jones believed that ‘luck’ played a considerable role in her current financial wellbeing. She was fortunate to have an additional partner pension to supplement her original pension rate and described herself to be *“luckier than others”* (personal communication, July 24, 2008). Respondents with income supplements believed themselves to be better off than other aged pensioners – *“Being a pensioner myself, I understand what it is, but a lot of pensioners are in dire straights who’ve just solely got a pension. I’m fortunate, I’ve got some savings, but a lot of people don’t and it’s very, very hard at the moment”* (Margo, personal communication, July 17, 2008).

The perceived inadequacy of the age-pension has been part of a current nation-wide debate. At present, the Commonwealth Government is being lobbied by various seniors groups concerning the recent heightened cost of living to older people receiving the single pension (ABC, 2008c). According to one article, a recent international study has identified the single-aged welfare provisions to be less in Australia than other industrialised countries (ABC, 2008b). Crowe further stated that there are over one

million older people in Australia who have been adversely affected by the poor pension rates (ABC, 2008d, p. 2).

Staff member Dorothy, believed that there was a lot of discontent amongst older people towards the Australian Government – *“I think money is something they’ve all been complaining about the latest election – they don’t feel they were adequately represented”* (personal communication, July 16, 2008). In a 2008, news article Federal Treasurer Wayne Swan, was quoted as saying the single aged pension was “totally inadequate” but has said increasing the welfare benefit will only be considered in the next national budget (ABC, 2008c, p. 1). The Federal Opposition attacked the government for recognising the need to increase the single aged pension but not choosing to act immediately (ABC, 2008d). However, Prime Minister Kevin Rudd argued that his government had provided older Australians with monetary relief in the form of a one-off pensioner bonus and an increase in the quarterly utilities allowance (ABC, 2008e). Rudd reiterated that “these are designed to provide a helping hand on the way through until we receive the Harmer Report’s recommendations for the future” (ABC, 2008e, p. 1). The Minister for Families and Community Service Jenny Macklin, further stated, “if we’re to get this right, if we’re to make sure that we do address the inadequacy of the base-rate of the pension, then we do need to do some proper work to make sure that we do not get into this situation again” (ABC, 2008f, p.1).

Several respondents suggested that the current cost of living for older people was extremely high – *“The way everything’s shot up these days it’s very expensive for a pensioner”* (Margo, personal communication, July 17, 2008). Both CVI managers argued that *“aged pensions do not increase in line with the cost of living”* and that this correlated with an increased risk of *“poverty”* amongst older people (Anne, personal communication, August 25, 2008; Fay personal communication, August 28, 2008). The majority of respondents expressed that there was a clear inadequacy in the current pension rates and suggested that this has lead to a subsequent reduction in older people’s objective dimensions of QOL.

In a recent news article Ian Yates stated that “people cannot mange a decent life on the current pension system” (ABC, 2008g, p. 1). The member of the agency *Senior’s Voice* argued that the subjective indicator of QOL, autonomy of choice, has been threatened by the inadequacy of the current welfare system. It was stipulated that older people have to choose whether they can afford groceries, pay bills or access public transport (ABC, 2008g). The inability to travel may mean they cannot access medical services, thereby risking their physical wellbeing (ABC, 2008g). In addition, social

relationships have been strained due to a lack of opportunity to go out with friends, thereby fostering social isolation. Many older people receiving the current aged pension were also identified as being unable to afford housing costs.

The recent US market crash and the subsequent “global financial crisis” has forced the Australian government to act sooner than anticipated (ABC, 15, 2008, p.1) In December of this year “single aged pensioners will receive a payment of \$1400, with couples receiving \$2100” (Rodgers, 2008, p. 1). There has been wide-spread approval of this decision from various peak bodies and policy-makers (ABC, 2008h). Crowe stipulated that the payments will help older people meet the current cost of living (ABC, 2008h). Michael O’Neil, Chief Executive of *National Seniors Australia* has posited that the autonomy of choice of older people will be enhanced; they will be able to purchase a greater selection of food items (essential to living) and have a greater opportunity to partake in social engagement (ABC, 2008h).

Although the majority of clients in the aged cohort believed they were living adequately, financial indicators were still obvious objective measures of QOL. Respondents opined that the current pension rate was low and there was a high cost of living in Australia. The secondary data puts these respondent’s opinions into context and it would appear that older people as well as academics and most policy-makers view a lack of finances as a universal problem amongst older Australians.

4.11 Financial: Third Party Assistance

It could work for the better if it’s a lawyer or a bank because their basic needs would be taken care of. They would be comfortable, they wouldn’t be walking around the streets like some of them do, getting completely lost and disorientated...

– Dorothy, Staff Member from the CVI Day Centre

The majority of clients admitted that their financial matters were at least partially or fully controlled by members of their immediate family. “No, my daughter does that... I’m grateful for what she’s doing... she’s a very busy person” (Drew, personal communication, July 31, 2008). Many opined that they felt safe in the hands of family – “We sorted it out. So leave it to her, she’s the one who knows about it. Trustworthy person... She doesn’t need my money anyhow” (Jane-Davies, personal communication, July 31, 2008). One respondent had a different opinion, Jasmine-Rose stipulated that although she could approach her family for support, she “wouldn’t like to be a bother” (personal communication, July 10, 2008) and therefore opted to remain independent. Gnich and Gilhooly (2000) found that aid from family can sometimes

diminish an older person's subjective view of their financial situation by making them feel dependent.

Some staff believed that family members should not be put in a position of financial control at all, particularly for vulnerable older people –

If they can't cope, they should get somebody in, but you can't tell them that, Jonathan. If the bank manager knows the situation, he can come and have a talk with them; that's good, that's different. But a lot of oldies don't. You know and a lot of them are getting fleeced (by family)" (Margo, personal communication, July 17, 2008).

As Margo stipulated in the above quote, many of the clients interviewed said they would not choose to employ the services of an impartial financial partner - such as a professional like a bank manager or lawyer - over family members. In the care facilities studied by Roche (1990), the majority of clients had a third party representing their personal interests, however, like the staff members in this honours study, Roche (1990) recommended that this should be an individual or agency that does not have a personal stake in the client's life.

Client Ben suggested that although he received assistance from his family, third party control does indicate a diminished QOL – *"It most likely would, yes. I like to handle those investments"* (Ben, personal communication, July 10, 2008). A near consensus was reached amongst Staff members where third party assistance was viewed as a negative indicator of one's overall QOL – *"I would imagine it would be dreadful, because if you've been the person to look after your own finances to give it to somebody else, you'd be, 'what are they doing with it?'"* (Joan, personal communication, July 24, 2008).

There was a recurring theme amongst staff and managers that financial assistance would precede a total loss in one's autonomy of choice - *"it would be losing control... control over your life and your decision-making"* (Regina, personal communication, July 31, 2008). Staff member Dorothy and CVI manager Anne, both agreed that being psychologically incapacitated can limit an individual's ability to make choices. However they also suggested that subjective dimensions of QOL may not be diminished if an older person is forced to give up their control due to illness – *"When someone else takes control of the finances, it can assist with the person with dementia in staying in their own home longer, as bills will be paid, food will be brought and services to assist the person will be paid for"* (Anne, personal communication, August 25, 2008). Similarly, Matilda posited that although she enjoyed her financial

independence, if she were to become incapacitated she would accept it and adapt to the situation – “*you’ve got to meet these things as they come along*” (personal communication, July 24, 2008).

There was an underlying belief that third party assistance would indicate a diminished subjective QOL in respect to a loss of autonomy and an increase in dependence. A significant point of interest was that staff placed greater trust in impartial party’s (bank managers or lawyers) whereas clients were more comfortable giving partial control over to family members. Also, the presence of an age-related debility (such as a stroke) meant that older people might be more willing to accept third party assistance in the knowledge that they would have little or no choice.

4.12 Social: Contact and Service Delivery

It’s having a certain degree of independence. You can do what you want to. You can go out, and as you’ll see, when you get older, your friends get older and the ones that used to be able to drive and come see you, well, they’re not driving anymore... So they don’t come! And so, we use the telephone a lot but it’s no substitute for actually being around other people

– Drew, Client from the CVI Day Centre

Social contact was nominated as a significant indicator of one’s QOL amongst the client, staff and managerial cohorts. Again, there was a strong objective-subjective relationship in respect to social wellbeing. Overall, it was believed that social contact gave many older people’s life meaning (Dorothy, personal communication, July 16, 2008). Anne felt that older people needed “*to feel connected and needed within the community*” in order to experience a positive QOL in terms of physical health and mental wellbeing (personal communication, August 25, 2008). Furthermore, one’s contextual situation was considered to impact on older people’s social wellbeing. Dorothy (personal communication, July 16, 2008) and Margo (personal communication, July 15) argued that older people needed to be engaged in society after losing a spouse. It was believed that in such situations, social contact was essential to maintaining a widowed older person’s physical health and longevity.

CVI client Drew (personal communication, July 31, 2008), suggested that she suffered from a loss of social independence as a result of growing older. Drew adapted to this loss in social and physical functionality by utilising the telephone as a source of communication. However, according to Bowling (2005) one’s perception, as well as the contextual and historical features of an individual’s relationships, may also have an impact on social support. As such, it appeared that Drew felt indirect interaction was

not as beneficial to her socially as personal contact with her friends (whom she was used to visiting in-person).

Bowling (2005) argued that the availability of social contact does not necessarily mean that an individual has access to social supports (Bowling, 2005). Social support can be affected by the size of a social group, whether all members are close knit or related in either a familial or social context (Bowling, 2005). Also relevant is where individuals within this group are situated in terms of proximity to one another and how often congregation between members occurs (Bowling, 2005).

Discussion about social indicators of QOL appeared to be synonymous with talk about personal contact with friends, family and the CVI Day Centre – *“Just having company and people that you relate to... and having a meeting place like this, meeting up with people like you”* (Drew, personal communication, July 31, 2008). Centre-based care was viewed as a source of social activity and new opportunities – *“they’re getting out, they’re doing something they probably wouldn’t be able to do... it definitely improves their QOL... particularly the social aspect”* (Joan, July 24, 2008). Members of the staff population believed that centre-based care was not only a source of social stimulation and intrinsic satisfaction, but a panacea for ill health – *“with company comes contact... they feel better about themselves and they don’t get as sick as often”* (Margo, personal communication, July 15, 2008).

An important dimension to social support was the level of social engagement members had and how comfortable they were within their own community (Bowling, 2005). The activities delivered by the Day Centre and the contact clients had with younger generations were perceived to be positive for the subjective QOL of older people. One client reported that –

I like to come here. You’ve got a nice meal and someone to look after you. They give you nice games to play... Oh, yeah, it is nice to have a mix! It’s nice to see you young ones come in” (Jane-Davies, personal communication, July 31, 2008).

Staff member Regina (personal communication, July 31, 2008) suggested older people also benefited from having members of their own age cohort around them that they could relate to. Along this stream, Joan (personal communication, July 24, 2008) posited that the subjective concept of reminiscence was a major benefit to one’s social wellbeing – having *“somebody to talk to... pass the time of day with... nothing more soul destroying than sitting in-front of two walls watching TV all day”*.

Staff believed that the services offered by the Day Centre maintained older people's engagement in society and thereby enhanced their QOL –

they're not prepared to just sit back and let life pass them by, they want to be part of life. They want to be part of the society and they're still interested in politics and sport and they don't care that they're recipients" (Dorothy, personal communication, July 16, 2008).

Another benefit was to older people's social independence – *"they're still making a life for themselves. So they're not as reliant on contact with their family"* (Regina, personal communication, July 31, 2008).

In the primary data, the QOL benefits of centre-based care were recognised as being subjective in nature. Although it would appear that social contact was perceived to be a universal objective indicator of QOL, the subjective personality of older people was recognised as a determinant of one's choice to enter the social environment of centre-based care. For example, Dorothy stipulated that the older people from the Day Centre were *"all go- getter types"* and that certain individuals felt it was *"their right to have"* assistance. Acceptance of one's circumstances as an older person, who may be in need of support, was thought to play a large part in an individual's decision to enter centre-based day care (Dorothy, personal communication, July 16, 2008).

Overall, it would appear that social indicators are fundamental to older people's QOL. Of critical importance to the social wellbeing of older people was the presence of a spouse and centre-based care. However, there was a strong objective-subjective link in respect to social indicators of QOL. As depicted in the primary and secondary data, the value individuals placed on particular social constructs and one's attitude (personality) was important in ascertaining a socially positive QOL. Despite objective social indicators having a universally high importance to QOL, there was no one social construct identified to be of benefit to every older person.

4.13 Social: The Ability to Communicate

People who have difficulties in communicating are sometimes overlooked, people make choices for them, instead of finding out what they want

- Fay, Manager from CVI Administrative Offices

It was suggested that older people had different communication styles based on their personality and contextual situation; therefore, losing the ability to communicate can have a multitude of impacts on an individual's QOL. Fay opined that *"if a person is very social and they lose their ability to communicate effectively with others, it would be devastating. For someone who is more of an introvert, it may not be so debilitating"* (personal communication, August 28, 2008). Alternatively, although Dorothy (personal communication, July 16, 2008) believed that although people can be verbose or withdrawn, she suggested that one cannot infer that a lack of verbal communication indicates an individual has a poor QOL. She argued that instead, some people may communicate their emotions through actions and when a physical limitation prevents them from doing so, it can impact negatively on the individual's subjective QOL.

Staff member Margo also conceded that people were either introverted or extroverted. However, Margo (personal communication, July 15, 2008) believed that sociability was a sign of good communication and therefore, a better QOL. She stated that older people's social abilities were largely determined by their marital status – *"If they've got a spouse or a partner, they're fine. They can go with other people... they can talk and be open. But when a person's on their own, they tend to go in on themselves"* (Margo, personal communication, July 15, 2008). She suggested that older people without spouses become anti-social, gain unfavourable reputations within their peer group and are unsatisfied with life – thereby affecting objective and subjective dimensions of their QOL.

Despite this revelation, Dorothy (personal communication, July 16, 2008) posited that the loss of a spouse can be confounded by a *"communication breakdown"* between the widowed and their family. She suggested that clients who do not *"settle in"* are those forced to attend the Day Centre by their family – *"the family's said you need to get out more. You're stuck in here getting all depressed thinking about their past spouse that's died or whatever"* (Dorothy, personal communication, July 16, 2008). She argued that *"when you get older you become passive again and your children start telling you what to do"* and that loss of autonomy can *"erode away"* an older person's QOL (Dorothy, personal communication, July 16, 2008).

The ability to communicate was also correlated with ill health and a poor objective and subjective QOL. Joan (personal communication, July 24, 2008) argued that communication was directly linked to objective dimensions of QOL, in that it keeps an older person's mind active and in her opinion, delays the onset of age-related dementia. It was also opined that an older person suffering from the effects of a stroke would experience a severe decline in their QOL – *“For people who lose the power to communicate (because of health reasons) this would very frustrating and can have a huge impact on their QOL... Social isolation – frustration at not being understood or able to voice an opinion”* (Fay, personal communication, August 28, 2008).

It was suggested that losing one's mobility and the ability to communicate would diminish not only an older person's physical wellbeing but be detrimental to their subjective state of mind – *“It would be very bad... to be fit, to get around, to do things on their own and to be suddenly immobile... trapped”* (Margo, personal communication, July 15, 2008). Further, the QOL of a functionally disabled older person may be compounded by other's attempts to communicate with them –

when you meet somebody like that, you have to let them take their time, rather than put them under the stress of having to answer whatever it is that you're asking them. You have to have the patience to understand that disability without giving them another disability (Andy, personal communication, July 16, 2008).

The managers suggested that in fact, older people can be left out of the decision-making process altogether – *“People who have difficulties in communicating are sometimes overlooked, people make choices for them instead of finding out what they want”* (Fay, personal communication, August 28, 2008) – thereby restricting the individual's autonomy of choice. Being unable to communicate can prevent an older person from enforcing their rights, it limits their ability to seek further assistance and it hinders their capacity to interact in society (Anne, personal communication, August 25, 2008).

It would appear that communication may only indicate a person's QOL if their intrinsic values and attitude (personality) are taken into consideration. In addition, communication was strongly linked to other indicators of QOL. For example, the death of a spouse affected one's socialisation skills and negatively impacted on QOL (signifying bereavement). Poor physical wellbeing in the form of a stroke was also related to a diminished ability to communicate. Autonomy of choice was also an indicator considered adversely affected by an inability to communicate.

4.14 Social: Isolation, Depression and Choice

It can have a huge impact on their health and QOL... They disengage from society – stop caring about looking after themselves. They can become depressed and their general health suffers

– Fay, Manager from CVI Administrative Offices

Members of the client, staff and managerial sample groups suggested that poor health and isolation were two of the major objective factors that impacted on older people's QOL. Social interaction was correlated with a decrease in feelings of loneliness and isolation, as well as many intrinsic and physical gains. If older people "have an involvement in something, there is more motivation, their mind is stimulated, friendships are formed; which all result in a more positive attitude which brings health benefits and can also mean reduced need for medications" (personal communication, August 25, 2008). Experiences of isolation and the subjective indicator of depression caused "*a downward spiral*" where losses in physical health and mental acuity could be fatal (Andy, personal communication, July 16, 2008; Regina, personal communication, July 31, 2008). As stipulated by Richardson and Barusch (2006), the occurrence of death is strongly linked to depression (for example, developing cancer in later life after prolonged depression).

Autonomy of choice was an important subjective factor in determining whether or not social contact was valued however. Half of the client cohort stated that although they believed social contact was essential to their subjective wellbeing and QOL, they enjoyed their independence and needed to have some time away from people - "*I think you need it, you couldn't go without it - being with people. But I can go for periods where I don't have to see anybody*" (Matilda, personal communication, July 24, 2008). However, prolonged or forced isolation was considered detrimental to one's QOL - "*I wouldn't like it at all, because you have to have contact with people*" (Mary-Jones, personal communication, July 24, 2008).

The relationship between an older person's living environment and their perception of the situation appeared to be highly contextual. Key informant Danni (personal communication, September 4, 2008) argued that social contact is not related to one's place of residence. She opined that older people may have a very high standard of material living, however if they experience social isolation then they may view their QOL negatively.

Members of the staff population believed that retirement villages were rich sources of social contact "*because there are a lot of people around and you've got*

neighbours who're passing by and they knock on the door" (Margo, personal communication, July 15, 2008). However, client Jane-Davies (personal communication, July 31, 2008) reported having experienced social isolation living in a retirement village. Staff agreed that, despite the potential for social contact, residential care was not optimal for all older people's QOL.

Autonomy of choice and social contact, have been identified as important indicators of QOL. In light of this, Margo opined that retirement allows older people to have more personal freedom within their community – *"when you're getting older and coming up to retirement... you've got time... you get in touch with your neighbours and that's when you make more friends"* (Margo, personal communication, July 15, 2008). However, others did not believe older people had the freedom of choice to socialise within their community in modern times – *"Who are they able to see? Gone are the days when you used to see your next door neighbour and they used to pop in for a cup of tea. You can become quite isolated"* (Joan, personal communication, July 24, 2008). Key informant Nirva, suggested that even within their own communities older people can become disengaged from normal activities due to a lack of transport facilities (personal communication, August 27, 2008).

Older people were encouraged to seek social contact within their local communities in a newspaper article targeted at aged readers (The Senior, 2008). The article promoted 'Neighbour Day', a celebration where older people, particularly those living in isolation, could create support networks. According to the article, many older people lived in isolation because they did not wish to be viewed as a "burden" by their community members (The Senior, 2008, p.7). The article advocated for greater mixing between neighbours, so that older people would feel comfortable in asking for assistance if they were in immediate trouble (The Senior, 2008).

The conclusions raised from this data are extremely similar to those presented in section 2.12 above. There was a strong objective-subjective link in respect to the value placed on social constructs that may be used to measure QOL. Despite isolation (loneliness) and depression being conveyed as universally detrimental to the QOL of older people, there was no agreed upon solution in regards to reversing these negative affective states. Although it was agreed that action must be taken when individuals experience isolation or depression, care or interventions would need to be highly individualised; what might benefit one person, could prove to be ineffective for another.

4.15 Social: Access to Transport and Age-Friendly Cities

Some people think shopping is frivolous but it's not, food and beverage shopping is essential for them to be able to get through the week

- Nirva, Key Informant from a Peak Body WA Aged Service Delivery Organisation

Transport was another objective indicator strongly linked to other objective indicators of QOL. A recurrent theme in the primary data collected, was the correlation between one's access to transport and their level of social isolation. CVI manager Fay, opined that once older people are unable drive, their QOL suffers on many levels as they have "*difficulty accessing shopping and services*" and it "*can also lead to social isolation because they are no longer able to take themselves out and about*" (personal communication, August 28, 2008).

Social capital was defined by Bowling (2005) as the worth of social resources. Social capital is measured by assessing existing social structure (the types of relationships people forge) as well as an interrelationship between resources and people (being able to access certain sectors of society). An individual's actual and perceived levels of wellbeing were thought to be heavily influenced by social capital; therefore the concept was believed to be comprised of both objective and subjective QOL indicators. One of the objective indicators was access to community services (leisure, education, sport centres, green areas, and public transport). One of the subjective indicators was people's beliefs relating to access and inclusion (Bowling, 2005).

In the primary data, the situation of older people was thought to be compounded by the perceived inadequate access they had to transport services (Anne, personal communication, August 25, 2008). In WHO's (2007) global study regarding age-friendly cities, transport was an issue fervently discussed in their qualitative analysis. WHO (2007) suggested that access to transport services was a significant component of active-ageing. Danni (personal communication, September 4, 2008) opined that although bus travel enhanced one's independence, public transport could become problematic when the return home trip was too difficult for older people to complete because of increased tiredness or the burden of carrying shopping. It could be inferred that older people may benefit from age-friendly vehicle design, such as "raised platforms and low floors" or priority seating and wheelchair accessibility (WHO, p. 22).

A major component of age-friendly cities was "community transport services" – described as free buses that transport older people to "specific events and places" (WHO, 2007, p. 29). Key informant Nirva (personal communication, August 27, 2008)

discussed a similar senior's bus service, initiated by a local government in WA and designed to promote older people's inclusion in society. This service was designed to allow older people access to essential services and community-based activities. Older people would be taken to their destination and then later returned to their place of residence – thereby keeping older people without conventional access to transport “*engaged within their community*” (Nirva, personal communication, August 27, 2008).

Transport services were viewed by service providers as being directly related to social contact in old age. Two major components of social capital were the actual availability of transport services and one's beliefs about access to their community. As stipulated by Danni (personal communication, September 4, 2008), people may not elect to use bus services because of the potential problems that may arise however, if public transport or senior bus services were seen to be more accessible then older people would potentially become more involved in society. This therefore indicated an objective-subjective relationship between facets of the QOL indicator Transport.

4.16 Anxiety: Bereavement and Feelings of Loss

Well, I lost my wife 2 yrs ago. It upsets me; it upsets me, I get very depressed about it. I don't feel I am fitting in, I am not very happy with life as it is

– Ben, Client from the CVI Day Centre

In the literature, it was suggested that older people are at risk of experiencing negative affective states and can even die as a result of being ‘bereaved’ (Richardson and Barusch, 2006). Bereavement (a subjective indicator of QOL), specifically due to the death of a partner, was a strong indicator of depression in older persons. According to Richardson and Barusch (2006, p. 265), “bereavement creates major changes in people's roles, identities, social supports, finances and living facilities, and when health or financial stressors arise, bereavement becomes a chronic rather than an acute stressor”. Many members of the staff population posited that aged clients who had lost a spouse, developed poor socialisation skills and lost motivation. This indicated there was a strong objective-subjective link in respect to feelings of anxiety.

Several of the clients suggested that having a partner, or other family and friends was an important indicator of their QOL. Matilda stipulated – “*I'm lucky that I still have my husband. For company you know... 24-7 company*” (personal communication, July 24, 2008). Ben expressed a negative impact due to the loss of his wife – “*I mean you've only got one way to go. There's no pleasure in it when you're on your own*” (personal communication, July 10, 2008). Drew also experienced the loss of friends

through death and through “*losing touch*” – also describing such feelings of bereavement as negative (personal communication, July 31, 2008).

Key informants suggested that the subjective notions of a sense of worth, being valued and feeling respected were as essential to older people’s QOL as having their objective needs met. It was collectively argued throughout the primary data, that older people were undervalued in society. Staff member Dorothy suggested that older people experienced a sense of loss, in terms of their economic value to society –

You become a lesser person. You’re no longer needed for your work... you start to become a burden on your family... or they’ll sort of take this high horse attitude, they’ll say – ‘we’re more important because we’re still working; we’re still in the community’ (personal communication, July 16, 2008).

This was supported by Richardson and Barusch (2006) who suggested older people are concerned with their loss of employment and subsequent value to society. Key informant Eddie, also believed that older people measured their worth in society by their financial standard of living – older people believed that their past contributions to the community should be recognised and rewarded (personal communication, August 28, 2008).

Joan described loss in respect to one’s individual worth – “*It’s just you feel you are able to do things and you can’t do them... and its accepting that you’re no longer able to things, you’re no longer young enough for them*” (personal communication, July 24, 2008). Key informant Danni, suggested that such a perspective was a point of view widely believed throughout society – “*All of a sudden as you get older, you’re seen as someone who can no longer think and can no longer do things*” (personal communication, September 4, 2008). She also suggested that older people experienced a loss of worth as a result of entering into aged care services. The losses felt by older individuals, as described by Richardson and Barusch (2006) were concerned with a loss of one’s youth, their relatives, physical health and independence. In addition, older people may not be able to adapt to these losses if they were “sudden and unexpected, close in time” or resulted in “major disruptions in interpersonal or financial resources” (Richardson and Barusch, 2006, p. 97-98).

Experiences of the subjective indicator of loss generally indicated that an older person’s QOL was low. Losing loved ones may result in feelings of bereavement which can lead to depression and an overall diminished QOL. It would also appear that older people need to feel a sense of worth in order to experience a higher level of QOL. However, in reality they are often undervalued in society. As such, community

initiatives need to be put in place that promote feelings of personal worth in older people and aid them to develop coping strategies.

4.17 Reminiscence: Growing Older and Life Review

I find I look back quite a bit on the past. Which, I think most people do. Of course it always seems a bit clearer when you remember things

– Matilda, Client from the CVI Day Centre

A number of clients engaged in reminiscence, reflecting on their prior experiences and comparing their past to their current lives. Much of this reminiscence was centred on loss – a loss of functionality, worth, motivation and time. A client described how she no longer felt her life had purpose or was able to carry out tasks of subjective and objective importance to her –

I was a sort of engineer, a technician (doors, craftsmanship). I quite liked it and now, I have nothing to show for things. My house is not particularly clean; I have not knitted or crocheted something wonderful. I've not been domesticated, I don't like cooking. (Jasmine-Rose, personal communication, July 10, 2008)

Ben also suggested that he felt a sense of functional loss - *"The same as making something ... I've fixed everything and anything, but now I can't even do that"* (personal communication, July 10, 2008).

CVI Client Drew stipulated that she no longer experienced intrinsic motivation – *"Oh, I'm not able to do like I was. I'm old, I'm getting old... and I'm not able to do it... I think that life's passing me by. I wish I had more energy and get-up-and-go"* (personal communication, July 31, 2008). Members of the client and key informant population suggested that older people experienced a loss of mental acuity and a subsequent loss of time with negative repercussions to their overall QOL. Jasmine-Rose expressed a fear that she was losing control of her life and that time was slipping away – *"I don't like feeling helpless, I'd like to do more, – you can't think of the words sometimes, that's awful... but somehow, I'm not quick enough; I just don't seem to have the time I used to have"* (personal communication, July 10, 2008).

Although Jasmine-Rose found it difficult to talk about her past - through reminiscence, she realised that she had acquired something positive in her old age. Despite having been an independent youth, she was now more of a social being and recognised that she brought much joy to her peers – *"This friend of mine. She says you give me so much pleasure. So maybe I am giving things to people, which is nice"* (Jasmine-Rose, personal communication, July 10, 2008). Also from a more positive

position, Mary-Jones suggested that older people in her age demographic had experienced a great deal more useful life events and had been exposed to a higher level of education than the younger generations of today – “*We’ve certainly lived a lot - the war, those sorts of different things. I spent time in the army... We certainly learnt a lot more than kids these days in school* (personal communication, July 24, 2008)”.

As evidenced in the primary data, reminiscence can serve several functional purposes for older people suffering from feelings of loss. Individuals can retrospectively assess prior actions, recognise past failings and then draw from these experiences (Tilki, 2000). Tilki (2000) suggested that by focusing on their past strengths older people can better rationalise their current status and retain an identity of self-respect, a theme already identified above as being essential to QOL in old age. As they are generally excluded from civic, social and work force participation, reminiscence can enhance older people’s subjective QOL by helping to portray them as functional individuals within the community and this can improve their self value (Tilki, 2000).

4.18 Summary: Findings and Discussion

Based on the primary and secondary data, the overall concept of QOL was divided into two major categories; objective and subjective indicators of QOL. Despite each indicator primarily belonging to an objective or subjective category, each QOL indicator was further broken down into several objective and subjective sub-themes. As evidenced throughout the primary data, there was significant overlap between the objective and subjective indicators of QOL. For instance, the objective indicator of physical wellbeing was influenced by how an older person perceived their health, based on their attitude, their contextual understanding of the situation and their ability to adapt (all identified as subjective indicators of QOL). It was also found that there were many interrelationships between QOL indicators of the same broad objective or subjective QOL categories. For example, being able to see or hear (sensory) was related to other objective indicators, such as being able to engage or communicate with others (social).

The heterogeneity of older people was discussed by respondents throughout the interviews. The contextual situation of older people and their individual personalities were constantly reiterated as important factors in determining what interventions might be suitable for older people. Similarly, the subjective concept identified as autonomy of choice was widely regarded as an essential component of many QOL indicators. As such, a recurrent theme throughout the primary and secondary data was the importance

of individuating care and making it possible for older people to maintain control over decision-making for as long as possible. This was evident in discussion pertaining to in-home based care, age-friendly cities and service delivery.

Older people were portrayed as having a low value in society and this concept of 'worth' was intrinsically linked to experiences of loss amongst older people. The concept of reminiscence was discussed as a possible solution to this societal issue. By encouraging older people to learn from their past experiences, they can reduce feelings of loss and develop a greater self-worth, therefore enhancing their subjective perception of QOL. The implications the findings presented in this chapter will have for the development of a new or alternative QOL Framework, will be discussed in the following chapter.

Chapter Five

5.0 Overview: QOL in Australia – An Ageing Society and Future Research

The previous chapter outlined the various objective and subjective QOL indicators identified in the primary data, which were supported by sources from the literature review. Chapter four also argued that objective and subjective QOL indicators are sometimes interrelated. This chapter is a continuation of the findings and discussions pertaining to QOL paradigms in previous chapters. The advantages of being an older person in Australia and old age in general, are outlined below. This is followed by further analysis of primary and secondary data concerning an ageing society and the implications it has for Australian policies and practices. The CVI QOL indicator will also be analysed and discussed to establish whether the current *Referral and Assessment Form* should be amended to include new or alternative QOL indicators based on primary and secondary analysis. Avenues for future research will form the final section of this chapter.

5.1 Perception of Old Age: Advantages to QOL in an Australian Context

Most statistics in Australia show that seniors in Australia are relatively happy and optimistic...I mean, we've all got our concerns but most older people, report a reasonable level of satisfaction with their everyday life

– Eddie, Key Informant from Peak WA Body Aged Service Delivery Organisation

Initially, a great many respondents stipulated that there were no advantages to old age and perceived growing older negatively. Matilda suggested that QOL in later life was defined by “*general debility*” (personal communication, July 24, 2008). Other clients suggested that old age was marred by a loss in one’s overall capacity to complete tasks and in addition to this, a lack of environmental stimuli to keep one intrinsically motivated. Similarly, Roche (1990, p. 20) found that in her study, the level of “motivation” expressed by some clients to participate in activities was also an issue. However, after some prompting, benefits in old age were identified by all members of the sample groups.

There were several geographical advantages to being an older person in Australia. The first was identified by clients and key informants - the Australian climate. It was believed that cold weather was not favoured amongst older people and it was a benefit to their QOL that winter was short in duration. Furthermore, the fact that natural disasters rarely occur, that the Australian populous has adequate access to food

resources and that the country is not positioned in a war-zone were also seen as beneficial to older people's QOL. It can be inferred from this primary data that simply being 'Australian' means that there are fundamental advantages for the QOL of older people.

Staff and key informants listed a number of other advantages for older people living in Australia. Many of these advantages were related to the objective QOL indicators identified in Chapter Four. The first revolved around financial security – mainly the fact that older people did not need to work. It was believed that older people could retire in the knowledge that they would be provided with welfare from the government or have access to superannuation funds due to a strong economy. However, this financial security could be jeopardised by the inadequacy of the current aged pension rate and the recent Global Market Crash. Various secondary sources have suggested the crash will have adverse implications for older people's private financial funds in Australia (these arguments are presented in greater detail in section 5.3 below).

Overall, many respondents argued that Australia had an adequate health system and that services were accessible to older people whether at home or in residential care. Another benefit was the freedom that retirement offered older people to travel the nation. Freedom was the only subjective QOL advantage, as it was closely related to the concept of autonomy of choice. However it was suggested that freedom was largely dependent on the age of the older person, their ability to drive and whether they had access to financial or health resources. It was also argued that although an advantage to living in Australia was the longevity of its population, growing older was still detrimental to an individual's QOL and thus some advantages may be lost.

Staff member Joan (personal communication, July 24, 2008), suggested that modern innovations such as Day Centres and other forms of aged services are of benefit to current older Australians' QOL. It was her belief that such provisions negated isolation by promoting social engagement - a Seniors Card might allow an older person to have access to inexpensive public transport and therefore promote activity that includes them in society. Key informant Danni, hypothesised that *"if you've got a great family network and support in place"* an older person could *"have a great, fulfilling life"* (personal communication, September 4, 2008). It was her opinion that social isolation, in addition to not having access support, caused disadvantage amongst older people in Australia.

Most of the advantages identified in the primary data directly related to living in Australia, were objective indicators of QOL. A number of benefits were viewed as

being a result of the geographical position of the country, thus implying that being an older person in Australia was an advantage all to its own. A number of respondents identified various societal constructs as being advantages to older people – such as a strong economy and good health services. Also, modes of aged-service delivery were thought to promote social participation and therefore beneficial to the QOL of older people. The freedom to travel was related to the subjective indicator autonomy of choice. It was posited that one's freedom could be diminished as a result of increasing old age and physical or financial limitations. It would be prudent for legislators and service providers in Australia to continue providing financial, health and communal security (aged services) for older people, as each societal construct was evidenced in the primary data to be indicators of a positive QOL.

5.2 Perception of Old Age: General Advantages to QOL

People seem to be more kind

– Jasmine-Rose, Client from CVI Day Centre

Although not necessarily Australia-specific, several intrinsic advantages to old age were nominated by client and staff populations – the first being resilience. One staff member likened old age to going backwards – *“When you’re getting older you revert back to being a child... children are ignored... so you’re ignored again”* (Andy, personal communication, July 16, 2008). Similarly, key informant Nirva stipulated that members of her age cohort (baby-boomer) were burdened with looking after their ageing parents as they would children (personal communication, August 27, 2008). Despite the claims of Andy and Nirva, a member of the client sample believed individuals can become more independent as they grow older. Jasmine-Rose purported that in old age you actually gain *“self-confidence”* and *“can give-as-good-as-you-get when necessary”* (personal communication, July 10, 2008). Through the subjective technique of reminiscence, Jasmine-Rose made a distinction between her experiences in youth and life now, *“when you’re young, you have to be polite... I sort of stood back, but now I don’t”* (July 10, 2008).

Staff and key informants posited that older people often experienced loss in regards to their social value. However, client Jasmine-Rose felt that her status in society had changed primarily for the better - *“I feel like I get a lot more respect except perhaps from the youngsters, like the bus drivers or the school kids”* (personal communication, July 10, 2008). Jasmine-Rose suggested that occurrences of disrespect were rare and that she was resilient to adverse encounters, thus negating potential

threats to her societal value – *“Older people get more respect and if you don’t, you just say ‘ah, stupid teenagers’”* (personal communication, July 10, 2008).

Along this line of thought was the second subjective indicator, adaptability. It was opined by Andy, that *“people can’t or won’t cope with what it is to be old; it’s too much hard work”* (personal communication, July 16, 2008). Despite this, Jane-Davies suggested that adaptability was a positive dimension in old age and in maintaining one’s QOL – *“I think as long as you accept the situation, you can cope with anything... you just learn to accept that you’re old... and do the best that you can”* (personal communication, July 31, 2008).

Adaptability was another key component of old age for CVI client Drew. She viewed old age negatively and rather than accept old age, she instead resigned herself to growing older – *“you do with what you’ve got... make the best of it”* (personal communication, July 31, 2008). For her, growing old was not necessarily the issue, it was old age that was problematic – *“you learn to cope. You’re another year older, it’s nothing... old age is no good”* (Drew, personal communication, July 31, 2008). Holding a similarly negative perception about old age, Matilda suggested that unconsciously, people adapted to old age by *“preparing”* themselves for death (personal communication, 31 July, 2008).

Another subjective advantage to old age was described by staff members – *“people have got more patience as you get older...you understand a lot more – you’re very tolerant”* (Margo, personal communication, July 15, 2008). This could be grouped under the intrinsic dimension of *“wisdom”* (Regina, personal communication, July 31, 2008). It was Regina’s opinion that one of the advantages of older people was the gaining of wisdom and that they should be encouraged to share their experiences with the greater public; however such opportunities were not *“widely promoted”* in Australia (personal communication, July 31, 2008).

Key informant Danni (personal communication, September 4, 2008) stated that although there were programs in Perth that encouraged intergenerational mixing, there was a need for more of these services in centre-based and residential care facilities, as they have been shown to be beneficial to communities. Tilki (2000), argued that public knowledge about old age and even historical events can be raised by listening to older people and that through reminiscence, community-capacity can be enhanced. Reminiscence also allows older people to pass on wisdom to others (peers and carers alike) and therefore experience a sense of worth (Tilki, 2000). Sense of worth and

societal value have already been identified as important subjective indicators of QOL for older people in the previous chapter.

As conveyed in the primary data, reminiscence would allow for a cross-generational divide to be filled by permitting the experiences of older people to permeate younger society. The sharing of this valuable knowledge, common in many traditional cultures, has been lost in industrial nations and it is an important issue for consideration in Australia. Tilki (2000) stated that reminiscence allows older people to divulge memories and express their needs to service delivery agencies who can then provide better services and maximise the QOL of aged clients (the practical applications for reminiscence are discussed further in section 5.4 below).

Participants conveyed that one of the advantages to being an older person was the subjective QOL indicator, resilience. Despite the perceived loss of value attached to old age, it was found that older people can develop the means to counteract adverse encounters and gain respect from members of their community. Discussed above as an advantage to old age, adaptability appears to be a recurring theme from the primary data and was already identified in the previous chapter as a subjective indicator of QOL. Adaptability was broken down into acceptance and resignation. Acceptance was more of a natural process, where a person adapted to a situation willingly. Resignation was where an individual grudgingly adapted to a situation because of its inevitability. Wisdom was another new subjective QOL indicator identified in the primary and secondary data. It was widely believed that by reminiscing and passing on one's life experiences, older people could enhance understanding amongst the community and shape the QOC they received.

5.3 Ageing Society: Government Aged Care and NGO Service Delivery

I think the government is going to be running dry of funds; that's going to have an effect on the Quality of Care. Unless something's rapidly done about it

– Regina, Staff Member from CVI Day Centre

The future QOL of older people was considered to be influenced by the policies and actions of future governments and the human service industry. Government interventions and service delivery are both objective indicators of QOL. Some clients felt that the government was a positive influence on older people's QOL particularly in an ageing society – *"they're pretty well up with this sort of thing, the government... they're very conscious of it, anyhow"* (Jane-Davies, personal communication, July 31, 2008). Staff member Regina believed that the Australian government would need to increase funding to meet the demands of an ageing society and maintain the QOL of older people – *"I don't think it (an ageing society) will make much difference to them (older people's QOL) - if the government puts more money and resources in place, which I'm sure they'll have to do in the future"* (Regina, personal communication, July 31, 2008).

Conversely, Richardson and Barusch (2006) placed less confidence in political systems. The authors suggested that individuals who receive welfare benefits are always at risk of losing their financial security depending on governmental policies. In light of this, many clients believed that the government and related aged care service providers would not be able to maintain the future QOL of older people –

I don't think there will be too much increase in the facilities you get, because it works out you have to go longer and to more people doesn't it?... there's a lot of people now, who don't go out who are able to go out... Probably won't be any more money coming around from the government and so it's got to spread over longer - more people (Mary-Jones, personal communication, July 24, 2008).

Potential problems of an ageing society were largely objective. This is evidenced by the above quote. Other themes that emerged in the data analysis included a loss of service delivery, declines in social networks and diminished financial security; all objective indicators of QOL.

Although it was argued that theoretically, more money would need to be *"paid out by the government"* to meet the increasing demands of an ageing society, (Margo, personal communication, July 15, 2008) there was a sense that the next generation of older people would need to become increasingly self-sufficient – *"Well, I mean I'd be a baby-boomer. We are going to have to be mostly self funded for our retirement unless*

the government do something to get a bit more orderly" (Joan, personal communication, July 24, 2008).

This supposition was supported by Gnich and Gilhooly (2000). The authors argued that individuals are living longer and being made responsible for their own financial security in old age. It was widely posited throughout the interviews, that people would retire later and need to be reliant "*on the wealth accumulated during their working life*" (Joan, personal communication, July 24, 2008). It was feared that the government pension might no longer be available to older people and superannuation may be the only form of financial security. It would seem however, that later retirement is already a reality for older people.

A case was reported in the *West Australian Saturday Newspaper*, concerning the inadequacy of the current single-aged pension (WA1, 2008). A spokesperson for *Amana Living*, one of WA's largest aged care bodies, argued that WA pensioners are in a worse position than in other States due to WA's economic fervour, the subsequent rising cost of living and housing costs (WA1, 2008). As such, an older person was reportedly forced back into work at 70 years of age as a direct result of the Rudd government's initial decision to delay increasing the aged pension.

The concept of forced self-sufficiency was thought to be compounded by the recent trend of workers obtaining higher levels of education and aiming to leave the workforce at a younger age (Gnich & Gilhooly, 2000). The authors argued that this meant "financial resources have to be acquired in a shorter time and last a longer time" (Gnich & Gilhooly, 2000, p. 20). In light of this trend, one of the key informants suggested that later retirement and an increased reliance on one's own money will be a necessity in the future.

Key informant Eddie, stated that research has predicted people will be living longer and therefore retiring at 60 may mean people might not have acquired the necessary funds to support themselves into old age (personal communication, August 28, 2008). Similarly, Gnich and Gilhooly (2000) suggested that early retirement and a subsequent lack in funds would pose further problems for older people who have travel costs and need to uphold a private residence. Eddie argued that increasing the age for retirement was justified because "*the costs of the ageing population*" could then be met through the private funding of individuals (personal communication, August 28, 2008).

It was widely evident from the primary data that social engagement through services such as Day Centres and mixing with different people within the community, would remain essential for maintaining the future QOL of older people –

Interact with people... don't stay at home; it doesn't do you any good. Get out and about, it doesn't matter if you go to the local shopping centre, get on the bus, have a coffee, get in a cab, go where there's people round you. Try and get into a community centre. Where there's carpet bowls, craft work or anything going on. Because it's good for you, its good for the soul, it's good for your health, you'll live a longer happy life if you do (Margo, July 15, 2008).

It would appear however, that the aged service delivery sector may be adversely affected by poor recruitment rates, universally high costs and a greater demand for service. In turn, this may limit the number of services available to older people and impinge on the QOC aged clients receive; therefore diminishing their objective QOL.

One of the major issues raised about humans service delivery in the future, was concerning recruitment rates. It was stated that a “*lack of future generations entering this industry will affect QOL*”, it was further conveyed that “*the work is not valued or recognized*” and that “*the younger generations lean towards greater earning potential industries*” (Anne, personal communication, August 25, 2008). Similarly, Tilki (2000) opined that the free market economy under values the aged care sector and this in turn adversely affects the wellbeing of older people.

In order to keep up with the growing number of aged clients and maintain their QOL, it was opined that – “*they're going to have to have an awful lot more volunteers and community centres*” (Margo, personal communication, July 15, 2008). CVI Manager Anne posited that a lack in trained human service workers would mean that the QOL of older people would decline without additional family support (personal communication, August 28, 2008). However, Staff member Andy believed that the financial stresses of the future would lead to younger generations focusing on maintaining their own QOL and thus be unable to provide care or support to older people (personal communication, July 16, 2008).

Andy (personal communication, July 16, 2008) further suggested that relatively independent and healthy older people would need to look after the needs of frailer older people. This can be evidenced by the case of the 70 year old woman from the article described earlier, who worked as a carer at a retirement village looking “*after people the same age*” (Gibson, 2008, p. 18). As such, inter-dependence already appears to be a reality for current older people living in WA. However, one possible problem with this

solution was identified by key informant Danni (personal communication, September 4, 2008). She suggested that despite meaning well, aged volunteers might actually reduce other older people's independence by taking responsibility away from clients who could be encouraged to function for themselves.

Anne also suggested that a lack of workers would lead to the structure of aged services changing – *“the time support workers spend with clients will decrease with just the most essential tasks being provided”* (Anne, personal communication, August 25, 2008). It was also suggested that *“services in the future will be reduced, not only by lack of appropriate workers but also due to inadequate funding”* (Anne, personal communication, August 25, 2008). Similarly, staff member Dorothy (personal communication, July 16, 2008) feared that a withdrawal of funds in the human service sector and a lack of workers would severely limit the services available to older people in the future and change the dynamic of existing health services.

Other losses related to an ageing society encompassed issues within the health system, particularly the current lack of resources in the public sector and the private sector's inaccessibility due to high costs - although older people may become more physically fit, there would still be a great demand for medical services due to the magnitude of people (Nirva, personal communication, August 27). The rising cost of fuel, heating and cooling bills due to climate change and a lack of residential options (places to live) were also problem areas identified by participants. Gnich and Gilhooly (2000), stated that in the future, older people will need to secure a steady flow of money, secure savings and prepare for rising costs in health and residential care (Gnich & Gilhooly, 2000).

The cost of living was also considered to be an on-going issue. CVI manager Anne suggested that people who are dependent on a pension may not have *“the financial means access to not only pay for services but to also access leisure activities”* (personal communication, August 25, 2008). It was also predicted that future generations operating within a user-pays system would probably be paying more for services and therefore have *“higher expectations”* despite there probably being issues with the quality of services (Danni, personal communication, September 4, 2008).

A study conducted by Fujitsu Consulting, comprising of 6000 participants, found that 75% of Australia's baby-boomer generation may be unable to afford health care upon retirement. Fujitsu's Managing Director of Consulting, Martin North, stated *“one of the critical findings was that baby-boomers' were ill prepared for the financial*

demands of later life". Additionally, respondents in North's study viewed health insurance "as too expensive an option" (Ryan, 2008, p.1).

Returning to the issue of financial security, it would appear that North's respondents were also worried about the amount of superannuation they would have access to, even before the recent share market crash (Ryan, 2008). According to North, at the time of the study, in Australia there were approximately "5.6 million people between 45 and 65 years of age and less than a million of those have a secure future in terms of their superannuation and their health funding" (Ryan, 2008, p. 1). According to North, superannuation figures of \$200-400 000 would not be an adequate amount to support individuals in retirement and "many will be looking towards family or the government to cover health care costs" (Ryan, 2008, p. 2). As such, North called for a collaborative approach between service providers and legislators, to answer these concerns.

It would seem that the potential financial security of future older people has been jeopardised by global economic influences on Australian Superannuation funds (Ninemsn, 2008). In a recent news article, Australian Federal Senator, Sherry, stated that superannuation funding would be adversely affected due to the recent American share market crash. According to the source, it was unknown at the time how many Australians would be forced to supplement their superannuation funds with the aged pension upon their retirement (Ninemsn, 2008). Arguably, this could further compound the financial situations of the 'baby-boomers' described in North's study and despite the predictions made by participants in this Honours study, Australians may continue to rely heavily on the pension.

The world-wide phenomenon of an ageing population has far reaching implications for Australian service delivery and for society in general. As evidenced in the primary data, some respondents believed the ageing society will improve the QOL of older by forcing governments to increase funding to human services. Others were adamant that all sectors of society will be adversely affected by a decline in social expenditure and a combination of growing demand and a lack of human service workers. The financial indicator of QOL permeated this discussion and was predicted to cause many future hardships for older people in the community, aged clients and service providers in the Australian aged care industry.

5.4 Ageing Society: Future Planning and Models for Service Delivery

It's a shame we have to grow old...Unfortunately, society and governments – I would say – once you've passed the age of being useful to the big corporations, I mean... banks – the people who control the world – the oil companies and that... Once you have become too old, then they're not so worried about looking after you. I'd like to think though, as a human – a sign of our intelligence or our compassion – or a society, that we do look after our aged

– Dorothy, Staff Member from the CVI Day Centre

There was a collective sense amongst many respondents that the overall QOL of older people will decline in the future. “Centenarians, people who live to 100 years more are the worlds fastest growing demographic and by 2050, demographers predict more than three million baby-boomers world wide will have reached 100” (Taylor, 2008, p. 11). John McCormack, a Senior Lecturer in Health Sciences at *La Trobe University* interviewed more than 100 older people aged 100 or more for his Australian Centenarian study. He stated, “the big issue with the ageing population, isn't so much can we stay alive till 100, but what will our QOL be like when we get there?” (Taylor, 2008, p. 12).

As previously stipulated, this was a significant issue for respondents. One CVI manager stated that -

With medical advances it will mean the ageing society will live longer; this will create more people with need but with much more inadequate services than are around today, due to lack of workers and funding (Anne, personal communication, August 25, 2008).

Staff member Dorothy commented that she knew “*older people now who have got a better QOL*” than she could expect when she reached their age (personal communication, July 16, 2008). Again, although the managers posited that future aged services might be negatively impacted on by lack of funding and staff, it was believed that an increase in wages in the human services industry might encourage higher recruitment rates in the aged care delivery sector in Australia (Anne, personal communication, August 25, 2008; Fay, personal communication, August 28, 2008).

As previously stated, it was widely believed that older people would need to become financially self-funded through private means. It was suggested that current younger generations would need to plan for their futures now – saving one's money would improve people's objective QOL, by helping individuals pay for medications and afford adequate housing or residential services (Margo, personal communication, 15 July, 2008). This was supported by Gnich and Gilhooly (2000), who purported that

one's QOL is highly influenced by the objective indicator, finances. Having greater monetary resources can mean people will live longer, live a healthier lifestyle and be able to enter available health services. Dorothy believed political, industry and academic planning, would be key to maintaining the QOL of older people in the future – *“I don't think there'll be so much around when we're older; I don't know, unless there's a lot more people like you here, that are prepared to look into the future and plan things”* (personal communication, July 16, 2008).

Key informant Nirva believed that the role of policy-makers will increasingly be one of *“facilitation”* (personal communication, August 27, 2008). She argued that aged policy will need to be shaped by *“keeping in touch with the statistics and what's happening with demographics and the population changes”* (Nirva personal communication, August 27, 2008). The 2006-07 Federal Budget stated that aged care funding would be based on Australia's ageing demographics; it was predicted that Australia's Ageing Society would lead to *“rising demand”* in aged care services. (Australian Government Department of Health and Aging, 2006, p. 6)

It would appear policy-makers will need to work collaboratively with older people within society, *“seniors groups”*, industry and *“government workers”* – keeping abreast of *“trends and issues... and looking forward ... being proactive and looking into how a community might respond”* (Nirva, personal communication, August 27, 2008). It was recommended that new service delivery and care models would need to be produced in light of the increasing service demands of an ageing population; in addition, future models of care would need to offer services that were individualised to client's personal needs with new methods of evaluation introduced (Anne, personal communication, August 25, 2008; Fay, personal communication, August 28, 2008).

Members of the staff and key informant population advocated for the introduction of the *“Wellness Approach”* – a model that appeared to meet the above criteria (Anne, personal communication, August 25, 2008; Danni, personal communication, September 4, 2008).

The Wellness Approach is a philosophical change in the way that you think about and work with people who have an on-going functional disability – whether they're aged or whether they're younger. It's not looking at what they can't do; it's about looking at what they can do... It's about not going in and doing for; but its working with somebody (Danni, personal communication, September 4, 2008).

The model would affect in-home care services and the role of carer or support workers. Key informant Danni argued that traditionally, support workers tended to provide a holistic service where all activities related to an area of difficulty were undertaken by the worker. This expanded the older person's level of dependence to other domestic and care domains thereby limiting their QOL (Danni, personal communication, September 4, 2008).

As part of the Wellness Approach, rather than support workers taking control away from older people, the client would retain independence by being encouraged to carry out portions of a task that they can still manage. This would involve an ongoing assessment of what activities older people are still able to do, setting goals for older people to achieve and providing support only for areas of difficulty (Danni, personal communication, September 4, 2008). The philosophy of the Wellness Approach may also have implications for the evaluation of services and especially for assessing the QOL of aged clients. Key informant Danni stipulated that service providers should attempt to produce client questionnaires that explore the affect services have on older people's QOL, as part of their quality assessment process (personal communication, September 4, 2008).

In the literature, the subjective concept of reminiscence was also viewed as a positive direction for future practice and appeared highly compatible with the Wellness Approach. By allowing older people to reminisce, a full account of their physical and social histories can be obtained during the assessment phase. This would allow humans service workers to have a full account of aged clients' personal needs.

Reminiscence allows for the individuation of the older person and for their personal experiences to become apparent (Tilki, 2000). Similar to the Wellness Approach, by listening to the voices of older clients, aged care facilities will better deliver services relevant to the subjective needs of people (Tilki, 2000). As such, the heterogeneity of older people must be recognised and their capacity to participate in their own care acknowledged (Tilki, 2000). Again, this related to the goal oriented approach of the Wellness movement. Reminiscence may also help staff foster independence in clients by reminding aged clients of "coping strategies from an earlier time" that they could utilise to adapt to shifting physical or environmental conditions (Tilki, 2000, p. 114).

There are several additional benefits of reminiscence to older people and service providers. Carers who display an interest in what clients are discussing may maximise the feelings of worth in an older person (Tilki, 2000). Staff members who are exposed

to reminiscence will also be in a better position to understand the situation of older people and may gain insight into how they could apply the experiences of older people in their own lives (Tilki, 2000). It would appear that “listening to and hearing people” has the potential to heighten QOL more than caring for physical conditions in older people (Tilki, 2000, p. 118).

Although most respondents predicted that future QOL would diminish as a result of a rapidly ageing society, they were also able to provide some solutions to issues identified in prior sections. For example, by making the aged sector appear more lucrative to younger people, a new generation of workers might be encouraged to enter the industry and thus ensure that QOC would not diminish for older people. It was also posited that the rising cost of living in Australia could be minimised if individuals began financial planning in their youth, rather than relying on an aged pension that might be insufficient for future needs. It was evident from the primary and secondary data, that legislators could maintain the reach of aged services and models of care through collaborative action with older people. The individuation of care and promoting an equal relationship between aged clients and service providers were two goals related to the Wellness Approach and the subjective technique of reminiscence.

5.5 New or Alternative QOL Indicators and Framework

One of the main objectives of this Honours thesis was to determine if the QOL indicator used by CVI, the *Referral and Assessment Form*, needed to be amended (aged Team Leader, 2007). It was theorised that the indicator could be modified to include any new or alternative QOL indicators that might be identified in the literature review and analysed from the primary data collection. After an analysis of existing QOL Frameworks and indicators, in conjunction with the examination of QOL indicators discussed in the primary data, it would appear that the *Referral and Assessment form* would benefit from the addition of several objective and subjective indicators.

In the literature review the CVI model was identified as a ‘broad’ theoretical QOL Framework; containing a multi-dimensional, albeit objective focus in terms of assessing the QOL of older people. Originally, the *Referral and Assessment Form* was constructed from four main QOL themes; these were the ‘physical’, ‘sensory’, ‘intellectual’ and ‘social’ QOL indicators. It should be noted that although considered here as separate themes, ‘sensory’ and ‘intellectual’ were combined as a dual heading in the original CVI indicator. The thematic breakdown of these QOL indicators is presented in Table 5.1 below.

Table 5.1 Original CVI QOL Indicator and Thematic Categories

Physical	Sensory	and Intellectual	Social
Mobility (completing daily tasks)	Hearing impairment	Ability to communicate	Socialisation
Mobility (Personal Hygiene)	Sight impairment	Third Party financial assistance	Social engagement
Medical Issues	Assistance an older person requires to fulfil routine tasks	Mental capacity	

(Adopted from Aged Care Team Leader, 2007)²

As already stated, the above themes have been defined as being primarily objective indicators of QOL (Bowling, 2005). However Joyce *et al.* (1999) argued that QOL Frameworks that evaluated an individual's QOL from a purely objective position disregarded the subjective dimensions related to QOL. Also, unlike other multi-dimensional models (see Lawton in the literature review) *the Referral and Assessment Form* did not have a strong subjective component. Although the CVI indicator was used as a theoretical basis for this Honours study inquiry into QOL amongst older people, it became evident during the literature review and primary data collection, that objective indicators of QOL were intrinsically linked to subjective measures. As such, the various themes and sub-themes of the *Referral and Assessment Form* have been expanded to include further objective and subjective QOL indicators or moved to separate QOL categories. These new or alternative QOL indicators (listed below) could be used to refine and further develop the existing *Referral and Assessment Form*.

In both the primary and secondary data 'physical wellbeing' was identified as being a strong objective indicator of QOL. As in the original CVI model, this 'physical' indicator was broken down into the objective measures of 'mobility' and more specifically, the ability of an older person to complete 'daily tasks' and perform acts of 'personal hygiene'; as evidenced in Chapter Four, being able to carry out both activities was strongly correlated with higher experiences of QOL. However 'physical wellbeing' had a strong subjective dimension. Older people were more deeply affected by a lack of

² Table 5.1 is a visual representation of the QOL Indicator currently being used by CVI, the *Referral and Assessment Form*.

‘mobility’ when it prevented them from performing tasks of ‘intrinsic importance’ or affected their ‘autonomy of choice’. It was believed that one’s ‘attitude’ and ‘contextual situation’ also influenced the impact ‘physical wellbeing’ had on QOL.

‘Residential’ indicators of QOL were originally included as part of the ‘physical’ theme of the *Referral and Assessment Form*. However due to the indicator’s large size and level of apparent importance to QOL it was discussed in isolation from physical wellbeing. In the primary and secondary data, the objective indicator of QOL, residential, was presented as multi-faceted and further broken down into the objective indicators of ‘place of residence’, ‘in home care’ and ‘age-friendly design’; all areas identified as having a bearing on the QOL experiences of older people. However, an older person’s subjective ‘perception’ of their place of residence impacted on QOL more than physical benefits of an environment, as did one’s level of ‘autonomy of choice’.

New objective QOL indicators were developed in order to separately categorise other areas previously under the ‘physical’, ‘sensory’ and ‘intellectual’ QOL themes in the CVI QOL indicator. CVI’s thematic category ‘assistance an older person requires to fulfil routine tasks’, was broken down into the objective categories of ‘carer and support services’ and ‘technological aids and human support’. In the findings and discussion, the objective QOL indicator ‘service delivery’ was used as the main heading for issues related to ‘medical services’ and ‘carer and support services’. Furthermore, ‘technological aids and human support’ was discussed as a stand alone QOL indicator.

Each of these traditionally, objective QOL indicators were also influenced by subjective indicators of QOL. The impact ‘carer and support services’ had on an older person’s QOL was related to the level of independence they experienced. Although overall health was thought to be influenced by ‘adaptability’ and one’s intrinsic beliefs, the objective benefits of medical services outweighed subjective concerns. The subjective indicators of ‘resistance’, ‘adaptability’ and ‘loss’ were identified as factors related to an older person’s decision to utilise assistance. After primary data analysis, the themes ‘sight’ and ‘hearing’ were kept under the main objective heading, ‘Sensory’ indicators of QOL. It was evident from the primary data that ‘sensory’ indicators were of subjective importance to older people; many placed a high significance on their ability to read and conduct other activities.

The broader subject of ‘financial’ indicators of QOL was subdivided into fundamentally objective issues related to ‘government pension rates and ‘third party Assistance’ in Chapter Four. In respect to the tangible level of financial security older

people experienced, it appeared that one's subjective 'attitude' played a part in determining their perception of QOL – for example some older people suffering from economic hardship might engage in downward comparison and report their QOL as high. The presence of 'third party assistance' was correlated with a restricted level of 'autonomy of choice'.

Similarly to the above theme, based on the primary and secondary data, 'social' was considered to be a very broad topic area and was broken down into several categories. These included the objective categories of 'social contact and service delivery', 'the ability to communicate' (originally under the CVI heading of 'intellectual'), 'isolation' and 'access to transport and age-friendly cities'. However, the intrinsic 'value' placed on social contact or isolation, was a determinant of the impact it had on one's subjective QOL. Similarly, the inability to communicate could only be an indicator of a poor QOL if an older person had an outgoing 'personality'. The subjective-objective link evident in the concept of social capital was also discussed in respect to 'transport and age-friendly cities'. Also developed in the social category, were the highly subjective indicators of 'depression' and 'autonomy of choice'.

Identified in both the literature and the primary data collected were several subjective indicators of QOL. The first, 'anxiety' was further broken down into 'bereavement' and 'feelings of loss'. Again, this indicator was related to objective constructs in reality, such as the loss of a spouse. However, it was the subjective experience of 'loss' that impacted negatively on an older person's QOL. The second subjective QOL indicator was the concept of 'reminiscence'. Although primarily a personal reflection of one's life it also served functional purposes for service delivery as discussed earlier in this Chapter.

In light of the strong objective-subjective relationship that exists within the concept of QOL, the *Referral and Assessment Form* could adopt facets of Individualised QOL Frameworks (see Bowling, 2005), the Wellness Approach (see Danni, personal communication, September 4, 2008) and the concept of reminiscence (see Tilki, 2000). By incorporating a subjective element into the CVI QOL indicator, assessors would be encouraged to view older people as heterogeneous and therefore QOL needs are highly individual. This could be accomplished by including open-ended questions that allow respondents to describe QOL issues significant to them or how particular objective indicators make them feel intrinsically; rather than how they are feeling using pre-defined response scales.

By encouraging older people to reminisce, aged client's physical and social histories could be collected during the initial assessment phase. By providing a historical review of their life, the older person may feel empowered. For example, aged clients could identify ways to overcome objective hardships without the need for aged care assistance, thereby increasing the level of 'autonomy of choice' available to them. Furthermore, individualised measures would allow for flexibility in the collation of highly personalised information, focusing on what is of subjective importance to the older person. Assessors would be better positioned to recognise that the situations of aged clients are highly contextual and that older people may have the ability to direct their own level of care.

New or alternative QOL indicators added to the existing *Referral and Assessment Form* would most likely be used to enhance the subjective dimension of the CVI QOL indicator. The model would retain its original objective indicators as these four main categories were established in the primary and secondary data as being highly important to QOL in old age. However, these indicators would possibly benefit from being broken down into further objective and subjective QOL indicators that provide a holistic view of QOL. This is necessary to accommodate the level of individuality amongst older people in Australia.

5.6 Unintended Outcomes of the Thesis Research

According to Rubinstein (2002) a 'child-parent' power relationship may develop in the course of interviews conducted with a younger interviewer and an older participant. This appeared to be the case in this thesis study. Members of all participant populations elected to provide information about ageing and growing older in the form of advice – as a parent would to a child.

In brief interviews, a 'child-parent' power relationship may limit the discussion and determine the kinds of information that is gathered (Rubinstein, 2002). Presumably, the interviewee may adopt the authoritarian control a 'parent' has over a 'child' and thereby decide what direction the interview takes. Similarly, an older person may find it difficult to speak to a younger individual about significant matters that they perceive to be sensitive in nature.

Although there was a 'child parent' power relationship between the Honours candidate and respondents, it did not impact negatively on the data collection process. In fact, due to the length of interviews, familiarity was fostered between the researcher

and participants. This prompted the older respondents to divulge more information, sometimes akin to 'parental advice'.

Rubinstein (2002) discussed an interview where a proxy informant (a carer or support worker answering on behalf of their client) not only described her own interpretation of events, but how her aging mother felt and her own perception of her mother's later life. Again, this became apparent in this thesis study. Members of the staff, manager and key informant participant groups all drew from their own experiences with older family members, clients and dealings with older people in the community. It was important to the service providers that they be able to empathise with older people and particularly in conversations about QOL, hypothetically view situations from the perspective of older people.

5.7 Future QOL Research

Future studies into QOL could involve a series of unstructured interviews carried out as longitudinal research. There was a propensity for the interviews in this Honours study to take the form of narrative conversations and therefore, these were often extremely lengthy. As a result, a great amount of primary data not specifically linked to QOL was omitted from the discussion section of the Honours research thesis. The overall depth and content of the interviews suggests that further QOL research should be purely qualitative in nature in order for the subjective and highly contextual nature of QOL to be fully recognised and documented.

In terms of qualitative interviewing, Rubinstein (2002) advocated for a method of 'best practice' where multiple interviews spanned for a period of time until theoretical saturation was attained. As such, the research design could take the form of a long term study where a particular cohort of older people is continually interviewed as they progress through old age. The participants could be interviewed over a period of a few weeks, or until all QOL indicators were identified. This would allow for a snapshot of older people's QOL at different ages, perhaps conducted every five years, thereby documenting their changing views and needs in respect to QOL and informing policy and service delivery in an ageing society.

5.8 Summary: QOL in Australia – An ageing Society and Future Research

This chapter outlined the various advantages to being an older person in Australia. The majority of benefits were related objective indicators of QOL and it was argued that being Australian was a positive indicator of QOL in its own right. The subjective advantages of old age in general, were based on intrinsic growth and experiences gained throughout one's life. In this sense, Chapter Five is intrinsically linked to key terms and themes outlined in Chapter Four; such as the objective-subjective link that permeates the overall concept of QOL.

The implications a rapidly ageing society has for aged service provision and the QOL of older people was largely negative. It was widely believed that aged services will decline; the financial situation of older people will diminish; and that individuals are ill prepared for the demands an ageing society will place onto older people in the future. It was evident that governments, policy-makers and academics were viewed as essential to preparing Australia for the future and it was argued that collaboration was the only way the demands of an ageing population could be met.

It was determined that the QOL indicator currently being used by CVI could be modified to include further subjective and objective QOL indicators. It was further suggested that such a model would benefit from adopting methods used in Individualised QOL Frameworks, the Wellness Approach and the concept of reminiscence. A proposal for future research was presented in the form of a qualitative research design that would further evaluate the subjective views older people held concerning the broad area of QOL in old age.

6.0 Conclusion and Recommendations

This Honours thesis explored the concept of QOL amongst older people from the perspective of a small cohort of Australians. The thesis covered three main facets. The first was a review of the seminal and current academic literature surrounding the broad areas of gerontology, sociology and QOL paradigms. A review of existing QOL indicators and QOL Frameworks was undertaken as part of this literature review and several major themes were identified as a result of this analysis. Evidence from these secondary sources was also used to support primary data collected through further qualitative inquiry.

The second facet of this study was to ascertain how a sample of respondents perceived the concept of QOL. Participants included a group of aged clients and staff members from the CVI Woodvale *Adult Day Centre*. Also included in this sample were CVI Managers from the agency's Administrative Offices in Joondalup. Additional key informants were recruited from three peak WA aged care service providers. Primary data was collected in the form of semi-structured interviews and electronic surveys. New or alternative QOL indicators identified in the primary and secondary data were used to inform the further development of the *Referral and Assessment Form* (CVI's current QOL indicator model).

The third facet of the Honours study was concerned with the global phenomenon of a rapidly ageing population. Based on data from the literature review and qualitative inquiry, it was found that a rapidly ageing society had implications for the future QOL of older Australians. These included various societal changes relating to aged care service delivery practices and social policy development and implementation. As evidenced in the primary and secondary data, it was argued that governments, academics and policy-makers could employ several strategies aimed primarily at reducing the potential and significant implications that will almost certainly accompany Australia's rapidly ageing population.

These three facets of the thesis were originally listed and covered by five separate research questions. These were presented in the introductory chapter of this Honours thesis and acted as the guidelines for the development of this study. The issues that emerged as a result of the data analysis and as they relate to the five research questions will now be discussed in summary detail. As has been stated in the thesis *per se*, the evidence collected for this Honours study could only be viewed as indicative data. However, based on the fact that it was triangulated with secondary sources and interviews with staff, managers and key informants it is believed that the results could be applied to other NGO settings and be useful in informing further research and policy development. Recommendations relating to each objective will also be outlined below.

6.1 How does a small cohort of aged clients, staff members and managers from CVI and key informants representing peak WA aged services, perceive QOL amongst older people?

The overall concept of QOL was viewed by participants as being comprised of two separate dimensions; objective and subjective indicators of QOL. Objective indicators related to tangible phenomena in the physical world; such as one's 'physical wellbeing' or their 'financial' status. Subjective indicators were intrinsic constructs and strongly related to an individual's perception of the world; these included feelings of 'loss' or affective states like 'depression'. Despite each indicator primarily belonging to an objective or subjective category, there was a significant overlap between these two dimensions of QOL. In many cases an older person's QOL was directly influenced by their subjective interpretation of events in their lives, rather than their QOL being determined only by their objective environment.

The variation of responses made by clients indicated that older people are a vastly heterogeneous group. It was evident from the primary data, that the contextual situations of older people and their subjective personalities were important factors in determining whether aged care interventions would improve or diminish their QOL. A significant theme throughout the primary and secondary data was the importance of individuating care and providing a facility whereby older people have an active role in decision-making, thereby maintaining their overall QOL. The data also clearly showed that older people are not a homogenous group, therefore they may not benefit from standardised forms of aged care.

6.2 Recommendations

That the concept of QOL amongst older people be viewed as a multi-dimensional construct composed of both objective and subjective indicators.

That the existing interrelationship between objective and subjective dimensions be recognised by academics, service providers and policy makers when evaluating the QOL of aged clients, aged care services and facilities and older people in Australia.

That older people in Australia be viewed as a heterogeneous population with individual needs and QOL requirements.

That older people in Australia be viewed as cognisant individuals and active participants in decisions relating to aged care interventions.

6.3 To what extent is the current QOL indicator used by CVI, the *Referral and Assessment Form*, applicable to the group being studied?

The CVI QOL indicator was used as the theoretical basis for this Honours study. In the literature review the *Referral and Assessment Form* was outlined as being constructed from four 'broad' objective QOL constructs; 'physical', 'sensory', 'intellectual' and 'social'. Throughout the qualitative inquiry several objective QOL indicators were identified by the aged clients as being directly related to these four measures. These included the broad categories of 'physical wellbeing', 'sensory', 'intellectual', 'technological aids and human support', 'service delivery', 'residential', 'financial' and 'social' indicators of QOL. Due to the fact many clients perceived the original four objective areas as being significant to their QOL the *Referral and Assessment Form* could be applied to aged clients and thus, the group being studied.

Despite this, it was also evident from the literature review and primary data collected, that objective indicators of QOL were intrinsically linked to many subjective measures of QOL. Therefore, both objective and subjective indicators of QOL were significant to the aged clients interviewed as part of this Honours study. As such, because the subjective dimension of QOL was largely missing from the CVI QOL indicator, the *Referral and Assessment Form* may not be fully applicable to the aged client population and requires revision to include additional items relating to subjective QOL indicators.

6.4 Recommendations

That the *Referral and Assessment Form* retain part of its original thematic structure and therefore ensure that the objective indicators of QOL are applied to the aged client group under study.

That it be recognised the *Referral and Assessment Form* is missing a crucial subjective dimension to its composition and therefore not fully applicable to the aged client group under study.

6.5 Does the QOL indicator used by CVI need to be refined and further developed to incorporate additional QOL indicators?

As previously stated, the current QOL indicator applied by CVI was restricted to measuring only objective indicators of QOL. *The Referral and Assessment Form* was a standardised document and the provision for clients to engage with it in the form of open-ended, subjective responses was minimal. The importance of subjective dimensions of QOL and the interrelationship that exists between objective and subjective QOL indicators has been widely discussed in both the primary and secondary data of this Honours thesis. In light of this, it is suggested that the *Referral and Assessment Form* be refined and further developed to include new or alternative QOL indicators. Refer to Chapter Five for discussion about these additional QOL indicators.

Following an analysis of existing QOL paradigms and QOL indicators it was determined that the *Referral and Assessment form* could be expanded to include additional objective and subjective indicators of QOL, as well as a qualitative component. By incorporating a subjective dimension into the *Referral and Assessment Form* would mean that it would become more individualised, taking into account the heterogeneity of older people and their QOL requirements. It was suggested the *Referral and Assessment Form* could adopt methods used in the Individualised QOL Frameworks (see Bowling 2005), the Wellness Approach (see Danni, personal communication, September 4, 2008) and the subjective concept of reminiscence (see Tilki, 2000).

6.6 Recommendations

Refine and further develop the *Referral and Assessment Form* to include further subjective and objective QOL indicators that provide a holistic view of QOL. Refer to Chapter Five for discussion about these additional QOL indicators. This would be necessary for assessors to accommodate the level of individuality amongst older people in Australia.

Refine and further develop the *Referral and Assessment Form* to include open-ended questions thereby allow aged client to describe issues significant to their QOL or discuss interrelationships between objective and subjective indicators of QOL.

In light of the strong objective-subjective relationship that exists within the concept of QOL, refine and further develop the *Referral and Assessment Form* to include dimensions from *Individualised QOL Frameworks*, the *Wellness Approach* and the subjective concept of reminiscence.

6.7 How can the results of this project be used to better inform policy-makers and service delivery practices related to aged care?

As evidenced in the primary data and literature analysis it was suggested that future aged care policy and practice would need to be shaped by a multi-faceted plan of action. This would involve utilising statistical data and collaborating with older people, academics, aged care service providers and government bodies. It was suggested that new service delivery and care models and methods of assessment would need to be developed in order to meet the increasing demands of a rapidly ageing population and that services would need to become more individualised as a result.

The individuation of care and promoting an equal relationship between aged clients and service providers were two goals deeply promoted in the Wellness Approach (see Danni, personal communication, September 4, 2008) and the subjective technique of reminiscence (see Tilki, 2000) as discussed in Chapter Five. These approaches were described as having the potential to empower older people and promote greater independence amongst aged clients; therefore reforming traditional approaches adopted by policy-makers and in practice which seen by most respondents as being top-down and resulting in greater dependence amongst aged clients. The Wellness Approach and reminiscence were argued to be closely related in that the voices of older clients were

highly valued in both approaches and therefore able to deliver services relevant to the subjective needs of older people.

6.8 Recommendations

That older people, academics, aged service providers and policy-makers work collaboratively to produce new approaches to practice in order to meet the demands of an ageing society and provide individualised interventions.

To consider implementing the Wellness Approach which would help to ensure the independence of aged clients and provide care, based on an ongoing assessment of older people's level of need.

To implement reminiscence wherever possible which would help to account for aged clients' physical and social histories during the assessment phase; thereby allowing assessors to have a full account of aged clients' individual needs and indicating that the assessors have an interest in their clients. This in turn could potentially maximise the feelings of worth amongst older people.

6.9 In light of Australia's rapidly 'ageing society', will older people require greater input from policy-makers and service providers to ensure their QOL is considered, debated and maintained?

As found in this Honours thesis, the world-wide phenomenon of an ageing society is likely to have implications for Australian service delivery and for society in general. As discussed in Chapter Five the input of policy-makers and service providers was believed to be essential in maintaining the QOL of older people. Most respondents believed that government inaction would adversely affect all sectors of society. It was widely argued that social engagement through services such as centre-based care and community-based activities would remain essential objective dimensions for the QOL of older people. However, a decline in social expenditure, a combination of growing demand and a lack of human service workers was thought to have negative implications for the future QOL of older people. Overall, financial issues and budget constraints were predicted to be potential causes for a decline in the QOL of older people and restrictive of the necessary development of the aged care industry in Australia.

It was widely believed that QOL would diminish as a result of inadequacies in government policy and service delivery. It was suggested that presenting the aged sector as a lucrative industry would counteract poor recruitment rates and therefore ensure that QOC would not diminish and therefore, the QOL amongst older people would be maintained or improved. It was suggested that due to the rising costs of living in an ageing society, Australians should initiate financial planning in their youth rather than electing to rely on a government aged-pension, insufficient for the future QOL needs of older people.

6.10 Recommendations

Increased input from Australian policy-makers and service providers to ensure the QOL of older people is considered, debated and maintained in an ageing society.

Greater government funding to policy-makers and service providers in order to attract more human service workers, thus ensuring that the level of QOC is maintained in Australian service delivery.

An increase in the future services available to older people in order to cope with an increase in demand as part of an ageing society in Australia; centre-based care and in-home-care were identified as strong predictors of a positive QOL amongst older people.

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Appendices

Appendix A

INFORMATION LETTER TO CLIENT AND STAFF PARTICIPANTS

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A COHORT OF THEIR AGED CLIENTS IN PERTH, WA

You are invited to participate in a project which is being conducted as part of a Dissertation for an Honours Degree at Edith Cowan University. Details about the course are given below:

Course Code: V 76

Course Name: Bachelor of Social Science (V 76) Honours Degree

Faculty: Computing, Health and Science

School: Psychology and Social Science

The student researcher, Jonathan Georgiou, is currently undertaking a Bachelor of Social Science (V 76) Honours Degree at Edith Cowan University at the Joondalup Campus. The purpose of this project is to investigate the views and opinions held about quality of life of older people. This will involve conducting sixteen, 15 to 30 minute interviews with Community Vision clients and staff. Several surveys have also been constructed for managerial staff.

Quality of life indicators and frameworks are used to measure how well people are living. This research will aid service delivery agencies and policy-makers develop or further enhance existing quality of life indicators, thereby maximising the life status of older people. The main beneficiaries of this research will be human service agencies like Community Vision and their aged clients.

If you choose to participate in this project you will be asked to:

- **Participate in a 15 to 30 minute interview.**
- The student researcher will be using a digital audio recorder and may take notes to document conversations between the participant and interviewer.
- All interviews and formal conversations will be conducted in a private and comfortable setting at the Woodvale Community Day Centre.
- Only the student researcher and Honours Supervisor will have access to the original audio records, notes and interview transcripts.
- Pseudonyms (assumed names) will be used for all transcribed interviews to protect participants' anonymity.
- The audio data will be transferred to the student's private home computer for analysis and transcription.
- The data files containing the audio recordings (both on the Digital Recorder and the PC), hard copy transcripts and notes will be erased or destroyed at the completion of the research in line with NMHRC guidelines.

- Participants may feel discomfort discussing the topic of quality of life amongst older people. If at any time the participant wishes to end the interview or take a break then they may exercise that right.
- The researcher will be sensitive to the individual needs and concerns of the respondent and where possible, should be made aware of any such issues prior to the commencement of the interview.
- Any questions concerning the student researcher's background, purpose of the assignment, equipment or any other query surrounding the topic can be discussed prior to the interview taking place.
- If desired, respondents may obtain a copy of their transcribed interview from the student researcher (see contact detail below).

The information gathered will be used to complete the researcher's Dissertation for the University course noted above. Only the student and his Honours Supervisor will have access to the raw information. Any personal or identifying characteristics will be kept confidential. Respondents will not be identified by name in any written Dissertation or presentation of the results of this project. All information obtained during conversations will be used only for the purposes of this project.

Participation in this project is voluntary. If you choose to participate, you are free to withdraw from further participation at any time without giving a reason and with no negative consequences. You are also free to ask for any information which identifies you to be withdrawn from the study.

If you have any questions or require any further information about the research project, please contact:

Honours Supervisor: Dr Peter Hancock
 School of Psychology and Social Science
 Edith Cowan University
 Joondalup
Phone: 6304 5804
Fax: 6304 5833
E-mail: p.hancock@ecu.edu.au

or

Student Researcher: Jonathan Georgiou
 Bachelor of Social Science (V 76) Hons.
 School of Psychology and Social Science
 Edith Cowan University
 Joondalup / External Student
Phone: (08) 9307 25 20
E-Mail: jgeorgio.student@ecu.edu.au

Thank you for your time and consideration.

Appendix B

INFORMATION LETTER TO MANAGERIAL PARTICIPANTS

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A COHORT OF THEIR AGED CLIENTS IN PERTH, WA

You are invited to participate in a project which is being conducted as part of a Dissertation for an Honours Degree at Edith Cowan University. Details about the course are given below:

Course Code: V 76

Course Name: Bachelor of Social Science (V 76) Honours Degree

Faculty: Computing, Health and Science

School: Psychology and Social Science

The student researcher, Jonathan Georgiou, is currently undertaking a Bachelor of Social Science (V 76) Honours Degree at Edith Cowan University at the Joondalup Campus. The purpose of this project is to investigate the views and opinions held about quality of life of older people. This will involve distributing several surveys that have been constructed for Community Vision managerial staff. These participants will have the option of completing either a hard copy or an electronic version of the same survey document. Sixteen, 15 to 30 minute interviews will also be conducted with clients and other members of staff.

Quality of life indicators and frameworks are used to measure how well people are living. This research will aid service delivery agencies and policy-makers develop or further enhance existing quality of life indicators, thereby maximising the life status of older people. The main beneficiaries of this research will be human service agencies like Community Vision and their aged clients.

If you choose to participate in this project you will be asked to:

- **Complete a 15 to 30 minute survey interview.**
- The information letters, ethics consent forms and surveys will be sent to participants via Community Vision's internal mail system.
- The same surveys will also be sent electronically to participants work e-mail addresses and respondents may select this medium instead (whichever is preferable).
- Only the student researcher and Honours Supervisor will have access to the original survey interview responses and notes.
- Pseudonyms (assumed names) will be used for all survey interviews to protect participants' anonymity.
- The survey data and notes will be transferred to the student's private home computer for analysis.
- The hard copy and data files containing the survey information and notes will be erased or destroyed at the completion of the research in line with NMHRC guidelines.

- Participants may feel discomfort writing about the topic of quality of life amongst older people. If at any time the participant chooses not to complete the survey interview then they may exercise that right and inform the student researcher of their decision.
- The researcher will be sensitive to the individual needs and concerns of the respondent and where possible, should be made aware of any such issues prior to the commencement of the survey interview.
- Any questions concerning the student researcher's background, purpose of the assignment, equipment or any other query surrounding the topic can be discussed prior to the survey interview taking place.
- Respondents will be asked to return completed hard copy survey documents to the Community Vision Administrative Offices for collection by the student researcher.
- Respondents who completed the surveys electronically will be asked to send the documents to the student researcher's e-mail address.
- All respondents will be asked to return completed hard copy ethics consent forms to the Community Vision Administrative Offices for collection by the student researcher.
- If desired, respondents may obtain a copy of their completed survey from the student researcher (see contact detail below).

The information gathered will be used to complete the researcher's Dissertation for the University course noted above. Only the student and his Honours Supervisor will have access to the raw information. Any personal or identifying characteristics will be kept confidential. Respondents will not be identified by name in any written Dissertation or presentation of the results of this project. All information obtained during survey interviews will be used only for the purposes of this project.

Participation in this project is voluntary. If you choose to participate, you are free to withdraw from further participation at any time without giving a reason and with no negative consequences. You are also free to ask for any information which identifies you to be withdrawn from the study.

If you have any questions or require any further information about the research project, please contact:

Honours Supervisor: Dr Peter Hancock
 School of Psychology and Social Science
 Edith Cowan University
 Joondalup
Phone: 6304 5804
Fax: 6304 5833
E-mail: p.hancock@ecu.edu.au

or

Student Researcher: Jonathan Georgiou
 Bachelor of Social Science (V 76) Hons.
 School of Psychology and Social Science
 Edith Cowan University
 Joondalup / External Student
Phone: (08) 9307 25 20
E-Mail: jgeorgio.student@ecu.edu.au

Thank you for your time and consideration.

Appendix C

ADDITIONAL INFORMATION FOR MANAGERIAL PARTICIPANTS

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A COHORT OF THEIR AGED CLIENTS IN PERTH, WA

TERMS OF REFERENCE USED IN THE SURVEY BUNDLE

- **NHMRC:** National Health and Medical Research Council
- **HSW:** Human Service Worker
- **QOL:** Quality of Life
- **Older Person:** An adult 65 years and older

INSTRUCTIONS FOR SIGNING, COMPLETING & SUBMITTING FORMS

- Read through the hard copy Information Letter provided in the survey bundle.
- Read and sign the hard copy Ethics Consent Form provided in the survey bundle.
- Proceed to complete the hard copy Survey Interview provided in the survey bundle.

Alternatively

- Proceed to complete the electronic version of the Survey Interview.
- Once completed, return the hard copy Ethics Consent Form and the Survey Interview to Jean Garratt-Reed at the Community Vision Administrative Offices in Joondalup.

Alternatively

- Once completed, send the electronic version of the Survey Interview to the student researcher's e-mail address (see contact detail below) and return the hard copy Ethics Consent Form to Jean Garratt-Reed at the Community Vision Administrative Offices in Joondalup.

Student Researcher: Jonathan Georgiou
Bachelor of Social Science (V 76) Hons.
School of Psychology and Social Science
Edith Cowan University
Joondalup / External Student
Phone: (08) 9307 25 20
E-Mail: jgeorgio.student@ecu.edu.au

Appendix D

INFORMATION LETTER TO PARTICIPATING KEY INFORMANTS

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A COHORT OF THEIR AGED CLIENTS IN PERTH, WA

You are invited to participate in a project which is being conducted as part of a Dissertation for an Honours Degree at Edith Cowan University. Details about the course are given below:

Course Code: V 76

Course Name: Bachelor of Social Science (V 76) Honours Degree

Faculty: Computing, Health and Science

School: Psychology and Social Science

The student researcher, Jonathan Georgiou, is currently undertaking a Bachelor of Social Science (V 76) Honours Degree at Edith Cowan University at the Joondalup Campus. The purpose of this project is to investigate the views and opinions held about quality of life of older people. This will involve distributing several surveys that have been constructed for Community Vision managerial staff. Interviews will also be conducted with clients and other members of Community Vision staff.

Further interviews will also be held with individual key informants outside of Community Vision from various Human Service organisations and departments.

Quality of life indicators and frameworks are used to measure how well people are living. This research will aid service delivery agencies and policy-makers develop or further enhance existing quality of life indicators, thereby maximising the life status of older people. The main beneficiaries of this research will be human service agencies like Community Vision and their aged clients.

If you choose to participate in this project you will be asked to:

- **Participate in a 15 to 30 minute interview.**

- The student researcher will be using a digital audio recorder and may take notes to document conversations between the participant and interviewer.
- All interviews and formal conversations will be conducted in a private and comfortable setting at the work premises of the key informant.
- Only the student researcher and Honours Supervisor will have access to the original audio records, notes and interview transcripts.
- Pseudonyms (assumed names) will be used for all transcribed interviews to protect participants' anonymity.
- Generic names will replace the actual organisation's / department's names to protect participants' anonymity.
- The title of the key informants' position within their organisation / department will be included in the study in order to justify the participant's level of expertise.
- The audio data will be transferred to the student's private home computer for analysis and transcription.

- The data files containing the audio recordings (both on the Digital Recorder and the PC), hard copy transcripts and notes will be erased or destroyed at the completion of the research in line with NMHRC guidelines.
- Participants may feel discomfort discussing the topic of quality of life amongst older people. If at any time the participant wishes to end the interview or take a break then they may exercise that right.
- The researcher will be sensitive to the individual needs and concerns of the respondent and where possible, should be made aware of any such issues prior to the commencement of the interview.
- Any questions concerning the student researcher's background, purpose of the assignment, equipment or any other query surrounding the topic can be discussed prior to the interview taking place.
- If desired, respondents may obtain a copy of their transcribed interview from the student researcher (see contact detail below).

The information gathered will be used to complete the researcher's Dissertation for the University course noted above. Only the student and his Honours Supervisor will have access to the raw information. Any personal or identifying characteristics will be kept confidential. Respondents will not be identified by name in any written Dissertation or presentation of the results of this project. All information obtained during conversations will be used only for the purposes of this project.

Participation in this project is voluntary. If you choose to participate, you are free to withdraw from further participation at any time without giving a reason and with no negative consequences. You are also free to ask for any information which identifies you to be withdrawn from the study.

If you have any questions or require any further information about the research project, please contact:

Honours Supervisor: Dr Peter Hancock
School of Psychology and Social Science
Edith Cowan University
Joondalup
Phone: 6304 5804
Fax: 6304 5833
E-mail: p.hancock@ecu.edu.au

OR

Student Researcher: Jonathan Georgiou
Bachelor of Social Science (V 76) Hons.
School of Psychology and Social Science
Edith Cowan University
Joondalup / External Student
Phone: (08) 9307 25 20
E-Mail: jgeorgio.student@ecu.edu.au

Thank you for your time and consideration.

ETHICS CONSENT FORM

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS
FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A
COHORT OF THEIR AGED CLIENTS IN PERTH, WA

I have been provided with a copy of the Information Letter, explaining the project.

I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

I understand that participation in the research project will involve:

- **Participation in a 15 to 30 minute interview.**
- The student researcher will be using a digital audio recorder and may take notes to document conversations between the participant and interviewer.
- All interviews and formal conversations conducted in a private and comfortable setting at the Woodvale Community Day Centre.
- Only the student researcher and his Honours Supervisor will have access to the original audio records, notes and interview transcripts.
- Pseudonyms (assumed names) will be used for all transcribed interviews to protect participants' anonymity.
- The audio data will be transferred to the student's private home computer for analysis and transcription.
- The data files containing the audio recordings (both on the Digital Recorder and the PC), hard copy transcripts and notes will be erased or destroyed at the completion of the research in line with NMHRC guidelines.

I understand that my identity will be kept confidential; information collected during interviews will only be used for the purposes of this project and that I will not be named in any written Dissertation or presentation of the results of this project. I understand that I am free to withdraw from further participation at any time, without explanation or penalty.

I freely agree to participate in the project.

Name _____

Signature _____

Date _____

Thank you for your participation.

ETHICS CONSENT FORM

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A COHORT OF THEIR AGED CLIENTS IN PERTH, WA

I have been provided with a copy of the Information Letter, explaining the project.

I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

I understand that participation in the research project will involve:

- **Completion of a 15 to 30 minute survey interview.**
 - Only the student researcher and his Honours Supervisor will have access to the original survey interview responses and notes.
 - Pseudonyms (assumed names) will be used for all survey interviews to protect participants' anonymity.
 - The survey data and notes will be transferred to the student's private home computer for analysis.
 - The hard copy and data files containing the survey information and notes will be erased or destroyed at the completion of the research in line with NMHRC guidelines.

I understand that my identity will be kept confidential; information collected during survey interviews will only be used for the purposes of this project and that I will not be named in any written Dissertation or presentation of the results of this project. I understand that I am free to withdraw from further participation at any time, without explanation or penalty.

I freely agree to participate in the project.

Name _____

Signature _____

Date _____

*Thank you for your participation –
After signing please return this form to Jean Garratt-Reed at the Community Vision
Administrative Building to be collected by the ECU student researcher.*

ETHICS CONSENT FORM

DEVELOPING NEW AND ALTERNATIVE QUALITY OF LIFE INDICATORS FOR OLDER PEOPLE: A CASE STUDY FROM COMMUNITY VISION AND A COHORT OF THEIR AGED CLIENTS IN PERTH, WA

I have been provided with a copy of the Information Letter, explaining the project.

I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

I understand that participation in the research project will involve:

- **Participation in a 15 to 30 minute interview.**
- The student researcher will be using a digital audio recorder and may take notes to document conversations between the participant and interviewer.
- All interviews and formal conversations will be conducted in a private and comfortable setting at the work premises of the key informant.
- Only the student researcher and his Honours Supervisor will have access to the original audio records, notes and interview transcripts.
- Pseudonyms (assumed names) will be used for all transcribed interviews to protect participants' anonymity.
- Generic names will replace the actual organisation's / department's names to protect participants' anonymity.
- The title of the key informants' position within their organisation / department will be included in the study in order to justify the participant's level of expertise.
- The audio data will be transferred to the student's private home computer for analysis and transcription.
- The data files containing the audio recordings (both on the Digital Recorder and the PC), hard copy transcripts and notes will be erased or destroyed at the completion of the research in line with NMHRC guidelines.

I understand that my identity will be kept confidential; information collected during interviews will only be used for the purposes of this project and that I will not be named in any written Dissertation or presentation of the results of this project. I understand that I am free to withdraw from further participation at any time, without explanation or penalty.

I freely agree to participate in the project.

Name _____

Signature _____

Date _____

Thank you for your participation.



Community Vision Inc.

REFERRAL & ASSESSMENT FORM

REFERRAL INFORMATION

Referral Received by: _____ Date: _____

Name of Referrer: _____ Contact No: _____

Relationship to Client: _____

Client Contact Details:

Name & Title: _____ Male Female

Preferred Name: _____ Date of Birth: _____

Address: _____

Postcode: _____

Home Ph: _____ Work Ph: _____ Mobile: _____

Reason for Referral:

Service Requested: _____

Functional Disability ☐ Physical ☐ Intellectual ☐ Sensory ☐ Social

Comment: _____

Other Services Involved: _____

Please tick: ☐ Eligible → ☐ HACC ☐ CACP
☐ Not Eligible ☐ Waitlisted Other (Specify)

Referred to: _____

Do Not Continue if Client Not Eligible or Referred on for Other Services

INFORMATION SHARING – CARE PLAN AGREEMENT

The following statement must be read to the client before continuing with Assessment.

It may be necessary to provide information about you to other individuals and agencies to ensure the most appropriate community care and support services can be provided to you. In addition, de-identified client demographic and service provision information is routinely provided to the HACC Program, CACP Program, VHC Program for planning purposes.

You can withdraw your consent to the sharing of your personal information at any time.

An advocate or family member can be chosen to represent you at any time.

A Care Plan to accommodate your needs will be discussed with you and no other confirmation of accepting these services is required.

This statement has been explained to the client:

☐ No ☐ Yes

Client consents to sharing information:

☐ No ☐ Yes ☐ Yes with variations

Variations made by client: _____

ASSESSMENT

Assessor Name: _____ Date: _____

Assessment Type ☐ In Home

☐ Phone

Funding Programme ☐ HACC

☐ CACP _____ Other (Specify)

HACC Linkage Key: _____ Medicare No: _____

Client Personal Details:

Marital Status

☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower

Indigenous Status

☐ Non Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Not Stated

Living Arrangement

☐ Lives alone ☐ Lives with family ☐ Lives with others

Accommodation Setting

☐ Private Rental ☐ Owner Purchasing ☐ Independent /Retirement Village
☐ Public Rental ☐ Supported/Hostel _____ Other (Specify)

Country of Birth: _____ Language Spoken at Home: _____

Language/communication assistance is required ☐ Yes ☐ No

Culture/Language Assessment is required ☐ Yes ☐ No

Pension/Benefit Status

☐ Aged Pension ☐ Receiving DSC Funding ☐ Non Govt. Pension/Benefit
☐ DVA Pension ☐ Carer Payment (pension) _____ Other (Specify)
☐ Eligible for VHC assistance ☐ Unemployment Pension
☐ Disability Support Pension ☐ Other Govt Pension/Benefit

Carer / Contact Details

1st Emergency Contact/Carer Client Carer: Yes No

Name: _____ Relationship to Client: _____

Address (if different from Client): _____

Postcode: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

Carer Availability: _____

2nd Emergency Contact

Name: _____ Relationship to Client: _____

Home Phone: _____ Work Phone: _____ Mobile: _____

General Practitioner / Local Medical Officer Details

Name: _____ Phone: _____

Address: _____ Postcode: _____

General Health Assessment

Social History

Medical / Surgical History

Health Status Overall

☐ Excellent ☐ Good ☐ Poor ☐ Stable ☐ Unstable ☐ Deteriorating

Have your activities been affected because of your health status during the past 4 weeks?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Severely

Comments: _____

Medication List

Takes Medications: ☐ Completely independent ☐ With some assistance ☐ Completely dependent

Comments: _____

Known Allergies & reaction: _____

Vision

- ☐ Wears reading glasses
- ☐ Wears driving glasses
- ☐ Excellent (assess with glasses if used)
- ☐ Good (assess with glasses if used)
- ☐ Poor (assess with glasses if used)

Hearing

- ☐ Wears hearing aids ☐ Right ☐ Bilateral ☐ Left
- ☐ Excellent (assess with aids if used)
- ☐ Good (assess with aids if used)
- ☐ Poor (assess with aids if used)

Comments: _____

Have you experienced any pain during the past 4 weeks? ☐ Yes ☐ No

How severe was the pain on a scale of 1 – 10

	1	2	3	4	5	6	7	8	9

(1 slight pain and 10 is worse pain imaginable)

Comments: _____

Functional Needs Identification			
Activities of Daily Living Functioning <i>An identified need in columns 2 or 3 requires a comment</i>	Independent No help required	Semi dependent <small>Needs some help</small>	Dependent <small>Cannot manage without help</small>
Physical Functional Needs Identification	1	2	3
1. Can you do your housework?			
2. Can you do your laundry?			
3. Can you prepare your own meals?			
4. Can you go out unaccompanied shopping/banking?			
5. Can you walk?			
6. Can you climb or descend stairs?			
7. Can you get to places out of walking distance?			
8. Can you drive?			
9. Can you use public transport?			
10. Can you use a taxi? Subsidised Taxi vouchers used?			
11. Have you had a fall in the past 6 months?	<div style="border: 1px solid black; padding: 2px; display: inline-block;">No</div>	Yes → Date of last fall: _____	
Physical Functional Needs Identification Comments			
1. _____			
2. _____			
3. _____			
4. _____			

5. List Aids used to assist mobility -			
6.			
7.			
8.			
9.			
10.			
11.			
Self Care Functional Needs Identification	1	2	3
1. Can you take a bath or shower?			
2. Can you dress yourself?			
3. Can you manage your grooming?			
4. Can you manage your bowel and/or your bladder?			
5. Can you manage your eating?			
6. Can you move from bed to chair?			
Self Care Functional Needs Identification Comments			
1.			
2.			
3.			
4. Aids used:	Affects lifestyle	No	Yes → Consider Continence Referral
5.			
6.			

Intellectual / Sensory Functional Needs Identification	1	2	3
1. Can you communicate well with others?			
2. Can you relate in a group?			
3. Can you communicate with strangers?			
4. Can you use the telephone?			
5. Can prioritise daily activities?			
6. Can you manage your money?			
Intellectual Functional Needs Identification Comments			
1.			
2.			
3.			
4.			
5.			
6.			
Social Functional Needs Identification	No	Sometimes	Yes
1. Have you established / maintained reliable friendships?			
2. Have you contact with family?			

3. Have you contact with neighbours?			
4. Have you contact with social groups?			
5. Have you feelings of loneliness?			
6. Have you feelings of being depressed?			
Social Functional Needs Identification Comments			
1.			
2.			
3.			
4.			
5.			
6.			
Carer Need Identification	No	Sometimes	Yes
1. Do you have regular assistance from a family member?			
2. Do you have regular assistance from a friend/neighbour?			
3. Do you have regular unpaid assistance?			
Carer Needs Identification Comments			
1.			
2.			
3.			
Carer Assessment Required		Yes	No
General Comments			

Service Identification

What services/assistance is currently received on a regular basis?

- ☐ Allied Health
- ☐ Delivered Meals
- ☐ Other Food Service
- ☐ Transport
- ☐ Domestic Assistance
- ☐ H&G Maintenance
- ☐ Personal Care
- ☐ Social Support
- ☐ Day Centre
- ☐ Nursing
- ☐ Respite
- ☐ Other

Comments: _____

- Service Funded by
- ☐ HACC
- ☐ CACP
- ☐ EACH
- ☐ DVA/VHC
- ☐ DS C
- ☐ Other
- Client Referred
- ☐ No
- ☐ Yes →
- ☐ ACAT
- ☐ Aids
- ☐ Other

Comments: _____

- Mode of Payment
- ☐ CBA Deposit Book
- ☐ Invoice client
- ☐ Invoice carer

Service Requirement

	Service Type	Hours	Frequency
<input type="checkbox"/>	Domestic Assistance		
<input type="checkbox"/>	Meal Preparation		
<input type="checkbox"/>	Home Chef Meals		
<input type="checkbox"/>	Social Support/Shopping		
<input type="checkbox"/>	Day Centre		
<input type="checkbox"/>	Personal Care		
<input type="checkbox"/>	Podiatry		
<input type="checkbox"/>	Respite		

Total Hours required: _____ (Consider CACP/EACH referral if HACC client with more than 5hrs care a week)

Services are required on a Service Free Day? ☐ Yes ☐ No

Days/times when service cannot be provided?

	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Comments
am								
pm								

Specific Roster Coordinator Information

Assessor Signature: _____ **Date:** _____

Rostered Service(s) (Roster Coordinator to Complete)

CSP(s) Allocated: _____ **Start Date/time:** _____

Comments: _____

Service Confirmed: ☐ Client/Carer ☐ CSP **Data Entered:** ☐ SMS ☐ Excel

Satisfaction Service Review (Assessor to Complete)

Client Comments: _____

Outcome/ Action: ☐ Alter Services ☐ Review 6 months ☐ Other
(specify) _____

Assessor Signature: _____ **Date:** _____