Rural–urban variations in service provision for elderly people

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SUMMARY. Findings reported from a survey of 997 people aged 75 years and over living at home in a rural and an urban area showed that the two areas were similar in overall levels of support and in levels of perceived need. The rural area enjoyed rather more generous support from district nurses and health visitors than the urban area, a finding which challenges the widely-held view that rural areas suffer from lower levels of support and have higher levels of felt need. The few differences between the areas that did emerge were not necessarily a consequence of location; other explanations may be found in the operating styles of the services, and in the amount and type of informal support to be found in the two areas. Overall, the findings question the validity of a simple rural–urban dichotomy in studies of elderly people.

Introduction

THE rural–urban distinction in the provision and use of services for elderly people is one that generates some debate among researchers and social policy watchers.[1] Many argue that it lies at the root of a number of service problems such as poor access to and low take-up of services. Others maintain that the debate is dead and that its persistence diverts attention from more central concerns.

This survey, part of a wider study of patterns and pathways in care of the elderly,[2] was carried out in north-east Scotland in two areas, one primarily rural (north Grampian) the other urban (Dundee). A fairly broad definition of 'ruralness' was employed to include a number of small towns. The survey was designed to complement other components of the study by providing details of the use of services by two groups of old people living at home.

The rural area of north Grampian contains a high concentration of self-employed and agricultural workers. On the basis of 1979 data the number of community nurse visits is above the national average, residential home places are not far below, while the provision of hospital beds, sheltered housing and home help staff are significantly below the national average (David Goda, University of Edinburgh, unpublished results). There is no clear bias in service provision either towards institutional or community care.

The urban area of Dundee is a medium-sized regional centre with an ageing population, slightly older and more numerous than that of north Grampian and the service mix differs. Provision of community nurses, residential home places, sheltered housing and hospital beds is on or above the national average, while the home help service lies not far below; service provision is weighted towards the community. Overall, the levels of service provision in Dundee are higher than in north Grampian.

Method

The random sample of people aged 75 years and over living at home was drawn from computerized primary care registers covering the general practices in the two locations: 491 persons in north Grampian and 506 in Dundee were interviewed. The questionnaire covered eight areas: functional capacity, need for assistance with a range of daily tasks, use of health and social services, respondents' views on the need for services, the impact of informal networks and carers on respondents' circumstances, marital status and living arrangements, household composition and social contacts, and financial circumstances.

A selected range of findings drawing on data obtained for these areas is presented below. Statistical significance has been assessed by the chi-square test.

Results

Characteristics of the two areas

The age distribution, sex-ratio and socioeconomic grouping were similar in the two areas (Table 1). In both locations the respondents had been more static than might have been expected. Just over half lived alone, although overall the households were significantly larger in the rural areas ($P<0.05$) (Table 1). A higher proportion of those in the urban area either had no relations or friends/neighbours or never saw them — 5% as against 2.3% in the rural area. The most frequent contact with relatives was

Table 1. Social characteristics of the sample of elderly people.

	Percentage of respondents	
	Rural ($n=491$)	Urban ($n=506$)
Age (years)		
75–79	50.3	50.4
80–84	28.1	27.7
85–89	12.2	12.3
90 and older	4.1	3.8
Unknown	5.3	5.9
Socioeconomic group		
Professional and managerial	6.1	5.9
Other non-manual	9.0	15.2
Skilled manual	27.5	22.9
Unskilled manual	30.5	31.4
Unknown	26.9	24.5
Years in area[a]		
0–10	14.7	10.7
11–20	11.0	14.6
Over 20	74.3	74.5
Number of persons in household		
One	45.2	55.0
Two	41.1	36.7
Three or more	13.6	8.3

n = total number of respondents.

[a]Data missing for one respondent

weekly — 47% of the urban population saw someone as against 39% of the rural population; a quarter of the rural population saw someone daily as against 19% in the urban area. The most common contact with friends or neighbours was daily and, once again, it was more evident in the rural area — 71% of the respondents enjoyed such contact as against 62% in the urban area.

Knowledge and receipt of services

When asked about their knowledge and receipt of a range of services including the district nurse, health visitor, home help, meals-on-wheels and social worker a majority of respondents in both areas reported that they had heard of these services (Table 2). Only a small proportion of the survey population, however, was in receipt of the services that were asked about. The only significant difference in knowledge between the areas related to the district nurse service which was less well known in the urban area. Elderly people in the urban area also had significantly less contact with the district nurse service, health visitors and meals-on-wheels than those in rural areas.

Table 2. Respondents' knowledge and receipt of services.

Service	Percentage of respondents who knew of service		Percentage of respondents visited by service	
	Rural ($n=491$)	Urban ($n=506$)	Rural ($n=491$)	Urban ($n=506$)
District nurse	*90.4*	*81.0****	*32.2*	*14.4****
Health visitor	*69.9*	*67.8*	*19.8*	*9.5****
Home help	*96.1*	*99.0*	*16.1*	*19.2*
Meals-on-wheels	*93.5*	*96.6*	*5.9*	*2.4***
Social worker	*78.0*	*83.0*	*4.9*	*5.1*

** $P<0.01$, ***$P<0.001$, urban versus rural.

Perceived need for services

Perceived need for the services (plus chiropody) among residents not already receiving them is shown in Table 3. The figures represent demand that is additional to the services already provided. The only considerable level of unmet need was for chiropody. Generally, the level of unmet need among non-recipients was higher in the urban than in the rural area and for chiropody the increase was significant ($P<0.001$).

Table 3. Perceived need of services by those not receiving them.

Service	No. of respondents not receiving service		Percentage of non-recipients wanting service	
	Rural	Urban	Rural	Urban
Meals-on-wheels	430	477	*2.1*	*2.1*
Home help	393	404	*1.8*	*5.0*
Health visitor	244	295	*2.5*	*4.4*
Social worker	356	392	*2.0*	*4.3*
District nurse	285	337	*2.8*	*5.0*
Chiropodist	232	276	*12.1*	*20.6****

*** $P<0.001$, urban versus rural.

Ability to cope with personal care

The ability of these elderly respondents to cope with personal care was high across all ages in both areas. The majority reported no difficulty in managing for themselves the 11 tasks mentioned. The tasks most often found difficult are shown in Table 4. Urban and rural areas showed great similarity, with the exception of difficulty in getting about outside the house, which was significantly more common in the urban area ($P<0.01$).

Table 4. Respondents' ability to cope with personal care.

Function	Percentage of respondents incapacitated	
	Rural ($n=491$)	Urban ($n=506$)
Cutting toenails	*54.3*	*56.4*
Climbing stairs	*40.1*	*40.7*
Bathing	*35.0*	*36.4*
Getting about outside	*22.2*	*29.2***
Washing all over	*8.1*	*10.3*
Getting about the home	*7.1*	*6.5*
Making a hot drink	*5.3*	*5.1*

** $P<0.01$, urban versus rural.

Visits by services to the incapacitated

It has already been shown that, with the exception of home helps, service visits were higher in the rural area (Table 2). Although there was a higher service input to the disabled in both areas, the disabled in the urban area received proportionately more visits than the rural disabled (Table 5). The inability to bath has been used to illustrate this point, as other surveys have shown that bathing presents the greatest difficulty for elderly people in maintaining independence.[3]

Table 5. Visits by services to all respondents and to those who were incapacitated (cannot bath).

Service	No. of clients visited among total population		No. of clients visited among the incapacitated (cannot bath)	
	Rural ($n=491$)	Urban ($n=506$)	Rural ($n=178$)	Urban ($n=184$)
District nurse	158	73	68	48
Health visitor	97	48	46	26
Home help	79	97	49	59
Meals-on-wheels	29	12	17	10

Perceived need and source of help with daily tasks

The two main sources of assistance with daily tasks were relatives and the nursing and home help services. Generally, greater help was received in the rural area although the differences were only statistically significant in respect of cooking and getting out (Table 6). Not surprisingly, relatives provided the major source

Table 6. Perceived need and source of help with daily tasks.

Task	Percentage of respondents receiving help from:		Number of respondents wanting more (some) help	
	Any source	Relatives	Already getting help	Not getting help
Rural (n = 491)				
Shopping	*52.7*	*39.1*	2	10
Laundry	*44.6*	*32.1*	4	4
Cooking	*26.1*	*21.4*	2	2
Housework	*44.4*	*23.6*	6	5
Getting out	*24.8*	*24.2*	1	8
Urban (n = 506)				
Shopping	*50.9*	*36.2*	8	12
Laundry	*38.9*	*26.5*	4	11
Cooking	*15.6***	*12.6***	0	4
Housework	*42.5*	*18.2*	7	17
Getting out	*17.8***	*14.6***	8	19

** $P<0.01$, urban versus rural.

of support in both areas;[4] overall they gave greater support in the rural area, where the households tended to be larger.

Perceived need with domestic tasks among those already getting help was generally low though a little higher overall in the urban area (Table 6) and among those not getting help it was also low, although, again, slightly greater in the urban area. Those living alone were not generally lacking in support. Only in cooking was there a significant negative association between getting help (from any source) and living alone ($P<0.01$).

Discussion

The findings relating to the incapacity of the elderly respondents and their subjective reports of visits by nursing, home help and other services may be interpreted in a variety of ways. Although the number of visits by services was greater in the rural area, proportionately more in the urban area were to the incapacitated. This suggests that service provision in the urban area, while less generous, is being more successfully targeted upon those in greatest need. These findings may also be explained in part by the greater involvement of relatives in the rural area in care of the elderly. It could be argued that in the urban area services were, implicitly if not explicitly, compensating for a lower level of informal support.

The greater felt need for services among those not receiving them and for help with daily tasks among both those getting and not getting help in the urban area may reflect different social and cultural attitudes. Expectations may be higher in the urban area, elderly people perhaps becoming accustomed to services and even placing a higher value upon them. Again in the rural area a higher value may be placed on self-reliance, on not coming into contact with services, and on avoiding feelings of stigma associated with welfare services. Of course all our information about knowledge and contact with services was derived from subjective self-reporting and, without knowledge about the outcome and impact of the services, conclusions must be speculative. The greater difficulty which elderly people in the urban area found with getting about outside could result from differences in housing stock, more stairs in the city, or from differing lifestyles. Mobility may not be so much of an issue in rural areas.

In general the elderly respondents in urban and rural areas were not markedly different from each other. Moreover, it is by no means certain that the differences that did emerge could be accounted for simply by reference to locality. Some of the differences, such as the length of time respondents had lived in the area, were a reversal of the usual assumptions concerning the stability of rural communities and the mobility of urban ones. While locality may be one of the factors involved it cannot be viewed in isolation; differences in organization and structure of the services, and in the involvement of informal carers may be explanations. Thus, wider debates about the balance between family, community, State and private intervention should be independent of the crude, somewhat simplistic rural–urban dichotomy to which so much significance is often attached.

Our findings do not support a clear rural–urban division in terms of elderly people's contact and felt need for contact with services. In both areas services appeared to be reaching those who were in perceived need of them, family support was high, felt need for additional support was slight and any notable deficiencies in support — such as chiropody — applied more or less equally in both areas.

The message to emerge from these findings is that the key challenges facing those engaged in planning and providing social care are complex and are, or seem to be, essentially the same in both rural and urban areas. To focus discussion narrowly on the rural–urban distinction may be misleading and divert attention away from the real issues associated with the provision of appropriate services no matter where they may be located. Against the background of demographic shifts, in particular an increase of 50% between now and the end of the century in the number of very old people (aged 85+ years),[5] and public spending constraints, the rural–urban dimension from the evidence of this survey does not emerge as a central concern in the care of elderly people.

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Acknowledgements

We wish to thank Mrs Mary Bruce and Miss Isobel MacPherson for assistance with data extraction and also Mrs Lorraine Gibb for typing the manuscript. We thank the Chief Scientist's Organisation of the Scottish Home and Health Department for funding the study of which the survey is a part.

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