Final Report

Linkages among housing assistance, residential (re)location, and use of community health and social care by old-old adults: shelter and non-shelter implications for housing policy development

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

AAP – Adelaide Activities Profile

ACAT – Aged Care Assessment Team

ADLs – Activities of Daily Living

ALSA – Australian Longitudinal Study of Ageing

ANOVA – Analysis of Variance

ANCOVA – Analysis of Covariance

CACP – Community Aged Care Packages

ComQol – The Comprehensive Quality of Life Scale

CSHA – Commonwealth State Housing Agreement

DVA – Department of Veteran Affairs

EACH – Extended Aged Care at Home packages

HACC – Home and Community Care program

IADLs – Instrumental Activities of Daily Living

MANOVA – Multivariate Analysis of Variance

CHAPTER 1. INTRODUCTION: CONTEXT AND RESEARCH AIMS

1.1. Introduction

Within the policy arena it is increasingly being recognised that housing is an important facet in the complex and interrelated array of factors that influence quality of life and overall well-being. Australian governments are therefore seeking to better understand the influence of housing and housing assistance on the quality of life and overall well-being of individuals and consequently families and the community (AHURI Research Agenda 2000). In so doing they aim to achieve housing interventions that have a positive impact on overall health and well being and reduce the harmful consequences of other factors contributing to poor outcomes (Department of Health and Human Services, Tasmania n.d).

This paper is the final report of a project seeking to increase our understanding and knowledge of the influence of housing and housing assistance on the quality of life and overall well-being of the older population. The project explores the shelter and non-shelter implications for housing policy development of the relationships between housing assistance, residential location and relocation and the use of community and social care services by the older population.

As an introduction, this chapter reviews the context of the study as detailed in the Positioning Paper for the project (http:www.ahuri.edu.au/pubs/positioning/pp_oldold.pdf). The Positioning Paper describes the policy arena in terms of housing, housing assistance and aged care; the current housing situation of the aged; the overseas experiences with housing the older population, the delivery of services, the research into quality of life across housing types and the research strategy for the study.

1.2. Importance of housing for the aged

Housing for the older population has gained increasing significance over the last two decades. In the past addressing older people's housing needs and providing aged care services largely centred around relocating older adults from community living to residential care. Today housing for the aged has become an issue because of :

- The growing numbers and proportion of the older population
- Increasing life expectancy and the trend towards potentially longer periods of frailty and disability
- Increased understanding and recognition of the diversity and rights of the older population – recognition of the importance of independence, dignity, self-esteem, connectedness, participation, happiness and a healthy lifestyle. These qualities are difficult to achieve if housing is unsuitable or inappropriate to people's needs.
- Policy focus now on encouraging older people to remain in the community.

Encouraging older people and others with special needs to remain in the community has, around the world, been termed 'ageing in place'. This concept has become a policy priority and led to a reorientation of the way housing and social policy for the older population is conceived (Bochel, Bochel and Page 1999; Pastalan 1997). This policy orientation recognises the desire of older people to remain in familiar environments and is seen to best achieve optimum opportunity for well-being and healthy ageing.

For older people, housing can be extremely significant. While housing is important at any stage in life its importance may be amplified with ageing. The housing situation of the aged is the culmination of a lifetime of opportunities and obstacles. While an older person's housing may be able to meet their needs at a point in time this can quickly change and become increasingly complex as a result of the myriad of factors associated with ageing. Some of these may directly or indirectly precipitate a change in living arrangements.

In the context of this policy orientation on 'ageing in place' linkages between housing and service provision are very important to the welfare of the aged population. The aged are significant users of a wide range of services and housing can potentially operate as a significant mediator in the demand for assistance and use of services. Housing policy (and associated living arrangements and changes in them) may be an important lynchpin in ensuring a range of non-shelter outcomes such as levels of depression, self esteem, health and general well-being for example.

While there is a desire in the older population to remain in their own homes and to receive home based services, for the oldest age groups relocation becomes an issue. It is important to recognise transitions made from one form of housing to another may translate into differential use of services. For example, the movement from private to public rental may result in the use of more services or movement away from available, known services. Relocation therefore raises a number of issues for policy development – from a broader range of housing options through to addressing the impact of relocation on health and well-being.

Despite the growing recognition of the importance of housing for the health and well-being of older persons there has been little research around the world on the subject. Until recently research has tended to concentrate on specialised rather than mainstream or 'ordinary' forms of housing.

1.3. Policy – housing and aged care

1.3.1. Housing policy

While the Commonwealth and State governments are jointly responsible for funding housing assistance, policy and programs at all levels of government, past and present, in a number of arenas influence and impact on the housing situation of the population including the aged population (Kendig 1993; Department of Housing NSW, 1999). Until recently in Australia however housing policy has been formulated without widespread consultation, analysis of changing needs and recognition of the wide range of shelter and non-shelter implications of various policies (Howe 1992). It is only recently that policy development has encompassed a broader view of housing which incorporates an understanding of the need for co-ordination and links with other arenas such as transport, urban design, community facilities and care and support services (Pfeffer and Green 1997; Department of Health and Human Services, Tasmania,n.d).

Since the early 1980s there has been growing Commonwealth, State and local government attention to the issue of ageing and housing. At the Commonwealth level these include:

- the National Housing Strategy (NHS 1991, NHS 1992; Howe 1992)
- the Australian Urban and Regional Development Review (AURDR 1994a, 1994b; Morris Consultants 1996; Purdon Associates 1996; S & S Consultants 1996; Spiller, Gibbins, Swan 1996; DTRD 1996; AHURI 1996)
- and the Aged Care Mid-term Review (DHHCS 1991a, 1991b; DHHLGCS 1993).

The purpose of all of these studies has been to establish the current status of housing and to examine ways to increase housing options available to the community and particularly in relation to the aged, to examine the linkages between aged care and housing. Although such studies have led to an improvement in the range and adequacy of housing or accommodation options for the aged in recent years (Kendig 1999), it has occurred without a clear understanding of the effectiveness of programs and policies to meet the needs of the older population.

Australian governments' direct role in housing policy is through the provision of housing assistance which is enacted through the Commonwealth State Housing Agreement (CSHA), the latest being the 1999–2003 Agreement. This assistance is designed to meet a number of policy objectives covering broad economic and social arenas (community development, social infrastructure) as well as specific housing issues (affordability, dwelling modification, location, cultural needs, market failure) (AIHW 2000). This assistance is provided to households who are unable to obtain or retain suitable accommodation due to a number of reasons including cost, availability or suitability. Housing assistance is provided by the three levels of government via a range of programs to try to fulfil the government's aim of providing greater choice in the housing market.[1]

Much of the funding and direction for housing assistance is the responsibility of the Commonwealth government the delivery of such assistance, and the supply of housing is the responsibility of the States and Territories. The State and Territory governments provide matching funds to those provided by the Commonwealth through the CSHA as well as additional funds to undertake housing assistance programs. They supply and manage public housing, oversee community housing and are responsible for land taxes, stamp duties and residential tenancies legislation. It is the State governments' responsibilities to deliver CSHA programs such as Home Purchase Assistance, Aboriginal Rental Housing and Private Rental Assistance (SCRCSSP 2000).

1.3.2 Aged and community care policy

The effectiveness of housing assistance and housing policy for the aged is closely intertwined with a number of policy areas, in particular aged and community care policy. The recent interest in housing for the aged is one of the outcomes of a series of reforms (Aged Care Reform Strategy) to aged care beginning in the mid 1980s particularly as a result of the House of Representatives Standing Committee on Expenditure Report (1982) *In a Home Or at Home: Home Care and Accommodation for the Aged.* This report indicated the escalating cost to government of continuing to provide residential care and how this contrasted with peoples' wishes to remain at home and in the community. Since this report there has been a process of rapid change with the movement away from residential care to community care and a more holistic integrated approach recognising the importance of all aspects of ageing to general health and well–being.

This change in policy direction, focussed attention on 'ageing in place'. While this term as the basis of policies for the aged has been widely accepted throughout countries dealing with an ageing population, acceptance of this term occurred 'even though there is only a vague idea of what this concept actually means in practical and policy terms' (Pastalan 1997, 3). In Australia with the drafting of the Home and Community Care Act 1985, the complexity of providing a system of care to meet the needs of the frail aged and younger people with a disability in the community environment was little understood' (Gregory 1999,1). The shift in policy focus from

[1] The CSHA does not include Commonwealth Rent Assistance.

residential care[2] to home and community care[3] has implications for housing policy and planning in terms of the way accommodation and services fit together to best support frail older people and their carers. The dilemma of how to link housing with care remains a difficult proposition not only in Australia but also in many other parts of the world.

The Home and Community Care Program (HACC) is

- A complex diverse program involving Federal, State and local governments
- Provides a wide range of services to people in their homes.
- Was initially designed to provide a range of basic services to enable older people to remain in the community, thereby avoiding premature admission to residential care (a preventative strategy) however it soon became a system of targeted resources to those at greatest risk of admission.
- In 1992-93 the government introduced Community Aged Care Packages (CACPs) to provide a community alternative for frail older people whose dependency and complex care needs would qualify them for entry to a residential care facility at least for low level care.
- More recently the government has introduced Extended Aged Care at Home Packages (EACH). These packages provide nursing home level care to people in their own homes.

Besides providing care in the community to the older population Australia's aged care system also provides residential care. Residential care is financed and regulated by the Commonwealth government while the services are provided by the non-government sector (religious, charitable and private providers) although a small number of facilities are operated by State and local governments. There are two main forms of residential care – high (or nursing home) care and low (or hostel level) care. Access to residential aged care and CACP and EACH programs is reliant on assessment of suitability of an individual by Aged Care Assessment Teams (ACATs). The introduction of care in the home resulted in a decrease in the provision of residential care places and the provision of CACPs and EACH is funded by replacing an equivalent number of nursing home places (Commonwealth Dept of Health and Aged Care 1999).

1.4. Housing situation of the older population

The aged live in a variety of accommodation types reflecting the diversity required by the general community, past opportunities and obstacles in life, as well as innovative housing meeting specific requirements of an older life and lifestyle. Ninety per cent of aged persons live in private dwellings while the other 10 per cent live in non-private dwellings such as nursing homes, hostels, hotels, caravans and boarding houses (Howe 1992, 18). The dwelling type that people live in varies across the lifespan and ageing often results in a change of accommodation.

[2] Residential care – The provision of nursing home (high) and hostel (low) care. Generally, nursing homes have provided 24 hour nursing home and accommodation services, while hostels have provided accommodation services and personal care (assistance with tasks of daily living, such as dressing and moving around), with some nursing when required. While some nursing homes and hostels will continue to specialise in high care, low care, or dementia, an increasing number of facilities offer the full continuum of care, and allow residents to remain in the one place as their care needs increase. Older people cannot enter nursing home or hostel care without assessment by an Aged Care Assessment Team, (National Strategy for an Ageing Australia, 2000a, 21).

[3] Community care – Care provided in the community through the Home and Community Care program, Community Aged Care Packages and care services for veterans and war widows. A wide range of services are provided, including home help, meals on wheels, personal and nursing care, transport, home maintenance, and respite care. Some services provide high level care management for people with complex care needs (National Strategy for an Ageing Australia, 2000a, 19).

Home ownership is particularly high among the older population. At the 1996 census 80 per cent of the population aged 65 years and over owned or were purchasing a dwelling. While home ownership is generally viewed as advantageous by providing security of tenure, the potential for capital gains, and for some, the means to alter through the housing market their housing situation to suit changing needs, there is considerable diversity in the situation of older home owners.

Owner occupied dwellings may be individual home units or units in a retirement village or much more likely separate dwellings on reasonably large blocks in the suburbs of the metropolitan areas. Many of the aged home owners live in the family homes they bought as young homebuyers in the developing suburbs of the time.

At the 1996 census 5.3 per cent of the population aged 65 years and over lived in public rental housing. This is a particularly important avenue of accommodation for single older people, especially women. Public housing has traditionally been provided as a long term alternative to private ownership and currently around one half of all aged tenants in public rental housing entered the system as young adults in their twenties and thirties (Kendig and Stephens 1987). As they have aged through the system in larger family accommodation, often on large blocks of land, they have been encouraged to move to what was considered to be more suitable public rental accommodation.

At the 1996 census 6.4 per cent of the population aged 65 years and over living in private dwellings lived in private rental accommodation although this tenure can include non-private dwellings such as caravans and boarding and lodging facilities. Aged persons living in the private rental sector have been identified as those in greatest housing need (Kendig 1990; Roberts 1997). Recognition of the poor status of private renters in relation to other tenures led to the recent shifts in government policy away from the provision of public housing and rent rebates to rent assistance (Kendig and Neutze 1999; Yates 1997; Badcock and Beer 2000). Under the Commonwealth Government Rent Assistance Program, rent assistance through the Department of Family and Community Services and the Department of Veteran Affairs is paid to older people who rent privately (including boarders, residents in retirement villages and caravan parks) and pay rent above minimum threshold rent levels.

Inadequacies in the public and private rental market are putting increased reliance and pressure on the community housing sector. The community housing sector in Australia has targeted the older population. In 1998 36 per cent of people in community housing tenancies (10 432) were aged 65 years or over. Various community housing projects have been developed (Forsyth 1992; AURDR 1994a) and surveys of residents and studies of this sector indicate it compares as well if not better than the public sector in terms of standards of property, maintenance, locations to meet consumer needs and security of tenure (Shelter SA 1997).

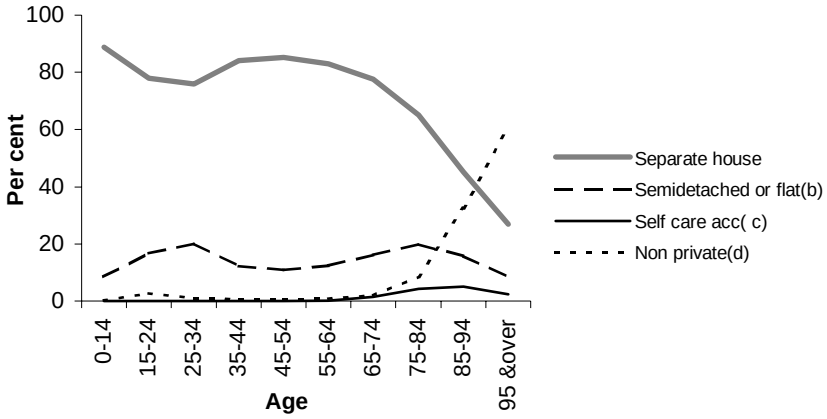
Retirement villages while remaining a small segment of the housing sector have grown significantly over the last two decades. There is no clear definition of what constitutes a retirement village and the legal definitions vary between the States and Territories (Stimson, Manicaros, Kabamba and Murray 1997; Eardley and Birch 1998). Retirement villages however are characterised by a number of features: They are segregated housing complexes specifically for aged people which include a range of accommodation from independent living units to hostels to nursing homes. Retirement villages are assumed to provide positive outcomes for residents with reports that people living in retirement villages ‘enjoy higher levels of life satisfaction and morale than their counterparts in wider society’ (McDonald 1996, 167). This form of accommodation is an attractive option for older women as they account for approximately two-thirds of all residents. Many of these women are lone person

households (Stimson, Manicaros, Kabamba and Murray 1997). As older women can often feel vulnerable, retirement villages, promoted as 'solutions to older people's concerns about security, home maintenance, increasing frailty and loneliness' (Reed G 1996, 5), can be an attractive proposition. There are a number of reasons people give for moving into retirement villages (Stimson *et al* 1997; Gardner 1994). These reasons include to pre-empt physical decline, to be free of home maintenance, to combat isolation and loneliness, to be safer, to be independent of family, to take advantage of supportive care, dissatisfaction with the previous housing environment, declining health of individual or partner, and widowhood.

1.5. Relocation

While the current generations of the aged population have a low degree of residential mobility compared to the total population it is clear from Figure 1.1 that with increasing age mobility rates increase. Between the 1991 and 1996 censuses while 21 per cent of people aged 65-74 and 21 per cent of the population aged 75-84 moved residence this increased to 30 per cent for those aged 85-94 and up to 37 per cent for the population aged 95 years and over (ABS 1999, 18). Although the very old were more likely to move they were less likely to have moved very far reflecting their very strong attachment to a particular locality or neighbourhood.

Figure 1.1 Type of dwelling, all persons, 1996



Source: ABS 1999

An understanding of factors associated with, or predisposing one to, relocation is important. Many studies have investigated the consequences of older people moving from one type of accommodation to another. Relocation is often portrayed in a negative light but a review of the literature suggests differing outcomes. Some studies found relocation had negative outcomes such as increased mortality and morbidity, depression, stress, declines in morale and happiness and overall decreased life satisfaction. In contrast other studies have failed to find negative outcomes and in fact some studies have reported improvements in quality of life (Gattuso 1996; Golant 1998; Pastalan 1983; Pearlman and Uhlmann 1988; Reed, Payton, and Bond 1998; Stein and Morse 1994). Pastalan (1983) suggests a major reason for these contradictory results is that there are a number of intervening factors which influence the outcome of moves – the characteristics of the people being moved, the reasons for the move, its meaning to the mover, and the helping techniques used to facilitate the move.

1.6. Shelter and service provision – other countries experiences

With general acceptance of the importance of ageing in place, many countries around the world are grappling with the task of trying to develop best practice initiatives in combining housing with support services. It is difficult to gain a clear understanding of different countries progress in this regard however as Means (1996, 207) comments, 'Individual countries differ over time and between themselves about the respective roles of hospitals, nursing homes, residential care, 'special needs' housing schemes and hostels in supporting disabled people with differing levels of 'dependency' need.' Social and cultural background is also important, for example in terms of the importance and expected role of the family in old age care. In addition the tenure structure existing in particular countries may influence the range of opportunities and choices for older persons.

Purdon and Associates (1996) presents an overview of overseas experiences in providing older people's housing and the programs and initiatives in various countries to address design and development, financing, service links, information and awareness and special needs. From an examination of policies and programs in New Zealand, the United States, Canada, Europe and the United Kingdom, the authors concluded many countries share a very similar set of experiences and that 'most policies and programs are a variation on a theme and some societies have more effective delivery mechanisms. In addition, these policies and programs are essentially responses to circumstances arising from previous practices and policies, and must be viewed in the overall context of each country's social and economic history.' Purdon and Associates also commented that in overseas research Australia is recognised as a leader in relation to specialist and social support provisions for the older population.

Despite differing starting points in the focus on community versus residential/institutional care there appear to be a number of common issues arising in the countries dealing with this dilemma:

- Considerable geographic variability in the coverage of community care services (Brotherhood of St Laurence 1994).
- The level of service provision is unable to keep pace with demand and projected demand (Pastalan 1997).
- The historical fragmentation of housing polices, health policies and community care and the policy statements that now refer to the need for coordination between agencies and departments, across geographic boundaries and the need to engage in partnership and pooling of resources to achieve the best results for clients. The lack of coordination between housing and services impinges on the concept of responding to a continuum of changes across the lifespan (Bochel, Bochel and Page 1999; Brotherhood of St Laurence 1994; Houben 1997; Pastalan 1997).
- Questions of limits to an 'ageing in place' philosophy.

1.7. Quality of life

1.7.1. Meaning of home

As a home is so integral to ordinary life we often fail to consider or even to recognise its importance to lifestyle and wellbeing. This may be particularly so for an older person especially those aged 75 years and over, who may spend a considerable part of each day at home. For an older person 'home' takes on increasing significance well

beyond the provision of a physical structure. Trying to establish the meaning of home is difficult. From studies (Davison, Kendig, Stephens and Merrill 1993; Dupuis and Thorns 1996; Rowles 1993; Raciono, Walker, Taylor and O'Connor 1993) it can be defined as a place of belonging and ownership, of comfort and security, evidence of personal and family achievement, choice of who is invited in and who is not, an individualised or unique atmosphere or tone, a place where one's time is one's own, and a place where the person makes decisions about the home environment.

While the residence in which older people live is important to their everyday feelings of well-being, the surrounding environment and local neighbourhood is equally important, providing a sense of identity, familiarity, social interaction and context in which life has meaning and importance. The nature and quality of the place in which a person lives is believed to contribute significantly to well-being an the ability to be independent and self-sufficient (Davison, Kendig, Stephens and Merrill 1993; McDonald 1997; Reed, Payton and Bond 1998).

There appears to be an inextricable link between where a person lives and how 'home', rather than just housing, must be part of a strategy to shelter older people. Quality of life and hence well-being is affected in tangible and intangible ways by living arrangements. Research has consistently shown that older people age with differing degrees of success and this is related to a better quality of life (Andrews, Clark, and Luszcz, 2000; Berkman *et al,* 1993; Jorm *et al,* 1998; Stawbridge *et al*, 1996).

1.7.2. Research into non-shelter outcomes of housing

Research into quality of life and wellbeing (however quantified) in older people in relation to housing has traditionally focussed on the move to residential care settings. It is only much more recently interest has turned, and limited research has been undertaken, to examining ageing in place and how non-shelter outcomes may vary from one housing situation to another. The relationship between housing conditions and physical health has long been established in the literature (Ambrose 1997; Birren, Lubben, Rowe and Deutchman 1991; Bland 1999; Dunn 2000; Marsh et al 2000; Oldman and Quilgars 1999; Phibbs 1999; Thomas 1986). For example, research has identified the direct and indirect effects of housing on the physical and mental health of occupants, as well as its impact on personal development and the fulfilment of 'life objectives' (Ambrose 1997). An understanding of the relevance and importance of housing in terms of overall well-being and quality of life is a much more recent field of study. Well-being for the aged has been explained in terms of the balance between autonomy and security. Much of the recent theory and research has identified older people's need to maintain perceived and effective independence as well as a strong need for physical, social and emotional security (Luszcz and Dean 1999; Parmelee and Lawton 1990).

One living environment that has been purported to provide a good balance of independence and security is the retirement village. While studies on the whole have reported general satisfaction with life in retirement villages (Eardley and Birch 1998; Kendig and Gardner 1997; McDonald 1996) a study by Biggs et al (Biggs, Bernard, Kingston and Nettleton 2000; Nettleton, Bernard, Biggs and Kingston 1999), actually compared the health status of a retirement community in England with a comparable community sample at two specific points in time, one year apart. The results of this research indicated that over the one year period the retirement village residents maintained their physical, mental and social functioning while deteriorating functioning was found in the neighbourhood sample. This implies particular characteristics of this retirement village have had a positive influence on the well-being of its residents.

While considerable research has been undertaken into relocation to nursing homes there has been little published work on the perceptions of people entering hostel care. A study by Reberger, Hall and Criddle (1999) examined the social, psychological and physical impacts of moving into hostel care. The participants in the study had to meet a number of criteria including living in the community within their own home, or in unserviced units within retirement villages and seeking permanent hostel care. The study showed that in most of the domains examined there was an improvement after admission to a hostel. Mental health was the only factor that did not improve significantly.

To try to gain a greater understanding of the field of 'quality of life' and to contribute to the theoretical field Ferris and Bramston (1994) undertook a study to clarify some of the important quality of life issues by asking older people in a variety of residential settings (nursing homes, hostels, retirement villages, family home) about their daily routines. Quality of life was measured by The Comprehensive Quality of Life Scale (ComQol). This measure accounts for both subjective and objective life quality. In addition it also identifies individual differences by asking respondents how important each aspect of their life is before having them rate how satisfied they are with it. The scale looks at seven life domains: material possessions, health, productivity, intimacy, safety, place in the community and emotional well-being. The results of the survey showed type of residence did not influence what was regarded as important in life but how satisfied one is with it. The most important considerations in quality of life were relationships, social networks and health. Nursing home residents recorded the lowest scores on both subjective and objective measures while the retirement village residents scored the highest values. While there was a difference between residents 'in care' (hostel and nursing home) or living independently (retirement village or own home) interpretation of these results is tempered by the fact those living independently were considerably younger than the 'in care' group – up to ten years.

These studies indicate that housing can influence the well-being of older people. Yet little attention has been paid to exploring how various types of housing tenure, or changes between them, exert their impact on older people's quality of life. With a policy focus on healthy positive ageing the need for such research is vital.

1.8. Research aims

The Positioning Paper clearly identified some key gaps in our understanding of the relationship between housing and healthy ageing. Broadly, the paper identified the following gaps in our research knowledge:

A lack of understanding of the role of housing in healthy ageing

There is a need to:

- Ascertain the impact of housing on non-shelter outcomes in the older population.
- Define the non-shelter impacts of different forms of housing and how these may contribute to improved psycho-social well-being for individuals, families and communities.
- Define key outcome measures, including housing related indicators for social sustainability / vulnerability among the older population.

A lack of information and understanding of relocation issues in relation to shelter and non-shelter outcomes

Greater awareness is needed about:

- How the types of housing assistance available promote or inhibit housing choices for older people.
- The critical housing related factors that interact with non-shelter impacts and their flow-on effect on specific shelter and non-shelter outcomes, including quality of life.

Limited knowledge of the place of housing assistance within an integrated service system

There is a need to gain an understanding of:

- The provision of housing assistance by the states and territories in relation to key health and social service provision.
- The way the states address ageing in place across tenures
- What elements of policy and practice enhance or inhibit the integration of housing and other services.

The objective of this study is to make a contribution to these research areas. In particular its aims are:

- To increase our understanding of the role of different forms of housing as a mediator of non-shelter outcomes in social, psychological and health domains – to what degree and how is housing important to individual well-being?
- Identification of the factors associated with or predisposing individuals to relocation – to move residence.
- To identify what influence relocation has on well-being – positive / negative outcomes.
- Define key outcome measures, including housing related indicators for social sustainability / vulnerability among the older population.
- To establish how well the housing choices for the aged meet the needs of the older population.
- To identify what policies, models and strategic planning processes exist for the linkage and integration of housing with community and aged care services.

1.9. Structure of the report

This chapter has provided some background information to the study. It has outlined the need to examine the relationships between housing, care and quality of life of the aged population. Chapter Two of this report discusses the use of survey data and group discussion to explore the issues identified. Chapters Three and Four present and provide a discussion of the findings of the research while a series of policy implications are outlined in Chapter Five.

CHAPTER 2. METHODOLOGY

2.1. Introduction

In order to explore the relationships between housing and healthy ageing, increase our understanding of relocation, and to establish the place of housing assistance within an integrated service system, this research involves a combination of qualitative and quantitative methods. The project involves analysis of a major multidisciplinary longitudinal study of older people and focus group analysis of state and local decision makers, relevant departments and non government bodies and older persons concerned with housing and aged care.

2.2. Survey data

This project utilises the Australian Longitudinal Study of Ageing (ALSA) (Andrews 2001; Andrews, Cheok and Carr 1989; Centre for Ageing Studies 1993, 1998a, 1998b, 2001). ALSA is a multidimensional/multidisciplinary population based study of human ageing. The general purpose of ALSA is to gain further understanding of how social, biomedical and environmental factors are associated with age related changes in the health and well-being of persons aged 70 years and over. Emphasis is given in the study to defining and exploring the concept of healthy and successful ageing.

The sample for ALSA was randomly selected from the South Australian State Electoral Database. Households were identified in which one or more individuals were born before 30 June 1922. The sample was for the Adelaide Statistical Division only and was stratified by age (into 5 year age groups – 70-74, 75-79, 80-84, 85 years and over) and by gender. Individuals living in the community and institutions were included in the sample. In addition to the specified person, spouses (aged 65 years and over) of specified persons were also invited to participate, as were other household members aged 70 years and over. Baseline data collection began in 1992 and this included a comprehensive personal interview, a home based assessment of physiological functions, self completed questionnaires and additional clinical studies. Since this first wave there have been five further waves of data collection. Waves 3 (1994) and 6 (2000) were a complete reassessment while waves 2 (1993), 4 (1995) and 5 (1998) of the study were short telephone interviews of about 20 minutes duration.

This study utilises the personal interview data and self completed questionnaire data at Waves 1,3 and 6. The personal interview is very large with over 700 questions. Figure 1 illustrates the population dynamics of the ALSA sample. At Wave 1 2087 older people were interviewed with 93.9 per cent living in the community and 6.1 per cent in residential care.[4] Through various reasons by Wave 3 our sample had declined to 1679 with 90.6 per cent living in the community and by Wave 6 our sample was down to 779 persons with 84 per cent living in the community. The major reason for the decline in participation in our sample was death. Over the eight years from Wave 1 to Wave 6 42 per cent of the sample had died.

As a secondary data source ALSA affords a number of practical advantages, predominantly economy of data collection through time, cost and personnel, however it does provide a challenge as housing was not a major theme of investigation in the survey and thus the key housing variables included were very broad and therefore did not allow for a number of in depth analyses. However along with the extensive information available on physical and functional health status, psychological well-

[4] Residential care is classified as a hostel or nursing home.
Community living is classified as living in a house, home unit, granny flat or bed sitter room. This could include living independently, in group housing or in a retirement village.

being, receipt of pensions, lifestyle activities, and major life events, for example, it provides an opportunity to explore relationships over time.

Variables used in the analyses covered a number of key areas: demographic, housing, social, psychological, cognitive and health. Each domain was operationalised using a number of variables, which ranged from single item indicators, to standardised questionnaires comprising multiple items. A full summary of items is provided in Appendix A, which details which Wave the items were assessed, a basic conceptualisation, score range and reliabilities where applicable.

2.2.1 Data screening and analyses

Data were analysed using SPSS for Windows, Version 10.0. A number of statistical techniques were utilised, and will be detailed in relevant sections of the results. Prior to conducting statistical analyses, data were screened for missing cases, outliers, normality, multicollinearity and singularity.

As archival data were used in the study, the extent of missing data was considerable (see Appendix B for summary of missing cases for variables). Although there was no attempt to estimate the data, an exception involved predictive models for relocation, where the missing listwise procedure reduced cases to a level where reliable analyses were not possible. This will be detailed further in section 3.4.2.2.

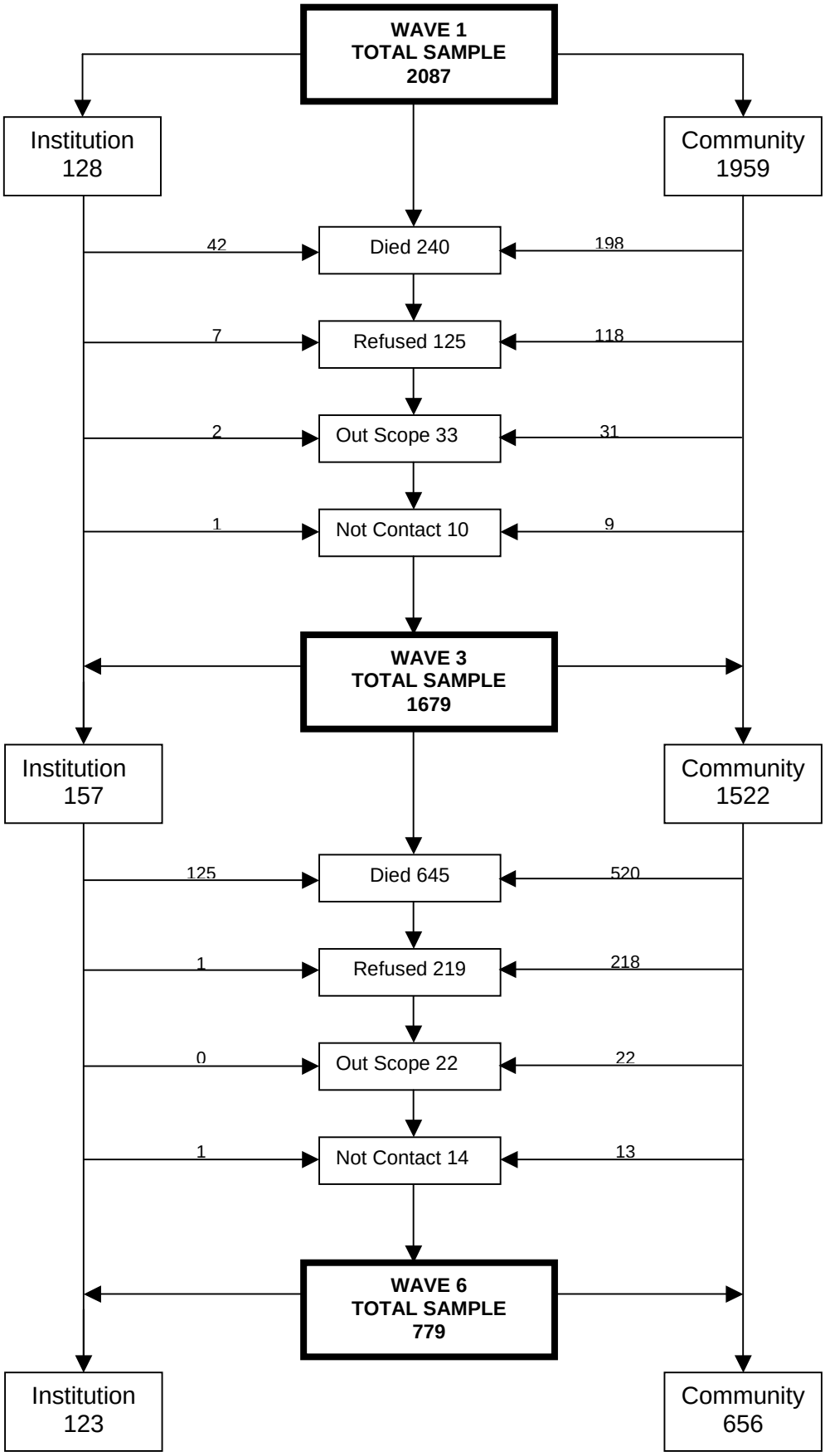
Assessment of outliers and normality were conducted for Wave 1 only. Examination of histograms and Normal Q-Q plots revealed relatively normal distribution for most variables. A small number of variables were found to have multiple outliers and violations of normality, and were transformed using Tukey's transformation ladder (Tabachnick & Fidell, 1996). Analyses were conducted using untransformed and transformed data, with minimal benefit observed. Hence, further analyses for all Waves were conducted untransformed, as any deviations detected would likely diminish due to the large sample size (Tabachnick & Fidell, 1996).

Wave 1 data were assessed for problems with multicollinearity and singularity. Although a number of variables in the data set were very highly correlated, this was either due to them being a composite of other variables (for example, general well-being), or multiple indicators of the same construct. However, as the project was fundamentally exploratory, it was considered necessary to include as many variables as possible, in order to capture maximum information regarding these relationships. Multicollinearity only became an issue with predictors in logistic regression, therefore in this instance, duplicates were removed from the equation. This will be detailed further in section 3.4.2.

2.3. State consultations

As housing is very much a state issue, to gain a greater understanding of current policy directions, linkages among housing assistance and services, and consequent influences on housing and non-shelter outcomes for the aged population, representatives in the various states with an interest in housing and aged care were consulted. The most efficient and cost effective method of gaining this insight was via focus groups. Representation for the focus groups was sought from a wide group of relevant government departments, elderly citizens organisations, local councils, major housing groups, aboriginal housing groups, ethnic groups, aged care organisations and service providers. The timetable for the focus groups and lists of participants are available in Appendix C. A focus group just involving older persons also was held in Adelaide.

Figure 2.1: Population Dynamics of the ALSA Sample Across Wave 1 (1992), Wave 3 (1994) and Wave 6 (2000), Number of Persons



The discussion in the focus groups revolved around a set of questions which included:

- How well do the housing choices for the aged meet the needs of the older population, and in particular the population aged 75 years and over? (Consider all tenures and types of housing)
- What are the impediments or barriers to the provision of appropriate housing for the aged / or which limit the choices people make? How can these barriers be overcome?
- What are the key non-shelter impacts of different forms of housing provision (including housing assistance) on individuals, families and communities?
- What policies (general and specifically for the aged) have been effective in increasing the range of housing available to the older population?
- How well do community and aged care services meet the needs of the older population?
- What policies, models and strategic planning processes exist for the linkage and integration of housing with community and aged care services? What policies and models appear to be successful?
- What environments have been created to foster linkages?
- What opportunities are available for the exchange of information and ideas across departments / agencies /non-government organisations?
- What role does/ can / should local government play in the provision of aged housing and the integration of community services and aged care services?

The focus groups have proven to be a useful research tool as they have:

- been valuable in highlighting the similarities and differences in approaches to housing assistance, integration of services and exchange of information;
- been a means of gaining a great deal of information in a short period of time;
- provided a forum for interaction between the organisations and people involved in the provision of housing assistance and community and aged care services to the older population;
- provided a setting for challenge and support of ideas, beliefs and experiences; and
- provided the participants with some familiarity with members of the project team which helps to facilitate further contact from both parties in regards to information arising from the focus group meeting.

While we sought to include a range of relevant departments, organisations and people in these focus groups we were not always successful in having the full range of attendance as anticipated. The relative importance organisations place on our meeting and other commitments they have, can limit participation by some groups including the most important organisation for this research project – the Department of Housing. Information was sought from these missing groups over the phone or via email but again responses were not always forthcoming. It would have been preferable if they were involved in the focus group.

The information provided at the focus groups is not a comprehensive overview of the housing situation for the aged in each state or of the services available. The focus groups provide a snapshot of some of the issues, positive and negative, affecting housing provision and housing assistance, the integration of services, and opportunities for the exchange of information and ideas across departments, agencies and non-government organisations. Our knowledge is reliant on the appropriateness of the people sent to attend, their willingness to contribute and to forward on appropriate documentation and studies.

CHAPTER 3. HOUSING, WELL-BEING AND RELOCATION

3.1. Introduction

Most, if not all, of the states and territories currently recognise and emphasise the importance of housing to the general well-being of individuals and consequently the wider community. The focus group discussions identified generally, and more specifically, how housing and the quality of the environment (physical, social, economic) in which older people live affects their quality of life and well-being.

Housing was identified as influencing companionship, independence, mobility, depression, feelings of security, confidence, happiness and the ability to cope with life. Collectively some indicators of social sustainability or vulnerability among the older population which influence well-being were identified. These indicators include level of income, savings and assets; housing tenure and type; geographic location of housing; extent of family support and social networks; level of health and dependency; and knowledge of how to access information. The influence of these indicators varies across the older population. The role of 'housing' per se as a contributor to well-being is inextricably linked to one's social and economic context.

It is reflected most strikingly when compared across and within tenures. While home ownership is generally viewed as advantageous as it provides security of tenure, the potential for capital gains, and for some the means to alter through the housing market their housing situation to suit changing needs there is considerable diversity in the situation of older home owners. For some, maintenance costs, lack of significant value in the home, feelings of insecurity, social isolation and increasing disability and loss of independence create situations of vulnerability that may consequently be detrimental to personal health and well-being.

The situation for people in public housing is also variable. The information provided at the focus groups indicated that residents of public and community housing were generally satisfied with their housing situation as these sectors can provide very appropriate housing for the older population, however there were exceptions. Public tenants, who are restricted in choice of location and environment, are vulnerable to isolation and depression. This can arise, for example, if the mix of people in the group is not right, or if they have to move away from family and/or the social networks that are important to their lives to take up the offer of accommodation. Of particular importance to health and well-being are the public housing developments of the 1950s and 1960s, believed to be appropriate at the time, which are now no longer desirable places to live. For example, in Victoria many older public housing tenants are housed in the high rise blocks in the inner suburbs. While these blocks are close to the city and offer opportunities for high levels of interaction recent studies have shown there are major problems regarding people's health and welfare. The overall stock has been neglected in the past and is in need of major upgrading. This, in addition, to the increased targeting of public housing to those most in need, and thus the resultant concentration of people with complex problems and needs, 'has changed the nature of life in many high rise towers' (McNelis and Reynolds 2001). The City of Melbourne commissioned a study of one of these tower blocks to find that there was no sense of community with a significant proportion of the residents socially isolated. Issues revolved around services, a perceived lack of safety, a lack of security and concerns over the welfare mix of people. So although public housing is available, there are issues around the lack of a healthy community (Lincoln Gerontology Centre 2000). The same sort of factors have made public housing estates throughout the country undesirable places to live and has led to the redevelopment of a number of these sites.

The well-being of the older population in the low cost private rental market or not in the housing market at all, is believed to be the most tenuous. Security of tenure was identified as a huge worry and stress, and the increasing closure of boarding houses and supported residential accommodation in the cities, causing displacement of the older person, was very threatening and appears to have detrimental effects on well-being. For example, a supported residential dwelling closed in the inner south of Melbourne and 60 people were relocated. A study of these people found that a number of different things had happened. Some were relocated to the outer suburbs but feeling lost in a different environment with little infrastructure to support their needs some returned to the inner south; some shuffled to rooming houses and supported accommodation elsewhere; some with behaviour problems found it difficult to find any alternative accommodation; some were hospitalised and then died (Victoria Focus Group). In addition the condition of some places, such as caravans and boarding houses, can make them unsafe and they are often described as 'terrible places to live' with 'many horror stories.'

Life in rural communities for the older population is becoming harder and harder. A lack of suitable accommodation and needed services leads to depression, isolation and potentially adverse outcomes. A lack of available accommodation for older single men in particular, results in some of them living in cars on the roadside moving from place to place and not belonging to any particular local community while others remain living in sheds awaiting suitable accommodation. While an extreme outcome, and though there are likely to be a complexity of factors involved, suicide among the elderly rural population in some areas appears to be on the increase (Queensland and Western Australian Focus Groups).

Clearly the housing situation of older people can influence their feelings of well-being and consequently overall quality of life. While there is important and valid qualitative research, information and opinion about the influence of housing on well-being, there has been very little quantitative analysis of the relationship. Against this backdrop results from ALSA will demonstrate how housing impacts on quality of life.

The availability of ALSA provides a unique opportunity to empirically examine the relationships between housing, housing related factors and well-being for a group of older people living in a major urban area. The rest of this chapter provides the results of analyses of the data available in the ALSA surveys to examine the role of housing in sustaining healthy ageing. In particular three broad areas are examined:

- The relationships between housing specific characteristics and well-being. Here the contribution of housing towards well-being as well as a comparison between tenures and types of accommodation on well-being indicators is made.
- The frequency of service use and the implications for well-being, the reliance on family support networks to age in place, and social sustainability factors which may be protective against vulnerability.
- The frequencies of relocation of both tenures and the sample as a whole, longitudinal predictors of relocation within the community or to institutions, and the long-term impact on well-being.

As the focus of this study is on housing, and not residential care, most of the analyses in this chapter are for the respondents in the ALSA surveys who were classified as living in the community (as opposed to an institution) at each wave of data collection.[5] As a general description of this population Table 3.1 provides a basic socio-demographic profile of the community sample at each wave. It is clear from this table that over time the population remaining is more predominantly female, widowed, of a slightly higher educational status, and with greater income and assets.

Table 3.1: Socio-demographic characteristics of the Community Sample at Wave 1, 3 and 6 .

Characteristic	Wave 1		Wave 3		Wave 6	
	N	%	N	%	N	%
Sex						
Male	1002	51.1	750	49.3	278	42.4
Female	957	48.9	772	50.7	378	57.6
Total	1959	100.0	1522	100.0	656	100.0
Age						
65 – 69	140	7.1	55	3.6	0	0.0
70 – 74	560	28.6	387	25.4	24	3.7
75 – 79	509	26.0	431	28.3	189	28.8
80 – 84	407	20.8	357	23.5	240	36.6
85 and over	343	17.5	292	19.2	203	30.9
Total	1959	100.0	1522	100.0	656	100.0
Marital Status						
Married/Defacto	1340	68.4	951	62.5	332	50.6
Not Married	109	5.6	76	5.0	24	3.7
Widowed	510	26.0	495	32.5	300	45.7
Total	1959	100.0	1522	100.0	656	100.0
Birthplace						
English speaking	1746	89.1	1355	89.0	589	89.8
Non-English	213	10.9	167	11.0	67	10.2
Total	1959	100.0	1522	100.0	656	100.0
Education level						
< 14 years	1080	55.6	832	55.0	331	50.5
> 15 years	863	44.4	681	45.0	325	49.5
Total	1943	100.0	1513	100.0	656	100.0
Not stated	16	0.8	9	0.6	0	0.0
Annual Income						
12 000 or less	628	34.3	509	39.2	146	28.9
12 001 – 20 000	839	45.8	570	43.9	190	37.5
20 001 – 30 000	207	11.3	131	10.1	105	20.8
30 001 – 50 000	135	7.4	73	5.6	50	9.9
Over 50 000	24	1.3	14	1.1	15	3.0
Total	1833	100.0	1297	85.2	506	100.0
Not stated	126	6.4	225	14.8	150	22.9
Total Assets						
10 000 or less	605	36.8	398	32.7	131	29.9
10 001 – 20 000	333	20.3	251	20.6	71	16.2
20 001 – 50 000	346	21.0	308	25.3	104	23.7
Over 50 000	360	21.9	259	21.3	132	30.1
Total	1644	100.0	1216	100.0	438	100.0
Not stated	315	16.1	306	20.1	218	33.2

3.2. Housing and well-being

In ALSA various aspects of housing and of the home environment were surveyed. As stated in Chapter Two, collecting information on housing was not a primary focus of the surveys yet the availability of such items as tenure, type of accommodation, condition of residence, home hazards, home maintenance, needed alterations and market value for example, provides an opportunity to explore the inter-related roles of housing and well-being. In relation to well-being there is no universal or generic definition of quality of life and therefore there are no agreed or universally used measures (Smith 2000). In this study well-being is operationalised by a number of indicators representing social, psychological, cognitive, and physical aspects of well-being[6].

[5] Due to the large number of variables examined across three waves of data collection many summary tables are presented as appendices rather than included in the text.

[6] For a complete list of variables, refer to the descriptive summary, Appendix A while Appendix B includes a summary of variables used in the analyses, detailing means, standard deviations, number of cases and missing data

3.2.1 Contribution of housing towards well-being

As an initial examination of the contribution of housing towards well-being, bivariate correlations were conducted cross-sectionally for participants living in the community at each wave to determine the extent of association between the housing related variables and quality of life indicators available in ALSA. These analyses (Appendix D) indicate housing was significantly associated with various domains of well-being, consistent with emerging community views.[7]. A number of general trends were evident for the various housing items, which included tenure, type of accommodation, comfort and condition of residence, home hazards, alterations needed for property, activity level and problems of home maintenance, home type, market value and household composition.

3.2.1.1. Tenure

In terms of tenure marked demographically differences were found between public rental, private rental and home owners at Wave 1, as well as considerable differences on various psychological, social, and health variables. For example, public renters tended to display significantly poorer well-being outcomes than home owners, while private renters tended not to differ significantly from either group, but were placed midway between the two. Similar patterns were revealed in Wave 3, although the strength of associations were somewhat reduced. Furthermore, by Wave 6, fewer differences again were observed between the groups for well-being, despite continued differences on demographic markers (differences between tenures on well-being domains will be discussed in more detail in section 3.2.2.1.2). An explanation to be explored further in section 3.2.2.1.2 is that by Wave 6, the participants remaining from the original sample may be viewed as successful agers, thereby representing a more homogenous group who do not differ considerably on many quality of life domains. Nevertheless, the trend for public renters to be disadvantaged across these domains was still evident.

3.2.1.2. Type of accommodation

As with tenure, differences between types of accommodation, which were assessed at Wave 1 and Wave 6 only, will be discussed in detail in section 3.2.2.2. Basic demographic differences were observed between the three groups, suggesting the various types of accommodation attract different sections of the community. While few differences were observed between the groups at both Waves, it was consistently found that those in group and retirement villages were more likely than participants living independently to see the need to move to a nursing home in the future, and to have put their names down at these facilities. Such a result may be reflective of a greater sense of flexibility of these participants in terms of housing options, which will be addressed in later sections of this chapter.

3.2.1.3. Comfort and condition of residence

Comfort and condition of residence, which were only assessed at Wave 1, revealed significant positive correlations with all indicators of psychological well-being, for example:

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for both community and total samples at each Wave. In addition, minimum and maximum scores for continuous variables and values coded for categorical variables are stated.

[7] Pearson (*r*) correlation was conducted between continuous variables, Point-biserial (r_{pb}) correlation was conducted between dichotomous and continuous variables, and Phi (□) correlation was conducted between dichotomous variables. Dummy variables were computed for tenure, type of accommodation, marital status and support preference, thereby reducing them to dichotomous variables able to be included in the analyses. When used in correlations, they must be interpreted as (for example) public rental (coded 1) versus private rental and home owners (coded 0). Interpretation of dummy variables used in Analysis of Covariance (ANCOVA) and regressions will be detailed at appropriate sections.

- depression (r = -.12, p < .01; r = -.11, p < .01),
- morale (r = .15, p < .01; r = .12, p < .01),
- self-esteem (r = .10, p < .01; r = .11, p < .01), and
- satisfaction with life in general (r = .23, p < .01; r = .14, p < .01)
- expectancy of control (r = -.10, p < .01; r = -.07, p < .05)

For a complete list of significant correlations see Appendix D.

This implies that the better condition your home is in, or the more comfortable you perceive it to be, the better you fare psychologically. It may be suggested that the associations were merely indicative of a spurious relationship with income and assets; that is, the correlation is simply an artefact of the variables' association with a third causal factor, income or assets. Partial correlation was conducted to test this assumption, controlling for both income and assets, and while the strength of associations were reduced slightly, all correlations remained significant, except for expectancy of control (see Appendix D:4). Hence, further examination of the correlations with other well-being indicators, specifically social items, may provide an alternative explanation.

Comfort and condition of residence also displayed significant positive relationships with:

- emotional support (r = .08, p < .01; r = .08, p < .01),
- instrumental support (r = .06, p < .05; r = .07, p < .01), and
- satisfaction with family contact (r = .12, p < .01; r = .11, p < .01).

These associations are suggestive of the meaning of one's home going beyond its mere physical structure, encompassing aspects of the wider social environment. In other words, housing takes on a subjective quality beyond the provision of shelter, to include aspects of daily living such as maintenance of relationships, accessibility to facilities, and the quality of the community within which it is embedded. Furthermore, these correlations may explain the relationship between condition and comfort of residence and psychological well-being. The evidence for social support having a positive influence on psychological adjustment is well-documented (Antonucci and Jackson, 1987; Chappell, 1991; Takahashi, Tamura and Tokoro, 1997; Thoits, 1995; Vanderzee, Buunk and Sanderman, 1997), hence if an elder's home is supportive of positive social interactions, this in turn may reinforce greater psychological health. Indeed, housing may play a vital mediatory role in the maintenance of social and psychological well-being, which may be particularly so for older adults who spend much of their time at home. While the causal nature of these relationships remains unclear, the results provide initial indication of an important interaction which warrants further investigation.

3.2.1.4 Home hazards and alterations for property

Home hazards, which asked participants about any feature of their home (eg. poor lighting, steps) that made daily living more difficult, was only assessed at Wave 1. Alterations needed for a property to make it safer or easier to live independently was only assessed at Wave 6. Both variables displayed similar patterns of results, thus will be discussed together.

The absence of any significant correlations between home hazards or property alterations and demographic markers, in particular finances (*income* r_{pb} = -.01, p >.05, r_{pb} = .02, p >.05; *assets* r_{pb} = -.02, p >.05, r_{pb} = .01, p >.05), implies that simply providing the older population with more money may not improve the quality of their housing. Access to information about what assistance is available may be equally important, although no statistical support can be provided for this assumption.

Assessment of the relationship with tenure revealed that although there were no significant correlations for property alterations (*public* ϕ = -.01, p > .05; *private* ϕ = .01, p > .05; *home owner* ϕ = .01, p > .05), there was a positive relationship for private rental and home hazards (ϕ = .06, p < .05), suggesting that this group were more likely than home owners or public renters to experience difficulty with daily living due to features of their home. This result may illustrate the suggested reluctance of the private rental market to make modifications to stock when an older person's needs increase. Furthermore, such housing may be detrimental to their quality of life, reinforced by negative correlations between home hazards and health outcomes (for example, functional ability r_{pb} = -.12, p <.01; medical conditions r_{pb} = .10, p <.01), although it must be noted that due to the non-experimental nature of the data, cause and effect remains unanswered.

3.2.1.5 Activity level and problems of home maintenance

Home maintenance was assessed in two ways at each Wave. Firstly participants were directly asked if they had difficulty or needed help undertaking home maintenance. In addition to this question an aggregate response was also created from answers to 7 items used to assess respondents' actual activity levels in undertaking certain tasks. It may be noted that a negative correlation was observed between the two variables at each Wave (*W1* r_{pb} = -.30, p <.01; *W3* r_{pb} = -.25, p <.01; *W6* r_{pb} = -.16, p <.01), indicating that participants who expressed problems with home maintenance performed significantly less household maintenance than those without difficulties.

Relatively few differences were observed for problems and level of home maintenance between tenures and types of accommodation across each Wave (see sections 3.2.2.1.1 and 3.2.2.2). Of particular interest, however, were the relationships with other housing related items. Difficulties with home maintenance indicated significant positive correlations with duration of residence across all Waves (*W1* r_{pb} = .07, p < .01; *W3* r_{pb} = .10, p < .01;*W6* r_{pb} = .08, p < .05;), implying that the longer a person has resided in their home, the more likely they will encounter problems with home maintenance. It may be suggested that this is evident of the decline in overall quality of a property with time, which is reinforced by the negative correlation between duration and condition of residence at Wave 1 (r = -.17, p <.01). Furthermore, the negative relationship observed between home maintenance problems and condition of residence at Wave 1 (r_{pb} = -.05, p < .05), supports the suggestion that participants with homes in poorer condition experience more difficulty maintaining them. This becomes particularly important when implementing a policy of ageing in place, as the appropriateness of such a policy is undermined if adequate assistance schemes to facilitate the process aren't available.

Of particular importance are the strong relationships identified between level and problems with home maintenance, and health across each Wave, although the strength of associations reduced by Wave 6. For instance, participants experiencing problems with home maintenance revealed poorer functional ability (*W1* r_{pb} = -.34, p < .01; *W3* r_{pb} = -.19, p < .01; *W6* r_{pb} = -.09, p < .05), and more difficulties with ADLs (*W1* r_{pb} = .28, p < .01; *W3* r_{pb} = .28, p < .01; *W6* r_{pb} = .05, p > .05), while those performing more household maintenance showed greater self-rated health (*W1* r = .33, p < .01; *W3* r = .37, p < .01; *W6* r = .27, p < .01) and fewer medical conditions (*W1* r = -.11, p < .01; *W3* r = -.10, p < .01; *W6* r = -.16, p < .01), to name a few. While it may be argued that calls for improved assistance with home standards and maintenance cannot improve an elder's declining health, it nevertheless may help ameliorate decline in other well-being domains. Indeed, the reduction of one stress factor may have enormous implications for other related quality of life factors.

Examination of correlations with social and psychological domains also revealed numerous significant associations with problems and level of home maintenance. Participants experiencing difficulties with home maintenance displayed, for example, poorer psychological well-being (eg. greater depression, *W1* r_{pb} = .19, p < .01; *W3* r_{pb} = .18, p < .01; *W6* r_{pb} = .12, p < .01), and more practical support from children (*W1* r_{pb} = .18, p < .01; *W3* r_{pb} = .18, p < .01; *W6* r_{pb} = .10, p < .05). The opposite was revealed for participants performing more household maintenance, showing greater psychological well-being (eg. greater self-esteem, *W1* r = .20, p < .01; *W3* r = .23, p < .01; *W6* r = .15, p < .01), and an increase in various social interaction variables (eg. social contact with family, *W1* r = .13, p < .01; *W3* r = .16, p < .01; *W6* r = .15, p < .01) (For a complete list of significant correlations see Appendix D). While it may be suggested that an increase in psychological adjustment may be a result of participants feeling good about their ability to maintain their home and consequently themselves, a more likely explanation is that those who perform more household maintenance are ageing better across a range of well-being indicators. The converse may be true for elders experiencing difficulties with home maintenance. While causal inferences cannot be made, and may perhaps be viewed as unnecessary, it nevertheless must be recognised that home maintenance and social, health and psychological well-being indicators appear interconnected for the older population. Hence, the complexity of these relationships must not be overlooked when developing housing assistance programs.

3.2.1.6. Home type

Home type was categorised for participants living in the community as house or unit. The majority of participants resided in houses, with 70.5 per cent, 68.4 per cent and 69.7 per cent at Wave 1, Wave 3 and Wave 6 respectively. While few relationships were revealed between home type and various well-being indicators, considerable demographic differences were evident. Elders living in units or flats were observed to be significantly older, more likely to be women, born in English speaking countries, living in rental, group or retirement accommodation, had less income or assets, and were less likely to be married at Wave 1. A fairly consistent pattern of results was also found for Wave 3 and Wave 6 (see Appendix D).

Chi-square analyses revealed that participants in units were significantly greater utilisers of community support services (*W1 unit* 21%, *house* 14%, χ^2 = 16.07, p < .001; *W3 unit* 36.8%, *house* 25.1%, χ^2 = 20.32, p < .001; *W6 unit* 56.3%, *house* 41.6%, χ^2 = 12.07, p < .001). Such differences may be due in part to elders in units tending to reside in rental, group or retirement accommodation, where they may have greater access to information about services available. This will be addressed further in section 3.3.1.

Similarly, significant differences were observed for having one's name down at age-specific accommodation (*W1* ϕ = .11, p < .01; *W3* ϕ = .11, p < .01; *W6* ϕ = .15, p < .01), with participants in units more likely than those in houses to have made such preparations. In addition, results revealed a greater proportion of participants in units had relocated at each Wave (*W1 unit* 21.4%, *house* 4.0%, χ^2 = 147.16, p < .001; *W3 unit* 13.0%, *house* 2.6%, χ^2 = 64.36, p < .001; *W6 unit* 10.1%, *house* 30.2%, χ^2 = 41.28, p < .001). Taken together, these results imply that participants who had moved previously may be less daunted by future relocation, thereby taking steps to anticipate such events.

One of the few differences observed across the various well-being domains was for depression. Analysis of Variance (ANOVA) revealed that participants living in houses displayed lower depression at Wave 1 (F (1, 1874) = 11.63, p < .001) and Wave 3 (F (1, 1373) = 10.85, p < .001). Although no differences were observed at Wave 6, it has been previously noted that the remaining sample may be more homogenous,

hence explaining the absence of any effect. Nonetheless, while it cannot be assumed that home type influences one's level of depression, the wider social realm that it encompasses may. To test this assumption, a number of ANCOVAs were conducted to control for the influence of age, gender, marital status and assets separately. Significantly different levels of depression for each home type remained in all instances, however marital status was the only covariate which considerably reduced the strength of the effect (*W1 F* (1, 1872) = 6.35, $p < .01$; *W3 F* (1, 1371) = 4.12, $p < .05$). Hence, features of the social environment, in this case marital status, which are characteristic of participants in different home types may be influential in the differing levels of depression. However, due to the effects remaining significant after controlling for these influences, there is nevertheless something quite distinct about a house as opposed to a unit which may have contributed to such a difference.

3.2.1.7. Market value

Assessment of the market value of residences at each Wave revealed few significant associations with quality of life domains. However, examination of the correlations with psychological well-being variables indicated a limited number of general trends. For example, significant positive correlations were observed for general well-being (*W1 r* = .13, $p < .01$; *W3 r* = .03, $p > .05$; *W6 r* = .13, $p < .01$) and satisfaction with life in general (*W1 r* = .14, $p < .01$; *W6 r* = .134, $p < .01$), suggesting that participants with a home of higher market value displayed greater general well-being and satisfaction. Such relationships are possibly a consequence of the influence that finances may have on these global indicators of psychological adjustment. Furthermore, examination of the positive relationships between market value and other demographic markers imply that participants with a greater market value for their home may be socio-economically advantaged. For instance, they reported having

- more education (*W1* $r_{pb} = .16$, $p < .01$; *W3* $r_{pb} = .16$, $p < .01$; *W6* $r_{pb} = .17$, $p < .01$),
- more income (*W1 r* = .29, $p < .01$; *W3 r* = .26, $p < .01$; *W6 r* = .30, $p < .01$),
- more assets (*W1 r* = .34, $p < .01$; *W3 r* = .27, $p < .01$; *W6 r* = .23, $p < .01$) and
- multiple sources of income (*W1* $r_{pb} = .17$, $p < .01$; *W3* $r_{pb} = .12$, $p < .01$; *W6* $r_{pb} = .21$, $p < .01$).

Hence, perhaps the existence of an association between market value and psychological well-being is more representative of the influence of socio-economic status, rather than housing itself. A more detailed examination of these factors as social sustainability factors will be reported in section 3.3.3.

3.2.1.8. Household composition

Household composition assessed the number of people living with participants at each Wave. Strong positive correlations were observed with a number of variables in each quality of life domain. For example, those with a larger household composition were:

- younger (*W1 r* = -.24, $p < .01$; *W3 r* = -.24, $p < .01$; *W6 r* = -.23, $p < .01$),
- more likely married (*W1* $r_{pb} = .68$, $p < .01$; *W3* $r_{pb} = .71$, $p < .01$; *W6* $r_{pb} = .78$, $p < .01$),
- a home owner (*W1* $r_{pb} = .17$, $p < .01$; *W3* $r_{pb} = .13$, $p < .01$; *W6* $r_{pb} = .23$, $p < .01$),
- had a positive self appraisal of life expectancy (*W1 r* = .12, $p < .01$; *W3 r* = .09, $p < .01$),
- use fewer services (*W1 r* = -.17, $p < .01$; *W3 r* = -.25, $p < .01$; *W6 r* = -.31, $p < .01$), and
- had better morale (*W1 r* = .14, $p < .01$; *W3 r* = .13, $p < .01$; *W6 r* = .11, $p < .05$).

For a complete list of significant associations see Appendix D.

The existence of strong associations with most variables may be partly due to household composition representing more of a social influence, rather than housing *per se*. However, if housing as a whole is to be viewed as encompassing not only a physical structure, but also the wider social environment, then the inclusion of household composition in this category is appropriate. The dichotomy of household composition, co-resident status, has also been used in the assessment of social sustainability or vulnerability factors. Further analysis of the relationships between household composition, other housing indicators and well-being domain will be discussed below in section 3.2.1.9.

3.2.1.9 Summary of correlations

It must be noted that the predominant use of correlation above might be considered to be a more descriptive rather than inferential technique. However, due to the exploratory nature of the project, use of correlation is sufficient in providing initial evidence of associations, which need further investigation. Furthermore, it may also be argued that the above recommendations have been based on very weak correlations, which may simply be a result of high power in the analyses.[8] While the strength of associations are low, this may be attributed to a number of other factors. The majority of variables used were based on single questionnaire items. For example, condition of residence was assessed by asking participants "Overall would you say this house, flat or unit is in good, average or poor condition?" Use of single items not only reduces the sensitivity of the variable in capturing maximum variance, but also has a greater amount of error associated with measurement. This is compared with validated and reliable questionnaires comprising multiple items. In addition, the mathematics of correlating very different variables (for example, dichotomous, with single continuous, with multiple item aggregates) may also reduce the strength of associations (Tabachnick & Fidell, 1996). Nevertheless, the correlations reflected significant and systematic associations, and cannot be attributed to simply an abundance of power. Moreover, as ALSA was not designed as a housing study, the items included were very broad and may not have discriminated fully between participants. Hence, if consistently significant results were obtained with these basic items, future studies using more appropriate measures may find even stronger evidence for these relationships.

3.2.1.10 Multiple regression analyses

After examining bivariate correlations between housing and well-being above, multiple linear regression was employed cross-sectionally for Wave 1 only, to assess both the combined contribution of housing towards well-being for the older population, as well as which individual housing item was the strongest predictor. This was achieved by examining both the variance for the model and the standardised regression coefficients respectively. Tenure, type of accommodation, comfort and condition of residence, home hazards, home type, number of rooms, duration of residence, and household composition were regressed on all continuous social, psychological, health, and cognitive quality of life indicators. It may be noted that housing items which had considerable missing data were not included as predictors. In addition, N-1 dummy variables were included as predictors for tenure and type of accommodation. These must be interpreted as (for example) public rental (coded 1) versus the non-represented category (coded 0). Hence, public rental and home owners which were included in analyses are in reference to private rental.

[8] Power is the probability of correctly identifying an association between two variables. It is desirable to have enough power in analyses to identify meaningful relationships, however because increasing the sample size increases the power, with such a large sample there is a danger of having too much power where all (very weak) associations are significant, yet meaningless.

Multiple regression analyses revealed that housing contributed a significant, yet small proportion of the variance of well-being, ranging between approximately 2-6 per cent depending on the criterion variable. For example, the combined housing items explained:

- 5.7% of the variance in depression (R^2 = .057, F (12, 1759) = 9.23, p < .001),
- 5.0% of the variance in functional ability (R^2 = .050, F (12, 1830) = 8.10, p < .001), and
- 5.3% of the variance in instrumental support (R^2 = .053, F (12, 1830) = 8.62, p < .001).

For a full summary of regressions see Appendix E.

Hence, this suggests housing has a significant impact on quality of life for the older population. Although no obvious trends were evident, psychological variables were perhaps slightly more sensitive to the impact of housing, as the amount of variance explained was greatest for these variables. This reflects similar patterns observed in the above correlations.

Examination of individual predictors revealed both positive and negative influences of housing. For example, participants experiencing higher levels of depression revealed

- smaller household compositions (β = -.13, t = 5.44, p < .001),
- poorer condition (β = -.08, t = 3.32, p < .001)
- and comfort of residence (β = -.07, t = 2.71, p < .01),
- more home hazards (β = .08, t = 3.23, p < .001) and
- were more likely public renters compared with private (β = .09, t = 2.31, p < .05).

A general trend emerged that household composition was the most significant predictor in most instances, which may be explained by its broader socially supportive nature, which has been detailed above. In addition, comfort and condition of residence also contributed to greater physical, psychological and social well-being, which may be a result of the more subjective nature of these assessments, as has been previously noted. To a lesser extent, tenure and home hazards contributed to well-being on a number of occasions (see Appendix E).

The limited amount of variance explained by housing was not unexpected, given the vast array of past and present experiences which may impact upon health, social, or psychological adjustment for older adults. Nevertheless, these results highlighted the appropriateness of regression analyses. Indeed, assessment of the amount of variance housing accounts for in well-being is not necessarily an informative approach for policy development. Hence, the above regression analyses were not repeated for Wave 3 or Wave 6. Alternatively, comparisons of well-being indicators for tenure, and type of accommodation using ANOVA and ANCOVA were conducted, in order to provide an overall profile of participants living in these differing forms of housing. This may allow for both evaluation of the effectiveness of the housing, in addition to emphasising the needs to be addressed in these sub-populations.

3.2.2. Well-being comparison for tenures and types of accommodation

The following section will provide an overview of the basic differences between tenures across the three Waves in each of the quality of life domains. To a lesser extent, examination of the differences between type of accommodation will also be discussed. ANOVA was conducted to test these differences initially, followed by ANCOVA to test the unique differences between the groups after removing any effect from age, gender and marital status. The influence of assets was also controlled for

in a series of ANCOVAs, however because assets may be viewed as a qualifying feature in the accessibility of the various tenure types, this was considered less important.[9]

3.2.2.1 Tenure

Table 3.2 provides the socio-demographic characteristics of community residents for each tenure at Waves 1, 3 and 6.[10] As indicated in Table 3.2, basic characteristics of participants differed between tenures across Waves. This was supported by results of Chi-square analyses, which reported significant differences for:

- age (*W1* χ^2 = 25.90, $p < .001$; *W3* χ^2 = 24.80, $p < .001$; *W6* χ^2 = 15.00, $p < .001$)
- marital status (*W1* χ^2 = 72.08, $p < .001$; *W3* χ^2 = 43.27, $p < .001$; *W6* χ^2 = 43.90, $p < .001$)
- ethnicity (*W1* χ^2 = 11.43, $p < .01$; *W3* χ^2 = 8.34, $p < .01$; *W6* χ^2 = 7.69, $p < .05$)
- co-resident status (ie. participants living alone: *W1 public* 39.0%, *private* 47.7%, *home owner* 23.3% χ^2= 50.60, $p < .001$; *W3 public* 45.2%, *private* 51.0%, *home owner* 28.2% χ^2= 27.37, $p < .001$; *W6 public* 76.9%, *private* 77.6%, *home owner* 44.0% χ^2= 33.29, $p < .001$) and
- level of education (*W1* χ^2= 30.10, $p < .001$; *W3* χ^2 = 18.78, $p < .001$; *W6* χ^2 = 7.68, $p < .05$).

[9] Due to the missing listwise procedure, MANOVA could not be utilised in this instance, as the number of cases for analyses were reduced to an unacceptable level.

[10] N=88 (4.5%), N=72 (4.7%) and N=28 (4.3%) of the community sample were not stated for tenure at Wave 1, Wave 3 and Wave 6 respectively.

Table 3.2: Socio-demographic characteristics of Tenure at Wave 1, 3 and 6 .

	Tenure Type [a]																	
	Wave 1						Wave 3						Wave 6					
	Public Rental		Private Rental		Home Ownership		Public Rental		Private Rental		Home Ownership		Public Rental		Private Rental		Home Ownership	
Characteristic	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	*213*	*11.4*	*111*	*5.9*	*1547*	*82.7*	*164*	*11.3*	*83*	*5.7*	*1203*	*83.0*	*41*	*6.5*	*49*	*7.8*	*538*	*85.7*
Sex	*213*	*100.0*	*111*	*100.0*	*1547*	*100.0*	*164*	*100.0*	*83*	*100.0*	*1203*	*100.0*	*41*	*100.0*	*49*	*100.0*	*538*	*100.0*
Male	96	45.1	54	48.6	810	52.4	72	43.9	33	39.8	611	50.8	16	39.0	18	36.7	229	42.6
Female	117	54.9	57	51.4	737	47.6	92	56.1	50	60.2	295	49.2	25	61.0	31	63.3	309	57.4
Age	*213*	*100.0*	*111*	*100.0*	*1547*	*100.0*	*164*	*100.0*	*83*	*100.0*	*1203*	*100.0*	*41*	*100.0*	*49*	*100.0*	*538*	*100.0*
65 – 69	11	5.2	1	0.9	124	8.0	1	.6	2	2.4	51	4.2	0	0.0	0	0.0	0	0.0
70 – 74	51	23.9	23	20.7	473	30.6	37	22.6	13	15.7	328	27.3	0	0.0	0	0.0	23	4.3
75 – 79	58	27.2	29	26.1	400	25.9	42	25.6	19	22.9	358	29.8	11	26.8	9	18.4	164	30.5
80 – 84	55	25.8	33	29.7	296	19.1	44	26.8	27	32.5	258	21.4	18	43.9	15	30.6	199	37.0
85 and over	38	17.8	25	22.5	254	16.4	40	24.4	22	26.5	208	17.3	12	29.3	25	51.0	152	28.3
Marital Status	*213*	*100.0*	*111*	*100.0*	*1547*	*100.0*	*164*	*100.0*	*83*	*100.0*	*1203*	*100.0*	*41*	*100.0*	*49*	*100.0*	*538*	*100.0*
Married/Defacto	110	51.6	58	52.3	1131	73.1	78	47.6	40	48.2	811	67.4	8	19.5	10	20.4	300	55.8
Not Married	24	11.3	17	15.3	62	4.0	16	9.8	10	12.0	45	3.7	5	12.2	3	8.1	16	3.0
Widowed	79	37.1	36	32.4	354	22.9	70	42.7	33	39.8	347	28.8	28	68.3	36	73.5	222	41.3
Birthplace	*213*	*100.0*	*111*	*100.0*	*1547*	*100.0*	*164*	*100.0*	*83*	*100.0*	*1203*	*100.0*	*41*	*100.0*	*49*	*100.0*	*538*	*100.0*
English speaking	199	93.4	106	95.5	1357	87.7	153	93.3	79	95.2	1054	87.6	39	95.1	49	100.0	477	88.7
Non-English	14	6.6	5	4.5	190	12.3	11	6.7	4	4.8	149	12.4	2	4.9	0	0.0	61	11.3
Education level	*213*	*100.0*	*111*	*100.0*	*1541*	*99.6*	*164*	*100.0*	*83*	*100.0*	*1198*	*99.6*	*41*	*100.0*	*49*	*100.0*	*538*	*100.0*
< 14 years	155	72.8	53	47.7	830	53.9	116	70.7	40	48.2	643	53.7	29	70.7	26	53.1	261	48.5
> 15 years	58	27.2	58	52.3	711	46.1	48	29.3	43	51.8	555	46.3	12	29.3	23	46.9	277	51.5
Annual Income	*207*	*97.2*	*105*	*94.6*	*1455*	*94.0*	*152*	*92.7*	*73*	*87.9*	*1011*	*84.0*	*32*	*78.0*	*41*	*83.2*	*419*	*77.9*
12 000 or less	104	50.2	47	44.8	454	31.2	84	55.3	34	46.6	360	35.6	15	46.9	18	43.9	109	26.0
12 001 – 20 000	94	45.4	46	43.8	675	46.4	65	42.8	29	39.7	458	45.3	12	37.5	17	41.5	157	37.5
20 001 – 30 000	7	3.4	7	6.7	181	12.4	3	2.0	5	6.8	115	11.4	5	15.6	2	4.9	93	22.2
30 001 – 50 000	1	0.5	5	4.8	122	8.4	0	0.0	5	6.8	64	6.3	0	0.0	4	9.8	45	10.7
Over 50 000	1	0.5	0	0.0	23	1.6	0	0.0	0	0.0	14	1.4	0	0.0	0	0.0	15	3.6
Total Assets	*196*	*92.0*	*98*	*88.3*	*1289*	*83.3*	*139*	*84.7*	*70*	*84.3*	*950*	*79.0*	*27*	*65.9*	*38*	*77.6*	*363*	*67.5*
10 000 or less	145	74.0	36	36.7	404	31.3	91	65.5	19	27.1	271	28.5	18	66.7	10	26.3	99	27.3
10 001 – 20 000	27	13.8	24	24.5	273	21.2	25	18.0	13	18.6	201	21.2	4	14.8	13	34.2	51	14.0
20 001 – 50 000	19	9.7	20	20.4	288	22.3	22	15.8	25	35.7	249	26.2	3	11.1	10	26.3	91	25.1
Over 50 000	5	2.6	18	18.4	324	25.1	1	.7	13	18.6	229	24.1	2	7.4	5	13.2	122	33.6

[a] N=88 (4.5%), N=72 (4.7%) and N=28 (4.3%) of community sample not stated for tenure at W1, W3 and W6 respective

This suggests that differences between tenure go beyond merely choice of housing, reflecting characteristic differences between elders occupying these tenures. Further differences between other socio-demographic indicators were evident. Significant differences between level of income (*W1 F* (2, 1764) = 27.91, $p < .001$; *W3 F* (2, 1231) = 18.50, $p < .001$; *W6 F* (2, 489) = 8.12, $p < .001$) and assets (*W1 F* (2, 1580) = 67.76, $p < .001$; *W3 F* (2, 1154) = 44.66, $p < .001$; *W6 F* (2, 425) = 11.42, $p < .001$) were found at each Wave, although the strength of the effect reduced slightly over time. In addition, differences between pensioner status were observed, with public renters reporting most reliance on a pension as their only source of income, with private renters and home owners displaying less reliance respectively (*W1 public* 64.3%, *private* 37.8%, *home owners* 28.3%, $\chi^2 = 111.08$, $p < .001$; *W3 public* 61.6%, *private* 39.8%, *home owners* 32.4%, $\chi^2 = 53.70$, $p < .001$; *W6 public* 68.3%, *private* 40.8%, *home owners* 40.0%, $\chi^2 = 12.59$, $p < .01$). Furthermore, receipt of financial housing assistance was assessed at Wave 6 only, with significant differences revealed between tenures (*public* 48.8%, *private* 28.6%, *home owners* 1.5%, $\chi^2 = 177.32$, $p < .001$). This result was not unexpected, however, particularly the disparity between public renters and home owners, as one of the qualifying features of accessing public housing is to be economically disadvantaged. It may be assumed that the converse is true of those who own their own home. The importance of these differences becomes apparent when examining various quality of life indicators. As the literature suggests, levels of socio-economic disadvantage have enormous implications for health outcomes (Phibbs, 1999). Our results tend to reinforce this view, and go further by addressing social and psychological outcomes as well. Specific details of these results will be reported in section 3.2.2.1.2. Hence, implementation of effective housing policy requires concentration on the varying needs of these groups. Nevertheless, consideration of basic differences on quality and condition of housing is equally important, and will be discussed below.

3.2.2.1.1. Tenure and housing

Differences between tenures on housing related factors, such as type of accommodation, duration of residence, condition, comfort, home hazards, alterations needed for independent living, level and problems with home maintenance, and likes and dislikes about home were examined across Waves. Table 3.3 shows the distribution of participants by tenure and type of housing, with significant differences observed. Public renters and homes owners predominantly lived in independent accommodation with less in group housing or retirement villages respectively. However, private renters were distributed approximately equally across the three types of housing. However, private renters were distributed approximately equally across the three types of housing. Similarly, examination of ANOVAs revealed characteristic patterns for the tenures on duration of residence. It was consistently found that home owners had resided in their homes for significantly longer periods than both private and public renters, and private renters had also lived for significantly shorter periods in the one house than public renters (*W1 F* (2, 1862) = 58.91, $p < .001$; *W3 F* (2, 1439) = 35.89, $p < .001$; *W6 F* (2, 619) = 25.34, $p < .001$).

Not only were the types of accommodation and duration of residence significantly different between tenures, but an effect of the quality of the housing was also observed. Condition of housing, comfort of residence, and home hazards, which were only assessed at Wave 1, revealed that public renters tended to report poorer outcomes. Results of ANOVAs indicated they were significantly poorer than both home owners and private renters on comfort of residence (*F* (2, 1868) = 26.79, $p < .001$) and significantly poorer than private renters only on condition of residence (*F* (2, 1868) = 4.78, $p < .01$). Analyses also revealed that private renters had significantly better condition of residence than home owners. After controlling for demographic influences, the pattern of results remained significant (Appendix F:1).

Furthermore, although the overall condition of private rental was better, examination of specific features which may be hazardous for daily living (eg. steps) indicated that private renters experienced significantly more hazards (*public* 7.5%, *private* 10.8%, *home owners* 5.0%, $\chi^2 = 7.99, p < .01$). Hence, although private rental accommodation may be in better overall condition, which was not unexpected, given the frequency of these participants in group and retirement villages, the appropriateness of this housing for the older population may not always be optimal.

Table 3.3: Proportion of tenures living independently, in group housing or in retirement villages at each Wave

	Tenure											
	Wave 1						Wave 6					
Type of	Public Rental		Private Rental		Home Ownership		Public Rental		Private Rental		Home Ownership	
Housing	N	%	N	%	N	%	N	%	N	%	N	%
Independent	179	84.0	43	39.1	1466	94.8	32	78.0	12	24.5	470	87.4
Group Housing	33	15.5	29	26.4	33	2.1	7	17.1	22	44.9	43	8.0
Retirement Village	1	.5	38	34.5	48	3.1	2	4.9	15	30.6	25	4.6

percent stated within tenure type
type of accommodation not assessed at Wave 3
Wave 1 $\chi^2 = 433.56$, $p < .001$; Wave 6 $\chi^2 = 121.81$, $p < .001$

The above implies that alterations may be necessary for a small section of the older population in order to live independently. Assessment of the types of alterations needed was conducted at Wave 6 only, and although it has been previously noted that the remaining sample may differ somewhat than participants in Wave 1, a general trend emerged. As can be seen in table 3.4 as a general guide, for the total sample structural changes (24.5%) and multiple alterations (25.5%) were the most common answers.[11] This response varied by tenure with the most common alterations need for private renters being structural changes (36.4%), compared with home owners (25.0%) and public renters (0.0%) reinforcing the inappropriateness of some private rental accommodation to the needs of the older population. This supports previous claims that to advocate a policy of ageing in place, strategies for addressing the changing needs of the older population in terms of housing specifications are essential.

Table 3:4 Alterations needed for property to allow safer or more independent living (Wave 6)

	Tenure						Total community sample	
	Public Rental		Private Rental		Home Ownership			
Alterations	N	%	N	%	N	%	N	%
Rails, bar straps	3	42.9	1	9.1	9	11.3	13	13.3
General maintenance	0	.0	0	.0	17	21.3	17	17.3
Structural changes	0	.0	4	36.4	20	25.0	24	24.5
Security	1	14.3	2	18.2	7	8.8	10	10.2
New/changed heating / cooling	0	.0	0	.0	3	3.8	3	3.1
Multiple changes	3	42.9	1	9.1	21	26.3	25	25.5
Other	0	.0	3	27.3	3	3.8	6	6.1

percent stated within tenure type

[11] Due to the small response rate, Chi-square tests of significance could not be conducted.

Given the above results, it is somewhat surprising that consistently significant differences were not observed between tenures for problems with home maintenance. Furthermore, although differences between the level of household maintenance conducted were evident across Waves, results of ANCOVAs were non-significant, revealing that a participant's age and sex were more influential in the amount of household maintenance they performed (For a summary of these analyses see Appendix F:2 and F:3). Nevertheless, as previously discussed, problems and level of home maintenance have considerable implications for well-being, and the absence of any effect of tenure should not discount this.

Part of the problem whereby home hazards and home alterations become an issue for older people to remain living independently is that in building and purchasing/renting homes, little consideration has often been given to the needs and requirements of the older population and of the need to consult with older people themselves. One way in which ALSA addressed this concern was to ask participants "What is the main thing you like/really do not like about living in this home?" While responses to these questions were relatively low, a number of general trends emerged, although Chi-square tests of significance could not be conducted reliably. Nevertheless, patterns were evident between both tenures, and the sample as a whole (Table 3.5). It was found that access to services (20.7%), ambience / aesthetics of location (20.1%) and specific features (eg. space, comfort, garden, 23.3%) were most liked by respondents. Furthermore, while nostalgia was quite high for public renters (24.3%) and home owners (12.1%), it was relatively unimportant for private renters (3.0%), which may be a reflection of the mobility of private renters in terms of housing. Examination of dislikes revealed that specific features (19.2%), neighbours (18.7%) and area / location (eg. traffic, noise, proximity, 17.2%) were most disliked by respondents, while the cost of housing was relatively minor (1.0%). In addition, comparisons between tenures revealed that neighbours were the most disliked feature for public renters (41.2%), compared with private (25%) and home owners (15.9%), which may be a reflection of the level of choice of property that each group have respectively. Taken together these results support the increasing awareness that factors other than just cost and finances are important to the well-being of older people.

3.2.2.1.2 Tenure and well-being

As noted above, a series of ANOVAs and ANCOVAs were conducted cross-sectionally at each Wave to examine the basic differences between tenures on all domains of quality of life. Appendix G provides a summary of analyses, including means and adjusted means, main effects and planned comparisons. While it is beyond the scope of this paper to detail the analysis of every individual quality of life indicator, general trends will be presented for each domain, although it must be noted that significant results may not have been obtained for each indicator.[12]

Examination of health indicators revealed few consistent differences between tenures across time. A number of general patterns were evident in Wave 1, with public renters displaying significantly poorer outcomes on self-rated health (F (2, 1861) = 5.65, $p < .01$) and IADLs (F (2, 1864) = 5.75, $p < .01$), although no effects were evident at Wave 3 or Wave 6. Similarly, private rental reported significantly more medical conditions than public rental or home owners at Wave 6 (F (2, 616) = 5.57, $p < .01$), but no effects were evident at other Waves. Those variables that consistently displayed no differences between tenures were health trajectory, number of falls, self appraisal of life expectancy and health professionals consulted. Furthermore, many effects evident in ANOVAs were reduced when controlling for the influence of age,

[12] Although utilising these statistical techniques with very unequal cell sizes was not ideal, it was nevertheless a true reflection of the frequency of tenures in the general population, and accordingly was not altered. It may be noted that results in parentheses are for ANCOVAs, unless stated otherwise.

Table 3.5: Participant's likes and dislikes about their place of residence (Wave 6)

Likes and dislikes about place of residence	Tenure						Total community sample	
	Public Rental		Private Rental		Home Ownership			
	N	%	N	%	N	%	N	%
Likes								
Close to family	2	5.4	5	10.2	30	6.3	37	6.5
Access to services	8	21.6	13	22.4	96	20.0	117	20.7
Nostalgia (ie. memories, built themselves)	9	24.3	1	3.0	58	12.1	68	12.0
Ambience / Aesthetics	6	16.2	7	14.3	101	21.0	114	20.1
Specific features (eg. space, comfort, garden)	8	21.6	7	15.3	117	24.4	132	23.3
Easy to maintain	2	5.4	5	11.3	18	3.8	25	4.4
Cost	1	2.7	1	2.0	11	2.3	13	2.3
Security	0	.0	4	9.2	17	3.5	21	3.7
Independence	1	.0	6	12.3	32	6.6	39	6.9
Dislikes								
Space	1	5.9	4	25.0	14	8.2	19	9.4
Neighbours	7	41.2	4	25.0	27	15.9	38	18.7
Can't cope / manage at home	0	.0	0	.0	3	1.8	3	1.5
Too much maintenance (home and garden)	0	.0	0	.0	27	15.9	27	13.3
Loneliness / too far from family or friends	0	.0	1	6.2	16	9.4	17	8.4
Area / Location (eg. hills, noise, traffic)	3	17.6	0	.0	32	18.8	35	17.2
Carers at aged-care complex	0	.0	1	6.2	3	1.8	4	1.5
Specific features (eg. poor condition, design)	5	29.4	4	25.0	30	17.6	39	19.2
Too far from or can't access facilities/services	1	5.9	2	12.5	16	9.4	19	9.8
Cost	0	.0	0	.0	2	1.2	2	1.0

percent stated within tenure type

gender and marital status. In particular, removing the effect of age altered results which reported public rental experiencing more problems with ADLs, and private rental having poorer functional ability than home owners. However, functional ability continued to reveal a significant pattern for public renters who experienced poorer outcomes than home owners (*W1 F* (2, 1864) = 5.37, $p < .01$; *W3 F* (2, 1436) = 5.15, $p < .01$; *W6 F* (2, 620) = 2.80, $p > .05$), although no effect was evident at Wave 6. Health related items, such as service use and self-appraisal of future need for a nursing home provided greater consistency across Waves. ANCOVAs revealed private renters were significantly more likely to need a nursing home in the future (*W1 F* (2, 1678) = 2.91, $p < .05$; *W3 F* (2, 1310) = 8.73, $p < .001$). In addition, private and public renters tended to report greater use of community services than home owners (*W1 F* (2, 1864) = 4.66, $p < .01$; *W3 F* (2, 1447) = .3.28, $p < .05$; *W6 F* (2, 621) = 2.83, $p < .05$), which will be detailed further in section 3.3.1.

While few consistent results were observed for health outcomes, a number of variables reflected a disparity between public renters and home owners. This was reinforced when examining psychological and cognitive well-being indicators. Consistent results across Waves were obtained for depression and morale only, which may reflect a more global or whole of life quality, compared with other

indicators of psychological well-being such as self-esteem or expectancy of control. ANOVAs revealed public renters experienced greater depression than private renters and home owners, which was also obtained after removing the effect of age, gender and marital status (*W1 F* (2, 1789) = 8.89, $p < .001$; *W3 F* (2, 1306) = 5.64, $p < .01$; *W6 F* (2, 516) = 4.40, $p < .01$). Similarly, examination of morale indicated that public renters reported poorer morale than home owners, which remained significant in ANCOVAs (*W1 F* (2, 1115) = 3.68, $p < .05$; *W3 F* (2, 881) = 4.16, $p < .01$; *W6 F* (2, 336) = 2.91, $p < .05$). While no other effects were observed at Wave 6, a pattern of results emerged between Wave 1 and Wave 3. For example, public renters displayed significantly poorer general well-being (*W1 F* (2, 1775) = 11.40, $p < .001$; *W3 F* (2, 1277) = 8.07, $p < .001$), and less satisfaction with place of residence (*W1 F* (2, 1855) = 26.13, $p < .001$), finances (*W1 F* (2, 1855) = 9.94, $p < .001$), friends (*W1 F* (2, 1834) = 7.66, $p < .001$) and life in general (*W1 F* (2, 1852) = 3.60, $p < .05$) than private renters or home owners. For a full summary of analyses see Appendix G.

As noted previously, it is well documented that social support has a positive influence on psychological adjustment. Hence, it was considered that perhaps the distinction between public renters and home owners above may be explained in terms of lack of social support. However, examination of social indicators revealed the opposite. ANOVAs indicated public renters had significantly larger family networks (*W1 F* (2, 1868) = 8.69, $p < .001$; *W3 F* (2, 1442) = 1.69, $p > .05$; *W6 F* (2, 625) = 4.30, $p < .01$) and greater support from children (*W1 F* (2, 1868) = 5.90, $p < .01$; *W3 F* (2, 1442) = 2.56, $p < .05$; *W6 F* (2, 625) = 4.51, $p < .01$), compared with home owners and private renters, which may influence greater psychological health. The absence of such an outcome implies that public renters probably experienced poorer psychological well-being or health for other reasons. No differences were observed between tenures when examining functional support indicators such as emotional support or satisfaction with contact with family. Hence, it may be suggested that differences were only observed for structural support items, which have limited effect on psychological well-being compared with functional support (Antonucci and Jackson, 1987; Hawley and Klauber, 1988; Krause, 1997). Examination of other social indicators may provide an alternative explanation. In comparison to private renters and home owners, public renters displayed:

- significantly smaller social networks (eg. friends) (*W1 F* (2, 1864) = 7.73, $p < .001$),
- fewer group memberships (*W1 F* (2, 1864) = 5.82, $p < .01$), and
- smaller household composition (ANOVAs *W1 F* (2, 1868) = 27.94, $p < .001$; *W3 F* (2, 1304) = 11.86, $p < .001$; *W6 F* (2, 590) = 16.10, $p < .001$).

This pattern of results is indicative of social isolation, which may lessen any positive influence from structural or instrumental support.

Examination of social indicators for private renters suggest they may be socially vulnerable. They tended to report significantly:

- smaller family networks (*W1 F* (2, 1864) = 11.23, $p < .001$),
- smaller household compositions (ANOVAs *W1 F* (2, 1868) = 27.94, $p < .001$; *W3 F* (2, 1304) = 11.86, $p < .001$; *W6 F* (2, 590) = 16.10, $p < .001$),
- less contact with family (ANOVAs *W1 F* (2, 1864) = 6.22, $p < .01$; *W3 F* (2, 1442) = 3.15, $p < .05$; *W6 F* (2, 625) = .87, $p > .05$), and
- less support from children (*W1 F* (2, 1864) = 6.22, $p < .01$; *W3 F* (2, 1443) = 2.83, $p < .05$).

It may be argued that these results are perhaps a reflection of the large proportion of unmarried or widowed participants in this tenure, and do not appear to have a detrimental effect on other well-being domains. Nevertheless, the reliance on one's

family for care and support, when adequate assistance is not available from community services, is not always an option, and may explain the tendency of private renters to prematurely relocate to institutions. This will be detailed further in section 3.4.1.2.

As a final note, it may be argued that the absence of many significant results in Wave 6 may be a consequence of insufficient power in the analyses due to the small cell sizes. While this may have had some impact, it may also be suggested that characteristics of participants remaining in Wave 6 have produced this pattern. Consistent results were evidenced between Wave 1 and 3, which were conducted two years apart, suggesting the overall pattern of participants in tenures had not changed. However, by Wave 6, which was conducted six years later, remaining participants appeared to represent a more homogenous group than the original sample, which is somewhat reflected by the generally lower variance of measures at Wave 6, compared with previous Waves (see Appendix B). Furthermore, examination of the proportion of participants in institutions increases over time (*W1* 6.1%, *W3* 9.4%, *W6* 15.8%), thus it may be implied that participants who experienced poorer well-being outcomes may have moved to institutions or died. Hence, those remaining may be viewed as ageing well, thereby functioning fairly successfully on all quality of life indicators, regardless of tenure.

Taken together, these results suggest that although considerable differences between tenures were not obtained for all quality of life indicators, a number of characteristic distinctions were observed. In particular, it may be noted that private renters and home owners were similar in their health and psychological well-being, with non-significant differences evident on most outcomes, although means and adjusted means for private renters tended to be slightly lower. This unexpected relationship will be addressed below in section 3.3.2.1.3. In addition, while few significant differences were observed between public and private renters, public renters and home owners were quite distinct, with public rental tending to report significantly poorer outcomes on most indicators. While the nature or extent of influence that tenure itself has on these differences is not clearly understood, these results nevertheless provide initial indication of characteristic differences which warrant further investigation. Indeed, the provision of a basic profile of each group is an essential first step in developing appropriate and effective housing policy.

3.2.2.1.3 Private renter examination

The above analyses suggest that in terms of well-being, private renters tend to be better off than public renters, displaying more resemblance to home owners. This result was somewhat surprising, given reports at focus groups and in the literature (Phibbs 1999; Easterlow, Smith and Mallinson 2000) which suggest private renters to be most vulnerable due to lack of security of tenure. To investigate possible explanations for these results, a series of t-tests were conducted at Wave 1 only, to test for possible sub-groups within this tenure which may have increased their overall well-being.

As the literature suggests, elders in retirement villages tend to experience greater quality of life (section 1.7.2). Results in section 3.2.2.1.1 reveal a considerably greater proportion of private renters residing in retirement villages than public renters or home owners, which may have influenced the overall group. T-tests comparisons between private renters living in retirement villages and those living in both group housing and independently revealed that participants in retirement villages paid significantly less weekly rent (t (103) = 2.09, p <.05), and had a smaller family network (t (108) = 2.75, p <.01). No other effects were observed.

An alternative explanation explored was that few private renters in the sample lived independently in the general private market, with most living in age-specific accommodation at Wave 1 (60.9%). It was considered that those living independently may display poorer well-being outcomes. T-test comparisons between private renters living independently and those in both group housing and retirement villages revealed that independent participants paid significantly higher weekly rent (t (103) = 3.12, p <.01), and had significantly larger family networks (t (103) = 2.67, p <.01), with no other differences observed. Furthermore, one-way ANOVAs comparing the unique effect of each type of accommodation on private rental reported no significant differences between each housing type on any health, social or psychological indicators.

In addition, the potential influence of assets was also examined, given the greater proportion of private renters in higher income and asset categories compared with public rental. However, no differences were observed between comparison groups, which included pensioners versus participants with multiple income sources, and various combinations of assets groups (<20K, 20-50+K; <10K, 10-50+K; 10-50K, 50+K), except on income specific items. Hence, it cannot not be assumed that private renters experienced greater well-being than expected due to the influence of specific subgroups within it.

The above analyses provided no insight into the well-being outcomes of private renters, hence examination of duration of residence was also conducted to investigate other possible explanations. While correlations previously noted revealed that private rental had a significantly shorter duration of residence than public rental or home owners, the frequency of private renters within each category revealed that 20% had resided in their home for more than 20 years. Furthermore, cross-tabs with age tended to indicate the greatest proportion (86%) of these participants were 80 years of age or older, suggesting they may have moved into their accommodation at retirement age. This pattern of relocation, which indicates a certain degree of planning, was also reflected in the less than 5 years duration category, with a large proportion (47.8%) being participants aged 70-74 years. Hence, the assumption of private renters experiencing vulnerability due to lack of security of tenure may not be as apparent for this population. Moreover, limited sampling of elders living in caravan parks or boarding houses may have resulted in our private renters being more representative of home owners than a group most at risk.

3.2.2.1.4 Asset comparison

It may be argued that differences observed in well-being are merely an artefact of the distinct financial situations of the tenures. In other words, significantly more home owners, and to a lesser extent private renters, had higher income and assets compared with public renters, thereby influencing the increased level of well-being in the group as a whole**.** This is somewhat reflected by the positive associations quality of life has with assets, as indicated in section 3.3.3. Therefore, to test this assumption, ANOVAs were conducted at Wave 1 only, comparing the well-being of participants in the lowest asset category (<10K) across tenures. Results indicated very few significant differences, the exception being age (F (2, 582) = 10.92, p < .001), household composition (F (2, 582) = 15.47, p < .001), duration of residence (F (2, 579) = 15.25, p < .001), and household maintenance (F (2, 568) = 3.96, p < .05). These results suggest that elders who are economically challenged experience poorer well-being outcomes, regardless of tenure. However, it must be recognised that the complex role that housing may play in this process cannot be discounted, yet remains unclear. Furthermore, whether or not well-being differences between tenures can be attributed to socio-economic status, these differences are nonetheless characteristic of the groups, and illustrate the varying needs which must be addressed to adequately improve housing assistance.

3.2.2.2 Type of accommodation

Type of accommodation, which detailed whether participants lived independently, in group housing, or in a retirement village, was only assessed at Wave 1 and Wave 6. Appendix B details the proportion of participants in each type of accommodation, with the majority living independently at each Wave. Examination of socio-demographic information was conducted using Chi-square analyses and ANOVAs. Results revealed consistent characteristic differences across Waves for:

- age (*W1* independent younger than group and retirement villages F (2, 1935) = 9.08, $p < .001$; *W6* independent younger than group F (2, 653) = 4.03, $p < .05$)
- gender (ie. participants who are female: *W1 independen*t 48.0%, *group* 60.7%, *retirement village* 53.5%, $\chi^2 = 7.33$, $p < .05$; *W6 independent* 55.6%, *group* 71.2%, *retirement village* 58.8%, $\chi^2 = 6.43$, $p < .05$)
- marital status (*W1 married:* independent 70.6%, group 45.8%, retirement village 60.9%, *not married*: independent 5.2%, group 12.1%, retirement village 4.3%, *widowed*: independent 24.2%, group 42.1%, retirement village 34.8%, $\chi^2 = 34.69$, $p < .001$; *W6 married:* independent 55.3%, group 20.5%, retirement village 45.1%, *not married*: independent 3.0%, group 8.2%, retirement village 3.9%, *widowed*: independent 41.7%, group 71.2%, retirement village 51.0%, $\chi^2 = 32.95$, $p < .001$)
- co-resident status (ie. participants living alone: *W1 independent* 24.9%, *group* 51.4%, *retirement village* 40.2% $\chi^2 = 44.40$, $p < .001$; *W6 independen*t 42.8%, *group* 79.2%, *retirement village* 62.0% $\chi^2 = 37.03$, $p < .001$) and
- service use (ie. participants who use services: *W1 independent* 15.4%, *group* 23.4%, *retirement village* 23.9% $\chi^2 = 8.85$, $p < .01$; *W6 independent* 42.1%, *group* 65.8%, *retirement village* 58.8% $\chi^2 = 18.09$, $p < .001$).

No consistently significant effects were observed for education level, ethnicity, income or assets.

Appendix H details results of ANOVAs and ANCOVAs comparing groups on quality of life indicators. After controlling for demographic influences, relatively few effects of type of accommodation were observed. Differences consistently revealed across Waves were for household maintenance (W1 F (2, 1883) = 5.51, $p < .01$; W6 F (2, 440) = 9.87, $p < .001$), and social activities (W1 F (2, 1897) = 8.07, $p < .001$; W6 F (2, 435) = 4.94, $p < .01$) only. Significantly greater amounts of household maintenance was performed by independent participants compared with those in group housing, while participants in retirement villages were more socially active than independent or group housing residents. A limited number of other significant effects were obtained, albeit inconsistently (see Appendix H).

The absence of any real effect of type of accommodation on well-being may be the result of the difficulty of classification. As this variable was determined through self-report, rather than objectively, a certain degree of overlap may have occurred, particularly with regard to retirement villages, which often have no clear definition. Hence, perhaps the lack of definitive groups may have led to few quality of life differences.

3.2.3 Summary

In summary, this exploratory analysis of the relationship between housing and well-being for the older population surveyed in ALSA revealed:

- The socio-demographic characteristics of the older population living in each tenure (public rental, private rental, home ownership) varied.

- The characteristics of the population living in units also varied from the older population living in houses. The people living in the units were generally older, more likely to be women, to be living in rental, group or retirement village accommodation, to have less income and fewer assets and they were less likely to be married. The older people living in units were also more likely to have moved between the waves of data collection and they were more likely to have placed their name with age-specific accommodation.
- As a single item in the array of factors that potentially can influence quality of life, housing for the older population surveyed in ALSA contributed a significant yet small proportion of the variance in well-being, ranging between 2-6 per cent depending on the particular well-being indicator.
- An examination of the relationship specifically between tenure and well-being identified few consistent differences in relation to physical health indicators but significant psychological differences. In particular, across the waves it was found public renters experienced greater depression, poorer morale, poorer general well-being and less satisfaction with aspects of their life including their place of residence, finances, friends and life in general. In addition, while public renters reported significantly larger family networks they had significantly smaller social networks.
- Elderly persons with less financial resources experienced poorer well-being outcomes regardless of tenure.
- Characteristics of the home and surrounding environment can significantly influence well-being particularly psychological well-being. In ALSA, older people who perceived their housing to be comfortable and in relatively good condition displayed positive correlations with all indicators of psychological well-being – lower levels of depression, positive morale and self esteem and satisfaction with life in general. The comfort and condition of a person's home was also positively related to the level of emotional and instrumental support they received and the degree of contact with their family.
- This relationship between well-being and comfort and condition of residence varied by tenure. Public renters reported poorer outcomes while the condition of private rental accommodation was significantly better than for home owners. Though private rental accommodation may be in better overall condition, private renters were more likely than home owners or public renters to experience significantly more hazards (for example steps) which created difficulties with activities of daily living. Clearly, good condition of private rental accommodation does not necessarily equate with appropriateness.
- Home maintenance is an important issue for the older population. From ALSA it was established that the longer a person resided in their home, the more likely they were to encounter problems with home maintenance. In addition those participants in the survey who expressed problems with undertaking maintenance performed significantly less household maintenance than those without difficulties. Strong relationships were identified between the level and problems of home maintenance and health across the 3 waves of data collection. In particular, older people experiencing problems with home maintenance had poorer functional ability and more difficulties with activities necessary for daily living. In addition there was a relationship between difficulties with home maintenance and poorer psychological well-being.
- Household composition arose as a significant predictor of quality of life, showing strong positive correlations with a number of variables in each quality of life domain. For example those persons living with at least one other person were more likely to be married, a home owner, less likely to be depressed, had better morale and had a positive appraisal of their future life expectancy.

3.3 Service use, support networks and social sustainability

The following section examines the pattern of service use of older adults, particularly in reference to differences between tenure, type of accommodation, and other demographic characteristics. The implications of service use for quality of life indicators will be also explored. In addition, assessment of factors which may reduce social vulnerability will also be discussed briefly, including marital status or co-resident status, self-esteem, social activities, education level, assets, and source of income. Analyses were conducted on community residents only.

3.3.1 Service use

The proportion of participants utilising community services at each Wave are detailed in Appendix B. While relatively few elders accessed services at Wave 1 (16.1%), the proportion increased considerably over time, with 28.6 per cent and 46.0 per cent of participants reporting service use at Wave 3 and Wave 6 respectively. It may be suggested that this increase is a consequence of the widening needs of the ageing sample. However, examination of the mean age of community participants indicated the greatest mean difference to be only 4.86 years, between Wave 1 and Wave 6. Nevertheless, service use varied as a function of age at each Wave, with significantly greater proportions of older age groups utilising services. For example, 10.2 per cent of participants aged 70-74 years at Wave 1 used services, compared with 32.4 per cent of those aged over 85 years (χ^2 = 99.63, p < .001). Consistent results were obtained at Wave 3 and 6 (Table 3.6).

Examination of socio-demographic indicators revealed characteristic differences between service users and non-users across waves. Chi-square and t-test analyses revealed that a greater proportion of participants using services were:

- not married or widowed (*W1 married* 12.8%, *not married* 21.1%, *widowed* 23.9%, χ^2 = 36.12, p < .001; *W3 married* 22.2%, *not married* 30.3%, *widowed* 40.8%, χ^2= 55.33, p < .001; *W6 married* 32.8%, *not married* 45.8%, *widowed* 60.7%, χ^2 = 49.15, p < .001)
- female (*W1 male* 13.5%, *female* 18.9%, χ^2 = 10.71, p < .001; *W3 male* 24.1%, *female* 33.0%, χ^2 = 14.74, p < .001; *W6 male* 34.8%, *female* 65.2%, χ^2 = 13.27, p < .001)
- lived alone (*W1 alone* 26.9%, *not alone* 12.2%, χ^2 = 60.84, p < .001; *W3 alone* 43.8%, *not alone* 20.0%, χ^2 = 82.98, p < .001; *W6 alone* 62.0%, *not alone* 32.6%, χ^2 = 52.77, p < .001)
- born in an English-speaking country (*W1 non-English speaking* 12.2%, *English speaking* 16.6%, χ^2 = 2.72, p = .09; *W3 non-English speaking* 18.0%, *English speaking* 30.0%, χ^2 = 10.47, p < .001; *W6 non-English speaking* 23.9%, *English speaking* 48.6%, χ^2 = 14.75, p < .001)
- widowed in the past 2 years (*W1 no* 15.7%, *yes* 25.3%, χ^2 = 5.13, p < .05; *W3 no* 27.0%, *yes* 47.9%, χ^2 = 22.90, p < .001; *W6 no* 44.2%, *yes* 61.8%, χ^2 = 7.55, p < .01)
- lower income (*W1 t* (1831) = 2.08, p <.05; *W3 t* (1295) = .83, p >.05; *W6 t* (504) = 2.91, p <.01)
- lower assets (*W1 t* (1642) = 3.08, p <.01; *W3 t* (1214) = .93, p >.05; *W6 t* (456) = 1.96, p <.05)

No differences were observed for pensioner status or education level.

Table 3.6: Service utilisation as a function of age at each Wave

	Age Groups									
	65-69		70-74		75-79		80-84		85+	
Service User	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Wave 1										
Yes	7	5.0	57	10.2	66	13.0	75	18.4	111	24.4
No	133	95.0	503	89.8	443	87.0	332	81.6	232	67.6
Wave 3										
Yes	6	10.9	67	17.3	124	28.8	119	33.3	120	41.1
No	49	89.1	320	82.7	307	71.2	238	66.7	172	58.9
Wave 6										
Yes	0	.0	6	25.0	62	32.8	119	49.6	115	56.7
No	0	.0	18	75.0	127	67.2	121	50.4	88	43.3

Frequencies refer to community sample only
percent stated within age group
Wave 1 χ^2 = 99.63, p < .001; Wave 3 χ^2 = 58.77 , p < .001; Wave 6 χ^2 = 28.02, p < .001

Differing patterns of service use were also obtained for both tenure and type of accommodation across Waves. Chi-square analyses revealed that both public and private renters were significantly greater users of community services than home owners, as were private renters compared with public renters (*W1 public* 20.7%, *private* 27.9%, *home owners* 14.5%, χ^2 = 17.60, p < .001; *W3 public* 30.5%, *private* 34.9%, *home owners* 27.8%, χ^2 = 2.33, p > .05; *W6 public* 56.1%, *private* 73.5%, *home owners* 43.1%, χ^2 = 18.31, p < .001). Similarly, significant differences were observed between types of accommodation, with greater proportions of group housing and retirement village residents using services compared with those living independently (*W1 independent* 15.3%, *group* 23.4%, *retirement village* 23.9%, χ^2 = 9.10, p < .01; *W6 independent* 42.1%, *group* 65.8%, *retirement village* 58.8%, χ^2 = 18.09, p < .001). Taken together, these results imply that older adults who reside in accommodation where they have some level of contact with others (whether it be with a landlord in the case of renters, or neighbours for those in group housing or retirement villages) are more likely to use community services. It may be argued that this is a reflection of the fewer problems that home owners or participants living independently experience. While such an influence must be acknowledged, it may also be suggested that renters or those in age-specific accommodation have greater access to information regarding available services. Consultation with service providers has reinforced this assumption, as has the examination of reasons why elders don't receive help for problems with everyday activities.

Participants were asked at Wave 1 only to state the main reasons why they were not receiving help for problems with ADLs and IADLs (Table 3.7). While chi-square tests of significance could not be conducted due to the low response rate, a general trend emerged. It was found that the greatest proportion of participants weren't receiving help because they were too proud to ask for it (21.7%), or had no family or friends who could help them (20.7%). Almost equally important was the inability to access information about or arrange help from community services (15.8%). Furthermore, it was found that cost was the least frequently stated reason, with only 7.6 per cent of respondents indicating they couldn't afford to receive help. This result is reflective of those obtained in sections 3.2.1.4 and 3.2.2.1.1, indicating that an increase in provision of finances to older adults may not adequately address their complex housing needs. Indeed, greater income is of little use to elders who are socially isolated, if they have no idea about what help they can receive, let alone where to look. Hence, appropriate and easily accessible information may be of greatest importance in order to facilitate the use of community services and assist the older population to age in place successfully.

Table 3.7: Reasons for not receiving help with daily activities (Wave 1)*

Reasons for not receiving Help with daily activities	Total community sample	
	N	%
Not important enough now	32	17.4
Too proud to ask for help	40	21.7
Have no family or friends who are able to help	38	20.7
Can't access information or arrange help from community services	29	15.8
Can't afford help	17	7.6
Other	31	16.8

*Only asked of people already receiving help

The above pattern of service use also had implications for well-being. T-test comparisons between service users and non-users revealed a number of consistent differences across a variety of indicators. For example, participants who used services experienced:

- lower self-rated health (*W1 t* (1953) = 8.14, $p < .001$; *W3 t* (1469) = 4.79, $p < .001$; *W6 t* (598) = 2.78, $p < .01$)
- poorer functional ability (*W1 t* (1957) = 13.59, $p < .001$; *W3 t* (1512) = 7.69, $p < .001$; *W6 t* (649) = 7.58, $p < .001$)
- lower morale (*W1 t* (1168) = 4.93, $p < .001$; *W3 t* (920) = 3.17, $p < .01$; *W6 t* (355) = 3.02, $p < .01$)
- poorer general well-being (*W1 t* (1856) = 9.01, $p < .001$; *W3 t* (1341) = 5.47, $p < .001$; *W6 t* (521) = 4.16, $p < .001$)
- more support from children (*W1 t* (1957) = 2.87, $p < .01$; *W3 t* (1520) = 3.16, $p < .01$; *W6 t* (654) = 1.51, $p > .05$) and
- lower satisfaction with life in general (*W1 t* (1937) = 5.84, $p < .001$; *W6 t* (595) = 3.89, $p < .001$).

For a complete list of results see Appendix I:1.

While social support tends to have a positive influence on psychological adjustment, theory also suggests that there is an upper threshold beyond which reliance on support may be detrimental to well-being (Antonucci and Jackson 1987; Hawley and Klauber, 1988). Hence, it may be possible that service users experienced poorer psychological well-being as a result of their need and use of services. The significantly poorer functioning evidenced in other indicators, in particular health, however implies that differences observed were more likely to be a precursor, and not a consequence, of service use. That is, participants who experienced lower levels of adjustment across a number of well-being domains were more likely to seek help from services. To examine more closely the long-term effect of service use on well-being a series of repeated measures ANOVAs were conducted between Wave 1 and Wave 3, comparing differences on well-being indicators as a function of service use (see Appendix I:2). It may be noted that the effect of significant age differences between the groups was controlled for in the analyses. Repeated measure ANOVAs analyse the exact same people over time as the process only includes the participants at both time points who are not missing any of the data for the specific variables being examined. The results indicated that while the participants in ALSA who were using services had poorer functioning than non-users at wave 1 the degree of change in their functioning over time was no greater than for non-users. For instance, functional ability decreased at a slower rate for users (F (1, 1592) = 13.29, $p < .001$); self-rated health stayed constant for users, and decreased for non-users (F

(1, 1515) = 5.53, $p < .01$); and problems with IADLs decreased for users and increased for non-users (F (1, 1556) = 107.67, $p < .001$). Furthermore, while level of household maintenance remained constant for service users, the level of activity decreased for non-users (F (1, 1296) = 10.79, $p < .001$), although the pattern of service users experiencing greater problems was still evident. This suggests that the use of services may ameliorate or perhaps stabilise dramatic declines in health over time.

3.3.2 Service use and support networks

In addition to community services, support from children was also assessed as a means that may facilitate ageing in place. Support included practical assistance in such tasks as shopping, preparing meals, or being driven to the doctor. Correlations tended to reveal a positive relationship with age (*W1* $r = .15$, $p < .01$; *W3* $r = .08$, $p < .01$; *W6* $r = .01$, $p > .05$), indicating that older participants received greater support from their children, although it may be noted that the strength of the association decreased across Waves. Similarly, participants were asked whether or not they should be able to depend on their children, and acceptance of this also increased with age (*W1* $r = -.10$, $p < .01$; *W3* $r = -.13$, $p < .01$; *W6* $r = .04$, $p > .05$).

This pattern of reliance and practical support from children may in fact have detrimental consequences for psychological well-being. Correlations revealed that participants who received greater support from children experienced lower morale (*W1* $r = -.07$, $p < .05$; *W3* $r = -.12$, $p < .01$; *W6* $r = -.06$, $p > .05$) greater depression (*W1* $r = .10$, $p < .01$; *W3* $r = .12$, $p < .01$; *W6* $r = .01$, $p > .05$) and poorer general well-being (*W1* $r = -.14$, $p < .01$; *W3* $r = -.12$, $p < .01$; *W6* $r = -.02$, $p > .05$). In addition, elders who reported a greater dependence on children experienced poorer general well-being (*W1* $r = .13$, $p < .01$; *W3* $r = .09$, $p < .01$; *W6* $r = .05$, $p > .05$) and more external control expectancy (*W1* $r = -.08$, $p < .01$; *W3* $r = -.10$, $p < .01$; *W6* $r = -.03$, $p > .05$). Although cause and effect cannot be ascertained, such results imply negative implications for participants who increasingly rely on children for support rather than social relationships as they age, which is somewhat supported by the negative association between family social contact and age (*W1* $r = -.06$, $p < .01$; *W3* $r = -.19$, $p < .01$; *W6* $r = -.14$, $p < .01$). In other words, if the majority of one's social contact with family is when they are doing your washing, for example, then this may have negative consequences not only for maintenance of the relationship, but also for psychological health. Moreover, it may be suggested that the increase in dependence and support from children reflects a lack of choice for participants as they get older. Indeed, when asked what support preference they preferred if they were to become dependent on others, only 3.1 per cent, 2.0 per cent and 1.1 per cent of participants at Wave 1, 3 and 6 respectively reported they would move in with children, which was the least preferred option. Hence, increasing reliance on children for practical assistance may be out of necessity rather than choice.

3.3.3 Social sustainability

After review of the literature (see Positioning Paper) and consultation with the reference group and focus groups it is possible to suggest some indicators of social sustainability among the older population which may have a protective influence against vulnerability. The factors identified included home ownership; adequate assets, savings or income; suitable and desirable geographic location; good social family support, carer support and social support networks; good health and independence; knowledge of how to access information; and high self esteem. This chapter has already examined some of these indicators. This section will examine the influence of marital status or co-resident status, self-esteem, social activities, education level, assets, and source of income on well-being. ANOVAs, t-test comparisons and correlations were conducted to determine the ameliorative potential

that these factors may have against negative quality of life outcomes. While all significant relationships will not be presented (for a summary of results refer to Appendix J), the general trends that emerged for each factor will be briefly discussed.

3.3.3.1 Marital status

ANOVAs revealed that participants who were married tended to have better functioning on a number of domains, including health, finances, social, and psychological compared with those who were widowed. However, few significant differences were observed between married and unmarried participants, with respect to social and psychological well-being. This tends to suggest that while unmarried elders may not have the close support of a partner, they nevertheless appear to be coping successfully, possibly because their marital status was a choice or had been a long term situation, which they had adjusted to accordingly. This is compared with the negative implications evident for participants who were forced into widowhood.

3.3.3.2 Co-resident status

Similarly, co-resident status, which was assessed using t-tests, reinforced this point indicating that older persons not living alone had better outcomes across all well-being domains than participants living alone. It is interesting to note that older persons living alone reported significantly higher levels of social activity which many reflect an attempt to counteract the negative effects social isolation may have on quality of life. Correlations suggest that the participants in ALSA generally who had a greater involvement in social activities experienced positive well-being outcomes. The strength of the associations indicated social activities were most influential for psychological well-being (although significant positive correlations were also obtained for a number of health, social and financial indicators, albeit inconsistently). While those living alone were involved in a greater number of social activities, examination of social support however indicated those living alone received significantly less practical and emotional support. This may have had a stronger impact on health and psychological well-being. Indeed it is well documented that the quality of social support and interaction has much greater impact on well-being, compared with its quantity (Antonucci and Jackson, 1987; Hawley and Klauber, 1988; Krause, 1997).

3.3.3.3 Self esteem

Similarly, correlations revealed self-esteem to have a positive influence on well-being. Strong relationships were observed with psychological variables, which was not unexpected, and to a lesser extent, personal satisfaction. While few social consequences were evident, participants with higher self-esteem experienced better health functioning. In particular, they were less likely to indicate the need for a nursing home in the future, had a positive self appraisal of life expectancy, and utilised fewer services.

3.3.3.4 Education level

Examination of education level as a social sustainability factor indicated limited effects on quality of life. This may be due in part to the inability of the variable to discriminate effectively between groups. Nevertheless, t-test comparisons revealed participants who had fewer years of education experienced poorer health, cognitive and psychological functioning on a limited number of indicators. The strongest effect was evident for income and assets, and thus it is questionable whether other effects may be a result of a poor financial situation. The relationship between finances and well-being is discussed below.

3.3.3.5 Income and assets

While solely relying on the pension for income had a negative influence on some health and psychological indicators, the strength of the effect of assets was considerably greater, and ranged across all well-being domains. Correlations were conducted to examine these associations, and it was observed that participants with more assets consistently experienced better social, psychological, cognitive and health outcomes on most indicators. It is interesting to note, however, that these results run contrary to participants' reports that finances were the least important consideration with respect to both housing choice or service use. This may be a reflection of this cohort's tendency to be accepting and satisfied with whatever life brings them, compared with younger cohorts. Nevertheless, the more objective results of the correlations indicated that assets play an integral role in the maintenance of well-being.

Taken together, these results suggest being married, and to a lesser extent unmarried, not living alone, having greater assets and being more socially active may have protective qualities against social vulnerability.

3.3.4 Summary

To briefly summarise the pattern of service use among the older population and the use of support networks this study found:

- Service use increased across the waves of data collection as the sample aged.
- Service users differed from non-users socio-demographically and in terms of their physical and psychological health status.
- For persons needing extra help various reasons were given for not receiving help including being too proud to ask for it, no family or friends to help and an inability to access information about or arrange help from community services. Cost was generally not an issue.
- Analyses of the effect of service use on well-being suggests that it has a positive influence, ameliorating or stabilising dramatic declines in health over time.
- The need and willingness of the older population to rely on their children for support increased with age even though it was the least preferred option for care and support.

3.4 Relocation

The following section examines relocation. The frequency of relocation will be detailed, with particular reference to tenure and support preference. Assessment of longitudinal predictors of relocation within the community and to institutions will also be discussed, as will the impact of these types of relocation on well-being over time.

3.4.1 Descriptives of relocation

Relocation was assessed by asking participants whether or not they had moved between Waves, or in the 3 years prior to baseline. Appendix B details the frequency of relocation at each Wave, although it must be noted that this includes participants who had moved between institutions. However, as the project was predominantly about housing assistance within the community, this group was not of interest. Therefore, all longitudinal analyses were conducted by selecting community residents only at the previous Wave, and the total sample of the following Wave. For example, if examining relocation between Wave 1 and 3, analyses were conducted on Wave 1 community residents only and Wave 3 participants in both the community and institutions. Hence, this captured only participants who had moved within the community or moved from the community to residential care, compared with

participants who had stayed within the community. The following frequencies and resulting analyses filtered out participants who had moved within institutions or had stayed within an institution. Therefore, the recalculated frequencies indicated 10.6% of participants at Wave 3 had relocated between Wave 1 and 3, and 26.6% at Wave 6 had relocated between Wave 3 and 6. While it appears that relocation may have increased almost three-fold, which perhaps reflects the ageing sample, it may also be a consequence of the time frame amongst Waves. That is, the first time period between Wave 1 and 3 was only two years, while the time period between Wave 3 and 6 was six years. For a full summary of each housing transition, refer to Appendix B.

3.4.1.1 Motivation for and choice in relocation

Before assessing longitudinal predictors of relocation (section 3.4.2), it was informative to examine the motivation of participants for moving. In ALSA participants were asked "For what reason do you intend to move?" While it may be noted that this question was only asked of participants who indicated they planned to move again, rather than those who had moved or of all participants, it nevertheless provided a general indication of the motivation to relocate. A summary of responses across Waves is presented in Table 3.8, which reveals that the motivation most frequently stated by respondents at Wave 1 (38.7%) and Wave 3 (52.6%) was to move to accommodation which was modified, better designed or more suitable for their needs. In addition, cost tended to be the least stated motivation, with only 3.4 per cent, 1.3 per cent and 8.2 per cent at Wave 1, 3, and 6 providing this answer respectively. These results reinforce patterns previously established when examining alterations needed and likes or dislikes of housing. However, similar results were not evident at Wave 6, with 44.9 per cent of participants indicating that receipt of more or better personal care was the most important motivation to relocate. This is compared with only 10.9 per cent and 14.1 per cent of respondents at Wave 1 and 3 respectively. While this may be indicative of increased frailty of the ageing sample, it may also reflect a lack of support to facilitate ageing in place, despite continued interests in doing so, which is detailed below.

Table 3.8: Reasons for intentions to move again, Wave1, 3 and 6

Reasons for intentions to move again	Wave 1		Wave 3		Wave 6	
	N	%	N	%	N	%
To receive more or better personal care	13	10.9	11	14.1	22	44.9
Closer to things or people	20	16.8	9	11.5	11	22.4
Better neighbourhood	3	2.5	0	.0	0	.0
Cost of rent / mortgage or upkeep	4	3.4	1	1.3	4	8.2
Modified, better designed or more suitable accommodation	46	38.7	41	52.6	9	18.4
Family changes such as bereavement	6	5.0	2	2.6	0	.0
Other	27	22.7	14	17.9	3	6.1

frequencies refer to community sample only

Participants were asked their preferred housing options if they or their spouse became dependent on others and needed assistance. A summary of responses is detailed in Appendix B (see 'support preference'), which clearly indicated that staying at home with outside help was the predominant choice for 74.1 per cent, 66.8 per cent and 66.3 per cent of the community sample at Wave 1, 3 and 6 respectively. Although this option was more prominent for younger age groups (Table 3.9), the sample as a whole consistently reported a desire to age in place.

Table 3.9: Support preference as a function of age at each Wave

	Age Groups									
Support	**65-69**		**70-74**		**75-79**		**80-84**		**85+**	
Preference	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Wave 1										
Stay at home with help	122	87.1	431	78.4	368	73.7	289	73.5	241	72.8
Move in with children	4	2.9	13	2.4	12	2.4	17	4.3	15	4.5
Move to home for aged	8	4.0	59	29.4	64	31.8	36	17.9	34	16.9
Move to nursing home	6	4.3	47	8.5	55	11.0	51	13.0	41	12.4
Wave 3										
Stay at home with help	49	92.5	290	82.9	248	74.0	224	75.9	170	71.7
Move in with children	1	1.9	4	1.1	9	2.3	8	2.7	9	3.8
Move to home for aged	1	1.9	28	8.0	36	9.4	25	8.5	13	5.5
Move to nursing home	2	3.8	28	8.0	55	14.3	38	12.9	45	19.0
Wave 6										
Stay at home with help	0	.0	14	82.4	144	84.2	165	78.9	112	70.0
Move in with children	0	.0	1	5.9	1	.6	3	1.4	2	1.3
Move to home for aged	0	.0	1	5.9	14	8.2	21	10.0	28	17.5
Move to nursing home	0	.0	1	5.9	12	7.0	20	9.6	18	11.3

frequencies refer to community sample only
percent stated within age group
Wave 1 $\chi^2 = 26.51$, $p < .01$; Wave 3 $\chi^2 = 32.00$, $p < .001$; Wave 6 $\chi^2 = 15.14$, $p < .09$

As previously highlighted, the implementation of adequate support networks to aid this process is paramount, particularly when choices do not necessarily equate into actions. Examination of support preference for participants who had relocated from the community to residential care between Wave 1 and 3 revealed that only 32.4 per cent had reported this as their preferred option at Wave 1, compared with 58.1 per cent who had indicated a desire to remain at home with help. Similarly, only 22.0 per cent of participants who relocated to an institution between Wave 3 and 6 reported a preference for this move at Wave 3, with 76.8 per cent having preferred to remain at home. Evidently, an increased understanding of factors that may be driving elders to relocate regardless of their wishes is essential for maintaining and promoting their quality of life. The models of predictors of relocation examined in section 3.4.2 provide an initial step to achieving this outcome.

3.4.1.2 Tenure and relocation

While the original intention was to compare relocation of each tenure, that is, between tenures or to institutions, the small proportions of participants who had made these transitions did not allow for testing predictive models or the impact on well-being indicators with these groups. Hence, comparisons of participants who moved within the community or from the community to residential care, with those who stayed within the community, were used as an alternative. Nevertheless, basic cross-tabs indicated different patterns of relocation between tenures. Table 3.10 reveals a greater proportion of private renters had moved across each Wave. Furthermore, differences between the types of relocation were also evident. A

greater proportion of private renters compared with public renters and home owners had moved to institutions between Wave 1 and 3. The tendency of private renters to move to residential care was reflected in their support preference. When asked what they would do if they became dependent on others, private renters were more likely to indicate moving to an institution than home owners or public renters, although the effect was somewhat diminished by Wave 6.

It may be suggested that such patterns are illustrative of private renters being more accepting of changes to location, because of the lack of stability in housing they have previously experienced. In addition, significantly greater proportions of private renters were living alone at Wave 1 (47.7%), compared with public rental or home owners, hence perhaps greater social isolation or lack of support may have been influential. Furthermore, as previously noted, they may have little choice when faced with living in accommodation which has not been adequately modified to support increasing frailty. Either way, movement to institutions has marked negative effects on overall well-being, which will be detailed in section 3.4.2.2. Consequently, if certain groups in the community appear to move to institutions perhaps prematurely, then such issues warrant further investigation, and urgently need to be addressed in aged care and housing policy.

Having said this however, this pattern was not evident between Wave 3 and 6. In fact, only 30 per cent of private renters who relocated moved to institutions, compared with 45.8 per cent of public renters and 47.7 per cent of home owners. However, this may be accounted for by a number of reasons. Firstly, assumptions are being made on only 10 participants, thereby any differences have considerably greater statistical influence. In addition, while only N=34 (41.0%) of Wave 3 private renters were interviewed at Wave 6, a number of additional private renters were included in the group, having relocated from other tenures, or having been previously not stated on tenure. Hence, this may have increased the total number of participants who had moved within the community and thus distorted the proportion of total private renters who had relocated. Nonetheless, this may be a true reflection of a change in housing relocation over the past 8 years that would benefit from further research.

Table 3.10: Relocation, mortality and support preference of Tenure at Wave 1, 3 and 6 .

	Tenure Type [a]																	
	Wave 1						Wave 3						Wave 6					
	Public Rental		Private Rental		Home Ownership		Public Rental		Private Rental		Home Ownership		Public Rental		Private Rental		Home Ownership	
Variable	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Total	213	11.4	111	5.9	1547	82.7	164	11.3	83	5.7	1203	83.0	41	6.5	49	7.8	538	85.7
Relocation[b]	*213*	*100.0*	*111*	*100.0*	*1545*	*99.9*	*164*	*100.0*	*83*	*100.0*	*1203*	*100.0*	*41*	*100.0*	*49*	*100.0*	*538*	*100.0*
Yes	28	13.1	26	23.4	110	7.1	9	5.5	14	16.9	57	4.7	6	14.6	19	38.8	62	11.5
No	185	86.9	85	76.6	1435	92.9	155	94.5	69	83.1	1146	95.3	35	85.4	30	61.2	476	88.5
Relocation[c]	*174*	*81.7*	*88*	*79.3*	*1266*	*81.8*	*59*	*36.0*	*34*	*41.0*	*630*	*52.4*						
Yes	19	10.9	19	21.6	120	9.5	24	40.7	10	29.4	153	24.3						
No	155	89.1	69	78.4	1146	90.5	35	59.3	24	70.6	477	75.7						
Where relocated to[d]	*19*	*10.9*	*19*	*21.6*	*120*	*9.5*	*24*	*40.7*	*10*	*29.4*	*153*	*24.3*						
Institution	10	52.6	13	68.4	53	44.2	11	45.8	3	30.0	73	47.7						
Within community	9	47.4	6	31.6	67	55.8	13	54.2	7	70.0	80	52.3						
Retirement Village	3	15.8	3	15.8	12	10.0	1	4.2	2	20.0	15	9.8						
House	3	15.8	0	.0	20	16.7	6	25.0	2	20.0	35	22.9						
Unit or flat	3	15.8	3	15.8	35	29.2	6	25.0	3	30.0	30	19.6						
Support preference if become dependent	*212*	*99.5*	*106*	*95.5*	*1518*	*98.1*	*145*	*88.4*	*49*	*59.0*	*1080*	*89.8*	*34*	*82.9*	*46*	*93.9*	*462*	*85.9*
Stay at home with help	157	74.1	62	58.5	1193	78.6	117	80.7	32	65.3	844	78.1	20	58.8	31	67.4	372	80.5
Move in with children	17	8.0	0	.0	40	2.6	4	2.8	1	2.0	26	2.4	0	.0	0	.0	7	1.5
Move to home for aged	18	8.5	20	18.9	148	9.7	8	5.5	6	12.2	85	7.9	10	29.4	8	17.4	44	9.5
Move to nursing home	20	9.4	24	22.6	137	9.0	16	11.0	10	20.4	125	11.6	4	11.8	7	15.2	39	8.4
Response statistics[d]	*213*	*100.0*	*111*	*100.0*	*1545*	*99.9*	*164*	*100.0*	*83*	*100.0*	*1203*	*100.0*						
Interviewed	174	81.7	88	79.3	1266	81.8	59	36.0	34	41.0	630	52.4						
Refused	14	6.6	4	3.6	99	6.4	27	16.5	14	16.9	165	13.7						
Deceased	17	8.0	14	12.6	155	10.0	74	45.1	34	41.0	380	31.6						
Couldn't contact / moved out of scope	8	3.8	5	4.5	27	1.7	4	2.4	1	1.2	28	2.3						

[a] N=88 (4.5%), N=72 (4.7%) and N=28 (4.3%) of community sample not stated for tenure at W1, W3 and W6 respectively
[b] Examined cross-sectionally
[c] Examined longitudinally, ie. Wave 1 tenure by relocation Wave 1 to 3, Wave 3 tenure by relocation Wave 3 to 6, % stated of previous wave
[d] Examined longitudinally, % stated of previous wave

3.4.2 Longitudinal predictors of relocation

Assessment of social, psychological, cognitive and health indicators as predictors of relocation were conducted longitudinally between Wave 1 and 3, and Wave 3 and 6. Correlations were carried out with all variables in the data set across Waves. For example, predictors from Wave 1 were correlated with relocation between Wave 1 and Wave 3. Only variables exhibiting a significant association with relocation were included in logistic regression models, to examine their influence multivariately. Initial analyses conducted utilised a dichotomous outcome variable of relocated versus not relocated, regardless of destination. However, results obtained were both unexpected and inconsistent, suggesting that the variable may have combined two heterogenous sub-groups. Hence, two distinct variables were established, which compared both participants that relocated within the community or from the community to an institution, with those that stayed within the community. Appendix K:1 details frequencies of groups at both transition periods.

3.4.2.1 Relocation within the community

Correlations with relocation within the community are detailed in Appendix K: 2, with only significant associations reported. Relatively few correlations were obtained at both transition periods, implying that participants who relocated within the community did not differ considerably from those that did not relocate within the community, which is supported by repeated measures ANOVAs in section 3.4.3.2. However, a limited number of significant associations were consistently observed, which revealed that participants who moved within the community, compared with those who did not relocate within the community, were more likely:

- widowed in the past 2 years (*W1 – W3* ϕ = .09, $p < .01$; *W3 – W6* ϕ = .10, $p < .05$)
- intended to move again (*W1 – W3* ϕ = .30, $p < .01$; *W3 – W6* ϕ = .24, $p < .01$)
- had their name registered for age-specific accommodation (*W1 – W3* ϕ = .06, $p < .05$; *W3 – W6* ϕ = .14, $p < .01$) and
- to have a shorter duration of residence (*W1 – W3* r_{pb} = -.08, $p < .01$; *W3 – W6* r_{pb} = -.13, $p < .01$).

A number of other associations were observed either between Wave 1 and 3 or Wave 3 and 6, which included lower self-esteem, less satisfaction with place of residence, and tenure. For a full list of significant correlations, refer to Appendix K: 2.

Significant variables were included as predictors in logistic regression analyses. As noted previously, the two transition periods examined comprised different lengths of time, and thus variables may be interpreted as either short or long-term predictors, rather than reflections of each other. For this reason, analyses of each transition will be discussed separately.

The initial regression conducted between Wave 1 predictors and Wave 3 relocation included all variables with a significant bivariate correlation less than .05. A number of significant predictors were observed, however due to the missing listwise procedure, only 45.1% of the total number of possible cases (N=1522) were included. To increase the number of cases, variables with greater than 10% missing (self-esteem and likelihood of nursing home for spouse) were removed. Resulting regressions included 96.6% of the relevant sample, with a number of significant predictors obtained multivariately.

Results indicated that:

- participants who reported an intention to move again at Wave 1, were 13.50 times more likely to have moved within the community between Wave 1 and 3 (*Wald* = 83.41, $p < .001$, *Exp(B)* = 13.50)

- participants who were widowed between Wave 1 and 3, were 3.87 times more likely to have moved within the community between Wave 1 and 3 (*Wald* = 16.71, *p* <.001, *Exp(B)* = 3.87)
- and, for every 5-10 year decrease in duration of residence, participants were 1.32 times more likely to move within the community between Wave 1 and 3 (*Wald* = 4.34, *p* <.05, *Exp(B)* = 1.32 (inverse)).

The above regression was repeated after removing intention to move again. This was done to eliminate its strong influence in the model, which may have suppressed the significance of other predictors. In addition, the inclusion of this variable was considered somewhat uninformative, as it was more representative of a subjective evaluation of future plans, rather than a measure of something such as problems with IADLs which may be manipulated. The resulting analysis captured 97.2% of the relevant sample, and revealed a similar pattern of results indicated above for widowhood and duration of residence. In addition, it was found that with every unit decrease in satisfaction with place of residence at Wave 1, participants were 1.33 times more likely to move within the community between Wave 1 and 3 (*Wald* = 5.07, *p* <.05, *Exp(B)* = 1.33 (inverse)). For a full summary of results, refer to Appendix K:4.

Significant correlates of relocation within the community between Wave 3 and 6 included tenure and whether or not participants rented their home. However, due to problems with multicollinearity (rented house correlated with private rental ϕ = .55, *p* < .01, and public rental ϕ = .79, *p* < .01), both could not be used together as predictors. Hence, a series of regressions were conducted using each variable alternately. Initial regressions for tenure captured 89.2% of the relevant sample (N=656), with results indicating that:

- participants who were widowed between Wave 3 and 6, were 2.98 times more likely to have moved within the community between Wave 3 and 6 (*Wald* = 10.35, *p* <.001, *Exp(B)* = 2.98)
- participants who reported an intention to move again at Wave 3, were 7.35 times more likely to have moved within the community between Wave 3 and 6 (*Wald* = 29.78, *p* <.001, *Exp(B)* = 7.35)
- participants who had their name registered for age-specific accommodation at Wave 3 were 2.44 times more likely to move within the community between Wave 3 and 6 (*Wald* = 6.33, *p* <.01, *Exp(B)* = 2.44) and
- with every unit increase in emotional support at Wave 3, participants were 2.02 times more likely to move within the community between Wave 3 and 6 (*Wald* = 6.69, *p* <.01, *Exp(B)* = 2.02).

Analyses were repeated for rented house, utilising 90.5% of the relevant sample, with a similar pattern of results obtained. In addition, it was found that with every 5-10 year decrease in duration of residence, participants were 1.23 times more likely to move within the community between Wave 3 and 6 (*Wald* = 3.85, *p* <.05, *Exp(B)* = 1.23 (inverse)). Furthermore, as with analyses for Wave 1 to 3, the intention to move again and having one's name down for age-specific accommodation were removed from analyses. Resulting analyses captured 96.2% and 97.9% of the sample for tenure and rented house respectively, with the above patterns of results remaining. For a full summary of regressions, refer to Appendix K:5.

Taken together, these results indicate similar short and long-term predictors of relocation within the community. In addition, as noted above, relatively few predictors or significant correlates of relocation were obtained at all. While this may be a reflection of the two groups exhibiting similar characteristics across many domains, it may also be suggested that it was partly due to factors which were not surveyed in

ALSA. Nevertheless, a general pattern emerged, which indicated that elders who relocated within the community, did so because of situational influences, such as dissatisfaction with their home, lack of security of tenure, or widowhood, rather than physical or cognitive decline. Indeed, their residence within the community implies relocation to accommodation which is perhaps more suited to their needs, rather than that which provides personal care. Such patterns are reflective of trends for motivations to relocate at Wave 1 and 3 noted in section 3.4.1.1, which indicated modified or appropriate housing as the most important factor for relocation. However, it is interesting to note that family changes such as bereavement were reported as motivation to relocate by only 5.0% and 2.6% of the sample at Wave 1 and 3 respectively. Hence, results of regressions suggest that despite intentions to the contrary, elders are relocating when they are widowed. Evidently, a need exists for greater support and encouragement of the older population, so that they do not feel pressured to make impulsive decisions regarding housing at times of stress.

3.4.2.2 Relocation from the community to residential care

Correlations with relocation from the community to institutions are detailed in Appendix K:3, with only significant associations reported here. Unlike relocation within the community discussed above, a considerable number of consistently significant associations were observed over both transition periods, covering all domains of investigation. For example, results of correlations revealed that participants who relocated to institutions were more likely:

- older (*W1 – W3* r_{pb} = .22, p < .01; *W3 – W6* r_{pb} = .40, p < .01)
- had lower income or assets (*W1 – W3 assets* r_{pb} = -.10, p < .01; *W3 – W6 income* r_{pb} = -.12, p < .01)
- had lower morale (*W1 – W3* r_{pb} = -.10, p < .01; *W3 – W6* r_{pb} = -.19, p < .01)
- had more external control expectancy (*W1 – W3* r_{pb} = .12, p < .01; *W3 – W6* r_{pb} = .21, p < .01)
- more problems with ADLs and IADLs (*W1 – W3 ADLs* r_{pb} = .14, p < .01, *IADLs*r_{pb} = .20, p < .01; *W3 – W6 ADLs* r_{pb} = .21, p < .01, *IADLs* r_{pb} = .14, p < .01)
- lower functional ability (*W1 – W3* r_{pb} = -.17, p < .01; *W3 – W6* r_{pb} = -.16, p < .01)
- used more community services (*W1 – W3* r_{pb} = .20, p < .01; *W3 – W6* r_{pb} = .19, p < .01) and
- had less social contact with family (*W1 – W3* r_{pb} = -.07, p < .01; *W3 – W6* r_{pb} = -.08, p < .05).

For a full summary of findings, refer to Appendix K:3. Examination of multivariate predictors across each transition period will be discussed in turn below.

Significant correlates of relocation to residential care between Wave 1 and 3 included a number of highly related variables. Hence, due to problems with multicollinearity general well-being, co-resident status, and functional ability were not included as predictors in logistic regression. In addition, while assets, morale, self-esteem, expectancy of control, dependence on children and likelihood of a nursing home for spouse were also significant correlates, the number of missing cases for these variables was considerable. Therefore, in order to maximise the number of cases included in analyses, a series of logistic regressions were conducted, with baseline analyses including only variables with less than 10% missing cases. Variables were added in each successive model, and their influence was assessed according to the significance value. If this was less than .10, then the variable remained in the analysis.

The baseline model for relocation to residential care between Wave 1 and 3 captured 82.0% of the relevant sample (N=1514), with results indicating that:

- participants who had their name registered for age-specific accommodation at Wave 1 were 2.70 times more likely to move to an institution between Wave 1 and 3 (*Wald* = 6.94, *p* <.01, *Exp(B)* = 2.70)
- with every 1 year increase in age at Wave 1, participants were 1.13 times more likely to move to an institution between Wave 1 and 3 (*Wald* = 14.70, *p* <.001, *Exp(B)* = 1.13)
- with every unit decrease in cognitive ability at Wave 1, participants were 1.18 times more likely to move to an institution between Wave 1 and 3 (*Wald* = 12.80, *p* <.001, *Exp(B)* = 1.18 (inverse))
- with every increase in community services utilised at Wave 1, participants were 1.70 times more likely to move to an institution between Wave 1 and 3 (*Wald* = 4.05, *p* <.05, *Exp(B)* = 1.70).

The analysis was repeated, with the inclusion of dependence on children and likelihood of a nursing home for spouse, capturing 70.1 per cent of the sample. However, both variables failed to add to the model, hence were not included in subsequent models. Assets was then added in analyses of the baseline model, reducing the sample size to 71.3 per cent. While patterns observed above remained, a significant trend for assets was also observed (*Wald* = 2.93, *p* = .08, *Exp(B)* = 1.37). Therefore, resulting analyses included both psychological variables and assets. However, as the sample size dropped to only 43.3 per cent, the regression failed to calculate an equation, hence their contribution could not be assessed. For a summary of results, refer to Appendix K:6.

As noted previously, comparison of elders that relocated to an institution with those that stayed in the community indicated very unequal group sizes. This was a problem not only for reliability of results, but the ratio of predictors to cases. The number of predictors allowed in analyses is constrained by the smallest group size, not the total number of cases (Tabachnick & Fidell, 1996). Hence, in order to reduce the ratio, analyses were conducted on variables with bivariate significance less than .01. The resulting regression utilised 83.5 per cent of the relevant sample, and replicated the above pattern of multivariate predictors of relocation to an institution. Similarly, to reduce the ratio of predictors to cases, and remove the effect of variables which are perhaps less informative than others, both support preference and name registered at age-specific accommodation were not included in the model. While the above pattern of results remained, household maintenance was also significant, with results indicating that with every unit decrease in activity level at Wave 1, participants were 1.02 times more likely to relocate to an institution between Wave 1 and 3 (*Wald* = 4.10, *p* <.05, *Exp(B)* = 1.02 (inverse)). It is important to note here that while the odds ratio for household maintenance appears almost negligible, this is a consequence of its large range of possible scores (8 to 87). Hence, across this range of scores, such a small odds ratio can have considerable effect. Similarly, the small odds ratios observed for age and cognitive ability may be highly influential in predicting relocation.

The greatest proportion of the relevant sample captured in the above analyses was only 83.5 per cent, due to the missing listwise procedure of logistic regression. In order to maximise the number of cases assessed, the missing data was estimated and replaced with the group mean for variables with less than approximately 5 per cent missing data. For example, if a case was missing a score on self-esteem, it was replaced with the mean of the group which they belonged to (that is, either relocated to an institution, or stayed within the community). The above analyses were repeated using substituted data, with consistent patterns of results being observed. For a summary of logistic regressions, refer to Appendix K:6.

A series of regressions to assess multivariate predictors of relocation between Wave 3 and 6 were conducted as above, using correlates from Wave 3 with significance less than .05. Problems with multicollinearity were evident for general well-being and co-resident status only, hence these variables were omitted from the analyses. The baseline model captured 74.8% of the relevant sample (N=643), with results indicating that:

- with every 1 year increase in age at Wave 3, participants were 1.24 times more likely to move to an institution between Wave 3 and 6 (*Wald* = 27.96, *p* <.001, *Exp(B)* = 1.24)
- with every unit decrease in cognitive ability at Wave 3, participants were 1.23 times more likely to move to an institution between Wave 3 and 6 (*Wald* = 8.47, *p* <.01, *Exp(B)* = 1.23 (inverse))
- with every unit increase in depression at Wave 3, participants were 1.08 times more likely to move to an institution between Wave 3 and 6 (*Wald* = 6.20, *p* <.01, *Exp(B)* = 1.08)
- with every unit decrease in activity level of household maintenance at Wave 3, participants were 1.03 times more likely to relocate to an institution between Wave 3 and 6 (*Wald* = 4.10, *p* <.05, *Exp(B)* = 1.03 (inverse)).

Income was added to the model, reducing the sample to 66.4 per cent, however it did not significantly contribute to prediction of relocation. Similarly, self-esteem, morale and expectancy of control were included in subsequent analyses. However, as the model captured only 47.9 per cent of the relevant sample, and only the effect of age remained, reliability of results could not be assumed. Hence, assessment of psychological variables as multivariate predictors of relocation for both transition periods remained unanswered.

As with models which assessed relocation between Wave 1 and 3, data substitution increased the number of cases included in the analyses, but did not effect the overall pattern of results. Similarly, utilisation of correlates only that were significant less than .01 reduced the ratio of predictors to cases, but did not alter the pattern of results. Refer to Appendix K:7 for summary of logistic regressions.

Taken together, these results imply that the strongest multivariate predictors of relocation to an institution were age and cognitive ability, with depression, number of services, and household maintenance also predicting relocation, albeit inconsistently. However, reliance on findings of logistic regressions in this instance was perhaps inappropriate. As noted above, difficulties with unequal cell sizes, ratio of predictors to cases, multicollinearity, and missing data may bring into question the reliability of these results. Therefore, equal importance should be placed on findings of longitudinal correlations, which revealed a considerable number of meaningful predictors which had strong associations with relocation.

In sum, these findings indicate that unlike relocation within the community, movement to an institution may be based more on the receipt of care, rather than situational factors, with participants indicating greater problems across health, social, psychological and cognitive domains prior to relocation. This becomes particularly important when examining the effect on well-being, discussed in section 3.4.3.1. While these participants displayed greater problems prior to relocation, they also experienced greater decline in well-being after relocation. One way in which policy may address not only the issues elders face which may contribute to their relocation, but also the process itself, is to further develop the Extended Aged Care at Home (EACH) Packages.

3.4.3 Longitudinal impact of relocation on well-being

The impact of relocation on social, psychological, cognitive and health indicators of quality of life was assessed longitudinally between Wave 1 and 3, and Wave 3 and 6.

Repeated Measures ANOVAs were conducted across transition periods, comparing changes in well-being between participants with differing relocation status. This assessed whether or not these changes were a function of relocation, with all F statistics presented below reflecting the time by relocation interaction. As with previous analyses, the inequality of cell sizes was problematic, resulting in insufficient power for a number of analyses. This will be detailed at relevant points below. In addition, where the two comparison groups differed significantly on age, this was controlled for in analyses to remove any effect that age may have on the rate of decline in outcome measures.

The original intention was to examine not only the impact that destination (ie. community or residential care) may have on an elder's well-being, but to also assess the influence of the relocation process itself. Therefore, two separate analyses were conducted: comparison of participants who relocated to institutions versus those who relocated within the community to assess the former, and comparison between participants who had relocated and those who hadn't to assess the latter.

Findings of analyses comparing relocated versus not relocated revealed a considerable number of differences for health and social well-being indicators. That is, while participants that relocated experienced either equal, lower or in some instances better functioning on well-being measures prior to relocation, their rate of decline over time was significantly greater across both transition periods. This pattern was evident for:

- emotional support (*W1 - W3 F* (1, 1600) = 9.53, $p < .01$; *W3 - W6 F* (1, 746) = 41.06, $p < .001$),
- social contact with family (*W1 - W3 F* (1, 1600) = 8.78, $p < .01$; *W3 - W6 F* (1, 746) = 30.15, $p < .001$), and
- functional ability (*W1 - W3 F* (1, 1592) = 22.41, $p < .001$; *W3 - W6 F* (1, 738) = 60.05, $p < .001$) to name a few.

An effect of relocation on psychological indicators was not evident. For a full summary of results, see Appendix L:1. As with prediction models discussed in section 3.4.2 however, the appropriateness of combining participants who had relocated within the community with those who had relocated to institutions was questionable. Indeed, the considerable differences in functioning of both groups may have cancelled out any potential effects. Therefore, examining the impact of the process of relocation on well-being could not be conducted reliably due to the influence of destination. An alternative approach taken was to examine differences between participants who relocated within the community with those who had not relocated within the community. Although this could not completely illustrate the influence of relocation on quality of life, it nevertheless compared two groups which did not differ considerably prior to relocation (see section 3.4.3.2).

3.4.3.1 Relocation destination and well-being

This section examines participants who relocated within the community with those who relocated to residential care on all continuous quality of life indicators (Appendix L:2 reports results of Repeated Measures ANOVAs).[13] Analyses resulted in a clear

[13] Participants within the community were significantly younger at both transition periods, thus the effect of age was controlled for in analyses. As Repeated Measures require cases to have complete data at both time points, cases that were missing data at either point were dropped from analyses, resulting in a reduction in size of comparison groups that were already low in number. This was often a consequence of participants residing in

trend across well-being domains, which indicated a detrimental effect of relocation to institutions, compared with relocation within the community. Similar findings were observed for both transition periods, despite differing lengths of time, and thus will be presented together.

Examination of health indicators revealed that changes in physical ability over time were a function of relocation status. That is, elders who relocated to institutions experienced greater decline in health between Wave 1 and 3 and Wave 3 and 6. This pattern was consistently found for:

- functional ability (*W1 - W3 F* (1, 167) = 28.97, $p < .001$; *W3 - W6 F* (1, 738) = 60.05, $p < .001$),
- difficulties with ADLs (*W1 - W3 F* (1, 166) = 42.67, $p < .001$; *W3 - W6 F* (1, 189) = 23.16, $p < .001$) and
- difficulties with IADLs (*W1 - W3 F* (1, 140) = 12.07, $p < .001$; *W3 - W6 F* (1, 171) = 3.09, $p = .08$).

A similar effect was observed for number of falls (*F* (1, 164) = 10.77, $p < .001$), although only between Wave 1 and 3. For a summary of results, see Appendix L:2.

Similarly, strong effects of relocation were evidenced for social well-being. Participants who relocated to institutions displayed marginally lower social support prior to relocation, however a marked decline was observed across both transition periods, compared with the level of social well-being for elders who relocated within the community remaining relatively unchanged. This pattern of results was observed for:

- emotional support (*W1 - W3 F* (1, 167) = 9.97, $p < .001$; *W3 - W6 F* (1, 196) = 8.04, $p < .01$)
- support from children (*W1 - W3 F* (1, 167) = 9.23, $p < .01$; *W3 - W6 F* (1, 196) = 29.10, $p < .001$) and
- social contact with children (*W1 - W3 F* (1, 167) = 8.39, $p < .01$; *W3 - W6 F* (1, 196) = 28.67, $p < .001$).

The detrimental effect of institutionalisation on social well-being may have implications at both an individual and societal level, being attributed to a number of reasons. While it may be suggested that relocation to residential care provides an opportunity for family to relinquish responsibility of their parent, it may also be implied that the environment of an institution may not be conducive to the maintenance of these relationships. Furthermore, decreased social support may also impact on an elder's psychological adjustment, which is addressed below.

Examination of psychological and cognitive well-being revealed relatively few changes over time which were a function of relocation status. Significant interactions were obtained for depression (*F* (1, 105) = 4.21, $p < .05$) and general well-being (*F* (1, 103) = 5.86, $p < .05$), which revealed that participants who relocated within the community remained relatively unchanged on these indicators, while those who relocated to institutions experienced an increase and decrease in levels respectively. However, this effect was only obtained between Wave 1 and 3. No other effects of relocation destination were observed. This was somewhat unexpected given both the above results, and reports in the literature of the influence of social support on psychological adjustment. Moreover, while traits such as self-esteem tend to remain quite stable over time (Baltes and Baltes, 1990), qualities such as depression or

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institutions at the second time point, as this group were less likely to fully complete the survey. Hence, the small cell sizes resulted in substantial limitation of power in the analyses, leading to a number of non-significant results which may have otherwise been significant.

morale may perhaps be more sensitive to changes in an individual's environment, which is somewhat evidenced in relationships with housing reported in section 3.2.1. Although it may be argued that the destination of relocation simply has no impact on psychological or cognitive ability, the lack of any effect is perhaps more a result of insufficient power and degrees of freedom in analyses.[14] Hence, the examination of changes in psychological and cognitive well-being as a function of relocation status remained unanswered, although graphs of marginal means tended to reinforce the above trend of marked decline across time for individuals who had relocated to residential care.

Taken together, these findings suggest that changes in quality of life over time, regardless of the time period, may be a function of relocation destination. That is, participants who relocated to institutions tended to exhibit greater decline in functioning compared with those who remained in the community. However, it cannot be overlooked that on the whole, participants who relocated to institutions tended to experience poorer functioning prior to relocation. Hence, perhaps once an elder reaches a certain level of functioning, their rate of deterioration may increase. However, controlling for the influence of age differences between groups should have reduced this effect. Moreover, the detrimental effect institutionalisation has on quality of life may be equally a result of the environment which it encompasses. Residential care is widely regarded in the community to be a last resort, which is perhaps a consequence of the negative atmosphere which surrounds it. Given this, it is not surprising that elders may deteriorate in these conditions. Therefore, aged care and housing policy needs to establish an alternative option that provides an equivalent level of care (eg. extension of EACH packages), in addition to taking measures to creating a more positive and pleasant environment within institutions themselves.

3.4.3.2 Relocation within the community and well-being

Examination of findings for changes in well-being for participants who relocated within the community with those who stayed within the community between Wave 1 and 3 indicated relatively few effects of relocation status, suggesting that on the whole, participants who relocated within the community did not differ significantly from those who remained in the community (see Appendix L:3 for results of Repeated Measures ANOVAs)[15]. Nevertheless, a limited number of effects were observed, which tend to highlight the intention of movement to modified or appropriate housing reported in section 3.4.1.1. Results indicated that participants who relocated within the community experienced greater difficulty with IADLs at Wave 1, although remained relatively stable over time. This is compared with participants that didn't relocate, who displayed dramatic increase in difficulties over time, exceeding levels of those that had relocated by Wave 3 (F (1, 1503) = 4.02, $p <$ .05). A similar pattern was evidenced for difficulty with home maintenance (F (1, 1098) = 9.23, $p <$ .001). Further, while the effect of household maintenance was non-significant, this was perhaps a reflection of insufficient power, with the graph of marginal means indicating a similar trend. As implied above, the positive effect of relocation on these indicators supports the notion that participants who were experiencing difficulty with housework, gardening, or general maintenance for example, tended to relocate to accommodation which was more appropriate for their needs, and perhaps easier to cope with. Therefore, rather than experiencing increased difficulties over time, as displayed with participants who remained at home across Waves, participants who relocated reported better outcomes at Wave 3.

[14] Appendix L:2 indicates very small and uneven comparison groups assessed; consequently, power ranged from only .08 to .24.

[15] Age did not differ significantly between groups, and thus was not controlled for in analyses. It may be noted that considerable disparity between cell sizes, particularly between Wave 1 and 3, may have attributed to relatively few significant results.

The positive influence of relocation was also observed for general well-being (F (1, 1294) = 9.69, $p < .001$) and self-rated health (F (1, 1469) = 9.90, $p < .001$), with a significant trend for depression (F (1, 1332) = 2.94, $p = .08$). While both groups tended to display similar levels of adjustment at Wave 1, participants who relocated experienced increases in general well-being and self-rated health and decreases in depression, while participants who remained in their homes experienced decreases and an increase in these characteristics respectively. It may be suggested that these findings can be attributed to the positive influence of relocation evidenced for IADLs and home maintenance. As previously discussed, the reduction of housing related difficulties may ameliorate negative effects in other quality of life outcomes. While cause and effect cannot be ascertained, these results nevertheless provide initial support for this assumption.

While the examination of short term changes in well-being indicated a limited, yet positive effect of relocation, the converse was true when assessing long-term changes between Wave 3 and 6. Appendix L:3 details results of Repeated Measures ANOVAs, revealing relatively few effects of relocation, although this may be partly due to insufficient power in many analyses. Nonetheless, a limited number of significant results were obtained, which consistently revealed that participants who had relocated within the community, despite experiencing equal or better functioning prior to relocation, displayed a greater rate of decline in outcome measures by Wave 6. This pattern was evident for:

- difficulties with ADLs (F (1, 643) = 9.93, $p < .001$)
- functional ability (F (1, 646) = 3.29, $p < .05$)
- number of medical conditions (F (1, 649) = 5.50, $p < .05$)
- cognitive ability (F (1, 575) = 4.12, $p < .05$)
- emotional support (F (1, 654) = 10.20, $p < .001$) and
- life satisfaction (F (1, 373) = 3.31, $p < .05$).

No other effects of relocation were observed.

It must be noted that the assessment of changes in well-being across a six year period is perhaps inappropriate in this instance. The considerable length of the transition period makes it difficult to assume any changes in well-being were a function of relocation status, as opposed to other life events. It may be argued that this issue is equally relevant for examination of relocation destination previously discussed, hence these results must be interpreted with caution. Furthermore, it may also be suggested that residents in institutions experience a fairly restricted lifestyle, hence the potential influence of life events is perhaps less salient for this group. Nevertheless, the pattern of greater decline in mainly health outcomes for participants who relocated within the community was consistently obtained between Wave 3 and 6, although cause and effect relationships remain unanswered.

Taken together, these findings imply that overall, participants who relocate within the community exhibit fairly similar changes in well-being over time, compared with participants who did not relocate. This tends to support the assumption that the destination of relocation has far greater implications for quality of life, rather than the process itself. Nonetheless, limited evidence of considerable differences between short and long term effects of relocation were found, albeit inconsistently. While relocation exhibited a positive influence on participants in the short term, changes in well-being over a longer time period indicated the opposite effect. However, the complexity of these relationships remains unclear, and would benefit from further research.

3.4.4 Summary

Gaining an understanding of the predictors of relocation and its influence on well-being is difficult. This initial examination of the data from ALSA has revealed:

- At waves 1 and 3 the major reason given for an intention to move was for accommodation that was modified, better designed or more suitable for required needs. By wave 6 however the majority of the participants in ALSA indicated receipt of more or better personal care as the most important motivation for relocation.
- If the situation arose whereby the older participants in ALSA or their spouse became dependent and needed care the vast majority would prefer to stay at home with outside help.
- Examination of preferences with relocation status showed that of those who relocated from the community to residential care between wave 1 and wave 3, only 32.4 per cent reported this as a preferred option at wave 1, and only 22 per cent of those who relocated from the community to residential care by wave 6 reported it as an option at wave 3.
- Private renters had a greater propensity to move than home owners and public renters. A greater proportion of private renters moved to institutions between wave 1 and wave 3.
- Older persons who relocated within the community (that is not to residential care) overall, did not differ significantly from those that did not relocate, although persons who had been widowed in the previous two years, had an intention to move, had their names registered for age-specific accommodation, had a shorter duration of residence and greater dissatisfaction with their home were more likely to move.
- In comparison those older persons who relocated from the community to residential care did differ more significantly. As to be expected the older people who moved to residential care facilities were older, had more health problems and were consumers of community services. In addition they were also more likely to have a lower income and fewer assets and less social contact with their family.
- Assessing the impact of relocation on quality of life is difficult. Analysis longitudinally of the impact of relocation from the community to residential care indicated that the destination rather than the process had a detrimental effect on well-being. This needs further exploration as it is a complex issue with many of the participants who relocated to institutions having poorer functioning prior to relocation.
- Analysis of the impact of relocation within the community on well-being provided inconclusive results. Between wave 1 and wave 3 participants who relocated, generally did not differ significantly from those who did not relocate. Those that did move however, may have moved to more appropriate housing as the move reduced the difficulties they experienced with home maintenance and activities around the home like gardening, laundry and housework. The people who relocated experienced increases in general well-being and self rated health and decreases in depression. In contrast relocation over the six year period between wave 3 and wave 6 indicated that the older people who relocated within the community, despite having equal or better functioning prior to relocation displayed a greater rate of decline in outcome measures by wave 6.

3.5. Conclusion

This chapter has presented the results from focus group discussions and an exploratory analysis of the survey information on housing, service provision, relocation and well-being available in ALSA. While areas of inquiry in many cases could not be explored in great detail from the ALSA data because of the nature of the surveys, the findings of this chapter provide quantitative support for a number of the feelings and beliefs in the community about housing, care and well-being. The next chapter examines the role of government at all levels in providing housing and care for an ageing population.

CHAPTER 4. HOUSING ASSISTANCE, SERVICE PROVISION AND AN INTEGRATED SERVICE SYSTEM

4.1. Introduction

The inter-relationships between housing and well-being are influenced by one's circumstances throughout life and government policies which act to influence the housing market and provide some level of intervention and assistance. This chapter examines current policies towards housing and the aged, the housing options available, the availability of services to sustain housing choice and the place of housing assistance within an integrated service system.

4.2. Policy

The various frameworks for ageing at the National level (NSAA 2000b) and for the states (Ageing and Disability Department NSW 1998; Office of Seniors Interest, Western Australia 1998; Department of Families, Youth and Community Care Queensland 1999; Department of Health and Human Services Tasmania 1999) establish policy goals or objectives in relation to housing and the older population. Nationally it is recognised that ' a diversity of options is essential if older people are to exercise choice and avoid the dilemma of having accommodation that is either too demanding or overly supportive.' The strategy also states 'It is essential to take a long term view of housing and infrastructure to ensure that housing choices are developed in a way that is appropriate to the needs of Australians as they age' (NSAA 2000b,14,19). These broad goals are formulated by the states into such objectives as:

- Increasing the housing options that are more responsive to the needs of older people
- Improving housing designs that more appropriately meet the needs of the older population
- For older people to be able to receive assistance with home modifications to enable them to remain living in their own homes
- Increasing the information available for older people on housing options
- Providing accessible and supportive living environments to increase independent living.

Such objectives provide key areas for action for the appropriate departments (for example, housing, environment, planning, human services) within the states. While the various sectors of government may have this pro-active and visionary viewpoint, focus group discussions, relevant correspondence and reviews of the housing situation (Positioning Paper) suggest there a number of factors impacting on the availability of housing assistance to the older population which present significant limitations in fulfilling policy objectives. The state and territory housing authorities are facing significant and future challenges. These arise from:

- The narrowing of the definition of housing policy (to one of rent assistance) and abandonment of the understanding of the broad role of housing in 'creating a decent, fair and contemporary Australian society and economy' (Burke 2001).
- CSHA funding levels have declined in real terms in recent years (Department of Housing, NSW 1999; City of Melbourne 2001)

- Uncertainty of the future and model of Federal government funding to the commonwealth state funding arrangements and the shifting responsibility (actual, implied, anticipated) for the provision of housing assistance. This affects the priority assigned to housing assistance at all levels of government.
- Costs of operating have increased, for example in construction, salaries, information technology (Department of Housing, NSW 1999; Noad 1999).
- The range of services and products to be provided by housing departments or sections has increased (Department of Housing, NSW 1999; Department of Housing Qld, 2000).
- Increasing expenditure on existing stock for significant maintenance and upgrading and infrastructure improvement (Department of Housing NSW 1999).
- Past governments lack of support in providing social services including housing (Davidson 2001; Noad 1999; focus group discussion).
- Demand for housing assistance continues to grow and the needs of people requiring assistance are increasingly more complex (Department of Housing, NSW 1999; Department of Housing Qld, 2000). Such an increase in times of limited resources is necessitating an increasing targeting of services to those most in need.

In most states there are no specific housing allocation policies for particular groups and so seniors are treated like any other group. Where priorities have existed such as trying to house public tenant applicants aged 80 years and over within three months (NSW Focus Group) the extent of the waiting lists means these allocations are no longer working. In terms of extreme poverty the aged are no longer the most prominent group (with sole parents, unemployed single people and unemployed people with large families being those most at risk of poverty) (Mitchell 2000) yet housing support and other forms of assistance are integral to the ability of a high proportion of older people to continue to live outside an institutional setting. The provision of appropriate services, as the analysis of ALSA highlights can have a significant influence on the well being and quality of life to be experienced by older people yet the lack of appropriate housing could detrimentally affect access to appropriate and necessary services.

4.3. Housing Options

A major outcome from the focus group discussions is the lack of choice in available housing for the older population. The general belief from consumers and people knowledgeable about housing provision is that housing assistance for the older population has remained of low priority. There are four *main* forms of assistance available to this group – public housing, community housing, private rental assistance and home assistance for home owners.

4.3.1. Public housing

Traditionally housing assistance has been the provision of public housing. From the focus group discussions this form of assistance for the older population is generally considered to be good. There are a number of reasons for this:

- It is regulated by the government
- There are controls over rent levels and so it is affordable.
- Public housing authorities will make modifications to a property so a tenant can remain independently in their home.

- Public housing authorities provide specific housing for the older population. This has been a long tradition within some public housing sectors, although the bedsitter type accommodation once provided is no longer seen as suitable. The public housing sectors are moving older stock into renovation and refurbishment programs that provide accommodation that is more appropriate to the needs of an older person and new buildings and complexes have to meet minimum standards. In Western Australia for example the Ministry of Housing builds seniors complexes which contain from 5 to 30 one and two bedroom units. These complexes meet minimum standards by being built on flat land, have walk in showers and space to accommodate frames and wheelchairs. In addition the units have other features such as fitted security screens and doors, security lighting split stoves, gas heaters and power points installed at a height to avoid bending (WA Focus Group).
- The public housing sectors are instigating or investigating adaptable design features for their properties (Office of Ageing Qld 2000).
- Public housing is entering into joint ventures with private enterprise, community organisations and local government to supply appropriate and suitable housing.

While public housing in many respects is a good option for the older population it is not always a suitable option now for a number of reasons:

- The sparsity of public housing in all states means waiting list times though varying from area to area can be very long (a minority of applicants wait longer than three years). This is a significant length of time in what remains of an older person's life and is a strong disincentive to even applying.
- While the public authorities will try to maximise the opportunities for people to remain independent (through modifications, arranging information sessions for residents and providing residents with some links to other services) and while there is an increasing expectation of support, public housing authorities are essentially landlords and they can only provide for older people capable of independent living. Inability to properly care for a property can put a tenancy at risk.
- Public housing authorities face difficulties in supplying housing in areas people would like to live. In urban areas part of this problem arises from previous planning and development decisions where suburbs were designed for families with little regard to the ageing of these families and planning for an older population in the future. Public housing is restricted by the availability of land parcels in these areas. Housing is often available in the outer suburbs of the metropolitan centres however there are often limited services available in these areas for the older population. In many rural areas public housing is just not an option. In rural areas construction costs are higher and though authorities get rental returns in rural areas there is often no capital appreciation. In times of restricted funds, new models of affordable housing are mainly urban based.
- Public housing developments of the 1950s and 1960s which were believed to be appropriate at the time, are now no longer desirable places to live.

4.3.2 Community housing

Community housing is a very small sector of the Australian housing sector (less than one percent) yet for the aged it appears to be a most appropriate form of housing assistance if regulatory controls are sufficient. A significant proportion of community housing is provided to the older population (positioning paper). This occupation has not been driven by a housing policy but it has been driven at a program level where

demand from local communities has been for housing for the older population. The ability of community housing to provide is limited and its ability to do so over the next twenty years appears limited to those involved in the community housing sector.

For the older population as for other groups in the community, community housing aspires to the following advantages:

- Providing choice by being responsive to tenants varying circumstances and local housing needs.
- Is affordable with controls over the levels of rent.
- Provides security of tenure as long as the tenant pays the rent and cares for the dwelling.
- Is appropriate to individual needs as community housing associations and co-operatives develop proposals for community housing, its location and the intended resident profile. Thus the older person decides where they live, who they live with and the type of accommodation.
- Fosters connections between the housing and the community reducing isolation. Community housing is more closely integrated into the local community and provides great support for the older population. It can provide links to the services and supports older people may need to enable them to remain independent.
- Enables people to participate in decisions about their housing and be involved in the management of their housing (Noad 1999).

There are many examples of well managed, secure, appropriate and affordable housing within the community housing sector. Some partnerships in community housing have resulted in excellent housing for ethnic specific groups and for older Aboriginal people. In particular the provision of community housing for the older population in rural and regional areas where there is a lack of public and private rental accommodation has been particularly important in enabling older people to remain in the community. The community housing sector appears to be a good option for providing housing programs that are more responsive to the varied needs of older persons and local communities. In some cases it has become an alternative to a nursing home and therefore allows older people to remain in the community for the rest of their lives.

Although community housing aspires to be a most appropriate form of housing for particular groups in the community there are a number of factors highlighted which can detract from this aspiration:

- The community housing sector operates under a number of regulatory controls and systems and this can create difficulties for tenants. In Victoria for example the dwelling can be covered by the Residential Tenancies Act, the Rooming Houses Act or the Retirement Village Act (HAAG 2001).
- Much of the housing stock available to community organisations is old public housing stock. Often this stock is of poor quality and not of a standard suitable to house older people. Often funds for redevelopment are difficult to obtain.
- An area of neglect is creating a ‘home’ for older people. For people who are financially disadvantaged it is often what comes with the dwelling – curtains, heating, cooling that create a comfortable satisfying environment. This is important as the results from the analysis of ALSA showed people who perceived their housing to be comfortable faired better in terms of psychological well-being.
- Community housing organisations may be inappropriately managed which may seriously affect tenants’ rights.

4.3.3. Private rental

Low income older people unable to access public and community housing are reliant on the lower end of the private rental market. While the government provides rent assistance a number of issues were raised in the focus groups suggesting the private rental market is unsuitable for low income older people:

- Many older people in need are attracted to inner city areas because of the centrality of services and the previous availability of low cost rental housing. Gentrification in the inner city suburbs of the state's capitals however is having a major effect on the availability of accommodation and the lives of these people. Either older people are being displaced by younger wealthier people who can afford to pay more or the whole process of gentrification and changes to building standards (increasing land values, financial pressures, financial burden of compliance with fire and building safety standards) is causing a massive reduction in low cost housing. Low cost hostels, boarding houses and supported residential accommodation are all closing down yet this is at the same time that more people are requiring supported residential accommodation with the deinstitutionalisation process. If older people wish to stay in the city they are generally moving into, or staying in, sub-standard accommodation. In addition these residents feel very vulnerable in terms of being able to stay where they are and so are reluctant to complain or assert their rights for fear of displacement and possible homelessness.
- Displacement, without sufficient support programs can be very threatening to an older person and have detrimental effects on their well-being.
- Security of tenure and rent regulation are major issues worrying older private tenants. The lack of low cost housing and blanket rental subsidies results in tenants paying a significant proportion of their income in rent. Little disposable income remains for living expenses – food, clothing, heating, transport, medicines – and increases dependency on support systems and services. In addition changes to residential tenancies Acts in some states (deregulation of the notice period for rent increases, introduction of shorter fixed term leases, reduction of the maximum notice period required to be given to tenants) appears to have disadvantaged tenants.
- Access to the private rental market for older people may be hampered by the view older people may not be able to maintain the residence.
- Landlords are reluctant to modify accommodation to suit tenants' needs.
- New developments in the private rental market, such as that provided by the Brisbane-based company Village Life[16] may not be covered by any of the various residential or housing type acts. Tenants in such developments may have no legislative protection.
- With the loss of low cost rental accommodation caravan parks in some states are becoming a defacto low cost housing market. This option, is in many cases, inappropriate to the needs of older persons not only in terms of access to facilities (supermarkets, transport, health services) and infrastructure (adequate lighting, safety features, flat well maintained paths), but tenants may have limited legal rights.

[16] Village Life provides rental accommodation which allows older people to live in a retirement village type setting. The company builds units in a complex which has a community room and where managers live on site and provide three meals per day. Rent is 85 per cent of the pension.

4.3.4. Home ownership

The life course opportunities that have enabled the majority of the older population in Australia to own or purchase their homes has generally placed these people in an advantageous position in later life. The main housing related factors affecting older home owners are maintaining the quality of their homes and choice in the market if they wish to move.

Many older people wish to remain in their own homes but have major concerns about maintenance - needed repairs and modifications, maintaining the garden, dealing with trades people, and the costs of repairs (the current generations of the aged population are heavily dependent on a pension and thus have little disposable money). Many of the states and local councils run some type of maintenance/modification assistance program. Most of these programs revolve around safety issues and provide one-off assistance rather than regular ongoing help. The demand for such assistance is increasing and this is leading to the refining of criteria and introduction of waiting lists. Just as important as safety to older people however is the need for assistance in tasks (for example painting and gardening) that enable the person to continue to feel proud of their home. The focus groups clearly indicated that the burden of home and garden maintenance, or need for home modifications is often a strong factor in pushing people into relocating and this is supported by the findings of ALSA. In addition the members of ACAT highlighted that many of their referrals are due to home maintenance related issues.

Housing choices for home owners vary depending on their assets and the status of the areas they live in. People living in middle to lower socioeconomic areas and rural areas find the costs of trading on to more suitable accommodation is often beyond their means, and assets from the sale of a home precludes them from public housing. While there may be appropriate options in an area there is often a pricing differential between the older homes and the newer smaller homes, villas and units on smaller allotments. In addition the costs of relocation (stamp duty, real estate agents' commissions, removalist costs) can be a strong disincentive to moving. People are forced to stay where they are and this may compound HACC issues. Conversely, the lack of choice in rural areas may result in older people remaining in inappropriate or substandard accommodation or being forced to move to larger urban centres, sometimes a considerable distance from the local area. The movement of people, young and old, out of country towns leads to changes in the whole social and economic dynamics of the community.

The outer suburbs of the cities are presenting a challenge of how to develop appropriate responses to meet the housing requirements of an ageing population. Much of the housing developed is very homeogenous designed to accommodate families. Little thought at the time was given to the requirements of this population as it aged. Unless there is significant redevelopment in some areas housing options may actually decline and it appears problematic to get lower cost housing developed. In addition developments of the urban landscape in terms of regional shopping centres and enclave type housing is not necessarily suitable to the older population. As well, housing developed for the well aged retirement population along the coast may no longer be appropriate at the oldest ages and is often inaccessible in terms of service delivery yet there are no other options.

4.4. Service provision

The ability of the older population to age in place successfully is dependent on the quality, suitability and sustainability of their housing in conjunction with the availability of appropriate services. For many older people their housing, health and ability to care for themselves is good and they make few demands on the service system. For

others however, the interaction between housing and service provision is vitally important to their well-being. Housing assistance can impact on the quality of care received by older persons. A number of examples raised in the focus groups illustrate this point:

- the quality of a dwelling can influence the care required by an older person. If housing for example is in a poor state of repair then two to three carers may be required instead of just one or the poor state of the dwelling may exclude the older person from receiving care at all because of the occupational health and safety issues for the carer.
- Older hostels and retirement villages may no longer be appropriate in terms of catering for the disability needs of the current residents. For example, older buildings may not cater for walking frames and this has the potential to increase the risk of injury to an older person.
- Older people living in unstable housing in terms of tenure, through relocation may lose touch with the services and carers they are familiar with and knowledgeable about.

From the focus groups there was general agreement that the services provided through the Home and Community Care Program and the Department of Veteran Affairs were excellent, yet the discussions highlighted:

- The increasing difficulty for older people in accessing services as collective demands increase and service providers are restricted by funding levels. This situation has resulted increasingly in service providers changing the eligibility criteria. For example, the wording has changed from 'frail aged' to 'moderately disabled' to 'profoundly disabled.' This change in definition has considerably altered who is eligible for specific services. Generally only those in most urgent need qualify. This feeling within the community is supported by ABS survey data which in 1999 indicated that close to 300 000 (or over 30 per cent) people aged 65 years and over reported a need for assistance with everyday activities (personal care, transport, paperwork, housework, property maintenance and meal preparation) that was not being fully met. In addition some state government assessments of aged care service provision in their states indicated that there is considerable unmet need for HACC services (Clarke 2001;SCRCSSP 2001).
- Some service packages (for example EACH) have only been available as part of pilot projects and are not widely available to the general aged community.
- The situation of many is exacerbated by the lack of hostel and nursing home accommodation and therefore 'forced' ageing in place of some older persons. This problem is pronounced in rural areas and is particularly so for people with complex needs and/or challenging issues as most of the mainstream facilities do not have the capacity to provide for these people.
- It is very confusing for older people who are informed about the range of services available to them and their eligibility to receive such services, yet their inability to access the services because of limited places.
- There is a lack of a systematic way of identifying people who are in need of care and assistance. In addition, there are few programs which are funded to identify and negotiate with a person so they will accept services (ie overcome reluctance, feelings of loss of independence). Providers often have to take on this role but there is no recognition of this work.

- Maintaining continuity of care in terms of the care giver and the older person is often very difficult but important to the ongoing confidence, trust and well-being of an older person.
- Policies favouring providing care in the home can put increasing pressure on partners, families and friends who are forced into a carer role for the older person in need.

4.5. Housing assistance within an integrated service system

Much of the documentation in the policy arenas of housing and ageing refer to the need for collaboration, interaction and integration of housing with other services. If all levels of government are going to address ageing in place and if it is to be successful this interaction needs to occur not just between government departments but at a number of levels, for example between service providers, community organisations, all levels of government, and older person groups. Through such interaction the concerned bodies will develop a greater understanding of the issues and an increased potential for appropriate solutions that could positively influence the lives and well being of the older population.

The focus group discussions have clearly shown that this interaction (and therefore the possibility for greater integration and linkages among services) is only occurring to a very limited degree. In fact our focus groups have been seen as a very useful initiative in getting some of the relevant people and organisations in a state together, and as a possible catalyst for ongoing discussion. The issues raised in the focus groups were:

- While forums on particular issues have been held, and departments appear to be interested and make initial efforts, the commitment to the ongoing process is seen to be less than satisfactory, particularly by older persons' groups. Often there is little feedback or knowledge of ongoing processes.
- The objective of cooperation and interaction across departments and between organisations appears to be of greater practical reality for the aged care and service provision sector than for the housing and planning sector. The location of various government departments under the one umbrella, for example, a Department of Human Services, seems to be constructive in facilitating discussion and building relationships among various offices and departments.
- Government departments are 'mission focussed' making integration difficult. Variations in the lead time for planning across departments also makes it difficult for integration to occur– ie short term decision making versus long term visioning.
- The historical background in the delivery of services. For example in Victoria local governments have traditionally played a greater role in the provision of services (and the likelihood of consultation with various groups) than local governments in other states.
- Suspicion among service providers whereby discussions framed in terms of 'integration' sometimes mean (or may eventuate in) amalgamation.
- The process of competitive tendering for community service agencies inhibits co-operation. Although the tendering process encourages and may require co-operation between organisations, to gain funds organisations are pitted against each other as competitors. The act of consultation may increase an organisation's vulnerability to plagiarism of ideas and lack of edge in the competitive process. In the past organisations were not afraid to co-operate and help each other. In today's environment this is more difficult.

The inter-relationship between housing, provision of care and quality of life has resulted in the development of a number of programs linking housing with care. For a number of years now the Commonwealth government has supported and funded the *Assistance with Care and Housing for the Aged Program* (ACHA). This program targets low income frail elderly people in insecure housing or who are homeless. ACHA assistance may involve housing relocation and / or support to access community care services (Alt Statis and Associates 1996). This program has been assessed as being 'highly accessible and cost-effective means of assisting one of the most vulnerable and most disadvantaged groups in the community. It prevents many clients from having to be admitted to hospital or residential care, and also militates against transience by placing clients in appropriate and secure accommodation' (D' Arcy, Cartwright, Almond and Pollard 1998, 3) The program facilitates increased collaboration and understanding between the housing and aged care sectors, enhancing effectiveness. This program is put at risk however by the increasing difficulty of obtaining appropriate housing.

Considerable effort appears to be occurring in Victoria where the Department of Human Services (DHS) has developed a number of programs which link aged care and housing. The *Community Connections Program (CCP)* seeks to find and link vulnerable older persons with unmet complex needs who are at housing risk into available services. The *Older Persons High Rise Support Program* has been set up to assist in overcoming the problems identified for older people living in the high rise estates. The program provides an onsite worker who finds isolated tenants and provides social support and assistance with obtaining access to a wide range of health and community services. The third program *Housing Support for the Aged (HAS)* provides case managed packages of support for people entering public housing (HAAG 2001).

4.6. Conclusion

This chapter has shown that while objectives and strategies exist, and some excellent progress is being made in improving housing options and providing accessible and supportive living environments, there are significant limitations to fulfilling many policy objectives. These limitations hamper the potential of maximising older people's health and well-being.

CHAPTER 5. POLICY IMPLICATIONS AND CONCLUSION

5.1. Introduction

Within government there is increasing attention being paid to understanding, identifying and developing policies to meet the challenges and opportunities of an ageing population and in particular for these policies to encompass the promotion of overall well-being and quality of life of older persons. Housing is increasingly mentioned as a factor among a myriad of inter-related factors having an important influence on well-being. The increasing focus on housing is to some extent an outcome of the policy orientation on 'ageing in place'. Traditionally research into the quality of life of the older population in relation to housing has focussed on the move to residential care settings. As such only limited research has been undertaken to examine ageing in place and how non-shelter outcomes may vary from one housing situation to another. A major support to the success of an ageing in place philosophy is the provision of in-home care services as the need arises. Housing is seen to have the potential to operate as a significant mediator in the demand for assistance and the use of services. Taking advantage of the availability of longitudinal data, and discussion via focus groups of people involved in housing and service provision, the project set out to:

- increase understanding of the relationship between housing and well-being,
- gather opinion on how well the housing choices for the aged meet their needs,
- explore factors that may precipitate a change in place of residence and to examine the impact relocation may have on individual well-being
- examine the place of housing assistance within an integrated service system.

5.2. Key Research Findings

5.2.1 Housing and well-being

Through both the focus groups and the analysis of ALSA data the influence of housing on well-being was identified almost solely in psychological terms (companionship, happiness, depression, morale, self-esteem, ability to cope with life) with little direct influence on physical health. These findings are likely to vary and be affected by the quality of housing available in specific locations and the long term influence psychological health may have on physical health (Anstey and Luszcz in press).

The study highlighted that well-being varies by tenure. This is related to the differing socio-economic characteristics of the population living in each tenure but also by particular characteristics of the home and its social, physical and economic environment.

> From the analysis of ALSA data, home owners and private renters who have the means to make choices, tended to be in a more advantageous position than the older population living in public rental accommodation. Across the waves of data collection it was found public renters were more likely to exhibit depression, poorer morale, poorer general well-being and they were less satisfied with aspects of their life, including place of residence, finances, friends and life in general. There are many factors other than housing that can influence quality of life, and as the role of public housing in the last two decades or so has been to house those in greatest need, it is not unexpected those in public housing appear to experience a lower level of well-being. ALSA did not capture low income private renters living in boarding houses or caravan

parks, nonetheless the focus group information and observations suggest their well-being is likely to reflect, or be worse than, that of older people living in public rental accommodation.

Comparison of the older population living in different types of accommodation (independently, in group housing or in a retirement villages) in ALSA showed few effects on quality of life indicators. This result may have been an artefact of difficulty of classification of this variable in ALSA or show that this indicator has little direct bearing on well-being.

Certain aspects of the housing situation appear to influence well-being. These include location, comfort and 'homeliness'.

The focus groups identified that the locational setting, in relation to neighbours, access to services and design could influence feelings of isolation, depression, ability to cope independently and general happiness.

Characteristics of the home and surrounding environment can significantly influence well-being, particularly psychological well-being. Focus group discussions identified that creating a 'home' – a comfortable satisfying environment – rather than just supplying a house was important to older people's well-being. In ALSA, older people who perceived their housing to be comfortable and in relatively good condition displayed positive correlations with all indicators of psychological well-being (lower levels of depression, positive morale and self esteem and satisfaction with life in general). The comfort and condition of a person's home was also positively related to the level of emotional and instrumental support they received and the degree of contact with their family.

The relationship between well-being and comfort and condition of residence varied by tenure. ALSA public renters reported poorer outcomes while the condition of private rental accommodation was significantly better than for home owners. Though private rental accommodation may be in better overall condition, private renters were more likely than home owners or public renters to experience significantly more hazards (for example steps) which created difficulties with activities of daily living. Clearly good condition of any dwelling does not necessarily equate with appropriateness.

Home modification and maintenance were identified as important issues for the older population both in relation to safety and to enable the person to continue to feel proud of their home.

The need for modification often occurs as a once suitable home becomes increasingly less so. Age, and increasing difficulty in undertaking tasks or increasing disability may necessitate alterations.

From ALSA it was established that the longer a person resided in their home, the more likely they were to encounter problems with home maintenance. Strong relationships were identified between the level and problems of home maintenance and health across the three waves of data collection. In particular, older people experiencing problems with home maintenance had poorer functional ability and more difficulties with activities of daily living. In addition there was an association between difficulties with home maintenance and poorer psychological well-being. The focus group discussions highlighted that older people's increasing inability to undertake the home maintenance they see necessary, is a strong indicator to them that they cannot manage and therefore need to move. Members of Aged Care Assessment Teams indicated that many of their referrals are due to home maintenance issues.

Household composition arose as a significant predictor of well-being. Those persons living with at least one other person were less likely to be depressed, had better morale and had a more positive appraisal of their future life expectancy.

A significant influence on well-being is financial resources. In ALSA elderly persons with reduced financial resources experienced poorer well-being outcomes regardless of tenure.

5.2.2 Service use and support networks

The ability of the older population to age in place successfully can be dependent on the quality, suitability and sustainability of their housing arrangements in conjunction with the availability of appropriate services. In this project the analysis of ALSA provided information on service use for a sample of the older population, while through the focus groups the accessibility and suitability of health service provision for the older population was canvassed.

The analysis of service use for the participants of ALSA showed:

Service use increased across the waves of data collection as the sample aged.

There were socio-demographic differences between service users and non-users. A greater proportion of participants using services were unmarried or widowed, female, lived alone, widowed in the past two years, born in an English speaking country, and with lower income and less assets.

Service users differed from non-users in their physical and psychological health status. For example people using services had a lower self rated health, poorer functional ability, lower morale, poorer general well-being and lower satisfaction with life in general.

From ALSA there were differing patterns of service use for both tenure and type of accommodation across waves. Both public and private renters were significantly greater users of community services than home owners, as were private renters compared to public renters. Greater proportions of group housing and retirement village residents used services compared with those living independently. The association between service use and functional ability implies this may be a reflection that home owners or participants living independently experience fewer problems. However, it may also be suggested that renters or those in age-specific accommodation have greater access to information regarding available services which they can act upon. Consultation with service providers reinforced this assumption, as has the examination of reasons why elders don't receive help for problems with everyday activities.

For persons needing extra help various reasons were given for not receiving help including being too proud to ask for it, no family or friends to help and an inability to access information about or arrange help from community services. Cost was generally not an issue.

Analyses of the effect of service use on well-being suggests that it has a positive influence, ameliorating or stabilising dramatic declines in health over time.

The need and willingness of the older population to rely on their children for support increased with age even though it was the least preferred option for care and support. In addition the study indicated that reliance and practical support from children may in fact have detrimental consequences for psychological well-being. Correlations revealed that participants who received greater support from children experienced lower morale, greater depression and poorer general well-being. Although cause and effect cannot be

ascertained, such results imply negative implications for participants who increasingly rely on children for support rather than social relationships. This is consistent with the observed negative association between family social contact and age. In other words, if the majority of one's social contact with family is when they are doing your washing, for example, then this may have negative consequences not only for maintenance of the relationship, but also for psychological health. It may be suggested that the increase in dependence and support from children reflects a lack of choice for participants as they get older.

In relation to the appropriateness and accessibility of services to the older population the focus group discussions indicated there was general agreement that the services provided through the Home and Community Care Program and the Department of Veteran Affairs were excellent, but a number of concerns were raised:

The increasing difficulty for older people in accessing services as collective demands increase and service providers are restricted by funding levels. This situation has resulted increasingly in service providers changing the eligibility criteria. For example, the wording has changed from 'frail aged' to 'moderately disabled' to 'profoundly disabled.' This change in definition has considerably altered who is eligible for specific services. Generally only those in most urgent need qualify. ABS survey data and state government assessments of aged care service provision support these feeling within the community (SCRCSSP 2001; Clarke 2001).

Some service packages (for example EACH) have only been available as part of pilot projects and are not widely available to the general aged community.

The situation of many is exacerbated by the lack of hostel and nursing home accommodation and therefore 'forced' ageing in place of some older persons. This problem is pronounced in rural areas and is particularly so for people with complex needs and/or challenging issues as most of the mainstream facilities do not have the capacity to provide for these people.

It is very confusing for older people who are informed about the range of services available to them and their eligibility to receive such services, yet their inability to access the services because of limited places.

Identifying people who are in need of care and assistance is unsystematic. In addition, there are few programs that are funded to identify and negotiate with a person so they will accept services (ie overcome reluctance, feelings of loss of independence). Providers often have to take on this role but there is no recognition of this work.

Maintaining continuity of care in terms of the care giver and the older person is often very difficult but important to the ongoing confidence, trust and well-being of an older person.

Policies favouring providing care in the home can put increasing pressure on partners, families and friends who are forced into a carer role for the older person in need.

Housing assistance can impact on the quality of care received by older persons. An increasing concern is the quality of the dwelling. If housing for example is in a poor state of repair then two or three carers may be required instead of just one; or the poor state of the dwelling may exclude the older person from receiving care at all because of the occupational health and safety issues for the carer.

5.2.3. Relocation

Relocation occurs through choice or out of necessity to receive better care and assistance. Members of the focus groups indicated that moving to find more appropriate accommodation was generally desired and occurred by age 80. After this age older people generally appear to lose their willingness to move. This could be for a number of reasons including increasing disability and frailty but also because with the death of a spouse, plans for old age may loose their relevance and meaning. The examination of the data from ALSA revealed that at waves 1 and 3 the major reason given for an intention to move was for accommodation that was modified, better designed or more suitable for required needs. By wave 6 however the majority of the participants in ALSA indicated receipt of more or better personal care as the most important motivation for relocation.

Gaining an understanding of the predictors of relocation and its influence on well-being is difficult. This initial examination of the data from ALSA has revealed:

If the situation arose whereby the older participants in ALSA or their spouse became dependent and needed care the vast majority would prefer to stay at home with outside help.

Examination of preferences with reality showed that for the majority of those who relocated this was not a desired option. Of those who relocated from the community to residential care between wave 1 and wave 3, only 32.4 per cent reported this as a preferred option at wave 1, and only 22 per cent of those who relocated from the community to residential care by wave 6 reported it as an option at wave 3.

Private renters had a greater propensity to move than home owners and public renters. A greater proportion of private renters moved to residential care between wave 1 and wave 3.

Older persons who relocated within the community (that is not to residential care) overall, did not differ significantly from those that did not relocate. However persons who had been widowed in the previous two years, had an intention to move, had their names registered for age-specific accommodation, had a shorter duration of residence and greater dissatisfaction with their home were more likely to move.

In comparison, those older persons who relocated from the community to residential care did differ more significantly. As expected, people who moved to residential care facilities were older, had more health problems and were consumers of community services. In addition they were also more likely to have a lower income and fewer assets and less social contact with their family.

Assessing the impact of relocation on quality of life is difficult as many of the participants who relocated to institutions had poorer functioning prior to relocation. Analysis longitudinally of the impact of relocation from the community to residential care indicated that the destination rather than the process had a detrimental effect on well-being. This needs further exploration as it is a complex issue.

Analysis of the impact of relocation within the community on well-being provided inconclusive results. Between wave 1 and wave 3 participants who relocated, generally did not differ significantly from those who did not relocate. Those that did move however, may have moved to more appropriate housing as the move reduced the difficulties they experienced with home maintenance and activities around the home like gardening, laundry and housework. The people who relocated experienced increases in general well-being and self

rated health and decreases in depression. In contrast relocation over the six year period between wave 3 and wave 6 indicated that the older people who relocated within the community, despite having equal or better functioning prior to relocation displayed a greater rate of decline in outcome measures by wave 6.

5.2.4. Housing choice and an integrated system

The various frameworks for ageing at the National level and for the States establish policy goals and objectives in relation to housing and the older population. There remain a number of factors impacting on the availability of housing assistance to the older population which present significant limitations to fulfilling policy objectives.

As a consequence a major outcome from the focus group discussions was the lack of choice available in housing for the older population. The general belief from consumers and people knowledgeable about housing provision is that housing assistance for the older population has remained of low priority.

There are four main forms of housing assistance available to the older population – public housing, community housing, private rental assistance and home assistance for home owners.

Public housing assistance for the older population is generally considered to be good because it offers security of tenure and regulated rents. Authorities will make modifications to properties and provide specifically designed housing for an older population. While in many respects a good option for the older population it is not always a suitable option due to long waiting lists, restricted locations, need for major renovation and upgrading of old stock, and the increased targeting of public housing to those most in need and the resultant concentration of people with complex problems and needs.

Community housing for the aged appears to be a most appropriate form of housing assistance if regulatory controls are sufficient. The ability of the community housing to provide housing however is limited.

Low income older people unable to access public and community housing are reliant on the lower end of the private rental market. While the government provides rent assistance a number of issues were raised in the focus groups suggesting this form of assistance is unsuitable for many low income older people. For example, gentrification and changes to building standards is causing a massive reduction in low cost housing and supported residential accommodation, there are issues over security of tenure and rent regulation, rent assistance is a blanket subsidy and therefore its benefit in helping to alleviate costs varies from location to location depending on market prices, lack of modifications to private rental properties may make it difficult for older people to remain in or find suitable accommodation, and a lack of legislative protection of some forms of private rental accommodation increases the vulnerability of the older person.

While in general, home owners are in a much more advantageous position than older residents who need to rent there is considerable diversity in the situation of older home owners. Housing choices for home owners vary depending on their assets and the status of the areas they live in. People living in middle to lower socio economic areas and rural areas find the costs of trading on to more suitable accommodation is often beyond their means, and assets from the sale of a home precludes them from public housing. While there may be appropriate options in an area there is often a pricing differential between the older homes and the newer smaller homes, villas and units on smaller allotments. In addition the costs of relocation (stamp duty, real estate agents' commissions, removalist

costs) can be a strong disincentive to moving. People are forced to stay where they are and this may compound HACC issues. Conversely, the lack of choice in rural areas may result in older people remaining in inappropriate or substandard accommodation or being forced to move to larger urban centres, sometimes a considerable distance from the local area. The movement of people, young and old, out of country towns leads to changes in the whole social and economic dynamics of the community.

Assistance to home owners is in the form of help with home modifications or maintenance. While the states and local councils run some type of maintenance/modification assistance program, most of these programs revolve around safety issues and provide one-off assistance rather than regular ongoing help. The demand for assistance is increasing and this is leading to the refining of criteria and the introduction of waiting lists.

Much of the documentation in the policy arenas of housing and ageing refer to the need for collaboration, interaction and integration of housing with other services. Members of the focus groups indicated this interaction (and therefore the possibility for greater integration and linkages among services) is only occurring to a very limited degree.

5.3. Policy Recommendations

5.3.1. Housing Assistance

It is clear from this study that individuals who for one reason or another have not accumulated assets and, in particular, achieved home ownership, by the time they are 70 years of age are more likely to have lower levels of well-being than the rest of the older population. Clearly the role of housing assistance is to provide a stable basis of support to these people which may help to reduce the impact of other stresses.

The change in government policy that has moved away from the provision of public and community housing towards private rental assistance needs re-examination. The change in support and constraints upon the states which restrict significant ongoing development of the public and community housing sectors runs counter to the preferences of low income older people. The continual development and provision of appropriate public housing for the aged, and a strongly regulated and well-resourced community housing sector, have the potential to enhance community feeling, increase social contact and potentially support.

The move by State governments towards looking at ways to develop social housing that is responsive to the needs of current and future residents is important (for example Bisset 2000; City of Melbourne 2001; Department of Housing NSW 2001; Department of Human Services SA 2000). Moving beyond a solely landlord role and developing an ageing in place framework would assist in maximising the opportunities for older people to remain independent and maintain tenancies. The introduction of caretakers to provide basic assistance such as replacement of light bulbs and small day-to-day maintenance (Department of Health and Human Services, Tasmania 2001) and establishing strategic alliances with the aged care sector (DHS SA 2000; Victorian Govt Programs HAAG 2001) are important programs. They increase the potential for successful tenancies, stability of housing tenure and reductions or delays in entry to residential care.

Private rental assistance is an important avenue for some older people but for many it is an inappropriate form of assistance unless the private rental sector has the stimulation, willingness and ability to develop appropriate housing for low income older people. This needs to occur in association with government instrumentalities

putting into place the necessary legislation that will protect tenants' rights and examining the suitability of blanket rental subsidies.

The importance of home maintenance and home modification to the welfare of the older population cannot be understated. Where the cost of modification is not justifiable in context of the value of the home or it is more appropriate or desirable for the home owner to move residence, there is need to provide programs that assist older home owners to move into smaller or more suitable homes or into age-specific accommodation. Acceptable packages need to be developed that ease the financial disadvantage of moving and provide people of limited means with choice. There are some programs in Australia designed to assist older home owners to purchase or part purchase more suitable accommodation. For example, one of the better known programs (although no longer running) was the *Wisechoice Program* in Western Australia (Australian Urban and Regional Development Review-AURDR 1994a; D'Alessandro 1996; Nicholls 1996). In South Australia Aged Cottage Homes has increased opportunities for relocation by developing some interesting packages whereby older people are able to purchase a percentage of the equity in a home with the balance being held by the organisation (Reed G 1996). The feasibility of such programs and other models need further examination.

The availability of home maintenance programs is at the discretion of local governments resulting in considerable variability in the availability, range and quality of services offered. Considering the importance of these programs in assisting older people to feel they are able to stay in their homes there needs to be a much more co-ordinated response across cities and regions ensuring that all older people have access to a good quality program.

The relevance and appropriateness of housing to meet a rapidly changing ageing population would be enhanced with the development of innovative housing options which place a much greater emphasis on adaptable housing standards and acceptance of such standards by builders. Architects and designers with vision see it as a simple matter to design housing for all groups in society- young, old, disabled. Such houses would include wide doorways, level floors, handrails, non-slip floor finishes, correct bench heights, storage spaces which slide vertically up and down, heating surfaces to minimise the potential for burns, level surface systems that minimise the necessity to lift pots and pans, security lighting, natural light and ventilation, heating and cooling (Archibald 1999; Coker 2001). In addition, if designed correctly from the start, homes should be able to be readily modified as needs arise. This would allow residents to remain in the home and neighbourhood with which they are familiar. Adaptable housing design is applicable to all forms of housing, not just social housing, and at all points in the lifespan. Propagating the notion of adaptable design could induce those in mid-life to consider and anticipate their future housing needs at a time when they are in a position to afford and engage in renovations or modifications that would assist in their adaptation later in life.

As our results have demonstrated, people's well-being is influenced by the quality of the surrounding environment and local community in which their housing or residence is located. Adaptability therefore not only needs to apply to housing but be relevant to the neighbourhoods and environments in which older people live. There is a need for reform of planning processes and long term vision in which neighbourhoods are user friendly and can evolve with the changing nature of their residents.

The inclusion of all government aged care services under one umbrella of the Commonwealth Department of Health and Aged Care allows a coordinated response in the provision of information. The Department of Health and Aged Care has made strong efforts to advertise information about their services through full page

advertisement in the Emergency, Health and Help section at the front of telephone books and advertisements in newspapers regarding Commonwealth Carelink Centres. Information on housing options and of the need to consider and plan for future housing requirements with increasing age is not so easily available. This lack of information and disregard of the importance of planning for the future often means older people are forced to make decisions, or decisions are made for them, rapidly and at times of stress. This can lead to poor choices. These may ultimately affect older peoples' overall well-being and ability to cope with health changes or remain independent. This has obvious consequences for those associated with them and for the community and governments.

5.3.2 Service provision

Results from ALSA suggest that the provision of services in the community is preferable to residential care. This is true both in terms of what people say they want and in relation to observed quality of life and well-being. Service providers and older persons in the focus groups however highlighted the increasing difficulty for older people to access services as demands increase. Significant improvements in this sector of aged care is highly desirable and likely to reduce the pressure on nursing home places as many people waiting for nursing home beds could be catered for by provision of home care services, rehabilitation programs and short-term care during a transition from hospital to home (Yates 2001).

At present aged care services are targeted at the most frail and incapacitated. There was a strong belief within the focus groups about the necessity of a tiered system of care. It would not only cater to those in greatest need but also include interventions or preventive policies and care programs to cope with forthcoming need. Results from ALSA showed that the introduction of services improved older people's functioning. Thus the use of services may ameliorate or stabilise dramatic declines in health over time. Preventive policies are therefore seen as cost effective in the long term to the individual, community and governments.

While relocation to residential care may be a necessity for those with multiple needs, results from ALSA suggest maintaining or caring for someone in the community for as long as possible is likely to be less detrimental to an individual's well-being and maintenance of relationships. The innovative EACH program appears to be an excellent means of maintaining very frail people within the community. Assessment of the quality of life of people able to receive EACH packages with those moved to residential care would establish the effectiveness of these programs (from a quality of life perspective) and provide support for the expansion of this program.

Funds and recognition of worth have to be provided to programs that not only serve clients but also identify clients. The focus groups identified, and ALSA data confirmed, that a systematic way of identifying people who are in need of care and assistance, or reluctant to receive care, is lacking. Gaining someone's trust can be time consuming but efforts should be made to provide services to all those in need, not just to those who are more forthright at asking or accepting care.

The potential for optimum outcomes for older people in the provision of care is likely to occur when there is continuity of care in terms of the care giver and the older person. Investment in the appropriate skilled workforce and the provision of good working conditions is necessary to meet current and impending expansion of residential and community based services.

To enhance the well-being of aged persons whose final option is residential care there is a need to further develop ways to improve the environment not only for the residents but also for the family and community as a whole.

5.3.3 Integration

Implicit throughout this report is that a holistic approach has to become much more than rhetoric. An older person needing housing assistance and care has to be seen as one person in the system, rather than a person who goes from agency to agency in order to have a diversity of needs met. Integrative mechanisms need to be established by Commonwealth and State governments. Agencies and departments with separate functions, structures, administrations, responsibilities and geographical boundaries need to cooperate, coordinate and engage in partnership to achieve the best results for those to whom they provide services. Devoting greater effort to such integration would yield immediate benefits for today's ageing individuals and lasting rewards for future generations and society as a whole.

5.4. Conclusion

For the aged population, remaining in the community with assistance is seen and has been shown by this project to be important to people's capacity to maintain health and overall well-being. Yet the policy directions implicit in this factor remain essentially an aged care issue rather than the responsibility of a number of government sectors concerned more broadly with housing issues. While each state has developed, or is in the process of developing, a housing strategy, these have been designed in a National policy vacuum. In times of fiscal restraint and increasing demands upon the government sector, housing is not viewed with the same importance as say education and health. The lack of direction and constraints facing housing departments has resulted in housing policy being reactive rather than pro-active. This focus provides short–term solutions but the provision of a range of options with tenure security, affordability, location and reasonable and appropriate standards necessitates long-term vision and planning. A lack of long term planning also inhibits the ability to move towards a more holistic approach to ageing.

The needs and requirements of the older population today remain much the same as research indicated five, ten, fifteen years ago. While there has been an improvement in the range and adequacy of housing and services for the older population demand continues to overwhelm supply. The oncoming cohorts of older people may *proportionally* be wealthier than the present population aged 70 years and over but with the growing economic polarisation in society (Badcock 1997; Beer, Forster and Maher 1996) there will be considerable *numbers* of older people in need. These people it is predicted will be more demanding and outspoken.[17] As Kendig and Neutze (1999, 437) state,

> Overall, the baby boom cohort will have more resources and higher expectations than their predecessors in old age. They expect to set public agendas and are likely to demand change when they discover that 'ageing people' means them. …Yet even in this advantaged cohort some will reach old age without ever having owned a home or attained secure employment.

While state governments have good intentions regarding the provision of housing assistance and recognise the important connection between housing, health and well-being, it is clear from this report that there are many challenges to be faced and overcome if the outcomes of the National Strategy for an Ageing Australia are to be realised.

[17] There is already evidence of this. Some service providers in the focus groups indicated there is increasing demand from people in their fifties. This group are more willing to ask for help, are better informed and expect assistance.

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