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Forum

Myths and realities of ageing in rural Britain[1]

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ABSTRACT
Ageing in rural areas has received less attention in the literature than the proportions of older people living in rural areas might suggest. This paper looks at rural ageing in the United Kingdom based on the existing literature and on research in country areas in which the author has been involved. It examines some of the common myths about ageing in rural communities and explores these in terms of their accuracy when compared with the reality of the situation of older people in these areas. The realities of rural lifestyles, family and community networks, life satisfaction, health and access to services are briefly discussed. It is concluded that ageing in rural Britain has advantages and disadvantages but that it is conclusively neither better nor worse than ageing in urban areas. However, it is suggested that rural service provision demands a different approach from that which is appropriate in urban areas.

KEY WORDS – rural, community, transport, access, voluntary groups, church, migration, health, life satisfaction.

The First Global Rural Aging Conference was held in West Virginia in June 2000. This is significant because, although more than half the world's older people live in rural areas, it has taken time for gerontology to focus on the problems of rurality. Even within the European culture area (see Burholt and Scharf 1999; Scharf *et al.* 1999*a*; Scharf *et al.* 1999*b*; Wenger *et al.* 1999*a*), there are variations in the experience of rural ageing between countries. This paper looks at some of what is known and what is assumed about ageing in rural Britain.

Any discussion of older people in rural areas in the UK must start from the premise that as we age we become more different from one another and that the rural areas include a wide range of variation. Generalisations, therefore, must be made cautiously. Those who spend their retirement in rural areas include both those who are ageing in the place where they have lived for many years, and those who retired to the

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countryside to escape from urban areas or to return to their roots (Philip 1999).

The proportions of older people in local populations are higher in rural areas than in urban areas in most countries of the world, and older people are the largest group of low-income residents in rural Britain (Shucksmith 1999*a*). However, the literature on rural ageing in the United Kingdom is sparse and studies that have focused specifically on rural areas are few and far between. This paper aims to promote a broader understanding of old age in rural Britain by discussing a few of the common myths about rural ageing. It is explored in the context of that literature which is available, and of findings from the *Bangor Longitudinal Study of Ageing* (BLSA) that has been conducted in rural Wales between 1979 and 1999 (Wenger *et al*. 1999). It also draws on a recent publication commissioned by the Rural Group of Labour MPs (1999) and on the ESRC-funded study on Old People in Europe's Rural Areas (Grant No. R000231802). Where appropriate, findings from other developed countries are cited. The paper aims to stimulate discussion and research on the realities of ageing in rural Britain. A Special Issue of *Ageing and Society* is planned which will be devoted to intergenerational relationships in rural areas around the globe.

Background

In talking about ageing in rural areas we need to keep in mind some important distinctions. Older people include:

- both those who have always lived there and those who have come to the country to grow old;
- those in the Third Age, who are still active and healthy, and those in the Fourth Age, who may be frail, impaired or in poor health (Laslett 1991); and
- those dependent on the state pension as well as those with contributory pensions, savings and substantial capital and incomes.

Older people in rural areas are as different from one another as they are from their counterparts in suburban and urban areas. There are, however, certain aspects of life in the countryside, which they share as a result of where they live (Kim 1980, 1983). These are factors related to low population density and distance (Ansello 1980). In most rural areas around the world there are proportionately more people over retirement age than in other more urban areas (Joseph and Matthews 1993, Lawrence and Stehlik 1996). Within rural areas in Britain, however, the most sparsely populated parts with scattered settlement and remote hamlets, tend to have fewer older people in them. Older

people in rural areas are more likely to be living in the larger villages and small towns. As they get older, they tend to move in from the countryside to be closer to shops, services and other amenities (Wenger 1984, 1990; Warnes and Ford 1995; Burholt 1998).

Poverty in rural areas has been shown to be comparable with that in urban areas but older people living alone have been identified as one of the main disadvantaged groups (Shucksmith 1999*b*; RDC 1999). However, those older people with low incomes tend to be those who have always lived in the countryside and those who move in tend to have higher incomes. There may be little social exchange between these sectors of society. Assumptions of homogeneity in rural populations are often ill-founded (Wenger *et al.* 1999).

A recent study of successful ageing, as defined by people in their 80s or older and living in rural Wales, found that the maintenance of health, mobility and independence came top of the list (Wenger 1997, 1998). This was frequently expressed in terms of keeping on with present routines and activities, looking after oneself and maintaining relationships with family and neighbours.

In this paper some of the myths or idealised (idyll-ised) images of life for older people in the countryside are explored in comparison with what research on ageing in rural areas tells us. Four common myths are considered. These are that older people in rural areas:

- live in pretty villages and small towns, where they spend their retirement happy and contented with few worries or cares;
- have strong family support networks that are available to provide loving and appropriate care if needed;
- live in well-integrated communities that take special pains to ensure that the needs of older people are met;
- have better health and life satisfaction than people in urban areas, and so have fewer service needs.

These myths can be considered in terms of (i) how much they reflect reality; (ii) how much they may only partially reflect reality; and, (iii) how much is either inaccurate or omitted from the myth.

Older people in rural areas live in pretty villages and small towns, where they spend their retirement happy and contented with few worries or cares

There is of course some reality in this myth. Sparsity of population is associated with: a lower crime rate (Anderson 1999; RDC 1999); cleaner air; less crowded public transport, shops and pavements; and

lower car and household insurance rates. But there are disadvantages mixed in with these advantages. Not all villages are pretty. Some are characterised by industrial dereliction with little compensating access to cultural centres. Living in the countryside may seem like the ideal spot to live during the Third Age, but it becomes more difficult in the Fourth Age as physical capacity starts to wane.

Rural public transport is limited in Britain (Moseley 1999), and older people have been identified as one of the groups most affected by this (Farrington 1999). Driving and maintaining a car may be essential and this may become an expense that an older person might wish they could do without. Arguably, driving is more dangerous since there are proportionately more traffic accidents and more deaths from traffic accidents in rural areas (Roderick 1999). With increasing age, fewer older people continue to drive and car ownership becomes less likely. This can be due to impaired mobility, vision or hearing, as well as expense. While country dwellers tend to be generous in the offer of lifts, getting into cars or onto buses becomes more difficult with age, and older people become reluctant to accept lifts or to use the bus if they require help in getting in and out of vehicles (Wenger 1992).

Bus services are rudimentary in many rural areas. Often it is not possible to go and return in the same day to destinations beyond the nearest service centre. This means that attendance at specialist health appointments and visiting relatives or friends in hospital may not be easy. Very few rural communities are on train routes and fewer have a railway station (Wenger 1984).

In larger villages and small towns most weekly needs can be met within walking distance (Wenger 1984), although with advancing age walking distance tends to shrink. One older woman commented that everything seems to get further away as you get older. However, the availability of local shops and general stores is in decline (Philip 1999). Even if amenities are within walking distance, access may be difficult. Country lanes have no pavements. Public buildings tend to be older and are more likely to have steps and entrances that are difficult to negotiate. Roads and pavements are more likely to accumulate debris washed off fields and hedges, so that there are more hazards for the older pedestrian.

There are other aspects of this first myth that are usually not taken into account. In smaller villages and areas of dispersed settlement, even post offices, telephone kiosks and bus stops are few and far between (Philip 1999). Sparsity of population is also associated with a range of other factors: longer travel distances to necessary services; higher fares on public transport and less likelihood of concessionary fares. There is also a narrower range of suppliers, restricting choice and competition

and resulting in higher prices. Food and petrol are more expensive and, ironically, fresh food may be both more difficult to find and more expensive than in urban areas (Scott 1999). Because of the distances involved as well as the small size of the market, suppliers may charge for deliveries. There are typically longer waiting times for deliveries and repairs, which are often only available in each area on one or at most two days a week.

So, while it is true that retirement to villages and small rural towns can provide a pleasant environment, there are aspects of rurality which can make ageing more difficult. Most older people adapt to the circumstances in which they find themselves, but the rural idyll is not without its problems.

Older people in rural areas have strong family support networks that are available to provide loving and appropriate care if needed

This myth too has some truth in it. In the USA it has been shown that those who live in small towns and rural areas have more family members in their networks than those who live in cities. This has not been shown to be so in the UK (Wenger 1995). Even within Europe, however, there is wide variation between countries (Wenger *et al.* 1999), and migration patterns are likely to be more significant than rurality in determining social network composition (Wenger 1995).

Even for those who move to the country to retire, grandparents may be favoured holiday destinations when grandchildren (and grandparents!) are young. For those who have always lived in the countryside, children and other relatives may live or move away to larger towns for employment. While children are single they continue to think of their parents' home as home, and to make regular visits back for weekends and holidays. But as they marry and raise families, their visits tend to decline. In the more desirable rural areas, younger people tend to be priced out of the local housing market and so older people can become separated from their immediate family because their children have to live elsewhere (Bradley 1987). Those who move to the country on retirement sometimes move away from their adult children. Retirement migrants are more likely to be childless. This combination of migration trends, coupled with the social distance between retirement migrants and locals mentioned above, has led some authors to talk about the 'geriatrification' of the countryside (Philip 1999).

Older people who have always lived in areas of sparse population tend to be less dependent on contact with others than those who have

always lived close to neighbours. In British culture, expectations for care in old age exist only for spouses and adult children, but, even for adult children, no expectation exists for long-term care (Wenger 1994*a*). Where children live nearby, however, substantial amounts of support are provided (Burholt and Wenger 1999). This happens irrespective of rural or urban areas; but retirement migrants are less likely to have adult children living nearby (Harper 1987).

There is no truth in the commonly-held belief that older people in rural areas of the UK have stronger networks than those living in urban areas. Most older people have strong family support networks whether they live in rural or urban areas. What determines the strength of networks in old age is the migration patterns existing in the community and the family. Where there are high rates of population turnover, fewer people have local supportive networks. This is as true of villages as of urban neighbourhoods (Wenger 1995).

The proportions of those who have never married tend to be higher in rural areas. Amongst those already aged 80 or more, childlessness also is higher in rural areas (Wenger 2000; Wenger *et al.* 2000). Approximately half of those without children have never married, and the others have been married but have not had children. As a result of this and the lower population pressure on social housing, more older people live alone in rural areas (Wenger 1984; Shucksmith 1999*b*). So, the family support networks of rural residents in Britain are no stronger than those in urban areas.

Older people in rural areas live in well-integrated communities that take special pains to ensure that the needs of older people are met

Strong community networks have been identified in the rural communities of many countries (Shenk 1991; Wenger and Shahtahmasebi 1991; Mackenzie 1999). Research in the USA has found a strong correlation between the number of people in the support network and the perception of good physical health, and between the level of social support and good health (Johnson 1996).

As noted above, rural communities in most countries have higher proportions of older people in the population. Communities with higher concentrations of older people have been identified as being beneficial for elderly people by several authors (Rosow 1967; Steuve and Gerson 1979; Kivett 1985). Rural communities are, therefore,

likely to be more beneficial than urban areas. There is also evidence to suggest that non-kin personal relationships have a greater buffering effect in terms of emotional health than family relationships, although there are indications that linear distance has an effect on the extent of neighbouring (Wenger *et al.* 1999).

In the UK, older people tend to move in from the countryside to larger settlements and to closer proximity to amenities and services when their health begins to fail (Wenger 1992). Because population density is lower, few people live in flats or high-rise buildings; neighbours are therefore fewer and more visible. Older people in rural communities do have more contact with their neighbours than in many urban areas (Wenger 1984; Kivett 1985). Neighbours meet one another not only over the garden fence and on the road but also in the more limited numbers of shops and other public spaces. They are, therefore, much more likely to get to know one another and to notice if anyone appears to need help. However, those who live in villages may be more involved in neighbour relationships than those who live out in the countryside (Wenger *et al.* 1999).

Older people in rural communities are also more involved in voluntary groups than those in urban areas, particularly pensioners' and women's groups (Wenger 1984, 1995). They are more likely to belong to and attend a church. Because of the smaller scale of rural communities, a higher proportion of residents other than neighbours also know one another. Informal non-family support of older people from voluntary groups and/or churches reaches a greater proportion of older people in rural areas (Wenger 1999*a*). The receipt of help and support from community groups in rural communities is likely to reflect the greater integration of older people in community groups.

Village pubs, on the other hand, which formerly provided a social focus for many older men and couples, are becoming less and less local in nature as they seek to attract a wider, more affluent and younger clientele (Moseley 1999). Retirement migrants who maintain a lifestyle focused on the household can become socially isolated as they become more frail. The onset of dementia or the presence of poorly managed incontinence, for example, can result in the withdrawal of informal support from non-kin. These health problems are, of course, equally possible in urban areas. In general, the myth of well-integrated rural communities may not be true of every settlement but it is largely true for the majority.

Older people in rural areas have better health and life satisfaction than people in urban areas, and so have fewer service needs

Life satisfaction does tend to be better in rural areas (Wenger 1998), probably not unrelated to lower crime rates and the higher community integration of older people. Often they comment on the contrast of their situation to their image of urban areas. In the USA, at least one study (Kivett 1988) has found that, although rural older people score lower on objective indicators, they score higher on subjective wellbeing in comparison with urban areas. It is suggested that the presence of life conditions, which mediate objective disadvantages of rural life, raise perceived quality of life. Qualitative data showed that these factors were: strong social support networks, a sense of personal space and the ability to maintain a strong value system. Another American researcher found that the main difference between rural and urban widowed people was that those in rural communities reported higher levels of social support and a sense of belonging (Matthews 1988).

Reduced life expectancy has been noted in urban areas, but there is little convincing evidence of differences in health status between rural and urban areas (Roderick 1999). Smoking levels are lower and so is the prevalence of lung cancer, but the prevalence of other respiratory diseases is higher than in urban areas (Bentham 1984).

There is no evidence either to indicate that the needs of older people for health and social care are lower in rural areas. Very little however, has been published on this topic (Lishner *et al*. 1996) and misconceptions do exist. References to social care in rural policy documents have been described as uneven and disappointing (Gould 1994), and the rural dimension is often omitted from care plans (Scott 1999). Department of Health guidelines assume a community atmosphere and strong local networks and voice expectations of self-sufficiency and self-help. Local authorities often assume that if people do not ask for services, they do not need services, and so services are not provided, and so people do not think they'll get anything, and so they do not ask for services, and so on.

In terms of mental health, suicide rates are higher in rural areas, and this is related to social isolation and to easy access to firearms and poisons (Watt 1995). There is also evidence that rural populations have more negative attitudes to mental illness (Roderick 1999). This is likely to delay recognition or acceptance of problems and to lead to avoidance of early diagnosis and treatment.

Only the larger villages and market towns now have general practitioner practices. Low population density increases the cost of

domiciliary services in rural areas. Agencies have to cover larger, sparsely populated areas so the unit costs are higher (Roderick 1999; Scott 1999). On the other hand, primary health care practitioners (GPs and community nurses) make more house calls because of the dearth of public transport and because of the longer journeys which may be difficult for older people to make. Despite the problems faced by rural providers, levels of provision of home care and meals on wheels are comparable with urban areas, although they may be higher in the larger settlements and much lower in remote areas. There are, however, fewer luncheon clubs and day care facilities (Wenger 1999*b*).

Entry to residential care may take place at lower levels of dependency in rural areas because of the higher unit costs of domiciliary support (Wenger 1994*b*, 1999*b*). Movements into residential care or hospital are over longer distances, increasing discomfort for older people and difficulties for family and friends to visit. Small-scale sheltered housing schemes mean that more such accommodation is without warden support.

Specialist medical treatments can entail long journey times and distances. Long distance travel (especially by ambulance) for out-patient treatment or specialist assessment is resisted by older people in rural areas because of the length of the journeys and travel sickness (Wenger 1988, 1999*b*). There is also some evidence to suggest that rural residents suffer adverse effects from the time it takes for ambulances to reach accidents and medical emergencies (Roderick 1999). Minimum ambulance response times are set five minutes longer in rural areas than in urban areas (Roderick 1999), and they are often exceeded. Distances to intensive care units can increase risk.

Dentists, opticians and prescribing chemists are not available in many rural communities (Wenger 1984, 1999*b*). It has been recognised that access to health services is worse and that this may affect not only equity but also outcomes:

> … there is evidence that supports the contention that the inadequate provision and inaccessibility of health service provisions in rural areas may have a detrimental effect on health … (Roderick 1999: 46).

Again there is some truth in the myth. Life satisfaction tends to be higher in rural areas. However, there is inconclusive evidence that health is better, and social class rather than population density is likely to have more impact. On the other hand, access to domiciliary, specialist and emergency services is less adequate in rural than urban areas and it is felt that this is detrimental for health.

Conclusion

Even though the rural idyll is not a clear-cut rosy picture of chocolate box cottages in the glow of hazy sunshine, conventional wisdom is not devoid of truth. Rural areas in Britain do have a charm of their own with easy visual and physical access to country views and open spaces. They do have clean air, lower crime rates, less crowded facilities, low traffic volumes for most of the year and lower insurance rates.

Villages and country towns reflect a human scale and proximity to those local services and amenities that do exist. Family networks may not be stronger than in urban areas but most older people have strong networks wherever they live. One compensating factor for those older people in rural areas who do not have strong family networks is that older people are more integrated into neighbour and community networks than they are in urban areas: an ethos of mutual support is common. While health status in rural areas is no better than in urban areas, it is no worse and life satisfaction is higher. Growing old in rural areas is probably neither worse nor better than ageing in urban areas. However, it can be a qualitatively different experience.

In the UK and other developed countries, it has been noted that criteria for service provision derived from urban contexts fail to meet the specific needs of rural areas (Bull and Bane 1993/4; Saw 1996; Scott 1999). References to social care in rural policy documents are uneven and disappointing (Gould 1994). A need for a rural model of health and social care services in the countryside has been recognised for some time (Caldock and Wenger 1992) and Age Concern has published a resource pack for voluntary groups working in rural areas (Age Concern 1998).

As recognition of rural deprivation and social marginalisation has grown over recent decades, action to promote rural regeneration has grown. The impact of such schemes, however, has been uneven. Most funding agencies desire community involvement but this has been achieved mainly in identifying problems rather than designing solutions (Goodwin 1999). Most schemes have focused on economic regeneration and employment opportunities. Services to older people, for which the rural voluntary sector demonstrates some affinity and expertise, do not generate capital; social care however is a field where a more community-based approach may be more appropriate (Wenger 1999*a*). It is time for a change in patterns of service provision for older people in rural areas.

NOTE

1 An earlier version of this paper was presented as part of the Debate of the Age to Shropshire, Hereford and Worcester Age Concern, Ludlow, 1999.

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