

HEALTHY EATING
FOR HEALTHY AGEING IN RURAL
TASMANIA

FINAL REPORT

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University Department of Rural Health
University of Tasmania



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Research Team

Ms Kim Boyer (Chief Investigator and Senior Research Fellow, URDH)

Dr Peter Orpin (Senior Research Fellow and PHCRED Coordinator, UDRH)

Steering Committee

Carol Owen - Department of Health and Human Services, Tasmania.

Judy Seal – Department of Health and Human Services, Tasmania.

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The Research Team

Participating Service Providers

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Tracey Tasker

Junior Research Fellow

University Department of Rural Health

University of Tasmania

Locked Bag 1372

Launceston, TASMANIA 7250

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1. EXECUTIVE SUMMARY

Our study explored the benefits of three nutritional, structural and social approaches which have as their objective the support of healthy eating for rural older people through the provision of meals.

We worked with clients and providers of three service types – Eating with Friends, meals provided at Day Centres and Meals on Wheels in a number of rural settings across Tasmania.

The key findings from our study provide invaluable information on the people, the services and ideas for the future.

- Clients reported their favourite service aspects as the staff/volunteers, the familiarity and the variety of activities offered.
- Service providers and clients identified that companionship and social contact are essential components of a meal service.
- Our study confirmed the importance of models of social eating that reflect the diversity of older people by offering a range of opportunities and experiences. Current service models do not necessarily reflect this diversity.
- All services involved in our study rely in some way on volunteers and good will. Study participants concluded that the use of volunteers can be a limitation in terms of service sustainability, in particular the issues associated with recruitment and retention.
- Service providers involved in our study highlighted that successful sustainable service provision cannot be achieved if the model relies on one ‘local champion’.
- Services involving groups underestimated the influence of group dynamics, both positive and negative.
- Our study discovered numerous additional support networks operating throughout rural Tasmania with the aim to nutritionally and socially support older people.
- The findings suggest significant improvement can be made to existing service design and delivery to better meet the needs of older people, however further work is needed to explore longer term sustainable models at a community level.

The conclusions drawn provide the basis for recommendations to improve delivered meal services in rural Tasmania.

- The findings suggest that the social dimension of the services is paramount as far as the clients are concerned. Whether the services are meeting the needs of the truly socially isolated is a separate question; there are suggestions in the data that it may not be.
- There is considerable scope to further enhance the identified strengths in services. In particular, diversity of experiences as part of meals, transport/access and approaches which are inclusive and develop social networks need to be explicitly valued and developed in service planning.
- Service development would be strengthened by responding to the identified challenges such as the need for enhanced and more transparent feedback processes; consideration of group dynamics issues; formulating service profiles that truly reflect the role of services and recognition of the diversity of current and potential future clients.

- There are a large diversity of eating needs among older people and these are required to be encompassed by the three services. The richness of the eating experience is underpinned by its social context.
- The demographic profile of clients involved in our study suggest a greater proportion of women than men are using delivered meal services; certainly more women than men attended the service on the day of the study and were happy to be involved in the study.

There are many strengths within existing services however there is the need for change and further research.

To date, our study has produced the following publications:

- Dietitians Association of Australia (DAA) 2007 National Conference – Oral presentation and published abstract (Tasker T, Boyer K & Orpin P (2007) Food, eating and healthy ageing in rural communities. *Nutrition and Dietetics*, 64, S43).
- Australia Association of Gerontology (AAG) 2007 National Conference – Abstract and oral presentation (pending acceptance).

2. INTRODUCTION

The aim of our project was to explore the benefits and barriers of three nutritional, structural and social approaches which support healthy eating in rural older people through the provision of meals. The three models are:

- Eating with Friends Groups (EWF)
- Meals provided at Day Centres as part of a wider range of activities (DC)
- Meals on Wheels (MOW)

A brief description of each service is attached; refer to Appendix 1.

Services from a variety of rural geographical settings were involved in our study to identify from both consumer and provider points of view, the strengths and weaknesses of each service model and to develop options for future models which build on the strengths identified within the study services and which meet current and projected future needs at the level of the local community.

Services in our study were chosen based on geographical and organisational diversity and their range of consumers and are likely to be representative of rural areas across the state in the North, North West and South.

Our project was funded through the annual HACC Program Tasmania competitive grants process. It was structured as a joint undertaking between the University Department of Rural Health (UDRH), Department of Health and Human Services (DHHS) and the Home and Community Care (HACC) Program Tasmania.

Study Rationale

While the link between nutrition and quality of life is well understood there is a much weaker evidence base available to underpin the design of models for meal provision services for older people.

The changing profile of the ageing population is well documented. The forecasts include not only significant increases in the numbers of older people but changes in relation to cultural diversity; as a result of the ageing of migrant populations. Some individual urban based delivered meal service have started to reflect these changes however little planning has been done at a broader service level to address these needs.

Currently the level of government investment in delivered meal services, with the aim to support older people to remain living independently in their homes is significant. This is despite there being little known about whether or not current service models meet the needs of older people.

There is limited research investigating the impact the reliance on volunteers within current service provision has in terms of service sustainability. Within rural communities it can be assumed that there is significant reliance on volunteers and high levels of personal investment in services which again may impact on long term service delivery.

The initial focus was on services currently receiving or having received government funding. Whilst the three models chosen vary in design and implementation, they represent just three approaches to delivered meal services for older people.

Project Objectives

Our project objectives were to:

- Identify the strengths and weaknesses of current services providing meals to elderly rural people through the eyes (and mouths) of their consumers, would be customers and service providers.
- Explore alternative service models which may be more effective in meeting the 'healthy eating' needs of rural older people, including addressing the key aspects of social isolation.
- Engage government and non government policy and service leaders in this action research project, with potential for significant service improvement.

The Research Question

Our research question was framed to explore the extent to which existing service models for the provision of food to older people are meeting the full range of their needs around food and eating.

Research Sub-questions

Our subsequent research sub-questions were:

1. What role has and does food and eating play in the lives of older people?
2. How well are existing service models meeting the social and cultural attitudes and beliefs around food and eating for older people?
3. What are some of the relative strengths and weaknesses of existing service models in meeting these needs?
4. What elements need to be considered when developing new models to better meet the broader needs of older people around food and eating?

3. BACKGROUND

Ageing profile in Tasmania

Tasmania's population is ageing: "Presently one in every five Tasmanians is aged 60 or older" and "by 2019, Tasmania is expected to have the oldest population in Australia with approximately one in every four people being 60 or older"(Seniors Bureau, 2005). All regions (especially rural areas) have seen an increase in the number of older people in the last 10 years and this is expected to continue.

These forecasts have significant implications for services supporting older people, importantly services working towards assisting older people to live independently within their own homes.

Rurality of Tasmania

The rurality of Tasmania also presents significant challenges. Many older Tasmanians are reliant on the services provided within their communities to maintain and/or enhance their health and to support positive or successful ageing. HACC funded delivered meal services are crucial in providing rurally based older people with an opportunity to maintain their health, independence and to participate in their local community.

Social determinants of health

Social engagement is a strong health determinant: "Friendship, good social relations and strong supportive networks improve health at home, at work and in the community" (World Health Organisation, 2003). "Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued" (World Health Organisation, 2003), this belonging has a powerful protective effect on health (World Health Organisation, 2003).

Other social determinants identified as having a significant impact on the health and well-being of older people are a sense of control, a sense of belonging and hope for the future.

Anthropology of food and influences on eating for older people

Food and eating are about much more than simply nutrition:

"Food has a pervasive role in human life; next to breathing, eating is perhaps the most essential of all human activities and one with which much of social life is entwined" . . . "Food is an important marker of identity at many levels and as a substance used in the creation and maintenance of social relationships, food serves to solidify group memberships and to set groups apart"(Mintz S W and Du Bois C M, 2002).

While health policies guide people about what they should eat, a more comprehensive, relevant picture of the role food and eating has in people lives requires consideration of the social and cultural meanings of food and eating.

Studies suggest that health and social factors which affect the food choices (and nutritional intake) of older people most commonly include: inadequate money; inadequate food storage facilities; physical disabilities affecting food preparation; poor access to shops; difficulties in undertaking the shopping; loneliness and bereavement (Wylie C et al., 1999).

Of particular interest when looking at the influences on food choice for older people is the role that the loss of a partner can play on food choice and nutritional intake: “Widowhood often means eating alone for many, if not all meals, a big change for some after years of companionship at mealtime” (Callen B L and Wells T J, 2003).

The influence of others has also been identified as playing a vital role in both food choice and overall food intake of older people. Significant others (spouse, partner, other relative, friend or neighbour) potentially influence choice; the degree of influence will depend on the credibility of the source and the closeness of the relationship between the parties (Herne S, 1995).

Social interaction and health

Social support and social interaction are well known to improve the overall health, specifically the nutritional health of older people. The link between social eating and improved nutritional intake is well documented; people report eating better (greater intake and broader variety) when in the company of others. Studies also report that opportunities for socialisation help older people maintain their nutritional health. This includes going to community meal sites (Callen B L and Wells T J, 2003).

(Refer to Attachment 1 for a more detailed background literature review).

4. METHODOLOGY

Our study collected survey, focus group and interview data from clients and service providers associated with three services providing meals to older rural people: Eating with Friends (EWF), Day Centre meals (DC) and Meals on Wheels (MOW).

Ethics

Our study was approved by the Human Research Committee – Social Science at the University of Tasmania (See information sheet and consent form Appendix 2).

Data Collection and Study Instruments

Our study utilised three data collection methods:

1. A General Information Questionnaire (GIQ – Appendix 3). The GIQ consisted of 26 item self administered client survey covering demographic information, general capacity (cooking, shopping), social networks, morbidity and use of community based services. Participants were also asked to indicate whether they would be prepared to be interviewed for the study.
2. Focus Groups
3. Semi-structured Interviews (face-to-face and telephone – Appendix 4). Interviews and focus groups were administered to both clients and service providers and contained open ended questions around needs, beliefs and experiences in relation to the service.

Study Participants

Participants were drawn from nine rural meal services: five EWF, two DC and two MOW.

Participating services were chosen based on their geographical and organisational diversity and their range of clients. In addition, former Managers/Coordinators and staff from two defunct EWF services were also included in the study. In two cases, EWF groups identified in the original proposal had ceased operation at the time of data collection and alternative groups meeting the inclusion criteria were substituted.

Recruitment

Three recruitment strategies were used:

1. Direct approach through the services – the Researcher attended the EWF or DC group and invited group members to fill in the GIQ and to participate in an interview or focus group.
2. Information mail out through the service – the Researcher contacted the Manager/Coordinator of the services and asked them to mail out the information sheet and GIQ to clients. Clients were invited to return the GIQ and provide details if they wanted to participate further in the study.

3. Local Media – The study experienced significant difficulty recruiting MOW clients and service providers. A general media invitation via local radio and community newspapers was only partially successful on boosting participant numbers from MOW.

Final Sample

- General Information Questionnaire – **63**
- Focus Groups – **3 (27 participants)**
- Interviews – **27 (30 participants)***

*Two interviews involved two people and one interviewee represented two services.

Study Constraints

In practice, our study met with three methodological constraints:

- Firstly – As discussed in recruitment (section four), it proved extremely difficult to recruit participants from among MOW clients and service providers. Unfortunately, therefore, our study is limited in what it can add to the evidence base for this model of delivered meal service.
- Secondly – Our study is unable to take account of a number of service models that lie outside the original research brief; for example, commercial delivered meal services and urban based culturally specific meal services. It is recognised that these services are an important part of the overall mix of services providing social eating experiences for older people and need to be included relevant in future studies.
- Thirdly – Our study does not provide full regional representation with greater numbers of participants from the North and North West regions (Refer to Table 3, page 12). Regional variation in Tasmania is well evidenced; this should be considered when applying the conclusions and recommendations state-wide.

5. FINDINGS and DISCUSSION

5.1 Study participation

The General Information Questionnaires yielded the following demographic data:

- The average age of study participants was 66 years (range 59 – 91 years).
- Study participants grew up in a variety of countries: Australia (52), England (6), New Zealand (2) and Denmark (1). Note – two participants did not respond to this question.
- Of the 63 completed GIQ, 55 females and 8 males participated.
- Of the three focus groups conducted, 24 females and 3 males participated.
- Of the 29 interview participants, 26 were female and 3 were male.

Table 1: Service by Data Collection Method

Service	Number of participants GIQ	Number of participants Focus groups/interviews
EWF	17	13
DC	34	9 (plus 27 from focus groups)
MOW	12	8

Table 2: Service by Participant

Service	Clients	Volunteers	Employees	Managers/Coordinators
EWF	10	2	-	1
DC	33	-	2	1
MOW	1	5	-	2

Table 3: Region by Data Collection Method

Region	Number of participants GIQ	Number of participants Focus groups/interviews
South	4	3
North and North West	56	25
East	3	29

The demographic profile of clients involved in our study suggest a greater proportion of women than men may use delivered meal services; or at least more women than men attended the service on the day of the study and were happy to be involved in the study.

Although the southern region was poorly represented in our study, this is unlikely to be a major problem due to the large amount of inter-service variation.

5.2 The role of food and eating in the lives of older people

In our study of food and eating, memories painted a picture of the diverse roles food and eating had, and continues to have, in the lives of older people. The vast majority of participants indicated that food is important to them, however, for a few, food and eating are not as important now as they once had been.

Food served a variety of roles for older people: it governed health and provided nourishment, it provided emotional comfort and on a daily basis, meals are seen as something to look forward to. *Life would be pretty dull without it (client)*. For others food is a reminder of times past and of the frailty of life. *I haven't enjoyed food since my husband died (client)*.

Continuing the thread of diversity, favourite foods were spread from the traditional fare (rice puddings, trifles, stews and baked dinners) to the exotic (mutton bird and swan). The way food was presented was identified as an important factor influencing the enjoyment of a meal. . . . *the fact that it's attractively well prepared. . . (client)*, and . . . *the look of a meal on the plate is very important (client)*.

Older people enjoyed their foods well cooked (but not overly so) and identified quality (meats) and freshness (fruits and vegetables) as important.

Study participants drew a distinction between food and eating. Food is food whereas eating involves others; it implies company and some sort of social interaction. Participants clearly identified that eating with others was much more enjoyable than eating alone. EWF and DCs provided clients with invaluable social interaction and almost at times it seemed, as an aside, they also happened to provide a meal.

The most memorable food experiences reported by participants further highlight the importance of family, adventure and the feelings of belonging and connectedness.

. . . they were about food and getting people together. My memories are of the family being together, people that we normally wouldn't see and that couldn't normally catch up did (client).

. . . when my sister came down from Queensland and Mum and Dad were still alive and living up here and we all had Christmas together. They lived up on the hill a couple of blocks away from where we lived and my sister and brother-in-law would come down from Queensland and we'd come down a couple of days before Christmas and we'd have Christmas together. We had Christmas eve together, and had a barbeque and then we had a big Christmas meal and that was beautiful . . . it was just a really big family event, all the family were there, all my children and partners and grandchildren. . . (client).

There are a large diversity of eating needs which are required to be satisfied by the three services. The richness of the food experience is underpinned by its social context.

5.3 Social and cultural attitudes and beliefs around food and eating for older people

The reported influences on food choice and food preferences again reflect the diversity of participants needs and life experiences. The literature suggests older peoples' food choices and preferences are most influenced by personal, socio-economic, educational, biological, physiological and psychological, cultural, religious and regional factors.

Study findings reflected this broad range of influences on food choices with those most commonly reported within the study being: a rural or farming background; the number of siblings; food availability and having grown up during the time of war.

Questions about individuals' social and cultural attitudes and beliefs around food and eating again highlighted the importance of social contact and interaction. Across all services, it was the access to other people and the anticipation of time shared that enhanced the eating experience. Even with MOW, which is not a 'social eating' model, clients expressed the importance of the social contact with the meal deliverers.

People repeatedly gave social explanations for their use of the services.

EWf –

*. . . it's a good way to meet people (client).
. . . to chat to people and find out what they're doing, and just hear lots of voices. . . (client).
. . . for the company. . . (client).*

DC –

*The friendship really . . . someone cares if you live or die. It can mean a lot to lonely people (client).
. . . I would not have cooked that good a meal for myself at home (client).
. . . we all have a good talk, and we discuss different things, or discuss who's having problems, who's ill, how are they. . . (client).*

MOW –

. . . I just can't believe how much they get in that little container. . . I've got two most beautiful people that bring the meals, they are the only people I see in my day quite often. . . (client)

Participants from all services clearly identified that eating with others was much more enjoyable than eating alone. Delivered meals were seen as not just the food but the company of those that delivered them.

These findings suggest that the social dimension of the services is paramount as far as the clients are concerned. Whether the services are meeting the needs of the truly socially isolated is a separate question; there are suggestions in the data that it may not be.

5.4 Relative strengths and weaknesses of existing service models in meeting the needs of older people

Obtaining critical feedback about the services involved in our study was difficult. Study participants were reluctant to provide criticism however some clients (and service providers) commented on the quality of the meal. *No I don't like the stuff you get here, I eat it, you've got to eat a meal (client). What I eat here I find boring and I don't like half of it (client). . . . a common complaint is that the meat is tough . . .the soups sometimes smells and looks like dishwater . . . (service provider).*

One interpretation of the lack of critical feedback would be that current service provision is fully meeting the needs of older people. *We are probably lucky to have these sorts of places (client).* An alternate explanation, or other factor may be that participants are grateful for what they receive and reluctant to criticise regardless of any dissatisfactions. *Not everyone wants a Day Centre . . .(service provider). . . .most of them are grateful but they'll put up with a lot, which is a shame . . because they should be able to speak up more. . . (service provider)*

5.4.1 Identified Strengths –

Two of the three services involved in our study clearly understand and embrace the ideas of social interaction and social cohesion. . . . *there's lots of nice people around you and someone to talk to (client).* Study participants reported feeling welcomed and embraced by the group from their very first experience. . . . *they've been like family to me. . . (client), andeverybody loves everybody (client).*

Services provided not only a meal that participants may not have prepared for themselves at home but also provided people with the opportunity to delight in new experiences and get out and about. *To me it gives us an opportunity to travel, to see outside activities, away from the Centre, to go to exhibitions, to go to interesting places, as a group (client). The day doesn't last long enough (client).* Many participants commented on the meal provided by the service. *The meals we get here are just perfect (client). I like everything; I like the food, and the company, the chairs and the mental stimulation and the activities (client).*

However it was clearly identified that the most important thing the services provided was in fact the social interaction. *Well the food is nice, but I mean I wouldn't mind that the food was terrible, I'd still go, just because I think I've got to make myself go somewhere regularly, and that's the only thing I do on a regular basis (client).*

Central to the idea of group dynamics, participants (both clients and service providers) highlighted that people needed to feel included and valued within the groups. . . . *a lot of the groups are natty little groups; they don't like things with other people. Here they have to eat, chat and do things with other people. They seem happy to do that when they're here but I don't think they would do that outside (client).* Importantly some participants felt that the groups were a catalyst for other social networks. . . . *a positive thing that comes out of a group like this is that its not just today that we're together, we make contact with each other during the week. Some of us didn't even know each other until we came here (client).*

As well, the groups served a range of other functions for people including providing information, support and guidance. *The company, the comfort. . . we can discuss anything can't we? (client). . . They share experiences...they feel safe and secure here. . .(service provider).*

5.4.2 Identified Weaknesses –

Weaknesses of existing service models

All service models identified that the use of volunteers can be a limitation. Participants reported being worried about the sustainability of a volunteer based workforce, particularly the issues of recruitment and retention. . . . *I would like to see more volunteers, young volunteers to train to be with the elderly (service provider).* There was a general consensus among participants that the services were reliant upon the goodwill of its members and the wider community.

Every service involved in the study had a 'champion'; someone who was the main driver. The services no longer in operation identified this was a limitation for long term service delivery and sustainability. If there was no succession plan the service could lapse with the loss of a key individual. *I was doing it as part of my work time, as a community development thing. . . we did it for about six months and then my workload got too heavy and I asked various organisations if they'd like to take it over and nobody could or would so it didn't happen. Then we just did irregular ones when I could manage it. . . (service provider).*

As mentioned previously, participants reported that group dynamics played a very important role in the services they used. Unfortunately group dynamics also had a negative effect within services. Some groups were reported as being cliquy; new comers to the group found it hard to know where to sit and there were often unspoken rules. . . .*they've got their little groups, they don't sit there because so and so sits there . . . (service provider). . . it's taken a long time, I've been here over two years, and it's very difficult, especially when you are older, to move into a new group, a new place, and start to know people (client). . . luckily when I went the first time there was only about half of the people there, and it didn't feel so huge (client).*

Clients also identified the influence of group dynamics in relation to the structure or physical set up of groups for instance the way in which the tables were arranged. . . . *a long table is not a conversational meal time shape (client). . . arrange the tables in a horseshoe for more interaction . . . (client).*

The presence of married couples whilst confined to just one group involved in the study, was identified by several participants as being a little off-putting and not what the group was designed for.

Recruitment of both the service workforce and clients was an issue for some services, but not all. One service had a waiting list for group membership. This however wasn't common. Recruitment was often ad hoc and was often done through another service (e.g. community nursing). . . .*referral to the group was passed on through the grapevine, we encouraged people to bring a friend. . .we usually had a list of clients to send a flyer to. . .we needed to spend more time working at recruiting people to come along to the group. . .(service provider).*

As always groups felt they could do more, provide more and be more responsive with access to additional resources. . . .*I think that there could be more activities. A few more outings and a bit more hands on for the clients would be good (service provider). . . . they feel safe and secure here, I think we should challenge them and talk about different things. Things like funerals. It would help their families too (service provider).*

The most common resource shortfall was transport. *Transport, we lack transport. People have trouble getting to appointments and going out for meals. People are socially isolated; they can't get to things that are on (service provider).* Some clients also identified transport as a limiting factor; some went so far as to provide ideas to overcome access issues*if you could, if we had the means to access people and take them there, take them to the group. You couldn't do that forever though . . . (client).*

Some centre based services felt they would be better equipped to meet client needs if they had extra space and staff. *We have only one room, in it we eat, do activities and encourage people to socialise in one space. This curtails the number of activities we can offer on the one day and at the one time (service provider).*

On the issue of the small number of men utilising the services, some participants thought*men are much less group orientated.* Interestingly some participants welcomed the idea of more men*we could do with more men in the group, it sort of evens the group up . . . it makes it different (client).* In comparison*men would change the dynamic . . . men have other networks, I mean; men go off to pubs and things (client).*

It should also be noted that social models of eating may not suit everybody and thought should be given to the idea that men may access social support and have existing networks through other means for example RSL clubs or local pubs. . . .*part of being a small community too; everyone knows everyone and when people might be in trouble and in need of some help (service provider).*

The profiles of the services involved in the study suggest that the services aim to address the issues of poor nutrition and social isolation amongst the target group. Interestingly in general clients did not identify services as playing a role in improving nutrition and did not identify themselves as being socially isolated.*I found that it was actually the ones already getting out and about that were coming. It wasn't the ones that were still at home by themselves, that needed company (service provider).*

For example:

John lives alone in a caravan park. He is unable to drive, so relies on public and community based transport. He has no family in Tasmania and limited contact with his family on the mainland. He plays lawn bowls once per week and attends EWF once per month. On hearing the service profile (where it suggests EWF groups help to address social isolation) he was deeply offended. He doesn't see himself as socially isolated.

As previously mentioned the changing profile of the ageing population is well documented and is a combined result of both an increase in the numbers of older people and of the changes in relation to the cultural make up stemming from ageing migrant populations. Study participants also identified changes in the profiles of people using delivered meal services . . . *.the generation that's getting it now are traditionalists that's for sure . . . maybe in the years to come, 5 to 10 years you are getting a different generation...(service provider).*

Urban based delivered meal services have integrated the changing needs of their clientele as evidenced by the availability of commercial and culturally specific delivered meals; examples of a modern take on traditional service models. Interestingly service providers involved in our study also identified the need for future services to recognise and reflect cultural diversity . . . *.when I'm getting MOW I might not want all that boiled stuff, I might want a nice stir fry (service provider).*

The identified strengths in services need to be enhanced in order to improve delivery. Particularly, diversity of experiences as part of meals, transport/access; and approaches which are inclusive and develop social networks need to be explicitly valued and developed in service planning.

Service development would be strengthened by responding to the identified challenges of enhanced and more transparent feedback processes; consideration of group dynamics; services profile that truly reflect the role of services; and recognition of the diversity of current and potential clients.

5.5 Refining existing services or developing new models -

Our study has indicated some elements for consideration in the improvement of existing service models of funded meal services for older, rural Tasmanians. Both the identified weaknesses of current service models and the specific comments from participants (clients and service providers) can be used to strengthen existing funded service approaches. These elements, as contained in the recommendations under 7.1, relate to service design and resourcing, training and support for staff and volunteers, and service delivery together with ongoing evaluation and review.

Our study, however, focused only on three government funded service models, and this creates a challenge in relation to articulating the findings to new service models. This restricted focus did not allow for the development of fuller understanding of the relationship between these services and other informal and private sector models of meal provision operating within our rural communities and to formulate a complete picture of the issue of healthy eating for older people in the context of the whole community fabric. This indicates that there is valuable additional work to be undertaken to explore more deeply the whole spectrum of community based food and eating linkages that might underpin a comprehensive service approach to supporting healthy eating for our older citizens. These services may range from local clubs, pubs and cafes to commercial home meal services.

Our recommendations are presented in two parts: **Refining Existing Services** and **Planning the Future** (see below).

6. CONCLUSIONS

The conclusions drawn from our study give rise to a number of broad overall recommendations for service improvement. These are provided in two parts **Refining Existing Services** and **Planning the Future** (see below).

The existing services have considerable strengths but changes are needed and ultimately we need to look at other community frameworks.

Study conclusions:

- The findings suggest that the social dimension of the services is paramount as far as the clients are concerned. Whether the services are meeting the needs of the truly socially isolated is a separate question; there are suggestions in the data that it may not be.
- There is considerable scope to further enhance the identified strengths in services. In particular, diversity of experiences as part of meals, transport/access and approaches which are inclusive and develop social networks need to be explicitly valued and developed in service planning.
- Service development would be strengthened by responding to the identified challenges such as the need for enhanced and more transparent feedback processes; consideration of group dynamics issues; formulating service profiles that truly reflect the role of services and recognition of the diversity of current and potential future clients.
- There are a large diversity of eating needs among older people and these are required to be encompassed by the three services. The richness of the eating experience is underpinned by its social context.
- The demographic profile of clients involved in our study suggest a greater proportion of women than men are using delivered meal services; certainly more women than men attended the service on the day of the study and were happy to be involved in the study.

7. RECOMMENDATIONS

7.1 Refining Existing Services – Recommendations

- 7.1.1** A training and development program for existing service providers needs to be put in place to ensure an enhanced understanding of social isolation and how it may be manifested, and then adjusting client recruitment methods as needed. Training (skilling) should also be provided to service coordinators and volunteers on understanding and positively managing group dynamics and client diversity.
- 7.1.2** Across all services, enhanced and more transparent feedback processes should be implemented. This may involve a program of external service evaluation.
- 7.1.3** In consultation with clients, service providers need to re-evaluate documented service aims to better reflect the value of the services and their social dimensions. For example, while recognising MOW is not a social eating service, the value of social contact for the client with the meal deliverer is clearly a critical element of the service and should be formally recognised.
- 7.1.4** Assessment of where additional resourcing would be most beneficial (e.g. transport to and from meals, additional outings etc) should be undertaken as a key part of overall service planning. For example, Day Centres should be supported in the process of consolidating their role of providing specific linkages between meals and participation in other meaningful (for clients) activities.
- 7.1.5** Succession planning processes should be encouraged to try to avoid services becoming ‘champion’ or single person dependent. Services should be supported to undertake additional succession planning for volunteers, including sharing of ideas between services of what volunteer recruitment processes are most effective.

7. RECOMMENDATIONS

7.2 Planning for the Future - Recommendations

To fully develop new service models we need to build both on existing funded services but also to understand more about the whole range of opportunities and existing services available at a community level. We also need to know more about the detail of demographic change as it impacts on older people living in and moving to, rural communities, together with appropriate responses which recognise cultural and social diversity. Therefore it is recommended that the following studies be funded:

- 7.2.1** A study based in one or two rural communities, to explore the existing infrastructure to support healthy eating for older people. The study would include investigation as to how HACC funded services contribute within the broader community profile.
- 7.2.2** A project investigating additional approaches to delivered meal services, such as commercial services and services tailored for specific cultural groups. Whilst these services are urban based, they employ a variety of additional strategies that may strengthen rurally based services.

APPENDIX 1

Australian Meals on Wheels Association

Vision and Mission

A flexible, adaptable national Meals on Wheels service for the frail, aged, younger people with disabilities and their carers in Australia.

The Australian Meals on Wheels Association promotes the concept of 'care in the community' and encourages and supports the involvement of volunteers in the provision of the Meals on Wheels service in Australia.

Eating with Friends

Eating with Friends (EWF) is an innovative approach to improving the health and wellbeing of older people in Tasmania.

The aim of Eating with Friends is to address the issues of social isolation and poor nutrition among older people by recruiting communities and volunteer groups to provide regular group meals to older, isolated Tasmanians.

There are currently 25 EWF groups operating throughout Tasmania.

Day Centres

Provide a range of group and individual programs and activities to frail, ageing and people affected by dementia and younger people with a disability and their carers. Centres may operate daily, weekly or less than weekly. Social interaction and enjoyment are the underlying values of many of the Day Centres in rural Tasmania. Costs for clients associated with the use the Centre vary depending on the Centre and the activities involved.

Programs and activities provided include:

- Program for dementia clients
- Respite day services
- Meals when at the centre
- Transport to and from the Centre, including a wheelchair lift bus
- Podiatry (twice every six weeks by appointment only)
- Woodwork Group
- Access to personal care services as required
- Physiotherapy assessments and support

APPENDIX 2

APPENDIX 3

APPENDIX 4

ATTACHMENT 1

Ageing profile in Tasmania

“In Australia, the number of people over 65 years of age has increased by 67% in the last 20 years”(Seniors Bureau, 2005). The number of older Tasmanians has also been increasing; “Tasmania is now the second oldest population in Australia after South Australia, with 18.4% of its population aged 60-plus” (Seniors Bureau, 2005). “This means that presently one in every five Tasmanians is aged 60 or older” (Seniors Bureau, 2005).

“By 2019, Tasmania is expected to have the oldest population in Australia with approximately one in every four people being 60 or older” (Seniors Bureau, 2005). All regions (including rural areas) have seen an increase in the number of older people over the last 10 years and this is expected to continue (Seniors Bureau, 2005).

This forecast has significant implications for services supporting older people, importantly services working towards keeping older people living independently within their own homes.

“Older Tasmanians are very diverse people; they have differing life experience, opinions, needs, desires and abilities” (Seniors Bureau, 2005). They come from different cultural and socio-economic backgrounds and most older Tasmanians are happy and live independent and productive lives (Seniors Bureau, 2005). “They are actively involved in economic activity, voluntary work and physical activities, as well as contributing to family and social commitments” (Seniors Bureau, 2005).

Rurality of Tasmania

The rurality of Tasmania presents significant challenges. Forty percent of older people living in Tasmania live in towns less than 5000 people (Llewellyn D, 2003). The population dispersion and a large number of rural and regional centres relative to population size complicate the States ageing profile (Llewellyn D, 2003).

In more detail ABS data indicates strong structural ageing as a result of declining fertility, numerical ageing as a result of increasing life expectancy and ageing based on increasing ageing migration of people over 55 and out-migration of working age people (Jackson N, 2005). These trends will test already limited services and infrastructure and complicate planning through variations in the level of service demand and impacts on the historical social and cultural structures of rural areas.

Many older Tasmanians utilise the services provided within their communities to maintain and/or enhance their health and well being as a part of positive or successful ageing. HACC funded delivered meal services provide rurally based older people with an opportunity to maintain their health, independence and to participate in their local community.

Social determinants of health

Differences in the health of individuals reflect inherent features of the societies in which they live. The way a society organises itself and delivers wellbeing to its members are major determinants of health. Social, economic and political factors have an important influence on health and longevity. Social position and lifestyle only partially explain ill health. “Psychosocial factors, such as a sense of isolation, deprivation or loss of control, are also important”(Marmot M, 2000).

“Friendship, good social relations and strong supportive networks improve health at home, at work and in the community. Social support and good social relations make an important contribution to health, furthermore social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued, this belonging has a powerful protective effect on health (World Health Organisation, 2003).

Other social determinants identified as having a significant impact on the health and well-being of older people are a sense of control, a sense of belonging and hope for the future.

Anthropology of food and the influences on eating for older people

Anthropology (the study of food and eating) has a long history.

“The richest, most extensive anthropological work has focused on food insecurity, eating and ritual and eating and identities. Food has a pervasive role in human life; next to breathing, eating is perhaps the most essential of all human activities and one with which much of social life is entwined” (Mintz S W and Du Bois C M, 2002).

While health policies tell people what they should eat, consideration of the social and cultural meanings of food and eating provides a more comprehensive, relevant picture of the role food and eating has in peoples lives.

Food is an important marker of identity at many levels – national, regional, familial and individual. “Like all culturally defined material substances used in the creation and maintenance of social relationships, food serves both to solidify group membership and to set groups apart” (Mintz S W and Du Bois C M, 2002).

Thoughts and ideas around food and eating are influenced by a very wide range of factors; however of particular interest in relation to older people are the ideas of:

- Expectation of food
- Familiarity
- Appetites, moods and emotions
- Meanings attached to foods
- Influences of others
- Culture

Influences on eating for older people

Food Choice

A definition of food choice from the literature reads - the set of conscious or unconscious decisions made by an elderly person at the point of purchase, at the point of consumption or any point in between (Herne S, 1995).

Models of food choice classify influences on food choice and can be used to examine the influences experienced at both an individual and population group level. Khan's model consists of the following factors:

- Personal factors: expectations of food, priority, familiarity, personality, appetites, moods and emotions, meanings attached to food, influence of others and marriage roles.
- Socio-economic factors: society, cost of food and the status of food, social class and income.
- Educational factors: education and social status, general education and nutrition knowledge and education and relevance.
- Biological, physiological and psychological factors: sex, age, biological influences of ageing (sense of smell, sense of taste, hunger and thirst), age and physiological influences of ageing (special diets, poor appetite, less pleasure from eating, fatigue, inertia, lack of vigour, difficulty swallowing, immobility, disability, lower physical activity, dentition, mental health), psychological factors (locus of control, depression, self esteem, attitudes towards eating, expectations, food meanings).
- Cultural, religious and regional factors: culture and religion, race and region.
- Extrinsic factors: environment and situation, time and seasonal variations and advertising (Herne S, 1995).

Additional studies specifically identify the health and social factors which affect the food choices (and nutritional intake) of older people most commonly include inadequate money, inadequate food storage facilities, physical disabilities affecting food preparation, poor access to shops, difficulties in undertaking the shopping, loneliness and bereavement (Wylie C et al., 1999).

Some or all of the influences listed in Khan's model above may influence food choice throughout life. Studies suggest that health and social factors which affect the food choices (and nutritional intake) of older people most commonly include inadequate money, inadequate food storage facilities, physical disabilities affecting food preparation, poor access to shops, difficulties in undertaking the shopping, loneliness and bereavement (Wylie C et al., 1999).

Of particular interest when looking at the influences on food choice for older people is the role that widowhood can play on food choice and nutritional intake. "Widowhood often means eating alone for many, if not all meals, a big change for some after years of companionship at mealtime" (Callen B L and Wells T J, 2003).

The influence of others has also been identified as playing a vital role in both food choice and overall food intake of older people. Significant others (spouse, partner, other relative, friend or neighbour) potentially influence choice; the degree of influence will depend on the credibility of the source and the closeness of the relationship between the parties (Herne S, 1995).

Nutritional health and older people

Nutritional health, eating a balanced diet, is an integral component of overall health, independence and quality of life in old age (Callen B L and Wells T J, 2003).

The study 'Views of Community-Dwelling, Old-old People on Barriers and aids to Nutritional Health' found nearly twice as many aids as barriers to nutritional health as part of the study (Callen B L and Wells T J, 2003).

The top five aids to nutritional health were:

- family and friends
- microwaves and frozen dinners
- transportation
- liking a wide variety of food
- proximity to a grocery store

The top five barriers were:

- health problems
- difficulty with transportation
- difficulty with motivation
- difficulty with appetite
- food dislikes

In more detail, social and environmental factors most frequently cited as being helpful in maintaining nutritional health included assistance from family and friends. "Help ranged from doing all the grocery shopping to occasionally sharing a casserole" (Callen B L and Wells T J, 2003).

"Social connectedness enabled these old-old people to continue to live independently in their own homes or apartments long after they might otherwise have needed to move to an assisted living situation" (Callen B L and Wells T J, 2003).

In terms of physical factors the most commonly discussed barrier to good nutrition was health problems (Callen B L and Wells T J, 2003). Participants discussed having to alter diet due to such health problems as gastritis, constipation, heart disease, diabetes, osteoporosis or allergies. Other physical conditions creating barriers were arthritis, making food preparation or opening packages difficult and limited vision (Callen B L and Wells T J, 2003). Appetite and dental problems were also reported as affecting nutritional health.

“Knowledge about nutritional health from the perspective of older people, what they find helpful and what they find difficult, can advance knowledge and may help lead to targeted, cost effective interventions for a rapidly increasing subgroup who are major consumers of both health care services and dollars” (Callen B L and Wells T J, 2003).

Social interaction and health

Building on the ideas outlined in the social determinants of health, social support and social interaction are well known to improve the overall health, specifically the nutritional health of older people. The link between social eating and improved nutritional intake is well documented; people report eating better (greater intake and broader variety) when in the company of others. Studies also report that opportunities for socialisation help older people maintain their nutritional health. This includes going to community meal sites (Callen B L and Wells T J, 2003).

The literature further suggests that social cohesion – defined as the quality of social relationships and the existence of trust, mutual obligations and respect in communities or in the wider society helps to protect people and their health (World Health Organisation, 2003).

As highlighted in our study, group dynamics, including peoples willingness to disclose and share information, peoples sense of belonging and ownership and the reported feelings of exclusiveness for new group members were factors that influence the meal experience.

REFERENCES

- CALLEN B L & WELLS T J (2003) VIEWS OF COMMUNITY-DWELLING, OLD-OLD PEOPLE ON BARRIERS AND AIDS TO NUTRITIONAL HEALTH. *JOURNAL OF NURSING SCHOLARSHIP*, 35, 257-262.**
- HERNE S (1995) RESEARCH ON FOOD CHOICE AND NUTRITIONAL STATUS IN ELDERLY PEOPLE: A REVIEW. WHAT MAKES OLDER PEOPLE FOLLOW PARTICULAR DIETARY PATTERNS AND WHICH FACTORS CONSTRAIN THEIR CHOICE? *BRITISH FOOD JOURNAL*, 97, 12-29.**
- JACKSON N (2005) TASMANIA'S TURNAROUND: MIGRATION IN THE APPLE ISLE. *ACADEMY OF SOCIAL SCIENCES IN AUSTRALIA*, 24, 25-37.**
- LLEWELLYN D (2003) INQUIRY INTO THE IMPACT OF TASMANIA'S AGEING POPULATION: SUBMISSION TO THE TASMANIAN PARLIAMENTARY JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT. HOBART, TASMANIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES.**
- MARMOT M (2000) SOCIAL DETERMINANTS OF HEALTH: FROM OBSERVATION TO POLICY. *MEDICAL JOURNAL OF AUSTRALIA*, 172, 379-382.**
- MINTZ S W & DU BOIS C M (2002) THE ANTHROPOLOGY OF FOOD AND EATING. *ANNUAL REVIEW ANTHROPOLOGY*, 31, 99-119.**
- SENIORS BUREAU (2005) ALL AGES, ALL TASMANIANS TOGETHER: A DISCUSSION PAPER TO DEVELOP THE TASMANIAN PLAN FOR POSITIVE AGEING 2006-2011. DEPARTMENT OF PREMIER AND CABINET TASMANIA.**
- WORLD HEALTH ORGANISATION (2003) SOCIAL DETERMINANTS OF HEALTH: THE SOLIDS FACTS, SECOND EDITION. IN WILKINSON R & MARMOT M (EDS.), WORLD HEALTH ORGANISATION.**
- WYLIE C, COPEMAN J & KIRK S F L (1999) HEALTH AND SOCIAL FACTORS AFFECTING THE FOOD CHOICE AND NUTRITIONAL INTAKE OF ELDERLY PEOPLE WITH RESTRICTED MOBILITY. *JOURNAL OF HUMAN NUTRITION AND DIETETICS*, 12, 375-380.**