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Health, Wellbeing and Community Involvement of Older People in Rural Scotland

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Abstract

Involvement in community activities offers a route to achieving one of the five “essential elements” of older people’s wellbeing as identified by McCormick et. al., (2009) – that of “having a role”, i.e. having a sense of purpose, belonging and value within society. This suggests that older people living within remote and rural communities would derive wellbeing benefits from participation in informal helping and volunteering. This chapter uses information from the European Union-funded O4O: Older People for Older People initiative, conducted from 2007-2010, which considered dimensions of older people’s participation in remote, rural communities with the goal of encouraging and studying how older people could help other older people stay living in their own homes and communities for longer. The chapter presents quantitative evidence from a survey of people aged 55 and over in four remote Scottish communities on the relationship between socio-economic characteristics and participation in community activities. Further insights are brought from the analysis of interviews conducted with older people living within the four communities. By taking these communities as case studies, the chapter is able to comment on the relationship between participation and older people’s wellbeing within the rural context.

Keywords: older people; community; participation; volunteering, rurality, wellbeing.

Introduction

Involvement in community activities offers a route to achieving one of the five “essential elements” of older people’s wellbeing as identified by McCormick et. al., (2009) – that of “having a role”, i.e. having a sense of purpose, belonging and value in society. The engagement of older people in remote and rural community activities, including informal helping and formal volunteering (in, for example, community organizations or charities), seems to make intuitive sense from a number of perspectives. Younger older people, such as

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recent retirees to rural communities, could use their time and skills to support older frailer people to stay living in their own homes and communities. In doing so, both those who give and receive help could benefit in terms of extending their social networks, thereby creating social capital, health and wellbeing. Rural areas may stand to benefit more from volunteering and informal help as there are higher proportions of older people, when compared with urban areas, and it is more difficult to gain access to, and provide, a range of services. Higher levels of volunteering are found in rural regions and there is evidence of greater social capital and stronger networks, trust and sense of belonging, in rural communities compared with urban communities (Fyfe and Milligan, 2003). Rural areas thus apparently show both a need for support for older people and the potential to provide this through community social resources.

The chapter uses information from the European Union-funded 'O4O: Older people for Older People' initiative, conducted from 2007-10 in Greenland, Scotland, Northern Ireland, Sweden and Finland. It focuses on data collected within the remote and rural Highland region of Scotland. The O4O project considered dimensions of older people's participation (both their informal and formal volunteering activities) in their communities with a goal of studying how older people could help other older people to stay living at home. As part of O4O, a questionnaire survey of all people aged 55 and over in four rural communities was conducted. It examined associations between health, demographic variables and participation in community activities. A summary of key findings is presented, alongside evidence from qualitative interviews with older community members. A range of evidence was produced in O4O; here, we consider findings in relation to health, wellbeing and older people's participation in formal and informal help-giving of various types. Findings are used as an underpinning for comment on relationships between involvement and the wellbeing of older people in rural areas.

Participation and Older People's Wellbeing in a Rural Context

There is increasing research evidence about associations between physical health, subjective wellbeing and participation (informal and formal volunteering in community activities). As well as cross-sectional international studies, there is longitudinal evidence showing associations between health and participation over time (Lum and Lightfoot, 2005; Luoh and Herzog, 2002). The theoretical foundation is that a sense of community belonging and existence of social capital lead to wellbeing which is then associated with improved health status (Berkman *et al*, 2000; House *et al*, 1988; Rowe and Kahn, 1998). The "density of an individual's social relationships" has been shown to impact upon health and wellbeing (Fernandez-Ballesteros, 2002) and participation in community activities is one way to increase social interaction. Volunteering has been shown to be related to reduced mortality (Lum and Lightfoot, 2005; Luoh and Herzog, 2002; Sabin, 1993), increased functional ability (Lum and Lightfoot, 2005), improved immune system function (Growald and Luks, 1988), and reductions in stress (Luks, 1988), chronic pain (Arnstein *et al*, 2002) and depression (Musick and Wilson, 2003).

Intriguingly, studies have shown that 'givers' benefit more than 'recipients' within volunteering relationships (Brown *et al*, 2003; Dulin and Hill, 2003; Liang *et al*, 2001).

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Considering participation of different age groups, older people have been shown to benefit most (Harlow and Cantor, 1996; Li and Ferraro, 2006; Van Willigen, 2000), partly as their health is more threatened (so they have more potential to benefit and changes are also easier to measure) and partly because people may find a renewed sense of purpose following the loss of longstanding work/family roles (Greenfield and Marks, 2004). While health and wellbeing are related to volunteering, if the volunteer is over-extended (too much volunteering), their health suffers (Schwartz *et al*, 2003). A volunteer must contribute a certain number of hours before health benefits ensue (Lum and Lightfoot, 2005; Musick *et al*, 1999).

Here, the relationship between older people's participation (formal and informal) and wellbeing within remote and rural communities is considered. 'Rural' and 'remote' have been variously defined and categorised. According to the Scottish Government's *Urban-Rural Classification*, the communities in this study are located within a 'rural' local authority district because Highland falls within the category of less than 100 people per square kilometre (Skerratt *et. al.*, 2010). In O4O, two of the communities that took part were more than an hour by car from the nearest city (Inverness) and had small populations (between 500 and 700). One community consisted of three small settlements in close vicinity, with a total population of around 1,500. One community was closer to Inverness (six miles), with 1,000 residents. Rural communities have been shown to have higher levels of social capital and volunteering (Onyx, 2000), associated with more traditional, interconnected social relations, the existence of strong and rich social 'ties' (Granovetter, 1985) and reciprocity. However, 'difference' can be conspicuous in rural communities (Little and Leyshon, 2003) and rural social exclusion can negatively impact on individual wellbeing (Meek, 2007). Internationally, rural areas tend to have higher proportions of older people compared with urban areas. They are becoming 'more old' as the trend is for out-migration of young people for employment and education (Giarchi, 2006). In O4O, older people were those aged 55 and over because the Scottish Government use this definition in their plan for older people (Scottish Executive, 2007).

Characteristics of Rural Older People's Participation

Methodology

Four rural locations in the Scottish Highlands took part in the study. Following ethics committee approval, the O4O *Rural Communities Health and Wellbeing Questionnaire* was sent by post from each community general practitioners' (GP) surgery to all registered

Health, Wellbeing and Community Involvement of Older People in Rural Scotland patients aged 55 and over. In total, 2,462 questionnaires were distributed, with a response rate (following one reminder) of 58% (1428/ 2462).

The questionnaire included health and wellbeing-related questions originating from the SF12 (Quality Metric, 2009), the social capital module of the UK General Household Survey and specific questions for O4O. Measures of informal helping (e.g. giving and receiving ‘favours’ from a neighbour) and formal volunteering (e.g. being on the management board of a local voluntary organisation) were included. Participation was defined by ten ‘participative factors’ including informal and formal activity.

To discover associations with participation, demographic and socioeconomic covariates were included: gender, self-assessed health, age, place of birth, length of stay in the community, employment status, highest educational attainment, access to a vehicle and community of origin.

SPSS 16.0 software and a two stage process of analysis identified which variables influence participation in community activities and the extent of their influence. Initially, chi-square tests were performed for the ten *participative factors* and individual-level demographic/ socio-demographic variables. Findings allowed examination of the relationship between level of participation and personal characteristics. Those variables that were associated with participation in univariate analyses were then entered into a binary logistic regression model. A ‘forward conditional’ model was used to identify the significant variables and an ‘enter’ model to obtain adjusted odds ratios. Differences were accepted as significant at $p < 0.05$ for all statistical analyses.

Place, Socio-Demographics and Older People’s Participative Factors

Characteristics Associated with Participation

Table 1 shows a summary of the chi-square tests carried out on the ten *participative factors* included in the study by age, health status, education, length of residence, gender, access to a vehicle and employment. Variables associated with participation are shown – the first five variables represent *informal participation* and the latter five variables represent *formal participation*. Non-significant results are blank in Table 1.

Table 1. Summary of Chi-Square Results.

	Gender	Health	Age	Origins	Length of stay in the area	Employment	Education	Access to a vehicle	Community
Doing a favour for a neighbour in the past 6 months		<0.001	<0.001			0.04	0.015	<0.001	<0.001
Receiving a favour from a neighbour in the past 6 months		0.045					0.047		<0.001
Providing unpaid personal care to someone			0.003					0.038	0.008
Willingness to use skills to help people in the community	0.007	<0.001	<0.001	0.004	0.019	<0.001	<0.001	<0.001	0.002
Dealing with an emergency in the community in the past three years		0.001	0.003			0.001	<0.001	0.01	0.007
Membership of a management committee of a local group		<0.001	<0.001			0.008	<0.001	<0.001	<0.001
Taking part in a community project in the past 3 years	0.046	<0.001	0.001				<0.001	<0.001	<0.001
Attending a community event in the past 6 months	<0.001	<0.001	0.024	0.018			<0.001	0.003	<0.001
Organising a new service in the community		<0.001	0.032		0.004	0.002	<0.001	<0.001	<0.001
Active membership of a local organisation(s)		<0.001		0.02			<0.001	<0.001	<0.001

Table 1 shows that health, age, education, access to a vehicle and community of residence tend to be associated with both informal and formal aspects of participation. No variables are obviously linked with only informal or formal participation. Willingness to use one's own skills to help the community was associated with all of the socio-demographic variables.

The socio-demographic variables such as gender, origins (whether an individual was born in the area in which they currently reside) and length of stay in community were infrequently associated with participative factors.

Community of residence was the only variable associated with all participative factors, suggesting that participation behaviours are place-bound. Although all O4O communities are part of the rural Highland region, findings show that community of residence is associated with participative behaviours, i.e. participative behaviours vary by place. Thus, an assumption often made, that rural communities equally possess the social capital essential to enhance their capacity through participation, would be misleading in the case of O4O included communities.

Access to a vehicle was associated with all participative factors, except receiving a favour from a neighbour. This suggests that, in remote rural communities, access to a vehicle enables participation.

Educational attainment and self-reported health levels were associated with all participative factors, apart from provision of unpaid personal care. Similarly, age was associated with all participative factors apart from 'receiving a favour from a neighbour' (which is likely based more on need and social 'connectedness' rather than age) and 'being an active member of a local organisation' (which is based on physical and social ability to be active). The nature of the association between participation and these socio-demographic factors is explored in the next section of this chapter.

How Place and Socio-Demographics Influence Participative Behaviours

A second stage of analysis was conducted for each participative factor using variables that were significant in univariate analyses (Table 1). Table 2 shows the adjusted odds ratios and their 95% confidence intervals for four selected participative behaviours. The logistic regression models extracted variables to leave only those variables which were independently associated participative behaviours, as shown in Table 2.

Table 2. Odd Ratios (95% Confidence Interval) and p-value results from logistics models for socio-demographic characteristics and doing a favour for a neighbour, willingness to use personal skills, participation in community projects and membership of a management committee participative variables.

	Doing a favour		Use Personal Skills		Community projects		Management Committees	
	OR (95% CI)	p-value	OR (95% CI)	p-value	OR (95% CI)	p-value	OR (95% CI)	p-value
Health (poor health)		<0.001		<0.001		<0.001		<0.001
Fair	3.02 (1.55, 5.90)	<0.001	2.55 (1.01, 6.45)	0.048	1.45 (0.65, 3.25)	0.36	1.72 (0.62, 4.77)	0.30
Good	3.15 (1.71, 5.81)	<0.001	6.55 (2.68, 16.0)	<0.001	2.59 (1.22, 5.51)	0.013	4.28 (1.64, 11.2)	0.003
Very Good/Excellent	4.14 (2.25, 7.63)	<0.001	8.67 (3.58, 21.0)	<0.001	3.62 (1.72, 7.63)	0.001	5.06 (1.95, 13.1)	0.001
Community A (Tongue)		<0.001		0.005		<0.001		<0.001
B (SWR)	2.51 (1.32, 4.81)	0.005	0.32 (0.11, 0.90)	0.03	0.93 (0.60, 1.44)	0.75	0.92 (0.58, 1.47)	0.73
C (Ardersier)	0.87 (0.50, 1.52)	0.62	0.20 (0.07, 0.54)	0.002	0.44 (0.28, 0.69)	<0.001	0.56 (0.35, 0.90)	0.016
D (Lochinver)	0.75 (0.40, 1.41)	0.37	0.20 (0.07, 0.59)	0.003	0.78 (0.48, 1.27)	0.32	1.25 (0.75, 2.08)	0.39
Age group (85+)		<0.001		<0.001				0.06
75-84 years	3.31 (1.78, 6.12)	<0.001	2.66 (1.24, 5.73)	0.012			4.16 (1.41, 12.3)	0.01
65-74 years	4.43 (2.43, 8.07)	<0.001	5.32 (2.45, 11.1)	<0.001			4.23 (1.46, 12.3)	0.008
55-64 years	6.08 (3.37,11.0)	<0.001	16.0 (7.3,35.9)	<0.001			4.33 (1.50, 12.5)	0.007
Education (No qualifications)				<0.001		<0.001		<0.001
O-levels/Standard Grades			1.58 (0.87, 2.87)	0.13	1.04 (0.70, 1.56)	0.84	1.44 (0.93, 2.21)	0.1
Highers			3.52 (1.48, 8.41)	0.005	1.35 (0.83, 2.20)	0.23	1.45 (0.86, 2.44)	0.16
HND/HNC			2.39 (0.85, 6.77)	0.10	1.87 (1.08, 3.21)	0.024	1.77 (0.99, 3.16)	0.05
Professional/University Degree			3.08 (1.87,5.07)	<0.001	2.30 (1.67, 3.17)	<0.001	2.52 (1.78, 3.57)	<0.001
Gender (Males)								
Females			0.57 (0.37, 0.87)	0.009	1.40 (1.09, 1.80)	<0.001		
Vehicle (no access)								
Access to a vehicle					1.85 (1.18, 2.87)	0.007	2.21 (1.30, 3.76)	0.003

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Table 1 highlighted that participative behaviour varies between rural *communities*. Table 2 shows that community C and community D have the least participation and community A and community B have the most. The regression results show that those living in community A and B are consistently more likely (in statistically significant terms) to be involved in both informal and formal types of participation and those living in communities C and D are consistently less likely.

Table 2 confirms that mobility (access to a vehicle) is positively associated with participation (particularly formal participation that may involve transport to a particular place or venue). The finding that some communities are more participative than others in different types of informal and formal participation, suggests that some communities are ‘stronger’ than others in relation to different ways of participating.

Those with access to a vehicle were 1.85 times (95% CI: 1.18 – 2.87) more likely to be involved in community projects and 2.21 times (95% CI: 1.30 – 3.76) more likely to be on the management committee of a local organisation. This emphasises the importance of transport to enable older people’s wellbeing in rural areas. Transport is needed to access these “beyond spaces” (Wiles et. al., 2009) outside the home in order to achieve particular kinds of participative activities that facilitate social interaction and sense of belonging.

Regarding *level of educational attainment*, Table 2 highlights that as the level of qualifications increases, the likelihood of participation concomitantly increases. The highest level of participation was found amongst those with professional skills and university qualifications. This association raises questions about why those with lower levels of educational attainment participate less. If participation facilitates social interaction, with associated health and wellbeing benefits, then what does this relationship imply for the wellbeing of those who perhaps lack the social or cultural capital to ‘join in’? Human and cultural capital appear important to participation; for older people’s wellbeing, there is a need to find ways to include and engage those who have fewer of these assets due to education and socioeconomic status.

Table 2 shows that the relationship between participation and level of *self-reported health* is one in which those who are healthier are more likely to participate. Those reporting worse health were less likely to participate, but more likely to receive a favour from a neighbour. This relationship is further explored in Table 3.

Table 3 Relationship between Self-Reported Health and Participation.

Participation Variable	Least Likely → → Most Likely			
	Level of Self-Reported Health			
Did favour for neighbour in last 6 months	Poor	Fair	Good	Very Good
Received favour from neighbour	Very Good	Fair	Good	Poor
Willing to use skills to help community	Poor	Fair	Good	Very Good
On management committee of local group(s)	Poor	Fair	Good	Very Good
Take part in community project in last 3 years	Poor	Fair	Good	Very Good
Attended community event in last 6 months	Poor	Fair	Good	Very Good
Active member of local organisation(s)	Poor	Fair	Good	Very Good

The relationship in Table 3 appears to be one where the healthier help the more vulnerable. Despite the potential to produce health and wellbeing benefits from participation, poor self-reported health places restrictions on an individual’s level of participation. Given the potential for wellbeing benefits from participation, focus on how to include those with poorer health is worthy of exploration (although some of the participative factors we studied could be judged to be more active behaviours). In line with findings about health, the regressions show a relationship where the oldest are least likely to participate and the youngest most likely.

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The regression modelling findings show the relationship between socioeconomic characteristics and participation to be one where individuals are more likely to participate if: they have access to a vehicle, higher levels of educational attainment (particularly University level), higher self-reported health, and are younger.

Figure 1 shows that for communities B, C and D, those that have the lower overall levels of participation (B and C) also have the higher proportions of people with socio-demographic characteristics associated with low participation (e.g. no vehicle; no qualifications; poor health and over 85 years old) and lower proportions of people with ‘participative’ characteristics (e.g. University qualifications and in the 55 – 64 age group). This suggests that the socio-demographic characteristics of a rural community could predict the level of local older people’s participation. Two applications of this idea might arise: help could be targeted to support those communities where people are more likely to participate; or, initiatives stimulated to support those communities that are less likely to have their own resources. However, community A, which has the highest overall levels of participation is anomalous in that it does not contain the highest proportions of ‘participative’ characteristics (e.g. it has one of the highest proportions of residents without access to a vehicle and the lowest proportion of residents with higher education qualifications). This suggests that there is something about being in community A that generates participative behaviours.

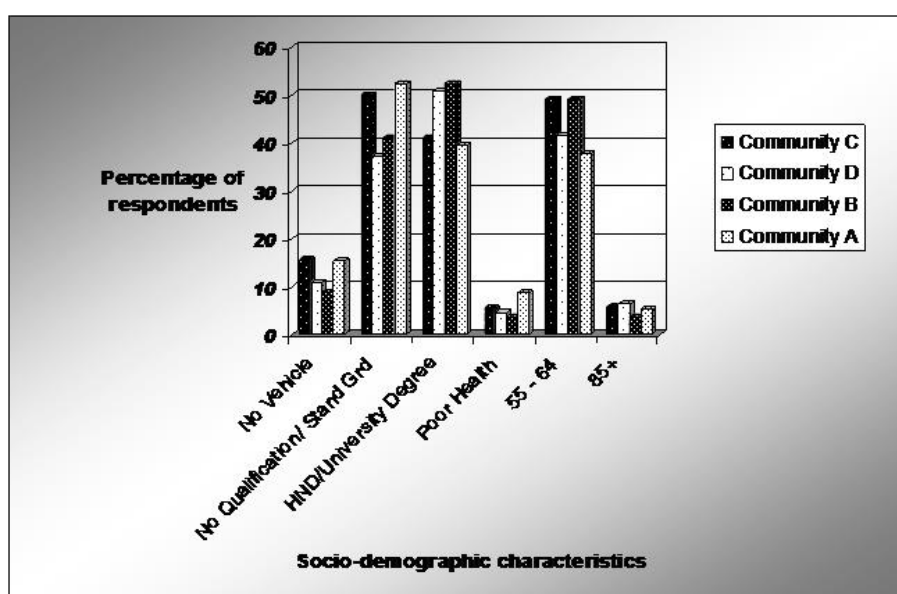


Figure 1. Socio-demographic characteristics that influence participation for each community.

Qualitative Understandings of Rural Older People’s Participation and Wellbeing

Methodology

In July/August 2009, 27 semi-structured interviews were conducted with people aged 55 years and over in the four communities described previously. Most interviewees were selected as people living in the communities who had ‘volunteered’ to participate in aspects of the O4O project, which involved helping to build voluntary organisations in communities to provide basic level services, such as lift-giving or domestic support. A snowball sampling method was used to recruit additional interviewees, with potential participants

suggested by the O4O ‘volunteers’. Interview topics included: what the community is like for older people, older people’s needs for basic services, current and future effects of volunteering to provide basic services and feelings about having an active role in the community. Interviews lasted between 20 and 40 minutes and were recorded and transcribed. Transcriptions were coded by theme and managed using NVivo. A large data-set was generated that reflected the range of experiences and backgrounds of older community members and their relationships to their communities. These interviews extend the evidence from survey results, telling about experience(s) of participation and wellbeing. Clearly, interviewees were those who were involved in, or favourable to, volunteering – and their associates in the community. This bias towards those who already participate should be borne in mind when considering the qualitative findings presented.

Perceptions of the Participation-Wellbeing Link

The majority of interviewees had been, or still were, active volunteers and believed in the benefits of formal and informal volunteering for themselves and their communities. A few explicitly stated that they thought volunteering was good for the wellbeing of the volunteer: “we’re healthier as we’re giving out and being part of things, much healthier” (community interviewee 20). Some interviewees stated that voluntary work kept them active and involved in community life and therefore healthy: “It keeps me going, it keeps me alive” (community interviewee 24). Other benefits included getting out of the house, seeing new places, meeting new people, acquiring new interests, using old skills or developing new ones, feeling useful and valued, a sense of satisfaction and using your mind and imagination. One volunteer described getting a “buzz” from helping and another said they got a “sort of well-being factor” (community interviewees 24 and 3). People did not say health was a main motivation; they simply enjoyed contributing: “I just like to help that’s all” (community interviewee 2). For some it was also a duty:

I do feel that if you’ve got your health and strength when you retire ... then you should be able to give something back to your community and do what you can. (community interviewee 9)

Many interviewees had a history of voluntary work including involvement in playgroups or schools, older people’s groups and outings, supporting and developing community buildings and facilities, organising events like the Highland games/village shows, fundraising for different organisations and work for churches. One interviewee said “you move with your children through the volunteering sector” (community interviewee 17). A few said they had been brought up to help others and be active in the community.

Interviewees thought that older people helped each other and that volunteering was important for the wellbeing and future survival of rural communities. Some expressed doubts about the future of volunteering due to social change and a perceived decline in ‘community spirit’. Several thought legislation requiring, for example, criminal record checks deterred volunteers. Many were pessimistic about the willingness of young people to volunteer and the consequent impact on the future sustainability of their communities. When commenting on their own future as volunteers, some people viewed older age as a point when they would choose to do less so they could enjoy their retirement:

I’m planning on giving up things this year, a lot of things because I’m a bit fed up ... it’s a tie really, you’re tied. I don’t have much time to myself and I thought when I retired I would get plenty of time to do my own thing but I can’t. (community interviewee 10)

Given survey findings that showed younger older people took part in a range of voluntary activities, this raises questions about interviewees’ informal ‘definitions’ of both younger people and when they themselves would ‘be older’ (i.e., ‘being old’ is a very vague definition).

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Some interviewees regarded participation as a lifelong activity, which depended primarily on their continued good health. This supports survey findings showing decreasing participation with age. Interviewees expected their health and energy levels to decline with age, curtailing their future voluntary activity. All agreed that rural communities had a continuing culture of helping, but some viewed it as the preserve of (a small group of) older people. Some stated a decline in community capacity and self-sufficiency resulting in an increasing reliance on externally provided services. A minority expressed a difference between ‘incomers’ and ‘locals’. There was some resentment about those moving into the area to retire, but who did not apparently wish to contribute to community life:

there are people who come into the area from outside and put down roots, have families. They become part of the community and you can see their children and so on and so forth. There are others who just simply come here to die ... it’s a taking relationship ... there’s no two way street. (community interviewee 14).

‘Incomers’ were described by some as ‘less self-sufficient’ and more likely to use their car to reach shops and services outside the community. There was a fear that failure to support local businesses undermines community sustainability. This perception may be counteracted by survey results showing that access to a vehicle increases likelihood of participating in local community activities. It was recognised that incoming retirees might need formal support because they lacked local social networks of friends and relatives. This perception exists despite the quantitative findings showing no association between place of birth and participation, and that length of stay in the community is associated with an increased likelihood of organising a new service.

It was noted that incoming retirees could find it difficult to integrate into the community and be accepted as volunteers even when they wished to contribute:

I’m regarded as an incomer obviously ... and there’s very much an attitude sometimes, no not just sometimes all the time, there’s a barrier somewhere that I don’t feel I can break down or get through ... I’ve found it difficult first of all to find a way about in the community here, although it’s a very small village. (community interviewee 18).

An emergent theme was the tension between informal helping and formal volunteering. Some valued giving or receiving without feeling a ‘service’ had to be reciprocated; others thought that rural communities thrived on mutual favour-giving and viewed formalising giving/helping as eroding community wellbeing and social capital.

Informal Participation and Connectedness within Rural Communities

An implicit ‘hypothesis’ emerged from several interviewee’s discourses: that there are some rural community residents who are ‘net payers’ into the community, i.e. those who give more than others; and some people who are ‘net recipients’ (i.e. those who receive more than others). This aligns with perceptions of a difference between the behaviour of ‘low-contributing’ incomers and locals who have significantly ‘paid into’ the community over time.

Quantitative findings portrayed a different story. The variables from the O4O survey ‘doing a favour for a neighbour’ and ‘receiving a favour from a neighbour’ might be used as a representation of informal reciprocal participation in the communities. Table 4 shows that the majority of older people *in all communities* had both given and received a favour from a neighbour in the last six months (81%). Thus, there is a marked overlap between giving and receiving, suggesting high levels of reciprocal informal help and contradicting qualitative perceptions of contrasting payers and recipients.

Table 4. Overlap between Giving/ Receiving a Favour.

Community	Gave and Received a Favour (%)	Neither Gave nor Received a Favour (%)	Overall level of community participation (rank)
All	81.7	7.2	n/a
A	81.5	6.7	1
B	90.5	2.8	2
D	76.0	10.2	3
C	76.9	9.0	4

Conclusions

In this study, the definition of ‘older people’ was broad. Findings have shown that older people’s participation declines with age and poorer health, and it might be useful to study participation more finely, within narrower bands of older age, to discover more about actual and perceived impacts of different types of participation on health and wellbeing across older age. Similarly, most of the participative factors included, though validated through their use as a battery of social capital questions in the UK General Household Survey, might be regarded as indicating quite active levels of involvement ranging from managing committees to volunteering, to attending local events. Study participants might have been involved in a range of other activities, such as meeting friends and making each other a cup of tea or going for a social walk together. Again, a more fine-tuned study might consider what older people do, and can do, to produce wellbeing for themselves and others if poor health prevents them from ‘more active’ participation.

Findings showed a link between participating in community activities and self-reported health. As health declines, participation declines and help from neighbours and friends increases, suggesting the causal mechanism is health enabling participating. We also found more participation among those with a vehicle and higher levels of education. If participation increases wellbeing, then study is required into how to increase participation for those with poor health, lack of transport and lower education levels in rural areas. Technologies may provide potential options to address these challenges. Qualitative findings showed that community members’ understood participation to be ‘good for their community’ and derived wellbeing from the idea of living in a community that ‘participates’ and includes/maintains “beyond spaces” (Wiles et al., 2009). There appeared to be a more submerged acknowledgement that participation in community activities might also be good for their own and others’ health. Although research evidence is growing and strong on the benefits of participation, the individual wellbeing benefits of participation perhaps need to be further highlighted to community members by health promoters.

There is a widespread assumption that rural communities are stronger in social capital than urban communities, although the ‘dark side’ of rural social capital has been highlighted by some writers. We found varying levels and types of participation in different communities, with a tendency for this to be associated with residents’ socio-economic characteristics. This aligns with calls for greater understanding of the patchy nature of rural disadvantage and argues for understanding and information about individual communities to underpin initiatives to increase capacity.

Quantitative findings produced a remarkably predictable and consistent story; for example, showing younger and healthier older people were more likely to participate, while older, frailer people were more likely to receive help from others. Qualitative findings revealed the complexity of participating within a rural community where ‘everyone knows everyone else’, highlighting tensions between formal and informal ways

of providing assistance and perceptions about ‘net payers’ and ‘net recipients’ linked to tensions around retiree in-migration.

The O4O project commenced with the (apparently rational) notion that, with growing proportions of older people in rural communities, many of them younger in-migrant retirees, there was a role for developing formal and informal helping of the frailer, by younger, fitter, older people. This was hypothesised as having the potential to release wellbeing benefits for both givers and recipients of services. Study findings show that while there is that potential (indeed, quantitative findings show it is actually happening), the social nuances of living in close-knit communities can interfere with apparently rational schemes for helping.

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