The barriers and enablers to service access for older women living alone

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Word Count: 7,098

Running Head: Service access for older women living alone

1 **The barriers and enablers to service access for older women living alone**

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3 Older women living alone are at risk of being socially and financially disadvantaged, which

4 impacts their wellbeing. Currently there is a significant gap in knowledge relating to older

5 women living alone. This study aimed to identify the barriers and enablers to service access in

6 this group. We undertook a qualitative study comprising semi-structured interviews in

7 metropolitan Melbourne, Australia. Thematic analysis was conducted to elucidate key themes.

8 Thirty-seven women were interviewed between May-August 2017. Six key themes were

9 identified: Financial; Mental and Emotional Health; Mobility and Ability; Transport; Social

10 Connections; and Knowledge. Access issues for older women living alone are multifaceted and

11 interconnected. Barriers and enablers to service access, as well as their intersections with gender

12 and living situation, should be considered in service design and re-design.

13

16

1 Introduction

2 Population ageing represents one of the most significant societal transformations of this century.

3 By 2050, the number of persons aged 60 and over globally is expected to more than double, while

4 those aged 80 and above are expected to triple (United Nations Department of Economic and

5 Social Affairs Population Division 2017b). The likelihood of a person living alone increases with

6 age, with more than one in four people aged 65 and over living on their own (Australian Bureau

7 of Statistics 2015). Globally, the median proportion of individuals living alone aged 60 or over

8 was 12% in 2017 (United Nations Department of Economic and Social Affairs Population

9 Division 2017a). Generally, older women are more likely to live alone than older men,

10 particularly in regions such as North America, Europe and Oceania (de Vaus and Qu 2015a,

11 United Nations Department of Economic and Social Affairs Population Division 2017a). In

12 Australia, 31% of older women live alone, compared with 18% of older men (Australian Bureau

13 of Statistics 2017). Some individuals choose to live alone, emphasizing values of independence,

14 freedom and self-reliance, however others find themselves living alone as a product of

15 circumstance, following the breakdown of relationships, or death or relocation of a spouse (de

16 Vaus and Qu 2015b). While living alone can be a positive experience, it has been associated with

17 numerous social- and health-related disadvantages, including poor self-rated health,

18 multimorbidity, psychological distress, impaired mobility, financial insecurity, and lack of social

19 support (Dreyer *et al.* 2018, Henning-Smith and Gonzales 2019, Weissman and Russell 2016)

20 Regardless of living status many older people around the world wish to age in place (Australian

21 Institute of Health and Welfare 2013, National Association of Area Agencies on Aging, National

22 Council on Aging and UnitedHealthcare. 2015); that is, to continue living safely and

23 independently in their community, and avoid moving to higher-level care. Staying in one's home

24 can become more difficult as a person ages, with increasing likelihood of impairment to physical,

2

1 cognitive, psychological and/or social functioning (Cheng, Fung and Chan 2008, Cohen-

2 Mansfield and Perach 2015, Kharicha *et al.* 2007). These deficits in functioning may intersect

3 with social and environmental factors to further affect the older person living alone – particularly

4 their mental and emotional health (Lucas 2007).

5 While individuals may be able to remain in the community utilizing informal care, there is a

6 diminishing pool of potential informal caregivers. Recent changes to family structure alongside

7 decreases in the fertility rate, increases in divorce and those choosing to live without a partner

8 have led to smaller families and therefore less individuals to care for older family members

9 (Redfoot, Feinberg and Houser 2013). Therefore, it often falls to formal services to support

10 individuals to remain in their home. Research has shown that appropriate and accessible home-

11 and community-based services allow individuals to achieve this goal of delayed high-level

12 service use, while providing economic benefits compared to residential care (Chappell *et al.*

13 2004, Gaugler and Zarit 2001). However, growing numbers of individuals living alone is likely

14 increase the need for formal home and community-based care.

15 Considering this increased need for home and community services, it is important to understand

16 the barriers and enablers to access experienced by potentially vulnerable groups in the

17 community. Research has identified different contributing factors, outlined in Table 1.

18   INSERT Table 1 ABOUT HERE

19 While these barriers have been discussed in isolation, they have not commonly been brought

20 together, and not with specific attention to gender. As discussed above, ageing is experienced

21 differently by women and men, therefore their experience of barriers and enablers to service

22 usage are likely to differ. While a substantial body of research is emerging regarding the

23 experience of growing older, these reports frequently lack distinction between older women and

24 men, and women's experience of growing older remains under-researched (Feldman and

3

1 Radermacher 2016). Furthermore, barriers and enablers are rarely examined specifically for those

2 living alone. To reduce inequity for this at-risk group, it is important to identify the barriers and

3 enablers to accessing and using health and social care in the community for this group. The aim

4 of this study was to identify the barriers and enablers to service access related to health,

5 wellbeing and quality of life in older women living alone.

6 **Methods**

7 This study was conducted and reported in accordance with the Consolidated Criteria for

8 Reporting Qualitative Research (Tong, Craig and Sainsbury 2007). This study is part of a larger

9 multicomponent mixed methods project which aimed to optimize the wellbeing of older women,

10 focusing on the social, economic and health disadvantage of individuals who live alone, co-

11 creating new services and strategies to optimize service access equity. A crucial aspect of the co-

12 creation process is to understand the barriers and enablers perceived by the end users, in this case

13 older women living alone, which was afforded by the current study.

14 *Research design*

15 We employed a qualitative descriptive approach for this study, which was appropriate given its

16 exploratory nature (Sandelowski 2000). This approach enabled us to develop a deeper

17 understanding of the lived experience of older women living alone, in particular regarding service

18 access, needs and barriers.

19 *Inclusion criteria*

20 Individuals were eligible to participate if they were aged 55 or over, female, and living alone in

21 the community. A broader age range than 'conventional old age' (65 years and older) was used to

22 capture issues relating to the difference between biological and functional age (Levine and

23 Crimmins 2018), and associated service eligibility and entitlements. Only those with severe

4

1 cognitive impairment were excluded from taking part.

2 *Recruitment*

3 We used quota sampling, informed by preliminary analysis of home nursing data and population

4 data (Author,2019a; Author 2019b; Australian Bureau of Statistics, 2017), to ensure that women

5 with a wide range of perspectives were included. Given the increasing health needs of this cohort,

6 home nursing data was used to capture those who were in a more vulnerable health state and in

7 need of accessing higher level supportive services. Sampling was based on socio-demographic

8 factors including age, socio-economic disadvantage, location, education level, country of origin

9 and receipt of home nursing care. In addition, the Index of Relative Socio-Economic

10 Disadvantage (IRSD) was used as a proxy for socioeconomic status. The IRSD uses a range of

11 social and economic information about people and households within postal area in order to rank

12 areas on a continuum from the most to the least disadvantaged (Australian Bureau of Statistics

13 2013).

14 We recruited participants through two avenues: a home nursing service, and the general

15 community. To recruit individuals from the home nursing organization, a list of current clients

16 meeting the inclusion criteria was provided by the organization's data analyst. For the general

17 community, information was provided to a range of stakeholder organizations and individuals

18 known to the research team for dissemination; with team members also attending community

19 groups and placing advertisements in community newsletters.

20 Eligible participants were contacted by a member of the research team, who explained the project

21 and what participation entailed. If they wished to proceed, they were provided with the

22 Participant Information and Consent Form via their preferred contact method (mail or email), and

23 a time for interview scheduled. Informed consent was obtained from all individuals. In addition,

1   participants were assured that their acceptance or refusal to take part in the study would not

2   impact on any relationship with the home nursing organization (if applicable).

3   *Data collection*

4   We conducted semi-structured interviews (see Figure 1 for the interview schedule) in the

5   participants' own homes or at a community place, at a mutually convenient time. This was to

6   facilitate access to participation, particularly for housebound individuals. The interviews were

7   conducted by members of the research team (████████), previously unknown to the

8   participants. ██ (BA(Hons), PhD), a female Research Fellow with substantial experience

9   conducting research with vulnerable populations, █ (BAppSci (Ex&SpSc) (Hons)), a female

10   Research Officer with significant experience conducting research with vulnerable populations,

11   and █ (BA/Sc(Hons)(Psych)), a female Research Officer with limited experience, conducted all

12   interviews. Unless an interpreter was required, or the interview was conducted in a public place at

13   the request of the participant, there were no other people present at the time of interview.

14   *INSERT Figure 1 ABOUT HERE*

15   Participants only knew about the professional role of the interviewer in the context of the

16   research study and the company that they worked for. Interviews were audio recorded and

17   transcribed verbatim by an external transcription service. Each transcript was checked for

18   accuracy against the interview recording. For interviews with participants where a translator was

19   utilized, both English and native language were transcribed to ensure accuracy. Transcripts were

20   not returned to participants. Data collection took place between May and August 2017.

21   *Ethics*

22   Approval to conduct this study was granted by the ████████ Human Research Ethics

23   Committee (approval no. █████).

1   *Data analysis*

2   We used thematic analysis to analyse the data, with an inductive approach used to allow for

3   themes and findings to be derived from the data, grounding the findings in the perspectives and

4   experiences of participants. We employed the six phases of thematic analysis described by Braun

5   and Clarke (2006) of familiarization, generation of initial codes, searching, review and naming of

6   themes, followed by report production, treating them in a reciprocal manner, allowing movement

7   back and forth between the phases as required. ■ conducted the primary coding, with ■

8   conducting the double coding. We used NVivo 11 (Q.S.R. International 2016) as a tool to assist

9   qualitative analysis. Regular discussions were held within the research team and the project

10   reference group to provide further insight to the themes arising from the analysis.

11   *Rigor*

12   We engaged in peer debriefing and reflexive conversations throughout the data collection and

13   analysis stages. Given our background as researchers who are embedded in the home nursing

14   service, the use of reflexivity was important to ensure that our beliefs and assumptions regarding

15   participant's views and the health system were not imposed on to the data, allowing findings to

16   inductively emerge from the analysis. Data saturation was reached before recruitment was

17   completed, however further participants were sought to ensure that diverse perspectives were

18   considered as per the quota sampling method.

19   **Results**

20   *Sample description*

21   Thirty-seven individuals agreed to participate. Interview duration ranged from 21 to 119 min

22   (mean 52 min). The mean age of participants was 73.2 years (*SD* 8.67 years). See Table 2 for

23   further demographic characteristics of participants.

INSERT Table 2 ABOUT HERE

2   Six main themes were derived from the inductive exploration: financial; transport; mobility and

3   ability; social connections and participation; mental and emotional wellbeing; and knowledge.

4   While both barriers and enablers to service use were elicited within the interviews, women found

5   it easier to speak about the barriers rather than the enablers; this is reflected in the below themes.

6   *Financial*

7   Several factors impacted on participant's financial situations, and therefore their ability to access

8   services. Women spoke of the overall higher cost of living alone than when living with others;

9   *"When you're on your own everything's doubled, you know what I'm saying?"* (#19). This cost

10   was further exacerbated by home ownership status, with those renting finding it difficult to make

11   ends meet; *"There's never anything left …it is very, very hard"* (#25).

12   The gendered nature of past employment patterns was linked with long-term financial security.

13   For many older women, limited or no workforce participation due to parenting or caring

14   responsibilities, compounded by lifetime lower wages and casual employment resulted in a lack

15   of personal financial resources, particularly superannuation:

16   *Super[annuation] - I mean when I first started work and all that super[annuation]*

17   *was not even known about and things like that. (#26)*

18   Given the dearth of superannuation for this group, the majority were reliant on a fixed income,

19   such as a government provided pension. For some, this enabled not only their access to services,

20   but their 'survival';

21   *[The government social security department has] been amazing and I wouldn't*

22   *still be standing if it hadn't been for the help that I got from them. They've just*

23   *been so supportive (#32)*

8

Many participants, however, expressed that the pension had not increased commensurately with the cost of living, causing financial hardship and forcing them to live from week to week;

> *I just wish that finances were a little bit better than they are. It's a bit of a struggle because the pensions don't go up. The foods go up. The fees go up but the pension don't go up and I'm only on the pension. So it's - ugh. (#12)*

Financial constraints forced difficult choices about spending. Spending was a calculated task, with many women describing a careful, budgeted, frugal life. This was particularly salient for women with health issues, who were often forced to prioritize their acute health care needs over preventative and non-urgent care, or other necessities. For many this impacted on their ability to do things they enjoyed and to socialize, further affecting their mental health and wellbeing;

> *A lot of friends go out for dinner and I have to say no because…I can only just cover everything… It does limit [what I can do], especially with my friends because they've all got money and can go around to patchwork shops and they're always going out for lunch in nice places…[it's] very depressing. (#06)*

Furthermore, women acknowledged that their current financial situation meant that they were unable to absorb any unexpected expenses. These women were acutely aware of the precarity of their situation, which further impacted their health and wellbeing;

> *I have enough to do my day-to-day stuff. It's if something out of the ordinary comes like a massive maintenance bill or something goes wrong with my car or something like that is when it all goes pear-shaped (#32)*

Transport

Transport was viewed as a major contributor to service access and retention of independence by women. Transport acted as an essential link to friends, family and the wider community,

9

including services. At the forefront of transport for these women was the ability to drive; seen as

an integral part of not only independence and access, but identity and wellbeing. The thought of

losing that ability was a frightening and daunting prospect for those still driving;

> *[Driving is] my salvation. Because sometimes I'm going for the blood test, going*
>
> *here and there and when I come home and I sit and I thought how I could do those*
>
> *things without driving? (#04)*

Health was the most common reason women were no longer driving, with significant health

events triggering the loss of a license. Some women modified their driving voluntarily, driving

less often or only in the local area as they felt unable to drive in the same way they used to;

> *I don't drive as far as I used to. So there have been changes. I wasn't terribly well*
>
> *last year and I stopped driving some distances. But I still get around locally, so I*
>
> *guess that's better than not getting around at all. (#16)*

Others had never learned to drive, instead relying on family or husbands for transportation;

> *It was my choice. I just never bothered. When I got married to my husband he*
>
> *used to drive me everywhere. He was a good husband. (#13)*

Effective alternatives to driving were important. Public transport was seen by some as a viable

alternative, but deterioration in physical capability coupled with inconsistent disability access and

safety concerns limited their ability to use public transport;

> *I'm a bit scared about trains now, because my walking ability has deteriorated.*
>
> *(#29)*

Those who were not driving lamented the lack of flexibility and spontaneity, and the reliance on

others to transport them, particularly for medical appointments;

> *The thing I miss most is I gave up driving, and that is a big, big one. That's the*
>
> *thing I feel most. Just trying to make doctor's appointments…Even getting taxis or*

1 *anything, you still get a taxi there but then you've got to organize to get back*

2 *home. You don't know how long the appointments are going to be. All that sort of*

3 *thing is the hardest thing for me. (#23)*

4 Many spoke of how friends and families drove them to engagements, but this was always

5 prefaced by concerns about reliance, and not wanting to worry them because they were busy;

6 *It's a huge thing. Because I know they're all busy and they've got their lives. When*

7 *you see them, they always say just ask if you need anything and you go yeah, yeah.*

8 *But then it's really hard if it comes to that to actually go can you help me? That's*

9 *really my issue…we don't want to be a burden to people. But on the other hand,*

10 *sometimes you just need help and you just have to suck it up and say please (#32)*

11 *Mobility and ability*

12 Mobility and ability affected many facets of the women's lives; particularly where they felt their

13 ability to perform tasks had changed. One area of particular frustration was domestic life –

14 traditionally part of the "woman's role". The inability to prepare food was difficult for women to

15 adjust to. However, a range of different strategies were adopted to ensure access to nutritious

16 food, including delivered meals, but also buying different produce;

17 *When [my neighbours] were both working full-time, and before I fell over, I was*

18 *doing a lot of cooking for them…But since my fall I can't do that anymore. My*

19 *hands are pretty bad as well now. So yes, I use a lot of frozen vegetables because I*

20 *can't chop stuff up as easily now. (#31)*

21 Other simple domestic tasks were also challenging –changing a light bulb was out of the capacity

22 of many women, forcing them to live with the issue until others were able to come and assist;

23 *I don't get up on anything anymore. So changing lightbulbs it sounds a funny thing*

11

but if they're high up that can be a problem. (#34)

Struggles with mobility had the biggest effect on the day-to-day life of many of the women, often confining them to inside the house unless assistance was rendered;

I can walk from here to the driveway and knowing that I've got the fence to hold onto and that sort of thing. I wouldn't be confident walking two or three houses down by myself because if there were some decent fences then yes, but there isn't. At night time, I get a bit nervous walking (#06)

Limited mobility hampered women's ability to access services outside the home, compounded by many services being poorly designed for those with mobility issues;

I don't have a good solution for getting out of the house…I mean getting to the doctor has been really difficult… to get to an actual doctor from the front - from wherever you're parked, you'd have to walk a really long distance. I mean maybe I should have a wheelchair or a scooter or something but that has all sorts of logistics (#30)

Some women expressed the distress and depression that they experienced at their newly diminished capacity to carry out everyday tasks, which were often linked with issues of pain;

I couldn't get inside without screaming because the pain down here was sort of like white fire… it was like a misty grey straitjacket because I think part of it there was a depressive element to it that I hadn't experienced before. (#30)

Women were acutely aware that their domestic capabilities and mobility was central to remaining independent, and that any decline in these may prompt significant life changes, such as moving into residential aged care or a retirement village;

If you're not mobile, if you're ill or something and you can't do your housework, or can't do your gardening, or can't get to places. I'm starting to think about that

12

actually, yeah. Go to a nursing - or retirement village. (#14)

Mental and emotional health

Mental and emotional health for women permeated through their life. Poor mental health was often linked with major life changes such as loss of a loved one, separation, serious medical events, or chronic illnesses, compounded by the fact they were living alone. For many, it was a case of *"taking it one day at a time"* and recognizing the impact that mental and emotional ill health can have on quality of life;

> *I've been probably suffering from depression, I've been seeing a psychologist since*
>
> *[my husband] left really and trying to work through that sort of stuff, because*
>
> *again, that kind of stuff stops you in your tracks. (#32)*

The loss of partners and friends could lead to isolation and loneliness for these women, as their support networks slowly dwindled around them;

> *I'm also at a stage of life as many ladies you talk to will be where old friends are*
>
> *passing away and that makes it more difficult too…It is a difficult part, yes and*
>
> *with each passing you feel that little bit lonelier (#16)*

Adapting to changing health for many women involved reconciling new limitations. Some spoke of the negative effect of these limitations, and coping through acceptance and a positive focus;

> *If you don't help yourself - because I have been in a black hole and I don't want to*
>
> *go back there. It's too painful…you've got to do everything in moderation. You*
>
> *can't do what you used to do. You've got to be happy with what you can do. But*
>
> *what you can't do, don't worry about it. Just be grateful every day that you can get*
>
> *up and look after yourself (#03)*

These newfound limitations, however, would often lead to women being housebound. These

women spoke of the apathy that this could bring;

> *On the days [the nurses] don't come I'm not washing my face or combing my hair*
>
> *mostly. I'm not getting dressed. I only get dressed if I go out. I think that's a real*
>
> *problem. I think actually getting dressed I think I would be less depressed…I went*
>
> *through this phase about nine months after I stopped work where I really couldn't*
>
> *see any point in doing anything at all. There was no point in learning a language.*
>
> *What's the point of doing it? What's the point of doing anything really? Why*
>
> *would you bother doing anything at all?...I wouldn't have had enough energy to*
>
> *actively commit suicide but I could have seen very easily how you could just turn*
>
> *your face to the wall and not bother, just die (#30)*

Social connections and participation

Women outlined that social connections and participation were imperative to their overall health and wellbeing. These interactions provided meaning and purpose within their life;

> *I think social contact is extremely important if you're going to survive. Because*
>
> *otherwise you just sit around. Life is meaningless. (#08)*

This, however, was becoming more and more difficult for women as they aged, with health issues often resulting in changing circumstances for themselves and those around them;

> *We're all going into care or dying or something, it's forever changing. But when*
>
> *you're a group of women, or group of anybody in my age group that's to be*
>
> *expected, that's how life works. Nothing stops, everything changes. (#17)*

Women felt their socialization was compromised by modern life, seen as becoming increasingly individual and separate. Many women felt that they could not call on their family as they led *"busy lives"*. While women understood this, it would sometimes leave them feeling down;

14

My daughter is very busy and so is her husband. They've got very busy lives, so I

don't see them very often… I do miss it. But their excuse is they're busy, so I have

to accept that… I do miss it terribly, but there's nothing I can do. (#25)

The busy pace of modern life had changed socializing, increasing the isolation that women felt, particularly if they were housebound;

People don't drop in to visit anymore. Years ago, people used to pop in to see

people. That would be nice if people just popped in a bit more often, but people

are so busy these days that they don't do as much of that sort of stuff. (#06)

The caregiver role was ingrained in many women, therefore becoming a *"burden"* was something they wanted to avoid. While some women had supportive families, many preferred alternative arrangements. This did not mean, however, that they totally eschewed family support;

Well mainly I don't want to be - you would have heard this a million times - I don't

want to be a burden. My eldest daughter is a nurse and she calls me the

independent b***h. Mum why didn't you ring? I could have taken you. (#27)

For those without family support (or who were unwilling to utilize it), friends would often become a dependable source of support;

If I've got appointments to go to specialists and that, my girlfriend takes me and

she sits in there and listens to what they've got to say, because I can't remember it

right. (#11)

Neighbours also provided assistance; with multiple women creating supportive communities around themselves to *"keep an eye on each other"*, with a covert system of surveillance to ensure that if something should happen to them, it would be noticed;

We get up in the morning and we check the blinds are open. If they're not open at

a certain time we check on them, ring them up… that's something that everyone

15

worries about on their own. I could have a heart attack through the night or

anything and nobody would know about…but somebody will check the next

morning sort of thing [if] my blinds are still closed. (#23)

Other women used formal services to achieve the same end; they ordered meals or organized care

not solely because they needed it, but because it meant someone would check in on them;

That's the reason I order those meals. I thought that every day somebody come

and check on me. (#04)

Knowledge

Frequently, women spoke about a lack of knowledge being a major barrier to accessing services.

For many, they knew that services must be available, but did not know where to look;

Yeah, you don't know what's out there. I don't think so. I don't know what's

available. I think maybe if we knew what was available it would help. (#22)

There was also a feeling that the aged care system was *"too much bloody system and not enough*

action" (#29) and was needlessly complex and confusing;

Navigating. It's very complicated. I just know talking to a few people they don't

know where to go to access services (#14)

Further exacerbating the difficulties with the aged care system was its reliance on technology.

While many of the women were technologically proficient, others had no technological literacy

and no desire to learn. This was viewed by some as a failing of those who designed the system;

First of all, there's a prerequisite. You have to have a computer and know how to

use it…. it's just a generational thing. (#21)

Those women who used technology saw it as a useful means to find information. There were,

however, concerns about privacy and security;

16

I'm pretty good on the computer and stuff. Google is my friend. Sometimes it's

really useful and sometimes not so. It is a good one to find out about [services].

(#32)

Another avenue that women drew on was established connections with family, friends and

community groups. Some heard of services through word of mouth, others had family members

or friends acting as knowledge brokers, assisting them to find services and navigate the system;

So we manage. We exchange information about a good gardener together or

someone who's happy to come in and do a bit of weeding, that type of thing. (#16)

This was not a one-way exchange; women wanted to help others to access services;

I want [the information] to be passed on because it's very important for what I've

learned to help others because they need to help themselves as well. (#03)

Many did note that the impetus was still on them to find the required information. This was

reasonable for those who had the time, inclination, ability and capability to do so, however those

experiencing ill health found this demanding;

I find that you can't just sit back. You've got to get yourself out there and do for

yourself, because things are not going to knock on your door and say 'here I am'.

(#26)

Discussion

This study detailed the barriers and enablers to service access for older women living alone. Six

major themes were identified, relating to finances, transport, mobility and ability, mental and

emotional health, social connections and participation, and knowledge. Older individuals are

increasingly likely to live with multiple comorbidities and require support from a range of health

and social care services to remain living independently in the community. To our knowledge, this

is the first study to elucidate the barriers that older women living alone face to remain living

17

1   independently in the community.

2   The financial situation these women described was often bleak. Rising costs of living, coupled

3   with a lack of fiscal resources, forced women into difficult choices about spending money. This

4   was particularly true for those with poor health, who prioritized spending on health-related costs.

5   This was not always the case; some women experienced a financially comfortable existence as

6   they aged. This finding is supported by previous research, which has shown that women not only

7   have higher health care expenses than men (due primarily to higher numbers of chronic health

8   conditions, experienced over longer periods), but that they have very limited capacity to support

9   themselves in retirement due to lower pay and superannuation throughout the life course

10 (Salganicoff *et al.* 2009). While much previous research has focused on the healthcare and related

11 costs (Andonian and MacRae 2011, Bacsu *et al.* 2014, De San Miguel *et al.* 2015, Goins *et al.*

12 2005, Nelms *et al.* 2009), this research highlights that alleviating pressure in other fiscal areas

13 will ease a burden that many women bear alone when living by themselves in older age.

14 Women identified issues with both driving and other types of transport, including public transport

15 and subsidized travel such as taxis. While concerns and ramifications of a diminishing ability to

16 drive are common in the literature (Goins, Williams, Carter, Spencer and Solovieva 2005,

17 Greaves and Rogers-Clark 2009), less acknowledged is that some of this cohort have never

18 driven; this was the responsibility of their spouse. Thus, the loss of their spouse or partner places

19 them in a difficult situation – intensified by feeling unsafe and/or unable to use public transport

20 (Andonian and MacRae 2011, Bacsu, Jeffery, Novik, Abonyi, Oosman, Johnson and Martz 2014,

21 Morris, Barnes and Fildes 2018). Furthermore, due to the financial issues outlined above it is also

22 possible that women were residing in an area with little public transport infrastructure.

23 Women's mobility and ability were at the forefront of their minds when discussing difficulties

24 they faced both within and outside the home. This is consistent with previous research indicating

18

1   that individuals living alone report more concerns regarding mobility than those living with

2   others (Tsai *et al.* 2013). Shortcomings of the built environment and limited transport options

3   restricted their movement in the community– including when accessing services. Within the

4   home both mobility and ability affected women's capacity to engage in activities of daily living

5   and maintain their household. These limitations impacted women's overall quality of life – a

6   finding supported by the literature (Banister and Bowling 2004).

7   Knowledge, or lack thereof, permeated women's narratives. The complexity of the health and

8   aged care system, alongside its dependence on technology left women both confused and unsure

9   about what they were entitled to and how to access it. While some women embraced technology,

10   others had no interest in it, supporting previous research indicating that older women (particularly

11   those aged 75 years and over) are low users of technology (Cresci, Yarandi and Morrell 2010,

12   Hodge *et al.* 2017). This, alongside a lack of skill and interest in technology (Coelho and Duarte

13   2015, Ofei-Dodoo *et al.* 2015), fosters low awareness of available services which are often

14   located and accessed through technological means (Boneham *et al.* 1997, Weddle 2012).

15   Therefore, it is important that services have multiple avenues of access available that are widely

16   promoted.

17   What became apparent is that each of these themes are a complex, interwoven web, particularly

18   when placed in the context of these women's roles in both work and family across the life course.

19   In addition, other diverse factors such as age, ethnicity, education and health status also inform

20   the services required by older women living alone to maintain independence.

21   Underpinning the interconnected themes was a clear preference for autonomy; to choose and

22   control how they want to live and the services they wanted to access, whilst being treated with

23   dignity and respect. These preferences have been identified previously as important to older

24   people (Dow *et al.* 2013). Further, this was linked with women's keen awareness and reluctance

19

to becoming a "burden" on those around them. Many of the women were experiencing a role transition, moving from the traditional "women's role" of domesticity and caring for others, to being cared for themselves. This disinclination to be a burden on others is found elsewhere in the literature (Greaves and Rogers-Clark 2009, Lau, Machizawa and Doi 2012b, Nelms, Johnson, Teshuva, Foreman and Stanley 2009) , and services that work to assuage this feeling in women will better meet the needs of older women. , thereby ensuring that they are able to age in a place of their choosing. This in turn will likely increase their independence and wellbeing, leading to a reduction in healthcare system use.

Therefore, services provided to older women living alone need to address or acknowledge where possible each of these barriers and characteristics to ensure optimal service access. Moreover, to successfully align with consumer directed care principles that place the consumer at the centre of their health and aged care (Delaney 2018), these perceived barriers and enablers should be utilized in the design or re-design of service offerings.

This is the first study to outline the barriers and enablers to service access for this group and provides useful information for policy makers and service providers to ensure that services provided to this group meet the needs of community members. Whilst efforts were made to include the perspectives of a diverse group of individuals; individuals from culturally and linguistically diverse backgrounds, those from mid-level socioeconomic areas and younger old were underrepresented compared with our sampling quotas and may benefit from further investigation.

Conclusion

Older women living alone are a growing cohort. Ensuring that they are able to age in a place of their choosing is imperative to ensure that they achieve optimal wellbeing, without placing undue stress on the health care system. Service barriers and enablers of financial, transport, mobility,

20

1 mental and emotional health, social connections and participation and knowledge affect how

2 women age in place in the community. These issues do not stand alone but are a complex

3 constellation of interrelated issues which intersect with the characteristics of the woman, to affect

4 her service usage and ability to age in place successfully. Services and policy makers must

5 address barriers to access to ensure that women who need support can access appropriate services

6 in the community.

7

8 **Acknowledgements**

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Tables & Figures

Table 1. Factors affecting service access by older people identified in the literature

System Related Factors	
Transport	Andonian & MacRae, 2011; Bacsu et al., 2014; Goins et al., 2005; Greaves & Rogers-Clark, 2009; Morris et al., 2018; Orellano-Colón et al., 2015
The built environment	Bacsu et al., 2014; Orellano-Colón et al., 2015
Inappropriate, unsatisfactory and missing services	Bacsu et al., 2014; Boneham et al., 1997; Goins et al., 2005; Nelms et al., 2009
Healthcare cost	Andonian & MacRae, 2011; Bacsu et al., 2014; De San Miguel et al., 2015; Goins et al., 2005; Nelms et al., 2000
Lack of referral from treating physicians	Arnold, Bruton, & Ellis-Hill, 2006; Buttery et al., 2014
Person-related Factors	
Disinclination to be dependent/a burden on others	Greaves & Rogers-Clark, 2009; Lau et al., 2012; Nelms et al., 2009
Low mood	Nelms et al., 2009
Fear	Greaves & Rogers-Clark, 2009
Social isolation	Goins et al., 2005; Nelms et al., 2009; Saurman, 2015; Vozikaki, Linardakis, & Philalithis, 2017
Lack of social support	Arnold et al., 2006; De San Miguel et al., 2015; Gabrielson, 2011; Hlebec, 2014; Saurman, 2015
Lack of self-confidence in navigating the system	Arnold et al., 2006
Low awareness of services	Boneham et al., 1997
Low awareness of eligibility	Weddle, 2012
Combined System- and Person-related Factor - Technology	
Unnecessary	Courtney, Demiris, Rantz, & Skubic, 2008
Complex	Coelho & Duarte, 2015
Costly	Ofei-Dodoo et al., 2015
Risk to privacy	Courtney et al., 2008; Mahoney, Mahoney, & Liss, 2009; Ofei-Dodoo et al., 2015
Lack of skill	Coelho & Duarte, 2015
Lack of training and interest	Ofei-Dodoo et al., 2015
Physical limitations	Coelho & Duarte, 2015; Ofei-Dodoo et al., 2015

Can you tell me a little bit about your life currently?
What kind of things do you like to do?
What kind of family support do you have?
What do you think is important for you to maintain or improve your health and wellbeing?
What do you think is important for you to maintain or improve your quality of life?

Can you tell me a bit about your health?
Do you have any health issues?
What are they?
Who do you go to help you with them? Do you need help to get there? Can you tell us a bit about this?

Is it important for you to stay living independently in your own home?
Can you tell me a little bit about why that is?

What do you think is the most important thing that helps you stay living independently in your own home?
Why?

Do you have any services to help you to stay in your home?
Why/why not?
What services are they?
Why did you choose/not choose those services?

Are there any things or services that you think would like to use?
These can be things that you know that exist, or things that you have thought up yourself. Why do you think that service would be helpful?

Here is a list of services currently available to women such as yourself. What services would you use? What services would you not use?
Why/why not?

Figure 1. Interview Schedule

Table 2. Demographic characteristics of participants

Age: M, (SD)	73.2(8.67)
IRSAD Quintile, n (%)	
1 (Decile 1-2; most disadvantage)	9 (24.3)
2 (Decile 3-4)	2 (5.4)
3 (Decile 5-6)	6 (16.2)
4 (Decile 7-8)	10 (27.0)
5 (Decile 9-10; least disadvantage)	10 (27.0)
Education level, n (%)	
Lower secondary or less	15 (40.5)
Upper secondary	6 (16.2)
Post-school qualifications	16 (43.2)
Location n (%)	
North Melbourne Metropolitan	7 (18.9)
East Melbourne Metropolitan	13 (35.1)
South Melbourne Metropolitan	8 (21.6)
West Melbourne Metropolitan	9 (24.3)
Country of origin, n (%)	
English speaking	29 (78.4)
Non-English speaking	8 (21.6)
Marital Status, n (%):	
Widowed	18 (48.6)
Divorced/Separated	12 (32.4)
Never Married	6 (16.2)
De Facto	1 (2.7)
Housing Situation, n (%)	
Own	25 (67.8)
Rent	12 (32.4)
Housing type, n (%)	
House	21 (56.8)
Unit/Apartment	2 (5.4)
Retirement Village	10 (27.0)
Public Housing	4 (10.8)
Home nursing clients n (%)	
Yes	18 (48.6)
No	19 (51.4)