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The Greying of Rural America

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There have been dramatic demographic changes in the United States in the past century, and this is especially evident in rural areas. In the 1920's, nearly one third of Americans lived on farms, but now only about 2% do (Elder, King, & Conger, 1996). However, nearly 25% of older Americans live in small towns and farm areas (U. S. Bureau of the Census, 1996). This demographic imbalance is due to a variety of factors, including "aging-in-place", out-migration of younger people to the cities, and in-migration of retired elders.

In California, this trend is especially notable. We have more elderly people than any other state, some 3.3 million (U. S. Bureau of the Census, 1996). In some of our rural counties, which are particularly desirable as retirement locales, one out of five people are over the age of 65 (U. S. Bureau of the Census, 1996). In many ways, the health of our rural communities depends quite literally on the health of its senior population. Thus, we felt it might be useful to dispel some myths about the aging process and indicate the ways in which the elderly contribute to intergenerational relationships, as well as to detail the special needs of rural elders.

DISPELLING MYTHS ABOUT AGING

There are many myths about senior citizens. Stereotypes include both negative images, such as the frail, cognitively-impaired elder or the cranky old geezer, and positive images such as the kindly old granny baking cookies all day long. In truth, none of these stereotypes are generally applicable to the elderly people of today. People are living longer and are healthier than at any other time in history, and gerontologists distinguish between the "young-old" (ages 65-79), the "old-old" (ages 80 - 99), and the "oldest-old" or centenarians.

At every age, there are large individual differences in physical, mental, and cognitive
functioning. Some 65-year-olds are nearly completely disabled, while some 80-year-olds are "pumping iron" or running marathons. In general, the young-old are

fairly healthy. While many have chronic illnesses, such as arthritis, hypertension, or glucose intolerance, most of these can be managed fairly well with diet, exercise and medication, allowing the young-old to lead active lives. As we shall see, these young-old seniors make large contributions to their families, social networks, and communities. As the retirement age continues to drop (currently the average age is 62), these healthy, active people have time to babysit for their grandchildren, take care of their own parents and elderly relatives, contribute to their communities by volunteering in social agencies such as the Senior Gleaners and other food banks, serve as political leaders or church elders, and, in rural communities, often manage general stores, cafes, barbershops, and gas stations which are crucial to keeping a small town alive.

While people of all ages may become socially isolated or depressed, most retired people do not experience such problems unless they experience other stressful events such as widowhood, serious illness (either their own or that of their spouse), or serious financial constraints (Bossé, Aldwin, Levenson, & Workman-Daniels, 1991). Indeed, older people often cope more efficiently with age, as long as they do not suffer from cognitive impairment (Aldwin, Sutton, Chiara, & Spiro, 1996).

It is the old-old, people in their 80's and 90's, who are more likely to exhibit serious chronic illnesses such as congestive heart failure, disabling arthritis, and osteoporosis. It is at this age that some elders who live in rural areas or retirement communities may move to
be closer to their children. For example, the "snow birds"—people who maintain winter homes in Florida or who have moved South to escape the winters—may move back North to be closer to their kin. Rural elders, however, may be particularly reluctant to move away from their farms and homes of many decades, and as their mobility becomes impaired, may become socially isolated. Indeed, many older couples so fear being split up by one member being institutionalized that they may refuse needed medical treatment, denying or minimizing the existence of problems (Gilmer, 1993).

It is also true that most elderly individuals do not suffer from major cognitive dysfunction serious enough to affect daily living. Only 15% of individuals over 65 years of age have a dementing illness such as Alzheimer's disease or multi-infarct dementia (which is caused by small strokes), but the risk for dementia does increase with age.

Declines in performance on standardized intelligence tests are generally not seen until after the age of 67 and remain fairly modest until age 81. Again, it is the old-old who are more likely to suffer from dementia, related to Alzheimer's disease, cerebrovascular disease, or some other medical condition that can affect brain function (for a review, see Aldwin, Ober, & Levenson, 1996).

Thus, it is important to emphasize that individual differences do increase with age. While some elderly, especially those over the age of 80, are physically, cognitively, and emotionally frail, and are in need of assistance, the vast majority of elders are reasonably healthy and often provide more assistance to others than they receive.

INTERGENERATIONAL RELATIONSHIPS

The relationships of family members to one another have historically been strong and vitally important. They continue to be so. Emotional support, advice, financial exchange, and caregiving are given and received by all generations within the context of the family. Strong family ties exist in all cultural and ethnic groups, although within each of the groups there is great heterogeneity (Bengtson, Rosenthal, & Burton, 1996). Because people are living longer, more families today than ever before live in three-generation households. The possibility of being a grandparent, and even a great-grandparent, is greater than ever. Further, it is likely that family members will spend more time caring for a grandchild, or a parent or grandparent, than ever before. Therefore, intergenerational relationships in the 21st century present new opportunities and new challenges.

Elder to Adult Child

The elderly person and their adult children generally maintain lifelong attachments to each other. Although relationships are reciprocal, older people usually provide more for their children then they receive. Among other things, they give emotional support, moral guidance, advice, and financial assistance. Depending on the needs, culture, and history of the family, the elderly person takes on various roles: story teller, baby-sitter, or counselor. For example, within Hispanic families elderly people are respected for the leadership role that they provide (Sotomayor, 1989). Traditionally, the older person is much more likely to give financial aid to the younger generation than to receive it. This changes only in later years when the elderly parent may need financial assistance as their own resources dwindle and their health and social care costs increase (U. S. Bureau of the Census, 1996).

Grandparent to Grandchild

The role of the grandparent in the life of the grandchild varies greatly, often depending on how close they live to one another and the needs of the grandchild. Nonetheless, the relationship of the grandparent to the child is very important. Grandparents provide companionship, emotional support, nurturance, and/or monetary assistance, such as savings for an education. In their interactions and story telling, they give their grandchildren a sense of their own history. One of the most frequent and appreciated activities of grandparents is baby-sitting. In fact, grandparents are by far the preferred baby-sitters when parents work (Werner, 1991).

Troll (1983) notes that the grandparent has a "family watchdog" role in the life of a child. If a crisis occurs, the grandparent can step in and provide assistance to the family. It is not unusual for grandparents to provide financial support to a family after a divorce. Furthermore, they give emotional support to the grandchild, helping them feel good about themselves (Werner, 1991). In many cases the grandparent takes on multiple essential roles, even to the point of providing a home for the grandchild. About five percent of children under the age of 18 currently live in the homes of their grandparents, up from three percent in 1970 (U. S. Bureau of the Census, 1996). At times the grandparent becomes a surrogate parent and the most important person in the child's life (Bengtson et al., 1996). Currently, as many as three million American grandparents function as surrogate parents to their grandchildren (Chalfie, 1994).

Elderly people often are not just grandparents to their own kin, but to other children in the community as well. They act as foster grandparents, or volunteers in day care, hospitals, and schools. The benefits of these roles are many and include helping young people gain useful skills such as reading and math. In many cases the self-esteem of the young people who receive this support increases (Werner, 1991).

Adult Children to Elderly Parents

Although mutual help is the norm in intergenerational relationships, there are times when the elderly person may need extra assistance. Next to the spouse, the adult child who lives nearest to the older person is the primary caregiver when help is needed (Spitze & Logan, 1992). Daughters typically provide personal assistance, as in bathing or helping with grooming, whereas men are more likely to help with transportation, financial advice, or yard work (Chappell, 1990). In view of the increasing involvement of younger men in caring for their own children, when compared to previous generations, it will be interesting to see if future cohorts of men take on different caregiving chores for their parents (Bengtson et al., 1996).

Adult children report that there is both a burden and a sense of satisfaction in providing care for parents. It can be draining, emotionally, physically, and financially, to care for a frail elderly person over an extended length of time. Daughters may have to leave their jobs in order to help their elderly relatives, which can impact their careers (U. S. Bureau of the Census, 1996). On the other hand, family members regularly report that they feel good about being a caregiver. Help is given out of a feeling of love as well as obligation. Furthermore, providing assistance is considered a payment for what the children have received in the past (Bengtson et al., 1996).

Thus, adult children play a significant role in the life of the elderly person. Interestingly, the baby boomer generation, many of whom are turning 50, have fewer children than previous generations (U. S. Bureau of the Census, 1996). This may present a problem for baby boomers in their older years.

Grandchild to Grandparent

The grandchild plays a significant role in the life of a grandparent. They provide love and affection and thus enhance the mental health of the grandparent (Kivnick, 1982). Perhaps more importantly, they provide a connection to the future with a promise of family continuity. Erikson, Erikson, & Kivnick (1986) tell of the importance of the grandchild in their book *Vital Involvement in Old Age*. Grandparents see themselves in the younger generation, by way of physical appearance, athletic inclination, musical talents, etc. Therefore, in their grandchildren they envision what they "could have been" and in this way have "a second chance at life".

SPECIAL NEEDS OF RURAL ELDERS

Greying of Rural America

Over 12% of the population in the United States is 65 years of age or older. One in four of these people live in small towns and farm communities (U. S. Bureau of the Census, 1996). Although a very heterogeneous group, elderly people who live in rural areas are more likely to be older (U. S. Bureau of the Census, 1996), to have less education, and to be poorer than those who live in cities (Clifford & Lilley, 1993). Although rural elderly have more children than city elderly, they are less

likely to be living with a child, and, in fact, more likely to be married and living with a spouse (Coward, Lee, & Dwyer, 1993).

Rural areas are the home of a very diverse population of people, somewhat influenced by in-and-out migration. First of all, there are the lifelong farmers. Non-farm rural elderly live in small towns within the rural community. Another group of elderly people have relocated to rural areas at retirement, often into organized communities, seeking a better quality of life (U. S. Bureau of the Census, 1996). The characteristics of this last group are different from other rural elderly in that they have higher incomes, more education, and better health. Some retired people return to the rural areas where they had lived when they were younger. This group is not necessarily in as good health or as financially secure as the previous group (Longino & Haas, 1993). Finally, some elderly with health problems leave rural small towns and farms to be closer to family and the resources found in larger communities.

The non-farm rural elderly, when compared to farm and city elderly, appear to be the most disadvantaged. They have less income, poorer housing, and fewer family members to provide them care if they need assistance. Furthermore, non-farm rural elderly report more medical conditions and rate their health as poorer than elderly who live in cities or those who are still engaged in farming. On the other hand, farm elders are among the healthiest of all elders, reporting fewer medical conditions or difficulties in completing normal daily activities. However, this same group also reports poorer self-perceived health than elders who live in the city, possibly explained by the physical demands placed on the active farmer when any type of health impairment would hinder performance (Coward, McLaughlin, Duncan, & Bull, 1994).

Only about eight percent of elderly people living in rural communities are from minority groups (Kivett, 1993). Their health, in general, is poorer than that of Caucasian elderly, and their access to care more difficult. African Americans, who make up the largest proportion of these elderly, often have extensive chronic health problems. Older Mexican Americans, who return yearly with their families to migrant camps, are more than twice as likely to live in poverty as Caucasian elders. They may speak little English and the assistance of their families is needed to make any connections in the community. Because of this they lack early access to medical services, often getting help only when very ill. Over half of the population of Native Americans live in rural areas. This group of people has major health problems including tuberculosis, diabetes, and vision and hearing problems. Almost three out of four Native Americans over the age of 65 are limited in their ability to carry out normal activities of daily living (Kivett, 1993).

Access to Health Care

Elderly people access and use health care differently depending on whether they live in rural areas or cities. Some of these differences are due to personal beliefs and values but availability of services is also a factor.

Rural elderly, more than city dwellers, call upon their family and friends for help when it is needed. They are much less likely to seek formal assistance, e. g., Meals on Wheels, Home Health Nurse, than their city counterparts. One reason may be that rural elderly believe that only family and friends should give help. Also, rural elderly people

are less willing, or less able, to pay for outside help. Although rural elders have more children than city elders, they do not share equally in caring responsibilities. As might be expected, it is the adult child who lives closest who provides the most assistance (Coward et al., 1993; Johnson, 1996; Krout, 1994). Children of elderly who live in the city more equitably share in these types of tasks.

There are differences in the use of health care by elderly who live in city or rural areas (Coward et al., 1993). Rural elderly people are more likely to visit general practitioner physicians but see specialists less than city elderly (Dansky, Brannon, Shea, Vasey, & Dirani, 1998). They go to emergency rooms less frequently (Hamdy, Forrest, Moore, & Cancellaro, 1997) and spend fewer days in hospitals (Dansky et. al., 1998). Furthermore, they are less likely to seek mental health care (Rathbone-McCuan, 1993).

On the other hand, when services are available, rural elders appear more likely to use them. For example, they are more likely to be admitted to skilled nursing facilities, at a time when they are less ill and are younger than their city cohorts (Coward, Netzer, & Mullens, 1996). Rural elders are more likely to use home health services than city elderly (Dansky et al., 1998). They also use senior centers more, a type of facility which is often geared to meet the specific needs of the local population (Stoller & Lee, 1994).

Newly relocated rural elderly use services more than long-time residents (Sennott-Miller, May, & Miller, 1998). These elders expect to have the same health care resources that were available to them in the city and often have difficulty adjusting to the limited services found in rural areas (Longino & Haas, 1993). Finally, African American (Ralston, 1993) as well as Mexican American elderly (Sennott-Miller et al., 1998) who live in rural areas use
fewer health care services than their Caucasian counterparts.

Geographic area affects the availability of social and health care services. There are fewer doctors and nurses in rural areas, as well as fewer hospital beds per person (Coward et al., 1994). Interestingly, there are more available skilled nursing home beds per capita in rural areas. This may explain, in part, the high use of these facilities by rural elderly, although use of these facilities is probably also tied to the lack of other health care resources (Shaughnessy, 1994). Meals on Wheels, homemaker services, health care clinics, and adult day care centers are less available to rural elders than those who live in cities (Coward et al., 1994). Although rural elderly people are more likely to use home health, there are fewer of these agencies in rural areas and they are usually smaller and offer fewer services (Dansky et al., 1998).

Problems with Rural Provider Provision of Health Care

Transportation, recruitment of health care providers, and cost of services are a few of the problems that make it difficult to provide health care to rural populations. Although rural areas in different parts of the country do vary from one another, one problem that they all seem to share is difficulty in providing transportation. Both road and weather conditions in rural areas can be poor, and older people are hesitant to drive in inclement conditions. Older women in particular are reluctant to drive rural roads in poor weather (Wallace & Colsher, 1994). There is little available in the way of public transportation in these areas, as the cost of such service is great. Therefore, transportation for elderly people to

clinics or hospitals is difficult to provide. It is

also hard to provide home health care or other
services on a regular basis. The distances are great and there are so few people to serve within a given geographic region, it is difficult to make these services financially feasible (Nelson, 1994). Finally, even the adult children who often provide transportation must travel further than is necessary in city areas (Stoller & Lee, 1994).

Attempts to recruit doctors, nurses, and other health care professionals to rural areas continue, although with limited success. It is difficult for health care professionals to financially maintain a practice in rural areas where the clientele is limited. Furthermore, other services need to be available to help maintain a practice, e. g., home health agencies, mental health practitioners (Coward et al., 1994).

Finally, it is expensive for communities to support social and health care programs. Both rural elderly and rural communities may have limited assets. Therefore, although there are many services that are beneficial for elderly people and their families, such as Adult Day Health Care or Meals on Wheels, they may not be economically feasible.

Intergenerational Land Transfer

The transfer of a family farm from one generation to another takes place after years of children and their parents working together. Children living in rural areas are expected to work on the family farm from the time they are quite young, and in fact, they are sorely needed. With time, the adult children take on more of the farm work and eventually become the owners. A reciprocal arrangement of giving and receiving continues throughout life, regardless of who owns the farm, including baby-sitting for grandchildren and caring for frail elderly.

Inheriting and maintaining a family farm can be a boon to many young people, but it is not always easy or successful. Transfer of farmland between generations is typically to a son, although not always. Women can inherit the farm from their parents or by marriage if they survive their husbands (Elder et al., 1996). Although not all children want to farm like their parents, they are more likely to stay in farming if the ties to the parents are strong and if the farm has been successful. However, in California, a serious loss of farm land has resulted from adult children either not being interested in continuing the family farm business or succumbing to the dramatic increase in real estate prices. In these cases, the land is generally lost to developers (A. Sokolow, 1998, personal communication).

Dysfunctional Autonomy

For a number of reasons the rural elderly person is at greater risk of inadequate health care than a person living in a city. Rural elderly have fewer members in their support network. They are more likely to be suspicious of any type of outside help, especially government programs. Furthermore, maintaining their independence is vitally important for many of these people and they do not want outside interference. Finally, this group of elderly, more than those who live in the city, often feel that they can depend on their own knowledge and skills to treat their health problems (Thorson & Powell, 1992). These factors, which are positive in many ways, can lead to failure to seek and accept assistance when it is needed.

Interventions

Developing intervention programs for rural elderly entail a number of unique problems,

due to the transportation problems, the expense of delivering health care and other problems to an often far-flung rural

population, and the emphasis on independence and self-reliance often exhibited by rural elders. Consequently, programs for the elderly are often expensive and may fail due to under-utilization. Therefore, there are a number of issues which developers of programs for rural elderly people should consider.

- *The culture of the rural community*. Rural communities may differ along cultural and ethnic lines. Rural elderly in North Dakota, for example, are culturally and ethnically different than rural elderly in West Virginia. Further, models of health and social care that work well in a city will not necessarily work well for people living in rural areas (Krout, 1994), and program developers should be aware of cultural opportunities and constraints for rural elders. Ethnic minorities living in rural areas may be particularly underserved by existing programs. A recent survey of nutrition sites in rural California found that almost no Mexican-Americans utilized this service, in part due to a lack of ethnically appropriate menus and in part due to a preference for relying on family networks. (R. McDonald, personal communication, 1993).

- *Personal and family beliefs and values.* Rural elders are more willing to participate in a program if they can reciprocate in some way or pay their own way, allowing them to maintain their independence and have control over decision making (Stoller & Lee, 1994; Craig, 1994).

- *Transportation*. Providing transportation services for the rural elderly and their caregivers may be expensive and time consuming. For example, the Yolo County Adult Day Health Center often spends four or more hours a day ferrying their clientele back and forth from their homes to the Center.

- *Community involvement.* Community agencies and leaders must be involved for programs to be successful (Foster, 1994; Iutcovich, Scheidt & Norris-Baker, 1993; 1993). The development of health and social care programs must work to bridge the gap between the community resources available and what is missing in the community.

- *Housing.* Many older rural homes are in sad need of maintenance. Retrofitting housing through the use of ramps, grab bars in showers, better lighting, and lower counters and stoves to accommodate elderly in wheel chairs, can enable the handicapped elderly to continue to live in their homes.

- *Health promotion*. Rural elders are at greater risk of inadequate screening for disease or disease prevention. Rural elders will use health promotion services, especially if it is encouraged by their physicians and if it is paid for by Medicare (Lave, Ives, Traven, & Kuller, 1995). However, they may also misuse medications, such as those for depression and high blood pressure (FallCreek, Muchow, & Mockenhaupt, 1994).

- *Programs for service providers*. Service providers in rural areas have less access to continuing education, yet providers are often caring for sicker, more frail elderly, with fewer other professional services to provide assistance. Programs for informal caregivers are also needed.

Cooperative extension services in many states, such as Missouri, Oregon, and Kentucky, provide programming for the

elderly. These may include programs which help the elderly handle financial and legal issues, as well as those targeting problems in health, housing and self care. Other programs foster improved intergenerational relationships or support

activities such as the Senior Olympics. Unfortunately, California, despite its large population of elders and the greying of its rural counties, currently has no extension specialists focusing on concerns of the elderly.

CONCLUSIONS

The value of maintaining elderly people in the community is great. They spend money in the community and support the tax base, and often run essential services which are needed for the maintenance of their communities. Elderly people often volunteer their services to help others. Further, they have a strong voice in community affairs and take an interest in what is going on (Liu, 1996). Even frail elders help to create jobs, as they need assistants to help them. Thus, the value of elderly people to rural communities cannot be underestimated. Therefore, it behooves us all not only to encourage but to enable our rural elderly to "age in place" (Havens & Kyle, 1993).

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