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Active Ageing of Elderly Living in Residential Care Facilities in Malaysia

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ABSTRACT: The concept of active ageing has gained significance in aging due to the need for integrated approach towards understanding the aged. For this purpose, the data collected from questionnaires distributed to 489 older people living in residential care facilities provided by Government, Non-Governmental Organisations (NGOs), and private sector in Malaysia were analysed quantitatively. Three dimensions of active ageing were assessed, named health, meaningful leisure and social environment. The results provide a comprehensive understanding of elderly and carries various implications for research and policy making.

KEYWORDS: Elderly, Active Ageing, Residential Care Facilities, Older People, Meaningful Leisure, Social Environment, Health

I. INTRODUCTION

Individual life expectancy has increased as a result of demographic changes and medical advancements. The number of elderly people receiving residential care is rising and is predicted to continue rising in the foreseeable future. Age-related low quality of life among the elderly is a global concern, particularly in residential care. Studies have shown that elderly people's physical, emotional, and social wellbeing is negatively impacted by inactivity (Adams, Leibbrandt, and Moon, 2011; Hutchinson & Warner, 2015; Miller 2016; Toepoel, 2013).

The quality of life in residential care can be impacted by both engaging in physical activity and meeting spiritual needs. Understanding how people' views, involvement, and the availability of enjoyable activities interact to preserve wellbeing is crucial (Miller, 2016). The term "active ageing" and the spiritual demands of elderly people receiving residential care are the focus of this study, along with how these factors relate to the quality of their lives. The difficulties that come with getting older are complex for many reasons, including frailty, preconceptions, gender, identity, and socialisation. Phenomenological analysis is a useful tool for comprehending how the elderly behave in their environment.

II. LITERATURE REVIEW

The process of maximising possibilities for health, participation, and security in order to improve people's quality of life as they age is known as active ageing, according to the World Health Organization (WHO, 2012). Furthermore, WHO has divided active ageing into six determinants, including health and social services, behaviour, personal, physical environment, social, and economic factors (Lai, Lein, Lau, & Lai, 2016). The International Council on Active Aging (ICAA), on the other hand, defines active ageing as being "involved in life." Regardless of age, socioeconomic background, or health, the focus is on emotional, environmental, physical, social, and spiritual wellness (ICAA, 2015). Multidimensional engagement, comprising physical, functional, psychological, and social health, can be used to describe successful ageing (Phelan, Anderson, LaCroix, & Larson, 2004). Additionally, older adults who engage in physical activities including biking, walking, fitness trails, and other activities to maintain their fitness and build strength, flexibility, and endurance should be included in the category of active ageing (An, Lee & Kim, 2013; Dahany et al., 2014; Sykes & Robinson, 2014).

In addition, Paul, Ribeiro, and Teixeira (2012) found that the social services, physical environment, health, and economic variables were pertinent to active ageing, which is connected to individual needs, resources, and outcomes. Similar to Boudiny (2013), who encouraged older people to participate in social and economic activities to stay active and independent. In order to foster more active ageing in the workforce, UNECE (2013) also promoted economic activities in line with the European Year for Active Ageing and Solidarity between Generations 2012 (EY2012) ageing framework (EY2012 British Society of Gerontology,

2012). Additionally, according to the Organisation for Economic Co-operation and Development (OECD), older individuals will become useful in society and economic activity if their employment chances are improved (OECD, 2006). The emphasis on activities that improve health and the ability to live independently was not included in the criteria, though (Sidorenko & Zaidi, 2013).

Bowling have concurred that senior citizens' social interactions and level of activity will improve if they participate in leisure and social activities (Bowling, 2008). Therefore, to promote healthy ageing, elderly people should be actively involved in their lives by taking part in geriatric clubs and community activities (Rattanapun, Fongkeaw, & Chontawan, 2009; Sutipan & Intarakamhang, 2017). Elderly people deserve to live better lives so they can continue to contribute to the growth of their country and feel valued by their community.

Additionally, being physically active and living in a healthy environment might encourage active ageing. The creation of better public exercise spaces where seniors can engage in daily exercise and other physical activities can encourage them to be more active (An et al., 2013). In addition, to promote active living, the neighbourhood and nearby facilities must be outfitted with high-quality, senior-friendly amenities and services (Bowling, 2008). If elderly persons can continue to engage in physical activity, they may be able to avoid developing chronic illnesses, which will allow them to live happier, healthier lives and reduce dependency.

Additionally, by taking into account their level of need, mental and physical wellbeing, and social obligations that are assigned to them, active ageing enables people to remain autonomous and realise their potential regardless of their age (Mayhew, 2005; Sutipan & Intarakamhang, 2017). Successful ageing was envisioned as multifaceted, involving avoiding illness and incapacity, maintaining high levels of physical and cognitive function, and continuing to participate in social and productive activities (Rowe & Kahn, 1997). Rowe and Kahn's conceptualization was further developed by McLaughlin (2010) using the six interpretations of not having a serious disease, not having an activity of daily living (ADL) handicap, scoring at the median or above on cognitive functioning tests, and being actively involved. Elderly folks who can live independently and maintain a healthy lifestyle are genuinely successful as they age.

People can realise their potential for lifelong physical, social, and mental wellbeing by engaging in active ageing. The process is what motivates senior citizens to take into account social, environmental, and physical factors when leading a healthy lifestyle. Active older adults will have a greater understanding of and appreciation for good ageing when they are gathered in one community. The policies and framework of active ageing, which are based on location and culture, are diverse and complex, according to Sidorenko and Zaidi (2013). To fill up the gaps in this study, it is important to discuss ageing and actively age from the perspective of residents of residential care.

III. METHODS

A. Population

The target respondents for this study are senior people residing in residential care facilities run by the government, non-profit organisations, and private companies. These facilities are required to register with The Registry of Society of Malaysia and the Malaysia Department of Social Welfare (JKM) (ROS). According to information and figures provided on the websites of the organisations, Peninsular Malaysia had 216 residential care facilities as of June 2016. Peninsular Malaysia's entire geographic area was divided into four regions for the survey's purposes: North, Central, South, and East. A multistage stratified sample process was used for the survey, and 12 residential care facilities were chosen at random from each of the four areas. According to the Department of Social Welfare Malaysia (JKM), 2016 report, there are 9, 520 old people living in 216 residential care facilities in Peninsular Malaysia that are run by the government, non-profit organisations, and the private sector.

B. Sample

The sample size for this study has been decided upon using a stratified random sampling. According to Table 3.5, the study's sample size was 9520 people from 216 facilities served by 3 providers. According to Sekaran and Bougie (2016), a sample size of about 297 respondents would be ideal for the survey's 1300-person population because "sample sizes bigger than 30 and fewer than 500 are adequate for most studies" (p. 295). It has been discovered that the stratified random sampling technique is effective and suited for gathering data from different strata (a number of subpopulations) within the population (Sekaran, 2003). This sampling technique involves defining the strata and figuring out how many people from each stratum to include in the sample.

C. Questionnaire Design

For the questionnaire survey in this study, a closed-ended structured questionnaire with a five-point rating system was employed. However, a number of research in the body of literature have used Likert scales with four, five, six, seven, and even

nine points. But in this study, a five-point Likert scale was employed. First, a scale with a midpoint is thought to present a better and more accurate result (Krosnic & Fabrigar, 1997) by enabling the respondents to simply and clearly express their position with regard to their choice of an item. This is why a 5-point Likert scale was chosen.

D. Data Collection

According to the results of the analysis above, this study uses a self-administered questionnaire to collect the information needed for analysis from the respondents. The use of questionnaires for data collecting is most frequently used in quantitative research. It describes a scenario in which researchers employ a set of predesigned written questions with clearly defined options and items recorded to elicit information on particular topics of interest from respondents (Kumar et al., 2013; Sekaran & Bougie, 2013). In order to obtain a significant amount of quantitative data for descriptive research, questionnaires are used as the primary data collection tool. It can be administered personally (i.e., by self-administering), via mail, electronically, or even by sending it right to the respondents. The questionnaire approach is more time and money efficient than the two ways of data collecting outlined above (Kumar et al., 2013; Sekaran & Bougie, 2013), however it occasionally experiences poor respondent response rates.

E. Data Analysis Technique

Version 24 of the Statistical Package for Social Science (SPSS) was used to analyse the data. In addition to its benefits like time savings, clear statistical results, and reliable results, SPSS software's ability to process massive amounts of data with unlimited data consumption is the primary reason that this study has opted to use it (Agusyana & Islandscipt, 2014).

IV. RESULTS

A. Response Rate

The success of a researcher in getting respondents to fill out the questionnaire, according to Babbie (2004), is gauged by the response rate. The questionnaires were hand distributed to the respondents in this study to ensure improved return rates. A personally administered questionnaire, according to Sekaran (2003), encourages respondents to respond honestly. Additionally, it aids in raising the proportion of positive comments from respondents (Dillman, 1978). Fourteen residential care institutions in Peninsular Malaysia received a total of 489 surveys, and all 489 questionnaires were returned for this study.

B. Demographic Analysis

The data were obtained from 489 elderly resides in residential care facilities provide by Government (n=192, 39.3%), NGOs (n=181, 37%) and Private (n=116, 23.7%). A summary of the demographic profile of 489 residents are displayed in Table 1.

Of the 489 residents, 280 (57.3%) were females and 209 (42.7%) were males. In this study, the largest proportion of residents was in the youngest old age group, age 60 to 74 years old (n=224, 45.8%) and middle old age group, age 75 to 84 years old (n=216, 44.2%). Both of this age group represents the fastest-growing segment of the elderly population in Malaysia (Department of Health, 2001). Totally, 49 residents (10%) were oldest old, age 85 years and above. United Nations 2001 has classified elderly into three life-stage subgroups which is young-old (60 to 69 years old), old-old (70 to 79 years old) and oldest-old (80 years old and above) (Zainab Ismail, Wan Ibrahim Wan Ahmad, & Zuria Mahmud, 2007).

With respect to ethnic and religion, half of the residents are Malay and Islam (n=255, 52.1%). For ethnic, its follow by Chinese 37.2 percent and Indian 10.6 percent. Other than Islam, 36.6 percent of the residents are Buddhist, 9.6 percent are Hindu, and 1.6 percent are Christian. In this study, marital status was classified as “never married”, “married”, and “divorced/separated”. The majority of the residents were married (n=293, 59.9%). More men (n=90, 43.1%) than women (n=60, 21.4%) were divorced/separated and 9.4% (n=46) of the residents were never married (Table 2).

Table 1: Characteristics of the Respondents (n=489)

Variable	Number	Percent
Facilities Provider		
Governments	192	39.3
NGOs	181	37.0
Private	116	23.7
Gender		
Male	209	42.7
Female	280	57.3
Age		

Youngest old	224	45.8
Middle old	216	44.2
Oldest old	49	10
Ethnic		
Malay	255	52.1
Chinese	182	37.2
Indian	52	10.6
Religion		
Islam	255	52.1
Buddhist	179	36.6
Hindu	47	9.6
Christianity	8	1.6
Marital status		
Never Married	46	9.4
Married	293	59.9
Divorced/Separated	150	30.7
Number of Children		
None	46	9.4
1 – 3 persons	226	46.2
4 – 6 persons	181	37
7 person and above	36	7.4
Education		
No Education	187	38.2
Primary School	151	30.9
Secondary School	100	20.4
College	51	10.4
Occupations		
Government	81	16.6
Self-employed	203	41.5
Private	45	9.2
Unemployed	160	32.7
Income		
Below RM1,000	322	65.8
Above RM1,000	167	34.2
Years of Staying		
1 to 5 years	291	59.5
6 to 9 years	189	38.7
10 years and above	9	1.8

Most of the residents in this study does not received education (n=187, 38.2%). The reason behind this is, at their age, most of them are from the baby boomer's era where at that time, educational opportunities are limited. Approximately 30.9 percent (n=151) completed primary school, 20.4 percent (n=100) completed secondary school and 10.4 percent (n=51) of the respondent graduated from college. Before entering the residential care facilities, the residents were predominantly self-employed (n=203, 41.5%) and unemployed (n=160, 32.7%). About 16.6 percent (n=81) of the residents in this study previously worked as government servant and 9.2 percent (n=45) declared they work in private sector. Referring to their income, 65.8 percent (n=322) of the residents get monthly income below RM1,000 before they have retired while 34.2 percent (n=167) are above RM1,000.

Looking at the years of staying, 59.5 percent (n=291) of the residents stayed less than five years. 189 residents or 38.7 percent of the elderly already living there six to nine years and 9 of the residents living there more than ten years. 226 of them (46.2%) have one to three children. 181 (37%) have four to six children, 9.4 percent (n=46) of them have no children and 7.4 percent (n=36) have seven or more children.

Table 2: Cross Tabulation of Gender and Marital Status

Variable	Gender		
	Male	Female	Total
Marital Status			
Never Married	12 (5.7%)	34 (12.1%)	46 (9.4%)
Married	107 (51.2%)	186 (66.4%)	293 (59.9%)
Divorced/ Separated	90 (43.1%)	60 (21.4%)	150 (30.7%)
Total	209 (100%)	280 (100%)	489 (100%)

C. Descriptive Analysis

The discussion starts with the findings regarding the respondents' opinions on six active ageing determinants which are health, meaningful leisure, and social environment.

Health: The respondents' views on health are displayed in Table 3. The data shows that about 8 percent of them strongly agree that they are healthy senior citizen without having to depend on others in managing myself. 1.6 percent of them take care of their nutrition through healthy and balanced eating habits. 32.1 percent of respondents said they have enough rest and sleep to stay active, while 22.5 percent said they often see a doctor to stay in shape.

Table 3: The Distribution of Respondents' Feedbacks on Health

Health	SD	D	N	A	SA	Mean
	n	n	n	n	n	
	%	%	%	%	%	
I am a healthy senior citizen without having to depend on others in managing myself.	3	173	119	155	39	3.11
	0.6	35.4	24.3	31.7	8.0	
I take care of nutrition through healthy and balanced eating habits.	0	185	149	147	8	2.96
	0	37.8	30.5	30.1	1.6	
I have enough rest and sleep to stay active.	0	184	148	157	0	2.94
	0	37.6	30.3	32.1	0	
Doing regular health check-ups is important to keep me fit and healthy.	0	288	91	110	0	2.64
	0	58.9	18.6	22.5	0	

*SD = Strongly Disagree, D = Disagree, N = Neutral, A = Agree, SA = Strongly Agree

Meaningful Leisure: Table 4 shows the respondents' views on meaningful leisure in relation to active ageing. A total of 21.5 percent respondents strongly agreed that they can maintain their hobbies and often been encouraged by the care takers to participate in an activity. 20 percent strongly agreed that the activities are limited, and 19.8 percent of the respondent strongly agreed that the offered activities are adjusted to their wishes or requests.

Table 4: The Distribution of Respondents' Feedbacks on Meaningful Leisure

Meaningful Leisure	SD	D	N	A	SA	Mean
	n	n	n	n	n	
	%	%	%	%	%	
The offered activities are adjusted to my wishes, requests	0	8	65	319	97	4.03
	0	1.6	13.3	65.2	19.8	
We are encouraged each time to participate in an activity	0	33	86	265	105	3.90
	0	6.7	17.6	54.2	21.5	
The variety of the activities is limited	0	18	92	281	98	3.94
	0	3.7	18.8	57.5	20	
I can maintain my hobbies here	0	33	86	265	105	3.90
	0	6.7	17.6	54.2	21.5	

*SD = Strongly Disagree, D = Disagree, N = Neutral, A = Agree, SA = Strongly Agree

Social Environment: Table 5 shows the respondents' views on social environment in relation to active ageing. A total of 20.7 percent respondents strongly agreed that the number of the activities are too small, and 54.4 percent agreed that they can learn new thing through the organized occasions. 20 percent of the respondent strongly agreed that people around the neighbourhood regularly come to their place. The social environment is very important for the elderly people to feel more comfortable and accepted by the community as well as maintaining their emotion and psychological well-being.

Table 5: The Distribution of Respondents' Feedbacks on Social Environment

Social Environment	SD	D	N	A	SA	Mean
	n	n	n	n	n	
	%	%	%	%	%	
There are enough organized occasions where it is possible as resident to learn new things	0 0	139 28.4	84 17.2	266 54.4	0 0	3.26
People of the neighborhood regularly come to our place (residential care).	0 0	0 0	81 16.6	310 63.4	98 20	4.03
The number of activities is too small	0 0	30 6.1	79 16.2	279 57.1	101 20.7	3.92

*SD = Strongly Disagree, D = Disagree, N = Neutral, A = Agree, SA = Strongly Agree

V. DISCUSSION

The results confirmed the majority of studies in the literature that found social support had a significant impact on quality of life (Netuveli, Wiggins, Hildon, Montgomery, Blane, et al., 2006; Platts, Webb, Zins, Goldberg, Netuveli, et al., 2015; Layte, Sexton, Savva, 2013). Older people view community involvement, enjoying their social interactions, and spending time with family as positive aspects of getting older (Shahar, Earland, Abd RS, 2001). Asians place a high value on filial piety, which includes living in one home with extended families and staying in close contact with them (Laidlaw, Wang, Coelho, Power, 2010). According to a study, seniors in residential care facilities who lack social connections, support, and engagement have poorer quality of lifes.

Social support is the provision of actual or fictitious resources to others in order to make them feel valued (Helgeson, 2003). For senior people who depend on groups or friends for routine activities, companionship, and to provide the necessary care for their well-being, it might be crucial (Melendez-Moral, Charco-Ruiz, Mayordomo-Rodriguwz, Sales-Galan, 2013). Positive social relationships (with family, friends, and neighbours) have been found in studies to improve quality of life. On the other hand, a lower number of social contacts, which could result from a social network losing some of its members, is strongly linked to a lower quality of life (Sok & Choi, 2012; Chan, Shoumei, Thompson, Yan, Chiu, Chien, et al., 2006). Higher levels of social support have been associated with a lower risk of mortality, illnesses, and mental disorders as well as an improvement in life quality (Reblin & Uchino, 2008; Karnell, Christensen, Rosenthal, Magnuson, Funk, 2007; Seeman, 2000). These results were in line with earlier research (Tseng, Wang, 2001; Sok, & Choi, 2012), which also noted the importance of social support for the elderly since it helps them feel valued and cherished and keeps them from feeling abandoned.

All domains of quality of life scores were significantly correlated with outdoor leisure activity. This is because engaging in recreational activities improves positive psychological and physiological processes (Kim, Yamada, Heo, & Han, 2014). Additionally, those who engage in such activities are more likely to have social interactions with others outside of their immediate circle, which may provide as an extra source of support. Leisure activity has been linked to a higher quality of life in earlier research by Paskulin and Molzahn (2007) and Luleci, Hey, and Subasi (2008). According to these research, senior citizens' quality of life can be significantly improved by engaging in recreational activities like walking, going to the mall, and gardening.

VI. CONCLUSION

This study demonstrated that dimensions of active ageing, such as health, meiningful leisure, and social environment are very important for the elderly living in residential care facilities.

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