# Aging Interdependently: A Critical Ethnographic Study of Successful Aging and the Oldest Old

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**Abstract**

In both Canadian policies and scholarly research, there is a tendency to presume that the perspective and service needs of all older people (aged 65+ years) are similar. Yet, less is known about the unique circumstance of the oldest old (aged 85+ years): a cohort with a diverse spectrum of experiences distinct from their younger older adult counterparts. This study explores the accounts of a group of community-living adults among the oldest old utilizing the services of an older adult recreational centre located in urban Ontario to understand successful aging in the very late life years. Prominent intersectional identity locations in this phase of life, specifically gender and disability status, are examined in light of essential support needs and the policy goals of Active Living and aging in place. Using qualitative approaches of critical ethnography and case study, semi-structured interviews were conducted with nine women and nine men (aged 85+ years), four staff members from the older adult centre, and one respondent family member. A combination of participant data, observations, and document analysis, together with a conceptual framework comprised of feminist political economy, life course theory, and intersectionality inform the final analysis of this work. Findings reveal that despite a deeply entrenched neoliberal doctrine of sustained independence, successful aging in the oldest old is influenced by prominent social determinants of health (SDOH) and best delivered through an interdependence model of support that includes both formal government services and informal networks of care. This involves strengthened welfare state programs in several service areas, including income supports, transportation mechanisms, personal care, home care, caregiver supports, disability supports, gender-specific provisions, and increased social connections. Broadly, this study concludes that an interpretation of late later life that is unconstrained by the limitations of neoliberalism and individualism is an important first step in cultivating equity for the oldest old.

## Dedication

This dissertation is dedicated to my four treasured grandparents. Although I had the privilege of meeting only two of them, my grandparents are the people who inspired my deep interest in aging and later life experiences. I remain eternally grateful for the legacy of their values and their continued spiritual presence in my life.

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# Chapter One: Introduction

*"To understand what it is like to live life*
*as a very old individual, gerontologists*
*may need to reverse the scientific paradigm*
*and replace conventional concepts and*
*theories with viewpoints from the older*
*adults themselves."*
(Gondo, Nakagawa, & Masui, 2013, p. 128)

## Introduction

The answer to the question of what constitutes successful aging is highly sought-after in policy, media, and social culture. Although health and disability-related experiences are intrinsic considerations in later life, discussions of disability or illness are often relayed as inhibiting factors to "independent", "optimal", "healthy", or "productive" aging (Aldwin & Gilmer, 2004; Depp & Jeste, 2006; Katz & Calasanti, 2015; Montross et al., 2006). In Canada, recent census data show that one in every six people—or 6 million Canadians—is classified as an "older adult" (Statistics Canada, 2019).[1] This number is projected to increase to 25%, or one in four, of all Canadians by the year 2055. In the province of Ontario, the total number of older adults (aged 65 years and above) is forecasted to double from 2.4 million people in 2018 to 4.6 million by 2046 (Ontario Ministry of Finance, 2019). In light of this coming demographic shift, one important priority for policy and scholarly research is investigating the most pertinent issues to those in this population.

Disability is more prevalent among older adults than any other societal group because the experience of acquired disability holds prominence in later life (Law Commission of Ontario,

[1] Consistent with many progressive works of gerontology scholarship, the term "older adults" refers to individuals whose numerical age is 65 years and older. This language is aligned with that of both Avers, Brown, Chui, Wong & Lusardi (2011) and Putnam (2015), who support this phrasing as more precisely accurate and respectful of people in late stages of the life course.

2012; Morris, Fawcett, Brisebois, & Hughes, 2018). The model of "successful aging" understands the intersection of aging and disability through a biomedical lens, in which successful aging constitutes maintaining high physical function and remaining free of disease (Bowling, 2007; Bowling & Dieppe, 2005; Martin et al., 2015). This gerontological framework assigns value to "healthy" and "independent" years, as well as time spent actively engaged with social life (Rowe & Kahn, 1997). Aligned with the neoliberal doctrine, it conceives individuals as largely responsible for their own fate as they become older (Depp & Jeste, 2006; Liang & Luo, 2012; Peterson & Martin, 2015). Through the successful aging model, older people are thus perceived as independent agents accountable for their own health and wellness in later life through autonomous choices and actions.

This paradigm of successful aging has been met with extensive criticism for the privilege it ascribes to biological health and individual lifestyle factors (Bowling & Dieppe, 2005; Peterson & Martin, 2015). By adopting a biomedical model of aging, the influence of power relations, material conditions, social factors, and larger economic systems are obscured (Armstrong & Armstrong, 2010; Coburn, 2010; Raphael, 2010). There is a known tension between human agency and macro-level structures, where the choices and capacities of aging individuals are influenced by the function and governance of larger systems (Kearns, 1993; Scambler, 2007). A more balanced view of aging is one that acknowledges this influential relationship, contextualizing the role of personal agency amidst structural constraints (Stowe & Cooney, 2015). Rather than as separate concepts, the two intersect in what Settersten (2003) refers to as "agency within structure" (p. 30). To better understand how the influence of structural forces effects individualized experiences, empirical work is required to examine meaning and ways of knowing at the micro-level of those who are aging. Understanding this

mutually inclusive dynamic between structure and agency is important for the development of effective health services, policies, and research concerning older people.

The structure/agency debate is present within the social determinants of health (SDOH) framework. Extending beyond micro-level analysis, the SDOH framework holds free market enterprise and the larger economic system responsible for numerous inequalities between individuals and groups in society. Literature concerning health equity and the SDOH indicates that societal/systemic forces, particularly level of access to basic goods and services, play a defining role in health outcomes (Raphael, 2008). In an aging context, the SDOH model highlights the extent that available resources impact the quality of life in later years, as shaped by position in the socioeconomic hierarchy in earlier life stages (Brandt, Deindl & Hank, 2012; Katz & Calasanti, 2015; Pruchno, 2015). Disadvantage can be further pronounced for older people lacking resources as they enter a stage of potentially increased need for care, social, and/or financial supports.

As people become older, they are more likely to acquire a disability and/or encounter some form of illness. Many function-based standards for success in later life are therefore potentially prejudiced by ascribing privilege to those who are considered “healthy” by normative measures of biomedicine (Bowling & Dieppe, 2005). These (normative) standards further the social exclusion of some older adults by fostering an inequitable divide between those who conform to socially accepted ideals of what it means to successfully age and those who do not. Research posits that numerous older people indicate feeling as though they are aging successfully, despite lacking in several elements endorsed by dominant function-based definitions (Montross et al., 2006; Romo et al., 2013; Strawbridge, Wallhagen, & Cohen, 2002). Conversely, many who do conform to the ideal state of biological function do not see themselves

as doing so (Strawbridge, et al., 2002). This discrepancy suggests that there is far more to be discovered in the complexities of individual aging experiences in society than state of biomedical health (ibid). Part of rectifying this limitation requires further empirical study of not only the SDOH in a later life context, but also intersectional perspectives, including the social locations of age, gender, disability, and class-based inequities (Daly & Grant, 2008; Minkler & Fadem, 2002). Understanding aging as a “dynamic process” (Bowling, 2007, p. 269), shaped by these varied identity experiences, should foster an inclusive dialogue that leads to a more accurate understanding of important issues facing older people as a diverse group (Katz & Calasanti, 2015).

In this dissertation, I explore the subjective views of successful aging held by a group of adults, aged 85 years and older, who live independently and access the services of an urban older adult community centre offering numerous programs oriented towards Active Living. In aging discourses, Active Living holds a similar premise to that of successful aging by privileging individual choice and action with regards to wellness. More specifically, this doctrine promotes healthy lifestyle approaches at the micro-level, thus “diverting attention” from the obligations of the welfare state, as well as the impact of larger structural forces which may constrain autonomous actors from succeeding in the complex goals of maintaining good health (Bercovitz, 1998, p. 322).

I employ qualitative approaches in the form of critical ethnographic case study, to express meaning and give voice to a group which demonstrates greater vulnerability to underrepresentation and/or silence within the dominant discourse (Sofaer, 1999). In utilizing a critical ethnographic approach, this study aims to capture the personal and lived experiences of the oldest old (aged 85+ years) as they understand and measure their own success in aging.

Individuals in this age cohort represent a markedly unique social group with health-, disability-, place-, and gender-related experiences that are more likely to diverge from that of younger older adults (Suzman, Manton, & Willis, 1992). In this study, I use the term "success" with caution, noting that it often holds a normative connotation or value judgement which can be taken as both ageist and ableist—meant as a "yardstick" upon which to measure good health and function (Holstein & Minkler, 2003; Van Wagenen, Driskell, & Bradford, 2013; Glass, 2003, p. 382). It is rather my intention to seek a more holistic understanding of aging, given its highly subjective nature. An interpretation of late later life that is unconstrained by the limitations of biomedical, neoliberal thought is a necessary component in freeing society of systemic ageism and an important first step in cultivating equity between and among generations.

## Statement of the Problem

Many policies tend to group older adults under one large umbrella, allocating services according to those characterized by a numerical age of 65 years and older, a time generally labelled and accepted as "seniorhood" by the dominant discourse. This occurs not only in aging policy, but also in research. Asla, Williamson, and Mills (2006) assert that a strict numerical age approach fails to draw an adequate distinction between older adults at different stages of later life. Here, the vast spectrum of deeply unique or personal experiences and needs of older adults is at risk of being obscured (Bowling, 2007; Bowling et al., 2005).

In this dissertation, I focus primarily on the oldest old, a term given to those who are 85 years of age and older (Bowling et al., 2005; Schneider & Guralnik, 1990; Von Faber et al., 2001). It is becoming an increasingly important priority in policy and research work to understand the unique perspectives of those within this rapidly growing group as distinct from their older adult counterparts. According to the most recent Canadian census data, the national

population of people who are aged 85 and older grew by nearly 20% between 2011 and 2016 (Statistics Canada, 2017). This rate of growth is four times faster than that of the overall Canadian population (ibid.). In Ontario, people 90 years of age and older were the fastest growing population group in the province, growing by almost 40% between 2011 and 2016 (Ontario Ministry of Finance, 2017). The circumstance of those in this age cohort is unique from that of younger seniors, making this a group worthy of focused investigation. People who are 85 years and older are particularly vulnerable to an array of unique health experiences, as well as a loss and decrease in their "significant other networks" (Asla et al., 2006, p. 51). These individuals are also far more likely to have exited the paid work force, to experience an acquired disability and/or chronic health condition, and to display a greater need for health services than people in earlier phases of older adulthood.

The oldest old are also faced with numerous complex and intersecting identity perspectives. This is particularly apparent with respect to class, gender, and disability. The majority of the oldest old are represented by low-income women, for example, who are often widowed, with higher rates of disability, and who are far more likely to be lacking in the SDOH due to socioeconomic disadvantage over the life span (Jones, 2007; Nussbaum et al., 2005; Seeley, 2012; Sharpe, 1995). Ontario Census data reveal that the proportion of older men to older women dramatically decreases for the oldest old versus that of people who are 65 years and older. While the ratio at age 65+ was 82 men per 100 women, the number drastically drops to just 42 men per 100 women in the 90+ age category (Ontario Ministry of Finance, 2017). The individualized factors of aging mean that women and men, who experience the life course very differently, enter later life with diverse histories that ultimately influence their position as they age. Scholars such as Daly and Grant (2008), Seeley (2012), Selmi (2011), and Sharpe (1995)

emphasize the importance of acknowledging multi-layered sources of oppression, including age and disability, and their impact on the later life experiences of women. It is important to redefine the restrictive lens of "successful" or "healthy active" aging, which privileges patriarchal notions of productivity, ability, and independence, to more open understandings of aging, particularly among the oldest old.

## Purpose of the Study

Though the focus of many current aging policy and research initiatives remains on maintaining high function and independent participation in late life, I argue that this view is limited and driven by medical model constructions of old age, health, and disability. The dominant discourse on aging overlooks the heterogeneous landscape of later life and its intersectional, spatial, attitudinal, socioeconomic and political factors. This perception is consistent with a larger neoliberal agenda that privileges independence together with a reduction in welfare state reliance and support. Furthermore, I contend that the essential role of interdependence in later life requires stronger representation in empirical study and aging policy. Beeber (2008) writes of the limiting "independence-dependence continuum," which views individuals under two restrictive lenses (p. 21). While independence is perceived as a state of self-sufficiency through individual responsibility for prosperity and success, dependence holds an entirely negative connotation as a burden to others and a status older people generally "seek to reverse" (Fine & Glendinning, 2005, p. 605). As an alternative to these models, interdependence embraces reciprocity and the extent to which older people require strong bonds, mutuality, and the support of both informal and formal resources to thrive (Beeber, 2008; Robertson, 1997). Although a preferred state of independence is the explicit expression of participants, this study

reveals a strong reliance on the interdependent support of others as an essential part of very late life that is implicitly evident within the data.

In this study, I critically examine the notions of dependence, independence and interdependence in very late life, as well as convey how aging and disability are perceived by the oldest old. In doing so, this work addresses two identified gaps in the literature. The first is the need to better understand the personal stories of older people. Successful aging scholars agree that far more work is needed to understand the convergence of objective criteria (equating satisfaction in old age to the absence of disability or loss in function) with the subjective attributes identified by older people themselves (Martinson & Berridge, 2015; Montross et al., 2006; Van Wagenen, 2013). Capturing these heterogeneous aging experiences amidst a dominance of biomedical perspectives provides space for the unique insights of older adults to emerge as a valuable addition to the dialogue (Depp & Jeste, 2006; Fisher, 1992; Gondo et al., 2013; Knight and Ricciardelli, 2003; Phelan, Anderson, LaCroix, & Larson, 2004; Strawbridge et al., 2002).

The second gap in the literature this dissertation addresses concerns individuals in the 85 years and older category, who are more likely to be considered “unsuccessful” agers and are hence excluded from the normative dialogue. The widespread assumption that the needs of this population are similar to those of younger older people leaves open the potential for the preferences of this group to be misunderstood. Martin et al. (2015) note the need for further research exploring the views of the oldest old in successful aging discourses. The 20-year age span between an individual who is 65 and one who is 85, for example, is likely to result in differing life course perspectives and service needs. Policies, care, and service provision can more adequately address issues of concern to the oldest old by learning what is important to

them. More research work that focuses on the varied experiences and needs of those in this life stage is essential to this process.

For the purpose of gendered comparison, participants in this study are represented by an equal number of men and women over the age of 85. The analytical lenses of feminist political economy, intersectionality, and life course theory are used as the primary frameworks in the final analysis. A feminist lens is highly relevant to the overarching themes I identified from the data, as gender relations are intrinsic to later life. These theories are particularly useful in situating larger important concepts of health equity, distributive justice, and the SDOH within this piece.

In conducting this research, data were collected at a community-based older adult recreational centre, located in the North York district of the City of Toronto. This facility offers several mechanisms of engaging older adults through various programs and services, with a mandate oriented towards Active Living in later life. As a non-health centred facility, this site was selected in order to access the oldest old of adults who live independently and utilize the community resources available to them. Because this population is often viewed through a lens of functional decline by dominant health discourses, in this dissertation I show that health, aging, and disability occur in many contexts outside of medicalized spaces such as hospitals and care facilities. Here I highlight access to formal and informal resources, intersectional perspectives, caregiver supports, and community-based resources. This serves a larger goal of combating negative perceptions of later life that fail to capture the true essence of successful aging beyond function-based criteria for good health. In this dissertation, these factors are considered together with the perspectives found in the reviewed literature, aging policy documents, theoretical frameworks, and personal narratives shared by the oldest old who participated in this study. Investigating the often-underexplored experiences of the oldest old in such contexts serves the

important function of promoting inclusivity and a progression of knowledge that will ultimately foster our understanding of equity across the life course.

## Research Questions

The following research questions, derived after a thorough review of the literature, provide the focus for this dissertation, its methods, and analysis:

1) In what ways is successful aging understood by community-living older adults among the oldest old (aged 85+ years)? [2]
2) In what ways do community-living older adults (aged 85+ years) experience aging in their very late life years, compared to their earlier older adult years (aged 65+)?
3) In what ways do gender and/or disability influence how the oldest old experience aging?
4) In what ways are the oldest old supported while aging at home in their communities?
5) What are important resources for the oldest old who are aging in place, and to what extent are these needs being met by current policies?

## Summary

This thesis is divided into eight chapters. Following this first chapter, which provides an introduction to this work, Chapter 2 engages with relevant literature pertaining to the themes of this study. The intersections of aging and disability are explored as they are constructed within biomedical and social frames. Connections are also drawn between notions of marketization, productivity, and systemic ageism/ableism that manifest at multiple layers in society. My discussion of these concepts lay the groundwork for an in-depth discussion of successful aging. Here, I explore conversations between scholars over the meaning of what it entails to

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[2] Community-living older adults, in the context of this study, refers to older adults who live independently and continue to autonomously make choices for themselves.

successfully age, in theory and practice. I emphasize Rowe and Kahn's (1987) foundational framework of successful aging, highlighting the responses of many contemporary authors who revisit the theory and critique the parameters of its meaning. I conclude this section with an exploration of Active Living perspectives, and a SDOH model of aging and later life.

Chapter 3 outlines three theories that form the conceptual framework of this thesis. Here, I draw upon the lenses of feminist political economy, intersectionality, and life course theory. I begin by briefly outlining the foundational lens of political economy in an aging context, before defining facets of its main successor: feminist political economy. In seeking to discern the perspectives and position of the oldest old, an analytical frame informed by feminist theory is a highly useful guidepost when reflecting upon the differing life course trajectories of men and women, especially as they occur within the confines and contexts of neoliberalism and patriarchy. I discuss these ideas and further highlight the importance of intersectionality as it accounts for the collision of identity locations. This chapter ends with a descriptive exploration of life course theory, a lens which examines later life as a culmination of lifelong histories, choices, and occurrences. Here, the tensions between structure and agency emerge as dual and conflicting factors throughout the life span.

Chapter 4 outlines the detailed methodology and methods of this study. As an ethnographic case study, a qualitative approach is used to interpret the personal expressions conveyed by the participant group of people aged 85 years and older. Here I describe methods of data collection, providing a detailed description of the research site and design of this study. After outlining these processes, I discuss the procedures involved in data analysis, as well as important ethical considerations of this work. Finally, as is an essential piece in all qualitative investigation, this chapter concludes with a discussion of trustworthiness.

Chapter 5 is the first of three chapters to draw upon thematic findings from the research data. Relying on a triangulated combination of participant responses, observations, and supplementary documents, I investigate meanings of successful aging and Active Living from the perspective of respondents. I do so with a focus on the independence/interdependence dyad as it is demonstrated in relation to these ideas. Here I further the discussion by examining the complex role of interdependence as it manifests through sustained autonomy and support from familial and other informal sources. Finally, I conclude this section with a discussion of disability as it is perceived by the oldest old participants in this study and in relation to living an active lifestyle. Despite the overt preference to retain their independent status, many participants referred to the importance of formal *and* informal supports from both their immediate social circles, and the state for their continued wellbeing.

Chapter 6 focuses on the theme of gender. Here, the conceptual framework of feminist political economy is strongly present throughout the analysis, as are intersectionality and life course theory. Given that this study involves both men and women in its sample, I comparatively examine responses in the contexts of care, gendered notions of productivity in both paid and unpaid spheres of work, as well as the gendered impact of partnership and spousal loss. Here, a life course perspective is relevant to understanding how the personal views of the oldest old in this study were shaped by their upbringing in neoliberal, free market society. This is particularly the case through the differing life course histories of men and women with respect to productivity and income, as a complex and prominent social determinant of health and aging. In this context, I discuss women amongst the oldest old who are at a heightened risk of poverty and income insecurity.

In Chapter 7, I turn my attention to a final dominant theme identified from the data: that of the oldest old aging at home. Here, I investigate the places in which participants chose to live, and the necessary interdependent supports they identified as essential to the process. I subsequently explore "place" as a complex process that intersects with notions of independence, dependence, and interdependence. Aging in place as a policy initiative enriches much of the discussion here. This is followed by a dialogue concerning choice in the context of home dwelling, with emphasis on the role of larger systemic forces in restricting one's capacity to choose, as well as the influence of financial and social constraints on personal agency/autonomy. Lastly, I explore transportation as an essential service and means of access for participants aging at home.

Chapter 8 presents my final conclusions. Here I provide a summary of the research findings in relation to the guiding questions posed in this thesis. I also explore scholarly contributions of this work to the larger field of aging research. Following this, I discuss the limitations of this study, and subsequently identify potential areas for future scholarly investigation. In closing, I offer a brief reflection through concluding remarks.

# Chapter Two: Literature Review

## Introduction

Aging is a highly complex phenomenon which intersects with numerous facets of identity across the life course. Though it is a shared experience common to all individuals, the way in which it is experienced is rich in diversity. In this chapter, I examine the particularities of later life discourse and ideology, engaging with works of scholarly literature. Discourse can be understood as an all-encompassing dialogue, whether conceptual, written or vocalized (Mills, 2004), that "transforms our environment into a socially and culturally meaningful one" (Blommaert, 2005, p. 4). Through discourse, ideology is constructed and conveyed as a belief system that informs social values and ways of knowing (Berlin, 1988; Gerring, 1997).

The dominant societal views on aging are defined by normative values, formed by and forming institutional, governing, and systemic frameworks of society. Yet, structural forces interact with the agency of autonomous individuals (Côté & Bynner, 2008; Kearns, 1993; Scambler, 2007; Sewell Jr, 1992). Wilkinson and Ferraro (2002) describe the structural/individual relationship, writing: "the individual is shaped by social structures and social processes, yet the individual also helps define the structure and process in what is referred to as human agency" (p. 353). As a result of these influences, perceptions about later life have evolved to hold certain meanings. These meanings are closely linked with notions of power, health inequity, productivity, institutionalization, medicalization, stigma, and body norms (Nelson, 2002; Nussbaum et al., 2005; Overall, 2006; Putnam, 2002; Selmi, 2011).

In this review of the literature, I draw from relevant readings and perspectives in gerontology, health equity and critical disability studies. The literature and ideas explored here provide important context for this dissertation. Here I emphasize the complexities of successful

aging in later life frameworks. Dominant understandings of successful aging rooted in biomedical thought assign value to disability-free years and time spent actively engaged with social life (Rowe & Kahn, 1997). Yet, this understanding is highly contested and criticized by several scholars for its neoliberal emphasis, placing the responsibility to age well on individuals themselves (Holstein & Minkler, 2003; Katz & Calasanti, 2015; Martinson & Berridge, 2015; Pruchno, 2015). I also engage with biomedical understandings of Active Living, as endorsed by aging policy dialogues and models of successful aging in the literature.

As a central theme in this dissertation, I seek not only to understand the prevailing ideas of scholarship concerning the successful aging model, but also to investigate lesser-explored features in its discourse. These gaps in the existing scholarship raise a need for further research in several areas. Two such prominent omissions highlighted in this study are the need to capture the subjective voices of the oldest old, and for more prominent inclusion of disability as an intersecting social location within aging discourse. In exploring the literature, it seems that much of the discussion concerns older adults as a collective group, with fewer studies specifically focused on the perspectives of those who are 85 years and older (Martin et al., 2015). This oversight is the product of a tendency towards the homogenization of expected experiences in the scholarship about later life.

Critics of successful aging theory draw attention to the gap in the literature overlooking how the theory interacts with diverse identities. My analysis of the literature towards sites of exclusion, highlights the identity locations of gender and disability insofar as they intersect with aging. The experiences, lives, working conditions and contributions of women have an effect on their later years that is distinct from male experiences (Nussbaum et al., 2005; Sharpe, 1995). While disability is a force present throughout the life course, it holds different meanings

associated with decline and frailty in later life than it does in youth or middle age (Gilleard & Higgs, 2011; Greenberg et al., 2002; Kane & Kane, 2001). When complicated by consideration of social class, any generalized description of the life course according to the narrow parameters provided by biomedical models of health and aging becomes problematic. Successful aging theory hence stands to benefit by acknowledging the important role of intersectional perspectives, which give emphasis to sites of oppression in its dialogue. Health equity discourse confirms that we are all far from equal. For systemic reasons outside of their control, people age in the midst of inequitable circumstances (Sidanius & Pratto, 1999). This notion forces us to consider the role of socioeconomic disadvantage, and the commonalities among groups who experience it, as well as the impact of social determinants of health (SDOH) on health and life course outcomes.

## Aging and Disability: Intersections and Contradictions

In order to adequately contextualize the lived experiences of older adults, it is important to first explore the scholarship of both aging and disability studies. Though constructed in parallel ways, involving normativity, medicalization and social models of thought, these discourses have evolved differently (Chivers, 2013; Overall, 2006; Priestley, 2003; Putnam, 2002). In this section, I explore how these approaches intersect and diverge from one another in defining aging experiences. I discuss ageism and ableism as two related systems of oppression that are highly present factors in later life. I also explore interdependence as inherent to the human condition, and a notion that fosters more holistic and inclusive understandings of later life that move away from the privilege of independence and economic production. Finally, I examine how larger neoliberal frameworks affect understandings of dependence, independence and interdependence amidst the dialogue of normatively constructed life stages.

As I investigate these ideas, it is important to first establish what is meant by neoliberalism in the broader contexts of this thesis. For the purposes of this study, neoliberalism is explored as an ideological concept involving preference of free market trade, a shift away from state welfare and regulation, and privatization of public interests. Its core principles are aligned with a "radically free market" (Brown, 2003, p. 1), where economic interests are privileged over that of individuals through an "enhanced role for the private sector" (Humphreys, 2009, p. 320). Navarro (2007) affirms that many of these neoliberal values serve the goals of capitalism, a system that is primarily concerned with the means of production, together with labour and class relations, for the sake of maximizing profit.

Within a neoliberal framework, individual actors are considered free and autonomous agents whose prosperity is largely centered in their independent market performance together with minimal protective welfare measures by the state. These influences obscure the macro-level factors that constrain and impact the capacities of people to thrive at a micro-level, including the devaluation of unpaid or informal work contributions and the absence of an adequate social safety net protecting those who are vulnerable. Western et al. (2007) write that "neoliberalism increases inequality, corrodes quality of life and produces an atomised society in which individuals are culturally disconnected from one another and from fundamental social institutions" (p. 402). In support of diminished government function, neoliberal policies directed at older people tend to shift increasing responsibility for health and well-being to individuals themselves, despite evidence suggesting that larger social factors are a primary basis for age-based health differentials across social groups (Asquith, 2009).

*Medicalization, Social Constructions and Normativity*

The most pervasive theories of aging and disability are biomedicalization and the medical model, both of which take a clinical function-based approach to health. Biomedicalization deems any form of deviation from a clinically healthy body to hold the negative connotation of sickness or frailty (Dovidio et al., 2011; Izaks & Westendorp, 2003; Sloan, 2009). In this way, it aligns with the dialogue of epidemiology and population health, where disease and health outcomes are precisely measured according to physiological and behavioral factors. This privileging of biological health within these discourses obscures social factors and elements of identity that are unique to individuals, thus implying a homogenous experience of aging which may not be reflected in individuals' lived experiences (Powers, 1995; Special Senate Committee on Aging, 2009). Amidst a history of disability as a source of oppression, privilege is assigned to youthful and/or non-disabled or healthy bodies (Overall, 2006). Foucault (2003) writes extensively of the powerful clinical lens, referring to the diseased "patient" in the medical encounter/setting where all other aspects of the self are ignored (p. 16). Yet, opponents of biomedicalization, such as Popay et al. (1998), are highly critical of the limitations presented by scientific paradigms of health, speaking to the extent that empirical social research rarely entails deciphering the "nature of class, identity, social action, and well-being" (p. 621). Opposition to biomedicalization draws attention to the numerous other factors that impact health and aging; those that are obscured by a fixation on function. A focus on biological health fosters perceptions of old age and disability as undesirable life traits, worthy of exclusion and undeserving of equal treatment.

Disability is largely perceived as a term that implies difference. It is a trait that sets one apart from the "ideal." Lennard J. Davis (2006) discusses a scale of normality, where the ideal state of health is one that no one can reach. Davis describes a "bell-shaped curve" representing a

"tyranny of the norm" (p. 6), and his model places those who deviate from this standard at its lower extremities. Davis' scale sends a message of biological superiority: people who are closer to the "norm" are likely to be in more prosperous positions of the social order. This is consistent with neoliberal notions by which those who perform more productively in society are of more value. Negative connotations associated with disability strongly connect with the aged, who are likely to exit working or productive life and/or encounter some form of functional change along the way (Overall, 2006).

The theoretical approach of critical disability is absent from certain aging dialogues. Kittay (2005) argues that disability differs from other forms of oppression that are socially imposed, calling it a "natural source of inequality" (p. 97). Generally speaking, the term disability applies to the minority of the population that is not considered of able body or mind. Interestingly, while disability is seen as a less-typical trait in younger years, it is viewed as intrinsic to later life and a source of societal exclusion at this stage (Boyle, 2008; Priestley, 2003). As a result, the othering of older people based on disability manifests in a different way than it does for younger adults.

Despite the greater acceptance of disability as an excepted occurrence in later life among older adults, it is typically perceived through a lens of presumed decline and loss of function. In this way, the concept of normality also transcends aging discourses. While it is anticipated that older people will eventually reduce their level of societal engagement and/or exit from productive working life in their later years, this is still negatively perceived as burdensome in a market-oriented society. Researchers refer to "normal" life course transitions, "normal" life stages, and/or "normal" levels of functioning at particular numerical ages (Davis, 2006; Gervais, 2011; Priestley, 2000; 2003). Socially accepted norms have come to divide the life course as

such. Many of these ideas align with what are considered to be healthy (young and productive) or unhealthy (older and disabled) bodily states. Out of these limited understandings, a change in thinking is required to comprehend the aging of societies beyond the limitations of biomedicine.

More recent scholarship has led to a shift in thinking towards the use of progressive social theory in the social science literature, as opposed to the clinical and biomedical models described above. The inclusion of social model theory allows for the consideration of larger structural social, political and economic influences upon well-being. Broadly speaking, this scholarly discourse questions the extent to which societal/structural barriers impact individuals at the micro-level (Darling & Heckert, 2010; Kattari, Lavery, & Hasche, 2017; Oliver, 2013).

While medicalization continues to dominate understandings of health and aging experiences, rights-based initiatives have spawned more progressive social model theories within critical gerontology and disability studies. It is here that normatively defined age cohorts and disability are considered a result of external, socially-created barriers rather than individual deficits (Overall, 2006; Priestly, 2003; Rioux & Daly, 2010). For example, one might be disabled by the restrictive parameters of a particular job position or similarly disabled by inaccessible spaces that inhibit physical entry. By this measure, if such barriers are eliminated, the disability is accommodated and full participation unthreatened. Unfortunately, deeply entrenched social categorizations accentuate human differences, making the removal of non-physical barriers (attitudinal, social, economic and others) more complex.

Beyond the socially constructed factors that impede equitable access for older adults, macro-level structures also support age classification methods. According to a report released by the Law Commission of Ontario (2012), numerous state benefits, privileges, societal supports, and milestones are awarded on the basis of chronological age. This system assumes that all

individuals have similar needs at particular stages, homogenizing the overall experience of later life. Here, the uniform treatment of older adults at the policy level emerges as a problematic result of allocating care on the basis of age alone. The highly standardized methods of caring for older adults living in community-based and institutional environments of society, for example, may fail to accommodate the diverse preferences of individuals at a micro-level (Powers, 1995). Gilleard and Higgs (2011) describe disability and old age as sites where personal identity and person-first narratives can and should be fostered. Instead, deeply entrenched systems continue to label and construct later life in a way that fails to recognize unique individual circumstances (Overall, 2006; Priestley, 2003).

Overall (2006) writes of the far-reaching implications of defining what might constitute old age and disability according to restrictive standards, rather than acknowledging that "all bodies experience this process differently" (p. 129). Unlike equality, which implies a level of sameness among individuals, recognition for the differing and unique experiences of people requires an equity stance.[3] Sameness does not imply equity, and in fact can hinder it. Iris Young (1990) speaks to this argument, writing that some groups are already facing greater disadvantage than others in society. Generalizations that assume all individuals come from a position of equal circumstance are dangerous. As a result, to adopt a similar approach to all individuals or groups without accounting for and recognizing their unique differences and disadvantages can be a means of perpetuating inequality. For these reasons, the health and well-being of older people, as well as the experience of aging itself, must be recognized as highly individual. This means

[3] Equity involves the fair and just distribution of resources across social groups. In a health context, reducing or eliminating health disparities is a significant goal of health equity (Braveman, 2014; Marmot, 2007). It is an aim that is best achieved through the implementation of strong protective measures at a systems level, with particular attention given to society's most vulnerable members who are more likely to require additional resources to prosper in ways similar to their more privileged counterparts.

acknowledging the dissimilar circumstances facing certain groups and accommodating needs in accordance with their relative disadvantage. As a term of social and distributive justice, equitable treatment forces systems to recognize the oppression of vulnerable or marginalized peoples – rather than silencing or ignoring them.

Homogenized care and/or treatment of older adults also impacts the ways in which age cohorts interact with each other. Nussbaum et al. (2005) offer that the construction of age categories is responsible for the "structure, function, and possible outcomes of intergenerational interaction" (p. 288). In other words, socially accepted norms that promote the view of old age as a time of decline, or proximity to death, influences how younger individuals treat the old. A highly negative perception of later life therefore has the potential to guide the relationships between multiple age groups, as well as the ways in which different generations interact with one another. Cultural biases are a learned dialogue, and gradual change towards looking at later life stages more favourably, rather than as a time of disadvantage, will gradually lead to more positive attitudes and impact systemic changes in policy and practice (Guan, 2008).

Both the aging and disability discourses are framed by biomedical/social models. Nevertheless, the literature suggests that progressive change with respect to empowerment and advocacy work are seemingly less pronounced in later life contexts compared to that of disability experiences in earlier years. This may be a result of stronger activist efforts among disability rights scholars and individuals than those doing similar work in aging. Disability approaches have evolved to become more positive and empowering. This change is largely due to the efforts of younger people with disabilities, as compared to the efforts of older adults (Gervais, 2011; Priestley, 2003; Putnam, 2002). The discourses of disability that are highly critical of biomedicine are comparatively broader and more inclusive, promoting a holistic understanding

of the experience that is not employed by models of aging which emphasize decline. Kane and Kane (2001), for example, write of the extent to which younger people with disabilities tend to reject being moved into a long-term care facility, fighting instead for supports that allow them to remain active in their communities and partake in advocacy work. Those of younger age groups also may tend to view their situation as hopeful, one in which they have "their lives ahead of them, with aspirations and goals" (p. 118). This is not the case for older adults, who have aged in a society that socializes individuals to see themselves in a stage near the end of life, thus feeling unworthy of such forward-thinking rhetoric and more accepting of institutionalized living (Greenberg et al., 2002; Kane & Kane, 2001; 2005).

Disability rights activism has tended to fixate on autonomy, rejection of biomedical norms, and movement away from stigmatization, whereas later life debates are contrastingly detached and rarely acknowledge extensive disadvantage (Gilleard & Higgs, 2011). This chasm between rights-based thinking and the more dominant, restrictive schools of thought is an important reason for the inequality of treatment between the young and the old. For instance, in Western culture, certain practices that are less acceptable for a younger or middle-aged individual by societal standards—such as the halting of life-saving medical treatment—may be more tolerated with older adults simply because of their age and a constructed perception of nearness to death.

An important first step in improving the perception of these previously negative categorizations of later life may lie in a closer association between the youth-centered disability movement and aging activism. The separation between aging and disability represents a gap that has the potential to change later life dialogues in positive ways. The aging perspective is less present in the discourse of disability-rights than acknowledgement of disability is in the aging

discourse, and this oversight is particularly detrimental to the less pronounced activist cause of older adults (Gervais, 2011; Powers, 2007). While disability is a human difference that inspires activism in earlier life stages, it is such an essential attribute of later life that it tends not to stand out as a feature worthy of advocacy (Boyle, 2008). Many older adults do not directly self-identify as disabled for reasons such as their late stage of life, notions of identity which vary based on the age of disability onset, loss of autonomy, and social categorization.

Because disability is assumed to be intrinsic to the aging process, it is not surprising that older adults have been less likely to be granted the rights to manage their own caregiving, maintain community living, and/or make their own choices (Kane & Kane, 2001; Kennedy, 2000). This has led to the loss of certain freedoms and control over their own lives, whether in community-based or institutional settings. More recently, Guberman et al. (2006) suggest a changing landscape as older adults increasingly desire autonomy from family support, where a greater reliance on outside services is preferable to becoming a "burden" to loved ones (p. 61). As a result of this changing landscape, families and their aging individuals appear to be transitioning towards acceptance of welfare support services that may enhance individual autonomy.

Later chapters of this work suggest a similar sentiment expressed by participants in this study, many of whom described a valued need to maintain their independence. Despite this increasing desire for self-sufficiency, however, advancing age inevitably leads to a heightened need for care/supports for the oldest old, most particularly for those with acquired disabilities. The presence of disability can in fact lessen the desire for independence (Guberman et al., 2006). In Chapter 5, this phenomenon is also explored in conversations with participants in this study. Though ultimately complex, it seems that aging frameworks, which are lacking in representation

in strong rights-based approaches of youth- and adult-centered disability movements, stand to benefit and advance from greater consideration of the intersections between aging and disability. Many aging theories, which "do not consider the cumulative experience of disability," can be applied to disability frames once they are "expanded in scope" to include service gains, autonomy and independent living (Putnam, 2002, p. 802). The inclusion of later life within disability frameworks, and vice versa, would redress an important gap requiring greater attention.

State-level policies do little to amalgamate the mutually informative spheres of aging and disability, instead allocating separate services, supports and accommodations based on disability in younger life stages and by chronological age when one seeks pension and retirement benefits (Priestley, 2000; 2003; Verbrugge & Yang, 2002). For example, the eligibility requirements of certain government support programs for older adults or people with disabilities have minimum or maximum age requirements: a potential source of exclusion if an individual does not conform to normative life stage expectations. Here there is also potential for greater complexity when transitioning between programs as one reaches the numerical age of disqualification for one service and qualification for another, usually between ages 60 and 65, where the process may not necessarily be seamless for service users. In this way, social models of disability can assist social models of aging to garner more expansive rights at the policy level so that smoother service transitions and fewer barriers exist (Putnam, 2002). Powerful forces that preclude the widespread adoption of equitable service policies across the life course largely stem from the influence of marketization (Priestley, 2003).

*Marketization*

Wherever possible, free market discourse encourages productivity and independence while discouraging the use of social supports. The interconnected concepts of independence, dependence and interdependence are important to the dialogue of aging and disability frameworks. Indeed, these concepts constitute a main theme identified within the participant data of this study. Contrary to neoliberal doctrine, people are by nature largely interdependent beings, relying on others and external sources of support throughout their lives (Reindal, 1999; White & Groves, 1997). As Elder Jr. (1994) writes, "human lives are typically embedded in social relationships with kin and friends across the life span" (p. 6). Individuals do not function as beings that are completely detached from one another, yet it is often the case that older people, and especially older people with disabilities, are viewed in a negative and dependent light because of increased need or use of care and/or welfare supports (Cordingley & Webb, 1997; Kittay, 1999).

In aging frames, neoliberalism applies not only in the context of marketization, but also in everyday life experiences, including care needs and daily assistance (Reindal, 1999). As later chapters of this dissertation suggest, there is a strong sentiment to maintain certain freedoms among the community-living older adult participants in this study. In particular, it seems that people are socialized with a strong sense of positivity and even pride in functioning well on their own and without assistance. Dependence is crafted as a highly undesirable state, and a sign that one has become a liability to the system.

Neoliberal ideology is woven into the fabric of our society. White and Groves (1997) speak to the extent that older people become less valued in Western society through a decrease in paid work participation and even privately in the domestic sphere. In this way, young and

middle-aged individuals fear later life and increased dependence as they engage with capital success (Gilleard & Higgs, 2011; Selmi, 2011). This perception obscures the contribution those in the older adult population may have made in their earlier lives prior to formal retirement. Rather than being rewarded for past services rendered, their focus becomes the inability to contribute in one's older age, and it is likely that their contributions are measured on a norm that is applicable only to younger citizens. The assumption of disability in later life only adds to an already high level of negative scrutiny in the free market. The extent to which disability is considered grounds for dependence on state supports, and acts as an inhibiting factor in active labour participation, doubly impacts older people who are already perceived as a significant burden to the economic system because of their age. These dominant ideologies of independence/dependence perpetuate negative attitudes towards certain individuals and social groups in society. Through this, ageism and ableism thereby emerge as negative forces that discourage and ostracize those who act as a continued "burden" on the system.

*Ageism & Ableism*

Ageism was first described by Butler (1969) who writes of "a deep-seated uneasiness on the part of the young and middle-aged, describing a personal revulsion to and distaste for growing old, disease, disability; and a fear of powerlessness, uselessness, and death" (p. 243). Age discrimination is hence defined by the fears associated with becoming older and nearing the end of life, fueling prejudiced and negative perceptions of later life (Nelson, 2005; Nussbaum et al., 2005; Priestley, 2000). The universality of the aging process influences the broad acceptance of ageist oppression (Cuddy & Fiske, 2002; Nelson, 2011). Ableism is similarly grounded in societal fears, where disability becomes an object of exclusion and stigma as well as a "dreaded condition" worthy of devaluation (Dovidio et al., 2011; Selmi, 2011, p. 23). One is most likely to

acquire disability in their later years, meaning that much of the age discrimination they face intertwines with ableism and what is perceived of as a diminished capacity to participate, both intellectually and physically.

For example, people commonly associate memory loss with old age (potential grounds for ageism in the work force), or it is often assumed that older people are not skilled to drive motor vehicles (representing a significant loss of independence for some). In many instances, we are socially conditioned to assume that older adults are incompetent because of deeply embedded ageism and ableism in the very institutional fabric of our society. Intellectual disabilities in older adults, particularly Alzheimer's and Dementia, are among the "most stigmatized impairments" (Blanck, 2011, p. 54). These socially accepted notions perpetuate ideal body norms, hold all individuals to the same standards, and reinforce the view that natural human traits associated with aging are burdensome and worthy of stigma (Overall, 2006). There is further evidence of older adults transferring this prejudice from youth into their own later lives (Kane & Kane, 2005; Levy & Banaji, 2002; Nussbaum et al., 2005; Sousa, 2013). Tolerance of ageism and ableism therefore stems not only from their universal applicability to all individuals across social groups, but the extent to which the self-imposed ageist/ableist feelings of older adults themselves hold prevalence (Levy & Banaji, 2002). The unfortunate result of this internalized ageism is that many older adults are unlikely to question poor treatment or stereotypes that may negatively impact them, believing that it is warranted or deserved (Nelson, 2002).

A lowered sense of self-worth in older adults is strengthened by the prejudice of professionals, particularly in medical and care contexts. As already explored in this chapter, old age and disability are largely defined by biomedical norms. The literature indicates that acute and long-term care settings are among the most significant sites of ageism and ableism

(Gallagher et al., 2006; Kane & Kane, 2001; 2005; Overall, 2006). In such settings, the "patient" or recipient of care is often in a subordinate role while the care provider is authorized to label and treat the individual. Here, a power relationship places the former at a disadvantage, made worse when an older "patient" receiving acute care is seen in a negative light of presumed illness, closeness to death, and/or incompetence (Nelson, 2011; Robb, et al., 2002). This often has a damaging impact on care, as ageist practices fail to cater to the diverse needs of older adults (Gervais, 2011; Kane & Kane, 2001; Ory et al., 2003).

This leads to the inevitable issue of compromised care of older adults, and more importantly, the negative impact of biomedical treatment where individuals may further internalize a sentiment of decline. The medicalization of care encourages ableist and ageist thinking by focusing on curative methods, seeing the problem in the individual rather than society at large. Yet, in order to foster a "healthier" older adult population, the solution seemingly involves combatting ageism at a systems level. Ory et al. (2003) describe ageism as an "insidious condition that dilutes the potential for successful aging" (p. 170). They further contend that a solution to ageism requires "strategies directed at all segments of society, including older adults and their caregivers, policy makers, and the population at large" (ibid). Their research reveals another source of tension between the role and influence of macro-level structures, as they intersect with individual choice and agency. As such, the core language of successful aging evolves as a method that discourages dependence at a systems level, encouraging a model of individualism. It is a highly contested approach that has stimulated scholarly discussion.

## Successful Aging

Successful aging is the subject of significant debate and varied perspectives in the literature. In this section, I explore meanings of successful aging in scholarship. This background functions as a frame for this dissertation, in the sense that it complements understandings of successful aging expressed by the participants in this study. Here I draw upon founding definitions within the biomedical literature as well as more holistic approaches to positive aging which move away from the limitations of function-based models (Asla et al., 2006; Bowling & Dieppe, 2005; Clarke & Griffin, 2008). Following this, I speak to the tensions between structure and agency as these shape life course events and influence old age experiences. Finally, I consider the role of gender in these dialogues, not only as a very relevant factor of consideration in later life discourse, but also as a poorly-described facet that is underrepresented by a number of prominent successful aging theories (Calasanti & Slevin, 2001; Liang & Luo, 2012; Martinson & Berridge, 2015). Where more dominant neoliberal and patriarchal models of successful aging privilege the young, able-bodied, male and paid worker, feminist approaches require researchers and policy makers to look beyond this limited scope (Cruikshank, 2013; Liang & Luo, 2012). Gendered analysis urges us to consider the "multidimensional" facets of difference in a way that non-feminist thinkers do not (Hankivsky et al., 2010, p. 3). In this section I engage with these themes, highlighting the need for stronger representation of the oldest old—many of whom are women—as a contributive voice in these conversations.

### *Successful Aging: A Cacophony of Conflicting Opinions*

Over the last three decades, successful aging has become a cornerstone theory of gerontology. The foundations of the model are most associated with the MacArthur studies, undertaken in 1988, which aimed to explore and consolidate meanings of successful aging. The

MacArthur studies were proposed and conducted largely through a lens of biomedicine. In summarizing the results, Rowe and Kahn (1997; 1998) arrive at a highly contested definition of successful aging that continues to be the source of significant debate in gerontology literatures. Their definition supports a scientific paradigm of health and aging across the life course which ascribes privilege to high function (Crowther, 2002). Within the framework developed by Rowe and Kahn (1997; 1998), three fundamental requirements of successful aging are identified. First, the absence of disease or illness; second, an absence of disability—both physical and cognitive; and finally, the importance of an active engagement with social life—either through paid or volunteer work (Crowther, 2002; Motta et al., 2004; Rowe & Kahn, 1997). This framework very much engages with earlier-discussed notions of normativity, drawing a distinction between usual and successful aging (Rowe & Kahn, 1987). Signs of usual aging include normative and expected signs of decline at a particular age. In other words, becoming older with a biologically predicted level of decline at a particular stage denotes a label of usual aging. Conversely, to successfully age infers a lack of disability and/or a higher than average level of function for one's age (ibid). In essence, this label of being a successful ager is given to those who exceed biomedical expectations of physical and cognitive performance. Through ascribing such privilege to being able-bodied, this perspective invokes an ableist interpretation and sentiment.

As established previously, neoliberal ideology favours traits that enable individuals to participate as productive citizens. For this reason, Rowe and Kahn's (1997) original conception of successful aging has become the subject of numerous opposing views for the multitude of facets that it is missing. As such, an important gap emerges in literatures with respect to our understanding of the extent to which those aging *un*successfully, who do not meet the normative standards of performance held by their younger or more privileged counterparts, are excluded

from the dialogue or seen in a negative light (Glass, 2003). To measure success requires uses of language that can be deemed exclusionary, as it applies a normative standard to a highly individual process. By definition, success is described as "reaching one's potential, being productive, achieving individual accomplishment, and, for the elderly, exhibiting behaviors that resemble those of young people" (Pecchioni, Ota, & Sparks, 2008, p. 172). This definition suggests successful aging is a truly arbitrary measure and a rather narrow view of the human experience.

Successful aging further reveals itself as a model whose assumptions about some level of control over aging processes overlap with the anti-aging movement (Flatt et al., 2013). In other words, the successful aging model can be a mechanism to halt what is considered an inevitable and highly negative aspect of decline in later life. The shared rhetoric between anti-aging and successful aging is concerning, emphasizing "some of the most problematic social, cultural, and economic consequences of efforts made to reconceptualize old age" (Flatt et al., 2013, p. 1). In this statement, deeply embedded, dominant dialogues of discrimination and oppression about later life interpret it as a stage to be avoided and feared. Together with this perception, social norms also have a tendency to promote avoidance of the aging process at all costs, viewing this as a tragic phase of life where one is no longer independent, where independence is a most valued commodity in free market enterprise (Minkler & Fadem, 2002; Nelson, 2011). Neoliberal society, where youth and productivity are tantamount, fosters avoidance of the aging process, thereby encouraging individuals to take action in support of staying young for as long as possible. This may manifest as efforts to remain active in societal roles through paid or unpaid work, as well as compensating for loss in function or some form of acquired disability, and even pursuing anti-aging treatments or clinical methods to stay "young."

Hence, underlying tones of ageism and ableism are evident in the dominant discourse, to the extent that older adults are negatively categorized for not conforming to the standards of their younger counterparts as well as Othered for reasons of physical or cognitive disability. Angus and Reeve (2006) extend this thinking, speaking to a newer form of ageism that seems to have emerged in place of previous broad fears of becoming older, to newfound reservations about becoming older with an acquired disability. This ableist perception resonates throughout Western culture.

While it is evident that youth, ability and productivity are held in high regard within Western capitalist models of societies, many Eastern cultures believe the opposite: old age is synonymous with wisdom and a time worthy of reverence and respect (Gallagher, 2012; Pecchioni, Ota, & Sparks, 2008; Wong, 1989). One prominent criticism of Rowe and Kahn's (1997) original successful aging philosophy lies in its Western cultural bias, where its dissimilarities from Eastern and other cultural contexts make the framework far from universal in its claims (Wong, 1989). Aligned with a more communal perspective, East Asian cultures in fact reject Western notions of individual responsibility for aging well in favour of familial relationships where caring for the health and well-being of older adults is a shared duty (Lin, 2015). Hence, what might be considered successful aging in one particular culture or context may hold an entirely different meaning in another.

There is a great level of responsibility at a systems level to include older people and account for their experiences as this does most certainly have an impact on cultural frames of understanding. Most successful aging literature views disability in an ableist and exclusionary way as well as being inevitable with increasing age. Minkler and Fadam (2002) emphasize that for older people who acquire disabilities to truly remain actively engaged in their later lives,

additional social supports and mandates must be implemented at the level of policy and government to strengthen the capacity of such individuals to participate.

If one were to assess two individuals who have completely dissimilar experiences with disability, it would be challenging to determine their level of success in a comparable manner because disability fosters a wide spectrum of subjective lived experiences. Disability experiences include sensory, mobility, and cognitive elements that manifest in a myriad of different ways. A holistic understanding of disability experiences can only be adequately captured through an investigative approach that seeks to learn about diverse social experiences (Bowling & Dieppe, 2005). Due to this complexity statistical investigations reduce understandings of later life to a quantifiable worth, when in fact there is much more to be discovered about aging experiences through qualitative inquiry, as I have endeavoured to pursue in the present study.

In their mixed-methods study, Von Faber et al. (2001) found that the quantitative element of their work garnered a response that was more aligned with biomedical perspectives of health, where a function-based analysis revealed a higher number of unsuccessfully aging candidates in the sample. Interestingly, the qualitative interviews conducted indicated a noticeably higher degree of participants who subjectively considered themselves to have aged successfully, through their adaptation capacity, despite failing to conform to the dominant public health framework (ibid). With the limitations of scientific/statistical paradigms of successful aging, a greater need to include the voices of older adults themselves emerges in the literature.

In response to biomedical and neoliberal formations of health and aging, several gerontology scholars endorse the importance of exploring subjective measures. Studies have been conducted to ascertain the validity of Rowe and Kahn's criteria for successful aging, as it is reflected in the responses of older adults themselves. In the work of Strawbridge et al. (2002),

the authors aim to understand the extent to which older adult participants deem themselves to be aging successfully, and whether they conform to the three standards provided by Rowe and Kahn. Strawbridge et al. (2002) discovered that half of their sample considered themselves to be aging successfully, despite not meeting these stipulations. On many levels, this suggests that successful aging is a deeply personal and individual phenomenon that occurs along several trajectories. More importantly it also indicates that disability is not necessarily the limiting factor that biomedical understandings tend to convey, when lived experiences are explored fully.

In later work, Bowling (2006) found that many who experience functional decline and/or losses aligned with Rowe and Kahn's three categories did not necessarily feel that they were unsuccessful agers. These contradictions showcase the need to further investigate the factors that older people themselves use to gauge a positive or negative aging experience. For some, a strong bond with children or family may sustain them, whereas others may look to financial security, spirituality, or a social network to maintain their well-being in later life (Asla et al., 2006; Chatman, 1992; Perkins, 2014; Wong, 1989).

Romo et al. (2013) support the value of capturing these subjective factors and using them in clinical and other such interventionist realms, thereby allowing older people to age successfully in alignment with their own values and standards. There are certainly numerous possibilities for success and happiness in later life outside of the strict parameters of function and physiology (Fagerström & Aartsen, 2013; Pruchno et al., 2010; Rubinstein & de Medeiros, 2015). Scholars speak to this by looking to historical factors over the life course, such as trauma or difficult events, that may have an impact on one's perception of later life success (Rubinstein & de Medeiros, 2015). Other subjective factors include cultural connections, living circumstance, social locations and the quality of relationships (Iwamasa & Iwasaki, 2011;

Martinson & Berridge, 2015). Much of the critical literature supports the conclusion that health and well-being in later life are dependent on a wide scale of factors that extend far beyond biology, entailing numerous social, political, economic, and structural forces (Dillaway & Byrnes, 2009; Ng et al., 2009). In this regard, the tensions between structure and agency continue to play an important part in the conversation.

*Structure and Agency*

The influence of structural forces versus individual autonomy or choice is highly relevant in the contexts of both health and aging. Liang and Luo (2012) posit that the interactions between these mechanisms provides an avenue through which later life meanings are constructed. It is therefore the relationship between structure and agency that largely governs the direction of one's experiences across the life course and informs the social norms that dictate our understandings about old age. The homogeneous model supported by dominant successful aging dialogues fails to adequately capture the heterogeneous nature of human agency on a truly subjective level (Liang & Luo, 2012).

The onus placed on the individual within the framework of successful active aging is highly limited. Because neoliberalism promotes a model of continued individualism, it is an ideological stance that obscures the true impact of larger structural forces as an inhibiting barrier to success in later life. The neoliberal agenda has in many ways caused a separation between the expectations of individuals and that of collective society and the state. Rubinstein and de Medeiros (2015) write that "there is a radical separation of person from society within the brand of individualism formulated under *the ideology of* neoliberalism that masks the influence of social forces and cultural constructs on individuals" (p. 37). Hence, avenues for success and prosperity in later life and throughout the life course become a potentially unattainable status for

those who cannot overcome their disadvantage. The pervasive effects of an expanded free market, where the responsibility to succeed is promoted as the sole responsibility of citizens, frees the state from developing stronger welfare-centered supports to bridge inequality.

As stated earlier, marketization is a phenomenon that most certainly impacts the health and aging of societies. Neoliberal ideology supports the notion of individuals as producers and assigns privilege to paid work contributions. Centering the discourse of successful aging on individual lifestyle factors is an important oversight that does not adequately account for the effect of these larger structural influences as central to the process (Stowe & Cooney, 2015; Wilkinson & Ferraro, 2002). It is imperative to acknowledge here that the structure/agency debate turns on the location, context, and concentration of power relations. Individuals do make active choices throughout the life course, but these decisions do not take place in a vacuum: they involve a complex process and are very much subject to external pressures.

Consider, for example, the range of choices available to an individual who is born into a low-income family. One is more likely to proceed through a childhood of vulnerability, with likely fewer opportunities available to them as they become older than one raised with economic privilege. If one were to trace the lives of such individuals into later years, these differing socioeconomic circumstances would impact later health. It is exceedingly difficult to rise in the social hierarchy of wealth and success in old age if one was without advantage in their earlier years (Law Commission of Ontario, 2012; Rubinstein & de Medeiros, 2015). In a study across several European welfare states, Brandt, Deindl and Hank (2012) found that “unfavorable childhood conditions exhibit a harmful influence on individuals’ chances to age well” (p. 1418). Minkler and Fadem (2002) further support this notion, speaking to the extent that external factors, including an inaccessible environment and low income in early life, led to increased

disadvantage in old age. In these ways, examining late life as a culmination of life course experiences allows for the observance of processes that happen over time and accounts for the extensive cultural, socioeconomic, historical, structural or individual influences that present themselves along numerous different trajectories (Daly & Grant, 2008; Stowe & Cooney, 2015). These processes occur at a macro- and micro-level and are continually changing and evolving, rather than remaining static. They are made even more complex as they intersect with multiple layers of interacting identities. In the context of this study, gender is a most critical feature of identity that holds a defining and complex role throughout all life stages, and especially so in later life, yet the effects of gender are inadequately captured within dominant successful aging discourses.

*Gender and Successful Aging*

Gender is a highly significant aspect of aging work. It is a particularly important consideration in this dissertation, where, as presented in Chapter 6, both female and male study participants indicated differing life course experiences that directly correlated with gendered roles and constructs of gender. The tendency of women to live longer than men means that they are more likely to live among the oldest old. As Diamond (1992) notes of very late life: "[T]his social class journey is traveled primarily by women…it is probably less precise to use the term *people* than *women* and *men*" (p. 66). The complexities of gender are hence deeply intertwined with later life. It is well documented that because women outlive men, they are therefore more vulnerable to old age disadvantage through increased stereotyping, likelihood of widowhood and institutionalization, and other social factors including unemployment, poverty, and poor literacy (Diamond, 1992; Nussbaum et al., 2005; Priestley, 2003; Sharpe, 1995). Men are also more likely to enjoy privilege in the free market system, where their paid work is valued throughout

their adult lives, while women's unpaid care work is largely devalued and often made invisible (Daly, 2013; Day, 2013; Sharpe, 1995). Such factors have a negative impact on the lives of older women. Throughout the life course, the later life experiences of men and women are varied and diverse, leading to different trajectories into late adulthood.

In successful aging literature, several theorists concur about the importance of gender differentials and the extent to which they are not sufficiently described by dominant frames of reference (Calasanti & Slevin, 2001; Cruikshank, 2013; Katz & Calasanti, 2015; Liang & Luo, 2012). Theories of successful aging which originally developed under Western notions of patriarchy are severely lacking in inclusivity. These normative understandings position men who are White, able-bodied, and middle class as being more easily able to attain and personify the privileged status of success (Cruikshank, 2013; Liang & Luo, 2012).

Mainstream views of successful aging, therefore, do not account for the widespread diversity of opportunity and experiences that gender entails. Pruchno et al. (2010) write: "That women experience more chronic conditions, greater pain, and poorer functional ability highlights the importance of including gender in future conceptual and empirical research regarding successful aging" (p. 677). This illustrates the extent to which the health experiences of women are uniquely different from men and worthy of further exploration. A history of vulnerability to certain risk factors throughout the life course will therefore inevitably have a significant impact on women's later years. Gendered experiences impact women's lives at each stage of the life course and influence their ability to successfully age. In order to understand gender disparities in later life, particularly among the oldest old, it is important to explore the life course trajectories of women.

Feminist scholars add a richness to gerontological literature by acknowledging the role and contributions of women throughout their lives, particularly in the private and domestic sphere, where their work is largely undervalued in the free market system. Throughout the life course, women typically assume the role of caregivers in the family, conforming to particular and expected roles (Moen et al., 1994; Tong, 2009). Patriarchy supports this notion of defined gender roles that place the male as the principal provider and associates the responsibility of the home and family with the female (Marshall, 2000; Tong, 2009). In this regard, Moss (2002) refers to women as "producers of human capital," where their work in the home, raising and caring for their children has market value through the maintenance of good health for the family (p. 654). These tasks have an impact on their function outside of the home, as their paid working lives are linked with conflicting responsibilities within the home. After domestic efforts made throughout their lives, the level of dependency for older women also grows later in life. Here there is also great potential for fostering an increased reliance of women on their male partners for economic support. As described in Chapter 6, this was a noted factor in the dialogue of a number of female participants in this study.

Women also function in a society that forces them to intermittently interrupt their professional lives for the sake of childbearing and childrearing, therefore putting them at a competitive disadvantage if and/or when they eventually do re-enter the work force (Calasanti & Slevin, 2001). As a result of this sporadic workforce participation, older women do not tend to garner the same financial benefits as those accrued by older men, who are more likely to have worked regularly without interruption throughout their lives. Older women who are far less inclined to have held paid work positions are in a potentially more vulnerable economic and social position upon reaching the age of retirement (Armstrong & Armstrong, 2010). This

situation fosters economic dependence in later life and arises from established political norms associated with women and paid work.

Neoliberal free market enterprise provides little accommodation for women who are faced with dual obligations in both the private and public realms. Once again, the tensions between structure and agency are evident, where successful aging through a gendered lens must consider the varying constraints that inhibit the life choices of women. The detrimental influence of larger patriarchal systems that makes it difficult for women to exercise their own agency or assert themselves throughout the life course is absent from successful aging discourse (Misra & Akins, 1998; Wharton, 1991). This phenomenon further reinforces gender norms and roles, giving little or no attention to the potential for welfare state mechanisms to share in care work responsibilities, which would thereby provide women with the opportunity to make different choices. Even social supports that are geared towards women by the state are discussed by some scholars as merely mechanisms that indirectly foster and strengthen neoliberal ideals and gender norms (Misra & Akins, 1998; Moss, 2002). The argument here is that by providing welfare supports to women, who are then given the means to more easily fulfill domestic and care responsibilities, they are still faced with the expectation of maintaining the structure of the family (ibid). The production of labour, and continued growth of the economic state relies upon the strength of these familial dynamics and the care work of women.

In the public sphere, the biological superiority applied to men by medicine translates into significant disadvantage for women within free market society. Reed (2005) writes that "the male body has served as the normative model for the construction of the concept of healthy" (p. 73). Here the implication is that the masculine form represents the "normal" body state. The implications of this are profound, as indicated by Cruikshank (2013) and Martinson & Berridge

(2015), who caution against the uniform standard that this message promotes. Of greater concern are those that do not fit within the narrow parameters of this persona and who are therefore at increased risk for poorer outcomes in later life. While prominent successful aging theories do equate biomedical health with success, as previously established, they also fail to adequately recognize the superior position ascribed to men in this regard. In assigning ideal health status to the masculine form, women are automatically placed at a biological disadvantage to men, just as Doyal and Pennel (1979) indicate in their discussion of the medical model in the context of gender. This subordination of feminine identity by medicine is one that is reflected in the way womanhood has evolved as a state worthy of devaluation and control.

The aging feminine body is the subject of even further devaluation when combined with medicalized understandings of old age that focus on illness and a state of decline in the final stages of life (Lindauer; 2003; Powell, 2006). Here, ageism and ableism intersect with gender-based discrimination, all of which are present in successful aging discourse. In recognizing this, numerous scholars advocate for stronger representation and inclusion of minority voices and perspectives in the theoretical framework (Calasanti and Slevin, 2001; Perkins, 2014; Pruchno, 2015). Biomedical marginalization is something shared between experiences of aging, gender and disability, all of which are identified as important themes in this study. Liang and Luo (2012) write that “for the elders in disadvantaged social locations, they are more likely to be the victims of the mainstream successful aging ideology” (p. 328). These limitations only become more pronounced when examined in the context of the oldest old, who are statistically more likely to be women, and whose experiences are unique from younger older adults.

*The Oldest Old*

Another identified limitation occurring within the literature of successful aging conversations is the lack of attention given to the oldest old. There are few studies that concentrate on this age group (Martin et al., 2015), and far fewer that apply qualitative methodologies. As a result, much of the existing scholarship in this area has a biomedical perspective that continues to ascribe privilege to function. As has been emphasized throughout, the implications of such ableist views are not only cause for more limited interpretations of later life, where numerous factors outside of the individual are obscured, but also a strengthened perception of homogeneity in old age experiences together with a resultant failure to appreciate diversity at this stage. For the oldest old, especially, it is commonly assumed that with increasing age they are far more likely to be unsuccessful in their aging due to inevitable disability. Baltes (1998) notes significant functional distinctions among the oldest old, compared to other groups, recommending that this be named "the fourth age" (p. 411). This categorization is problematic, however, as it assigns a normative label which ultimately limits our capacity to value diversity in aging processes. In a related vein, Motta et al. (2005) surmise that the oldest old who try to maintain a high level of activity and professional engagement, do so to compensate for age-related functional decline. Once again, the emphasis lies in ensuring that individuals maintain "productive social or working activity" (p. 249).

In opposition to these dominant medicalized perspectives, Von Faber et al. (2001) describe the "disability paradox," where nearly half of their oldest old participants expressed feeling an "optimal state of well-being" despite the presence of disability in their lives (p. 2699). The authors reason that perhaps in knowing that they are likely to experience some form of acquired disability, older adults compensate by developing other subjectively defined avenues

for their success (ibid). Further to this, it may be the case that very old adults who have experienced many years of decline and/or loss over a lifetime are better equipped to maintain a certain level of well-being because of previously developed coping skills (Cho et al., 2015). In this sense, there is validity in exploring the personal adaptive mechanisms of individuals as they become older.

Though the focus in literature seems to primarily attend to the individual, also worthy of investigation is the extent to which the efforts of the oldest old to age well may be constrained by external or structural factors. In alignment with the identified tensions between structure and agency, one significant conclusion of the Berlin Aging Study is that the level of decline experienced by the oldest old who are "resource-rich" is not as acute as those who are less privileged (Baltes, 1998, p. 414). From this inference, the question of resource allocation arises, as we explore how individuals attain equitable access to needed provisions in later life. To do so, we must certainly look to the influence of larger systems that impact the socioeconomic position of individuals, as well as the allocation of goods and services. Yet, these neoliberal contexts continue to be obscured by person-centered models. Asla et al. (2006) engage with this notion, recognizing the limitations of theoretical models that maintain an exclusive focus on "the individual in the context of their environment" (p. 56). Once again, the onus is placed on micro-level choices, rather than external forces, to abide by neoliberal performance ideals with very little emphasis on how older adults may otherwise be supported by macro-level means of assistance. Johnson et al. (2015), encourage policy makers to look to structural/macro-level forces in their assessment of later life experiences. This provides further support for expanding our empirical knowledge of both subjective aging measures and their related structural causes. Alongside the sense of individualism that is salient within meanings of successful aging, it seems

that the related concept of Active Living is one that also holds important implications for aging policies and practices.

## Active Living in Later Life

The notion of Active Living strongly connects with successful aging discourse, in that both support continued engagement with social life. It is particularly relevant to this dissertation as the chosen research site in this study offers programming oriented towards living an active lifestyle and the social participation of older adults. Many aging policy dialogues seemingly use the language of Active Living with certain underlying objectives that are aligned with neoliberal paradigms. Bercovitz (1998) notes the similarities between the discourses of Active Living and health promotion, positing that both fixate on notions of "lifestyle, empowerment, community, and collaboration" (p. 320). As we enter a time when people are living longer and well into their later life years, Canadian public policy is increasingly shifting towards these goals. In this section, I explore policy contexts and other perspectives of Active Living as they relate to later life discourses. I also note criticisms of the Active Living framework, many of which are analogous to the limitations of successful aging. Finally, I examine the links between doctrines of sustained Active Living and the SDOH model, in relation to larger macro-level agendas. In doing so, I rely upon the work of Raphael (2008; 2009) and others to illuminate the important questions of how resources are dispersed across the life course, and who is given priority in the allocation of goods and services. It seems that the Active Living agenda has much to gain from SDOH perspectives that draw attention to systemic disadvantage alongside individual constraints.

*Active Living: Critical Perspectives and Policy Contexts*

At the core of Active Living philosophy is, in the most simplistic sense, the continued maintenance of physical activity. In this way, Active Living presents as both a lifestyle and a policy initiative that is highly complex in its meaning. In many regards, the agenda put forth by this doctrine is analogous to that of successful aging frameworks (Sargent-Cox et al., 2015). There are several theorists who consider an active lifestyle to be synonymous with the ability to age well or successfully. Research supports that maintaining high levels of physical activity over a long period of time strongly equates with high levels of successful aging, whereas remaining sedentary correspondingly garners unsuccessful results in older people (de Rezende et al., 2014; Dogra & Stathokostas, 2012). This perspective aligns with that of clinically-based health definitions.

Bercovitz (2000) further extends these medicalized definitions of Active Living discourse, describing it as a notion that "seeks to address additional dimensions of well-being and quality of life, and looks at the process of physical activity (i.e. the entire physical activity experience) rather than strictly its physiological outcomes" (p. 20). Here the suggestion is that multifaceted benefits may be garnered from committed levels of activity. Over the last 20 years, an active aging movement in Europe is reflected at a policy level. Here, unlike the successful aging doctrines of the United States, a life course approach to Active Living has been implemented that engages with policy, organizational, societal, and individual action (Foster & Walker, 2015). In practice, however, Foster & Walker (2015) conclude that the model has failed to achieve these goals, and the result is a program dominated by economic parameters that privilege productivity and the extension of paid working life. This "productivist straightjacket within which the active ageing concept is confined" supports the underlying message that those

who maintain an active stance are not only helping themselves by partaking in healthy behaviors and lifestyle choices, but also benefitting the state and society at large (Walker & Maltby, 2012, p. S128). This sentiment is repeated in policy contexts of Canadian Active Living initiatives a notion I explore further in Chapter 5. In this regard, it can be said that the policy message of Active Living is actually a form of proposed solution to fiscal retrenchment of the welfare state (Bercovitz, 1998). In essence, the message shifts to one that encourages individuals to take responsibility for their own health and livelihood rather than imposing this duty on the public social system. Human capital hence continues to hold greater value than the human condition.

One can also look to who is missing from the Active Living debate. It is clear, for instance, that people characterized by one or more traits of disability, old age, femininity, or social class, all of which are minority voices, may not have access to the continued maintenance of active routines that are allowed by more privileged conditions. In this regard, Active Living is most easily sustained by those who conform to ideal body norms of masculinity, youthfulness, and being able-bodied. Just as it is observed that those who are wealthier tend to attain better health outcomes (Frohlich et al., 2006; Raphael 2012), maintaining high levels of activity and exercise becomes a luxury that is more possible through privileged socioeconomic circumstance. On this point, another limitation of Active Living emerges, where there is a failure to recognize the barriers facing underprivileged individuals who lack the time and funds to partake in it. Worse, older people who are in poor health and unable to actively engage due to their systemic disadvantage are perceived of as a “double burden” not only because of their inability to economically contribute as producers, but also for their increased need for public assistance (Foucault, 2003, p. 20). Dependence on welfare mechanisms is frowned upon and discouraged in the promotion of independent and active lifestyles. Older adults are further expected to assume

some form of productivity, as is encouraged in successful aging doctrines, or risk ageist/ableist labels associated with being unproductive and/or unsuccessful. Baltes (1998) writes of the ableism evident in notions of "active life," supporting the conclusion that more highly sustained levels of engagement in activity results in prolonged levels of "competent living" (p. 2). The use of "competence" here implies ability, associating the failure to participate in a productive capacity with disablement.

Health practitioners and service providers do little to dispel these abeliest/ageist stereotypes. In clinical encounters, for example, it was found that physicians operate under a belief of presumed decline when treating older adults and are therefore more likely to encourage physical activity in younger people than the aged (Ory et al., 2003). Agents of public services similarly indicate ageist treatment of older clients "by being unaware of their needs and covertly or overtly restricting services" (p. 166). In the midst of these problematic realities, it also becomes clear that with an almost exclusive focus on physical activity, cognitive or intellectual experiences represent a significant gap in the literature. By prioritizing physicality in Active Living discourse, we lose an important focus on less-visible disabilities that also require inclusive measures of support. Walker and Maltby (2012) speak to the dangers of ignoring certain groups, particularly the "frail elderly," when mobility is over-emphasized at the expense of mental health in policy-oriented discussions of old age (p. S128). It is here that the model of Active Living may benefit from the holistic stance of a more inclusive framework in the SDOH, encouraging a multifaceted approach to health and aging outcomes that accounts for numerous forms of systemic disadvantage.

*Social Determinants of Health and Aging*

A social determinants of health (SDOH) model deconstructs behavioural notions, placing the responsibility for the health and wellness of individuals on larger systemic sources. The framework supports a reframing of individual-centered policies which indicate that "critical perspectives on lifestyles are lost in the successful aging literature because individual choice is reduced to decontextualized health-relevant choices such as smoking, diet, and exercise" (Katz & Calasanti, 2015, p. 29). Rather, SDOH supporters are concerned with the unequal distribution of societal resources, social hierarchies, as well as access (or lack thereof) to goods and services (Raphael, 2008; 2009). Here, the conversation shifts towards factors that inhibit certain individuals from enjoying a standard of living equal to that of more privileged groups in society. In an aging context, emphasis is placed on poverty, income inequality, gender, and disability as particularly significant social facets of concern in later life (Special Senate Committee on Aging, 2009). Research evidence supports that better access to education, housing, financial supports, and other such SDOH are all salient mechanisms connected with aging well or successfully (Ng et al., 2009). Through its focus on widespread social contributors to disadvantage and oppression, the SDOH reveal that which is largely hidden by frames of Active Living and successful aging.

As previously stated, intersectional analysis is largely absent from Active Living discourse. Yet, older adults are already often characterized by the marginalized facets of gender, race, disability, sexuality, etc., with a likelihood of low income and increased reliance on state benefits. These individuals are therefore particularly vulnerable to compromised access to goods and services, as well as poor living conditions (Esqueda, 2011). The prevalence of intellectual disability among older adults is also worthy of note when considering this reality, given that

these are some of the most vulnerable individuals in society. It is often the case that intellectual disability, as a highly stigmatized trait, is characterized by a severe lack of access to even the most basic SDOH (Blanck, 2011). This is also a known barrier for many older adults.

Much of this marginalization is centered in the reality that social supports and societal advantage are very much dependent upon productivity and one's ability to partake in wage labour: a dominant perspective that fails to acknowledge minority groups who consistently encounter barriers. In neoliberal economies, state welfare supports are limited for those who are considered unproductive citizens. The resultant perception of older adults as burdensome, for their dependence on social assistance, ultimately marginalizes service users. In recognizing the increased needs of vulnerable persons, SDOH supports strengthened welfare mechanisms akin to those which have been implemented in social-democratic countries such as Sweden. This system allows individuals to enjoy essential services, including health and other welfare mechanisms, regardless of their market performance (Coburn, 2004; Esping-Andersen, 1990). In these societies, welfare benefits are established by the state and provided to citizens through the formation of equitable government policies and supports. This is at odds with dominant neoliberal models that privilege marketization, and a lesser role of state interference for the sake of economic progress.

Amidst this competitive climate SDOH encourages a significant focus on life-long access to resources, so that disadvantage is addressed holistically from the early stages of life. Research suggests that childhood poverty and experiences in younger years can have a life-long impact on opportunities and health later in life (Raphael, 2009; 2010). It would seem near impossible for a person who has spent the majority of their life in an impoverished position to suddenly attain privileged means in a later life stage when they are even more likely to meet numerous barriers

to progress. This notion is particularly relevant to the oldest old, who are especially vulnerable to poverty, disability, gendered-based oppression, and other such sources of marginalization. Baltes (1998) discusses the extent to which older adults who lack resources are far less likely to maintain heightened levels of activity. Further to this, she posits that sustained daily activity is associated with greater life satisfaction (p. 2). Barriers to access therefore present as an inhibiting force against opportunities for positive later life outcomes.

Moving forward from these difficulties is a task for policy makers. A most important priority in this endeavor will be to ensure that the voice of the individual is not lost amidst that of dominant collective interests. Currently, the approach of most policy endeavours seems to be the adoption of uniform measures that facilitate an aging lifestyle which is both active and successful. Given the diversity of aging populations, a more fitting objective should be one of inclusion. Societal access to "education, employment, quality housing conditions, healthy food, and recreation" are clearly structured in a way that marginalizes groups with less privilege (Martinson & Berridge, 2015, p. 62). Part of changing this landscape involves expanded discussions which entail a far greater focus on non-medical social causes of poor health. According to McGinnis et al. (2002):

> The health of populations is the product of the intersecting influences from … different domains, influences that are dynamic and that vary in their impact depending upon when in the life course they occur and upon the effects of preceding and subsequent factors. (p. 80)

The inclusion of a SDOH perspective across the life course is hence critically important to challenging dominant perspectives that are deeply entrenched with the language and philosophy of medicalization. Ultimately, positive later life outcomes that adequately meet the diverse needs of seniors will depend upon widespread systemic changes that manifests at both macro- and micro-levels of society. It is only once solid mechanisms towards this goal are in place, that

ageist/ableist meanings of successful or active aging will no longer dominate the ways that we envision later life.

## Conclusion

Aging research stands to benefit greatly from the inclusion of disability and gender as holistic and complex categories for consideration in the discourse. This chapter explores scholarly literature and policy-centered conversations connected with successful aging. In this review of the literature, the discussion has centered on constructions of aging, disability, ageism and ableism, as well as what it means to successfully age and sustain a lifestyle of Active Living. Many of these conversations extend well beyond the limited scope of biomedicine, presenting a multi-disciplinary approach. Stronger consideration for the complex roles of structure and agency is critical to these processes, as macro-level barriers to the personal choice and circumstance of individuals become the subject of greater scrutiny. Finally, it is the SDOH model that illuminates avenues for more inclusive dialogues going forward.

In a recent work, Rowe and Kahn (2015) respond to the many proposed variants to their original successful aging framework that have emerged in the 31 years since their initial conception, and a number of which are discussed in this chapter. In their article "Successful Aging 2.0: Conceptual Expansions for the 21st Century," Rowe and Kahn acknowledge the value of this voluminous critical response, noting that "to understand the complex relationship between aging at the societal and individual levels is perhaps the greatest gerontological challenge of our time" (p. 595). In this study I explore the personal and intersecting aging-, disability- and gender-related expressions of the oldest old as a product of both macro- *and* micro-level influences across the life course. I further critically examine neoliberal ideology in support of supreme independence, to include interdependence mechanisms of both formal and informal support for

the oldest old. It is my hope that this dissertation, and the data presented in the succeeding chapters of this work, will add a valued contribution to the existing literature explored here. In Chapter 3 that follows, the guiding theoretical frameworks of this study are explored for context and thematic relevance to the research questions posed in this thesis.

# Chapter Three: Theoretical Framework

## Introduction

In scholarly research, a guiding theoretical framework provides a "map for a study" (Green, 2014, p. 35), whereby theories give meaning to empirical research data (Fain, 2017). In this dissertation I rely upon the theories of feminist political economy, intersectionality, and life course theory, as they connect with health and aging. These lenses largely inform the final analysis of this work relating to successful aging, lived experiences of the oldest old, independent living, and disability in later life. Older adults are a vulnerable group, and old age exists as a potentially significant site of exclusion (Calasanti, 2005; Johnstone, 2013; Plath, 2008). Dominant ideologies seek to promote inclusivity through a model of individualism that privileges one's capacity to age well and successfully by their own actions and choices. As described in Chapter 2 of this thesis, the lifestyle goals of remaining active and independently engaged are wholly supported by a system governed by neoliberalism.

In this chapter, I provide an in-depth description of this study's conceptual framework. Green (2014) refers to the value of drawing on "concepts from various theories and findings to guide research" (p. 35). For the purposes of this study, I rely on three approaches which complement one another and inform, but do not limit, my interpretation of the data in subsequent chapters. These theoretical selections were confirmed during the processes of data coding and analysis, as opposed to preconceived ideas made prior to completing the research path and scope (Green, 2014; Morse & Field, 1996). The first contributing theory to shape this study is the lens of feminist political economy, as a succeeding framework to the foundational theory of political economy. This frame enriches discussion around the health experiences of men and women as producers of varied forms of work and capital. Feminism is a lens through which defining areas

of health, and the distribution of resources, benefit immensely (Bryant, 2009). It is a useful concept in this study because the gendered experiences of the oldest old within the context of the larger economic system is an important theme of discussion. A feminist political economy perspective gives a strong focus to middle-aged life years spent in a producing capacity. This is critical to understanding socioeconomic progression throughout the life course. As is shown in later discussion chapters of this dissertation, participants indicated a strong connection with the productive experiences of their earlier years and its continued effect on their socioeconomic position in late life.

While highly relevant to this study in these ways, feminist political economy does not give sufficient attention to later life and old age: a stage when economic production activity inevitably slows. Nor does it adequately account for disability as a prominent facet of life among the oldest old. To bridge these gaps and further the discussion, I draw on this model in a complimentary fashion with that of intersectionality and life course theory. In the second section of this chapter, where I explore the analytical framework of intersectionality in depth, I highlight aging and disability as significant social locations in later life. Intersectionality shapes my analysis through its focus on multi-layered elements of the self. Here, categories of difference are studied as *interacting* entities and features of identity (Crenshaw, 1991; Hankivsky & Christoffersen, 2008). Intersectional frameworks consider the ways in which systems of oppression interact not just between groups, but within them at both the macro- and micro-levels of society. This lens also encourages researchers and policy makers to look beyond limited biomedical understandings of health (Hankivsky et al., 2010). Here, my focus highlights sites of oppression and privilege, as well as the identity contexts in which they occur. Ultimately, the

emphasis placed on diversity and differences among people in this model is of great value to the gendered study of health and aging.

Following this, I finally investigate the significant contribution of life course theory (Elder Jr., 1994), as it encourages a holistic view of *all* life stages. Within this model, a wholly inclusive perspective of life-long narratives and experiences is emphasized, together with the ways in which different life stages are constructed and how this impacts late life experiences. In this section, equity between generations is examined alongside access to health resources, distributive justice, and the extent to which individual actors are constrained by the institutional fabric of society.

As a caveat, it is important to note that in highlighting the social location of gender in this study, my intention is not to devalue the health/aging experiences of men or imply that they offer a perspective that is less worthy of consideration (Doyal, 2000). Rather, in investigating successful aging in the oldest old, it is necessary to challenge the dominant discourses that tend to exclude facets of gender, age, disability, and other sources of oppression not discussed in this work. A critical examination of successful aging and late life experiences requires inquiry to extend beyond frameworks where men dominate and exist as more privileged in the economic, political, and social spheres of society (Armstrong & Armstrong, 2010; Doyal, 1995; Smith, 1987). It is my hope that the inclusion of both female and male participant voices in this thesis portrays a balanced impression of the gendered late life experiences of the oldest old. Ultimately, it is critical to highlight the often-invisible narratives of certain marginalized groups if the truly multilayered essence of aging in later life is to be conceptualized adequately.

## Feminist Political Economy: A Theoretical Framework

To understand the experiences of older adults in late later life, it is important to first consider the experiences of their earlier years, which govern progression in society and ultimately influence position and status in old age. Feminist political economy is one analytical lens that highlights the concept of gender inequity, particularly in productive middle-years of life (Armstrong 2001; Armstrong & Armstrong, 2010; Doyal, 1995). Themes of this framework include power and power relations, structure and agency, social identity contexts, and feminist/care perspectives. In this section, I begin by describing a political economy approach in an aging context as a predecessor to this theory. This model highlights the dominant influence of neoliberalism and market forces on health and life course experiences.

Following this background context, I subsequently consider the gendered insights of feminist political economy. Here, the works of Doyal (1995), Smith (1987), Armstrong (2001) and Hankivsky (2004) provide a broad spectrum of feminist considerations. I discuss the distinct experiences of women in the public and private spheres of paid and unpaid work; gendered dominance and subordination; the devaluation of work performed by women, particularly in the domestic sphere; and power relations at the macro- and micro-levels of society. Later life, in particular, is a time when women are likely to encounter unique health circumstances and tend to require health services more frequently (Nussbaum et al., 2005). The social reproduction of women in the domestic sphere, through unpaid care work and their role as child-bearers and child-rearers, has deep-seated effects on their health and socioeconomic position in the late stages of life.

*Neoliberalism and the Political Economy of Aging*

Before describing the lens of feminist political economy, it is important to first establish the primary concepts of its predecessor. The theoretical lens of political economy is an analytical model which examines the role and influence of larger structural forces, namely, neoliberalism and marketization, on health inequalities between groups (Coburn, 2000; Hofrichter, 2003). Consideration for the material and social conditions under which we function and live is central to this framework (Coburn, 2010). From a materialist perspective, Coburn (2010) emphasizes the role of class, production, and labour relations amidst the larger social and economic structures that govern wealth and resource distribution.

The political economy framework asks that scholars focus on the impact of larger systems on the health and socioeconomic position of populations and individuals. Social welfare and human interests are in essence diminished in favour of profit maximization. As Hofrichter (2003) writes, health inequalities occur through complex systems of discrimination embedded in the very institutional framework of society, fostering oppressive conditions and injustices. Coburn (2000) also speaks to deeply entrenched economic interests and the extent to which the systemic forces associated with neoliberalism have resulted in lowered health status for many individuals, arguing that this is due to high levels of income inequality between populations and lower degrees of social cohesion (p. 137). His focus is one that lends well to larger macro-level contexts and structures under which health and social status are produced, viewed, and studied (Tarlov, 2000). As a result, free agents of the market can prosper only through their own actions in the economic system (Coburn, 2000; Esping-Andersen, 1990; Navarro, 1999). This highly individual model is similar to the sentiment and expectation that one ages successfully through their own personal endeavours and choices.

Old age is not a life stage that can be examined in isolation. Rather, it must be explored as a product of one's progression through all of the life stages leading up to it. Research supports that one's social position in their old age is directly related to their status in childhood and mid-life years (Britton, Shipley, Singh-Manoux, & Marmot, 2008; Rubinstein & de Medeiros, 2015). In other words, one likely cannot age well in their final years if one begins from a position of disadvantage. A limitation of concepts supporting the neoliberal agenda such as successful aging and Active Living is that in their exclusive focus on individual action, these models fail to account for the diverse social locations from which people enter late life. Herein lies one distinction between equity and equality. While equality comparatively examines circumstances with the presumption that people come from a similar place of origin (Richardson, 2005), equity is a concept rooted in principles of distributive justice that accounts for social differences occurring between and among societal groups (Hsu, Anen, & Quartz, 2008; Kabanoff, 1991). This phenomenon is described as a social hierarchy: the system by which individuals experience unequal circumstances relative to other individuals and groups (Sidanius & Pratto, 1999).

Relative disadvantage implies that the more privilege a person enjoys in society, the greater their level of power, opportunity and status. This applies across the "social gradient," where incremental patterns of improved health outcomes can be seen between those at every level of the hierarchy and their respective superiors (Marmot, 1999; Raphael, 1998). Those at the lowest end of this hierarchical spectrum are economically poorer and have fewer resources available to them. Consequently, they are the most vulnerable and experience worse health and other poor outcomes through their lack of autonomy and power to change or enhance their position (Braverman & Gruskin, 2003; Dixon, 2000; Lin, 2001; Poland et al., 1998; Scambler & Higgs, 1999; Wilkinson, 1997; Wilkinson, 2000). It is most certainly more difficult for a person

who endures a state of poverty throughout their life to age well and prosper, compared to that of an individual who enjoys socioeconomic wealth and privilege in their earlier years.

The model of political economy can be applied in an aging equity context. The location of power emerges as a notable source of debate here, dictating differentials between macro- and micro-level structures, as well as individual groups across the life course (Armstrong, 2013; Priestley, 2003). Through this, the privilege ascribed to adult labour market performance becomes a significant source of marginalization for older adults who are largely removed from economic participation. Within this model, the normalized life course has been constructed in accordance with paid work efforts and defined within the confines of three distinct phases: "preparation, workforce activity and retirement" (Kennedy, 2000, p. 123). This highly limited scope allows for strong value to be placed on youth and ability, while devaluing the experience of those who encounter significant social barriers to workforce participation. This is particularly applicable to women, whose unpaid work contributions throughout the life course are often ignored and largely devalued in patriarchal society—as explored more extensively below. The dangers of defining the life course under such restrictive parameters is the potential to exclude numerous individuals from a process that is fluid, rather than fixed, as well as varied across societal groups and individuals (Kite & Wagner, 2002).

Braithwaite (2002) writes of societal struggles, with failure and loss in labour contexts, because of the extent that market performance is at the very center of capitalist and social structures (p. 321). A political economy of aging involves not only this devaluation of later life as work participation diminishes, but also the dominant influence of middle-aged cohorts on policy and supports pertaining to the aged (Putnam, 2002). Support policies where the decision-making power is ascribed to working class contributors—who tend to be middle-aged adults—

are more likely to be shaped by the perception of older adults as an economic burden. Such prejudice also manifests in the contexts of gender and/or disability, as well as other intersecting frameworks (Braedley, 2013; Day, 2013; Esqueda, 2011). On this topic Minkler and Fadem (2002) write:

> For older people with disabilities, older women, older people of color, and low-income elders, whose relationship to the labor market often has been one of marginalization, viewing productive aging narrowly in terms of paid work is particularly dangerous. (p. 232)

The groups described in this statement are those who have been excluded from a structural system that fails to facilitate or encourage their participation. The parameters of acceptance and privilege are limited to the young, Caucasian, able-bodied male as the ideal standard of the productive citizen. Conversely, those who do not fit this ideal form and fail to perform their economic duties, are likely to require social assistance or some other form of state-sponsored benefits, rendering them dependents in a subordinate position. From this model, feminist political economy emerges to address the significant, yet largely absent, component of gender in this theory.

*Feminist Political Economy*

Like political economy, a feminist political economy lens is also concerned with the structural influence of neoliberalism, profit maximization, and free market enterprise. Within this framework, however, these notions are examined in a gendered context, with particular emphasis on the labour market experiences of woman—as they have occurred under an extensive patriarchal history (Armstrong & Armstrong, 2010; Smith, 1987). In brief, patriarchy is a pervasive system of thought concerning gender, privilege, and the social order. Johnson (2005) writes, “Because patriarchy is male identified and male centered, women and the work they do

tends to be devalued, if not made invisible, and women are routinely repressed in their development as human beings through neglect and discrimination…" (p. 16). Hence, the model supports a view of oppression and disadvantage, calling for a closer examination of the ways in which the life course paths of men and women are dissimilarly constructed and lived. Under the model of feminist political economy, a gendered lens is applied where the more dominant voice of political economy fails to adequately address the effects of pervasive divisions between the sexes (Armstrong & Armstrong, 2010). In an early work, Armstrong and Connelly (1989) state that "although political economy recognizes class as gendered, much of women's lives become invisible from the standpoint of the relations of ruling, where the point of production is treated as the exclusive site of class and class struggle" (p. 7). Hence, feminist political economy builds upon the ideas of its predecessor, addressing the need to explore the largely silent voices of women that are ignored within dominant discourses.

Women, for example, have historically made a significant contribution through unpaid domestic work that is often met with devaluation in larger patriarchal society. This occurs while men are commonly perceived of as the primary source of income and valued as productive contributors. Feminine identity has hence been constructed in a way that promotes a perception of women's work as inferior to that of men, where gendered responsibilities are tensely situated between both the public and private sectors. Patriarchal norms also contribute to deeply embedded gender discrimination that manifests in social and political institutions, as well as multiple aspects of life (Hofrichter, 2003). Women have little autonomy or power to advance beyond the gendered disadvantage fostered by these processes. Smith (1987) explains that the dominance of men in the public sphere relies directly upon the subordination of women (p. 20). Feminist political economy accounts for the highly unique experiences of women—a diverse

group in and of themselves—who are often excluded and/or misrepresented by prominent models of health.

For the purposes of the present analysis, a gendered political economy perspective seeks to examine marketization and the increasing commodification of goods, services, and the human body by considering work as it occurs both outside *and i*nside of the home. This extends beyond limited patriarchal theories that are restricted to an analysis of the market in the context of paid labour and profit (Mosco, McKercher, & Stevens, 2008). By acknowledging both the private and domestic spheres of labour, this approach allows for a much richer method of examining sources of gender inequality that materialize in society *and* in policy.

Specific attention is also given by this framework to the significant power and control of the state in regulating activity in public and private space (Armstrong, 2001). With the inclusion of unpaid work in its doctrine, feminist theory not only provides a more holistic approach to market analysis, but also acknowledges the domestic work efforts that are often overlooked by other research methods (ibid). It lends well to discussions of the tension between human agency and the larger structural barriers to equality, accounting for the lived experiences of women and seeking to uncover systemic roots of gender discrimination (Bourgeault, 2006). Such analysis provides the researcher with an opportunity to look beyond divided spheres of labour by asking how and why the devaluation of unpaid domestic work has evolved and influenced the subordination of women in society.

Women's health, in particular, is one such area that has been largely influenced by patriarchy in the capitalist system together with their resultant exclusion from the paid workforce (Gordon, 1996). The work experiences of men and women are distinct, in that the work of women often involves informal care and other domestic work (Armstrong & Armstrong, 2010;

Doyal, 1995; Smith, 1987). While men make their primary contribution in the public sphere of the waged labour market, women tend to occupy *both* the public and private domains (Armstrong & Armstrong, 2010; Doyal, 1995). Feminist political economy is a relevant model in this dissertation, as the participant data speak to a gendered dynamic of differing labour experiences in earlier life years and through the life course—as is discussed in Chapter 6.

Women's health is also closely linked with their work, amidst highly gendered patterns of labour force participation. Over time, this dynamic occurs with an evolving model of the family itself. The traditional family structure of the male breadwinner becomes one where women increasingly partake in paid work to support the family, while continuing to perform the majority of unpaid domestic and care work in the home (Armstrong & Armstrong, 2010; Esping-Andersen, 1999). Armstrong (2001) writes of the extent to which freer markets have led to greater inequities for women in this regard (p. 24). Increased pressures associated with the performance of public and private work ultimately compromise the health of women, resulting in a number of conditions related to chronic stress (Armstrong, 2001; Doyal, 1995). Additionally, despite the immensity of their contribution in both spheres, their work is more recognized, valued and rewarded in one (Smith, 1987). This is particularly the case for low-income women who are already at risk for poorer health outcomes because of their disadvantaged position in the social hierarchy. Neoliberal, capitalist ideology only furthers these views with a fixation on the value of paid work, something that has heavily contributed to the subordination of women in the workforce. In essence, there is a need to assign far greater value, worth, and recognition to the unpaid work contributions of women throughout the life course. This involves going beyond market priorities by providing increased welfare supports to women.

The systemic oppression and marginalization experienced by women in the free market system is further perpetuated by dominant medical model norms of health that privilege the "healthy" paid worker. Here, notions of masculine biological superiority, as discussed in Chapter 2, lend well to the neoliberal goals of fostering market competition and profit generation. Policies also remain largely gender-blind in a neoliberal system that discourages strong welfare supports, favoring wage labour in a male-dominated market of individualism. In his work, *The Birth of the Clinic*, Foucault (2003) writes that the function of public welfare mechanisms, or other forms of social assistance, should ideally be provided through paid work, allowing the underprivileged a means of survival without presenting a financial burden to the state (p. 20). The maintenance of informal care work—largely performed by women—in the unrecognized private and domestic sphere similarly supports market interests by removing this responsibility from the public system (Poland et al., 1998). As a result, numerous women are left without adequate supports to suit their unique needs.

Through its placement in the private sphere, the unpaid care work of women has not been made "publicly and politically relevant" (Hankivsky, 2004, p. 1). This indicates that gender difference is obscured when serving the larger goals of freer markets, coupled with a minimal role of the state. It is a system under which understandings of women's diverse health experiences are limited; often defined by their reproductive capacities (Armstrong, 2001). Consistent with this, the World Health Organization (2011) understands gender equity as a concept that largely concerns childbearing, inclusive of access to contraception and abortion services. Clearly, in the midst of these medical norms, not only is the work of women largely devalued, their bodies and health are also misunderstood by a system that is orientated towards male experiences. From this perspective, gender exists as a highly complex social determinant of

health (Armstrong, 2001; Smith, 1987) and a necessary function in understanding the dynamics of health and aging.

As illustrated in this section, feminist political economy accounts for the essential need to include gender and other socioeconomic variables in conversations about health. In its attention to the relational dynamics of power and labour, however, this theory gives inadequate focus to identity contexts such as age and disability. Through this limitation, diversity among all women is potentially obscured (Doyal, 1995). In other words, the category of *women* is perhaps too broad in scope. For example, a woman of colour in Africa is likely to encounter entirely different work, family, health and aging experiences than a woman of middle-class status in a wealthy developed country such as Canada. Examining the commonalities and differences between women of diverse social and cultural circumstance is hence a complex task. Despite this limitation of the theory, Doyal (1995) defends the study of *women* as a lens of analysis supporting the notion that all women share in the experience of gendered oppression, irrespective of cultural, political, economic or social differences (p. 6-7). While Doyal's emphasis on the universality of women's issues as inherent to feminist inquiry is a salient point, learning the distinct experiences among women is also highly relevant.

Older women, in particular, require focused attention from scholars and policy makers because they typically experience higher levels of poverty and disadvantage. Their work and life experiences are likely to be far different than that of their younger counterparts. It must be recognized that later life experiences are highly gendered. Women tend to live longer than men and tend to spend their adult years of life intermittently participating in the paid workforce for reasons of familial and care work responsibilities (Calasanti & Slevin, 2001). Consistent with the main focus of this dissertation, the personal stories of older adults, and particularly those among

the oldest old, clearly represents a gap that requires further attention and exploration in these contexts. The intersection of old age, disability and gender is something that is missing from the discussion provided by feminists such as Doyal (1995), whose analysis would benefit greatly from a stronger inclusion of older women's voices. In response to this gap, I draw upon the model of intersectionality. Building on the framework of feminist political economy, an intersectional lens highlights human differences and oppression in varying social and cultural identity contexts.

## Intersectionality

The work of feminist political economists such as Smith (1987), Doyal (1995) and Armstrong (2001), has much to gain from giving greater attention to social categories of difference. Intersectionality builds upon the original ideas provided by feminist political economy by giving a much stronger focus to systems of oppression rather than limiting its concern to class relations as they intersect with gender (Armstrong & Connelly, 1989; Hankivksy at al., 2010). The model of intersectionality serves as a valuable addition to that of feminist political economy by expanding the analysis to include a more complex perception of inequality, privilege, oppression, and disadvantage (McGibbon & McPherson, 2011). It further emphasizes "an understanding of the many circumstances that combine with discriminatory social practices to produce and sustain inequity and exclusion" (Canadian Research Institute for the Advancement of Women, 2006 as cited in McGibbon & McPherson, 2011, p. 63). Here, attention is given to the unique nature of identity interactions and how they manifest at the levels of individuals and societal groups alike.

Calasanti and Kiecolt (2012) speak to the value of intersectional theory by pointing out that one cannot simply "add up privileged and disadvantaged statuses to compute an index that

would describe all groups with equal validity" (p. 265). In essence, forms of ageism, ableism, and other systems of discrimination are experienced in different ways depending on particular circumstances and how they intersect. Scholars must look beyond a more limited scope that assigns certain criteria to particular groups or individuals. Instead it is important to recognize that variances occur between and among people, and layers of inequality are embedded in the very institutional fabric of society (ibid). Having already given much attention to gender in the previous section, here I explore these ideas in relation to the identity contexts of age and disability.

*Intersectionality as a Theoretical Lens*

Intersectionality is a feminist theory that first arises in the work of Crenshaw (1991), who writes of gender as it intersects with racialized experiences. She gives the example of Black women describing the sexism they encounter as a "hybrid" compared to that of the "purer" gender discrimination experienced by their White counterparts (p. 145). As Crenshaw explains, White women do not face the added layer of marginalization that arises from the intersectional combination of gender and race (ibid). The same can be said of other identity contexts that overlap. People are often personified by complex social locations that change throughout the life course. It is very possible, for example, for one to acquire a disability and/or become older, both experiences which create more layers of identity at the time they are encountered. This further illustrates the extent that ableism, ageism, sexism, etc., act as tiers of oppression, culminating in unique intersectional perspectives (Emejulu & Bassel, 2017). In much of the feminist political economy literature, inadequate attention is given to the complexity of these oppressions as they occur in concert with one another. Instead, parameters of gender, age, disability, etc., tend to be viewed as singularly-defined entities. An intersectional framework enriches discussion about the

ways in which disability and age intersect not only in late stages of life, but also throughout the life span (Gibbons, 2016). In this study, both male and female participants indicated personal experiences that were intertwined with their age, gender, and/or disability status.

At present, ableist and ageist forms of oppression remain largely understudied within dominant discourses of successful aging (Gibbons, 2016). Intersectional study highlights these often-overlooked facets of identity. Feminist intersectionality is hence an important theory in the establishment of a more holistic understanding of specific sites of inequality. Hankivsky and Christoffersen (2008) describe this model as follows:

> Intersectionality is a theory of knowledge that strives to elucidate and interpret multiple and intersecting systems of oppression and privilege. It seeks to disrupt linear thinking that prioritizes any one category of social identity. Instead, it strives to understand what is created and experienced at the intersection of two or more axes of oppression (e.g. race/ethnicity, class, and gender) on the basis that it is precisely at the intersection that a completely new status that is more than simply the sum of its individual parts, is formed. (p. 275)

It seems as though new forms of discrimination, inclusive of multiple entities, manifest through this framework. These are the aforementioned "hybrid" facets of oppression that Crenshaw (1991) describes (p. 145). Through this lens, closer examination of the unequal access to resources, services, and care between individuals and groups is cultivated (Hankivsky & Christoffersen, 2008; Hofrichter, 2003). In order to understand the immensity of inequality that occurs across identity groups, it is important to first define the roots of oppression and privilege.

*Privilege & Oppression*

Oppression occurs through the extent of one's divergence from what is privileged as the "ideal" body, as defined by dominant social norms and previously explored in Chapter 2. It is a key concept of intersectional analysis. Privilege and oppression are relational: one cannot exist without the other. In essence, an understanding of privilege is required to study disadvantage

(Calasanti & Kiecolt, 2012). As discussed in previous sections of this chapter, political economy and feminist political economy are critical tools which reveal where privilege is located in Western society. Namely, in the productivity of citizens in the public domain of paid work endeavours. In this way, value and privilege are given to younger and independent individuals who contribute to the larger economic system. This notion is strongly aligned with the principles of neoliberalism and capitalism (Callahan, 1987; Callero, 2013; Rubinstein & de Medeiros, 2015). From this perspective, it can be inferred that those who do not make such efforts and require assistance in the form of welfare support represent a liability, and they are often labelled as such by larger society.

What is obscured by neoliberal ideology is the extent to which normatively constructed, and deeply embedded, barriers maintain a separation between contributors and non-contributors to the economic system. The model further fosters a system in which individuals evolve with a deeply internalized and normatively-defined consciousness towards their economic responsibilities. As a result, though working productive years tend to occur in middle age, people who age in a capitalist society likely do so with a strongly internalized sense of self that is intertwined with their capacity to contribute. To a large extent, individuals believe this to be a source of their value and worth, which is a necessary component of this pervasive economic system (Glass, Seeman, Herzog, Kahn, & Berkman, 1995). The stage of later life when older adults have exited the paid work force therefore represents a time that one must find new ways to participate actively and contribute productively. This internalized sentiment of production value is evident in the interview data of this study. As is revealed in subsequent discussion chapters of this thesis, participants, particularly male participants, indicate a strong reflective connection to

their earlier paid working lives as a defining part of their identity. This finding aligns with gender norms.

People who experience disadvantage, including women, people with disabilities, and older adults, are more likely to encounter obstacles to economic participation due to systemic barriers and a lack of support. Barriers to economic participation can often produce a lived experience shaped by material deprivation and the resultant worse health outcomes associated with disadvantaged positions in the social order (Raphael, 1998; Wilkinson, 2000). Older adults are exceptionally vulnerable to this status as their participation in paid work is more likely to have reached its conclusion upon retirement. Their working life experience is also likely to have been influenced by their unique intersectional identity context. Older women, especially those among the oldest old, experience an added layer of complexity in their life experiences.

Research suggests that there is a need to explore the family role assumed by many women in the private and domestic sphere, for example, and the long-term effects of these experiences in their later retirement years and beyond (Hooyman, 1999). The retirement experience of women in the baby boomer generation is distinct from that of their male counterparts. These women have been forced to "make difficult tradeoffs between labor, leisure, and caregiving time" which are even further impacted by choices made in their earlier adulthood (p. 117). Additionally, older adults, and particularly older women, tend to experience higher rates of poverty and therefore worse health than their younger counterparts (Gornick et al., 2009). This illustrates the cumulative impact of disadvantage throughout the life course and its connection to gender-based outcomes in later life. In Chapter 6 of this study, these notions of gendered life course histories and their relation to socioeconomic circumstance are extensively explored in the context of participant data.

In accordance with neoliberal doctrine, disability is also largely defined in a negative light by dominant norms. Esping-Andersen (1990) speaks to the exclusionary nature of the market for people with disabilities (p. 42). These individuals are more likely to require welfare supports and accommodations in order to enjoy equal access. Thus, disability exists as a source of low income, poverty, and loss of other important SDOH in a political system that lacks adequate welfare supports (Raphael, 2009). Older adults with disabilities are devalued for their inability to participate as active agents of the market. The apparent reason for this is that while these individuals are likely to have made a significant work contribution in their earlier life, many must rely on income and care-related supports upon formal exit from the labour market. Those aging with disabilities may never conform to the normative standards of performance held by their younger counterparts because their level of social/economic engagement and performance is dependent upon the removal of socially constructed barriers which inhibit their participation. Such a system further solidifies the exclusion of older adults from many realms of mainstream society and is the basis for age and disability-related discrimination. Deeply embedded ageism occurs in concert with other forms of discrimination, including ableism and sexism (Overall, 2006). This oppression transcends across multiple frameworks and intersects with other forms of social identity, particularly in later life. Oppression and disadvantage are therefore shaped by the ways in which life stages, disability, and gender norms have been constructed within intersectional identity contexts.

*Aging and Disability: Complex Layers of Identity*

Aging is unique from other social locations in that it is an experience that all groups share. Krekula, Nikander, & Wilinska (2018) write that “age as formed in and through interaction, negotiations, and on-going discursive processes involves everyone at different

levels" (p. 37). While people may be unique by race, gender, sexuality, disability, etc., they all become older with time. In this way, and at the most basic level, aging is not only a category of difference, but also one of sameness, in terms of its universality. That being said, not all individuals will live to experience old age or later life. Additionally, to reach the stage of the oldest old applies to an even smaller minority. As a society, we are socialized to make certain assumptions about different life stages and treat individuals in each age category in different ways. In the same way that the divisions between men and women in systems of labour and care have manifested through socialization and the dominant discourse to define gender norms, we have evolved with analogous constructions of aging (Calasanti & Kiecolt, 2012). Many of these perceptions are negative. For instance, members of Western societies have a more natural inclination towards caring for infants and youth, as a time of generally accepted innocence. Yet, later life is viewed and accepted as a time of decline and an undesirable stage with far less appeal. This is largely due to the presumption of functional decline through acquired disability.

The experience of disability strongly intersects with identities of age and gender. As established in Chapter 2, ageism and ableism are often overlooked facets of later life experiences. Braedley (2013) writes that both modes of oppression, along with classism, racism and homophobia, take "gender-specific forms" (p. 62). Older women's lives are an under-represented part of disability studies, and further work concerning the intersections of age, disability and other identity locations are worthy of further study (Thomas, 2006). In many cases, variances in disability are so pronounced that to consider this a singularized category may homogenize the experience in a damaging way (Schwab & Glissman, 2011). For example, certain facets of disability are completely ignored, overlooked, and highly stigmatized (Selmi, 2011). Intellectual disability in particular is a prevalent, yet often invisible experience among

older women, heavily subjecting them to the multi-layered effects of sexism, ableism, and ageism (Robb et al., 2002). The dominance of biomedical norms discourages women from speaking openly of their health concerns, where they are likely to be ignored or considered "pathetic, powerless, passive, and weak" compared to men (Nussbaum et al., 2005, p. 296).

In an aging context, disability also strongly intersects with age through the likely onset of acquired disability in later life. Disability, a source of marginalization at any life stage, is most prevalent among the older adult population (Law Commission of Ontario, 2012). In Western society, disability in later life is viewed as a prominent marker of unsuccessful aging (Raymond, 2019). In such cases, older individuals who experienced earlier years without disability face the added complexity of not only larger societal perceptions of decline and exclusion, but also internalized or self-perceived ageism. Lev, Wurm and Ayalon (2018) suggest that self-perceived ageism occurs from the internalized negative stereotypes associated with later life that are absorbed throughout the life course. Research shows that perceptions of the self with regards to old age have a significant effect on disability and health outcomes in later life stages (Levy, 2009). Those who hold a negative perception of aging not only experience worse functional health, but also do not live as long (Levy, Slade, & Kasl, 2002). The effects of ageism are pervasive, occurring at many deeply embedded levels of the system, population groups, and even aging individuals themselves. The theory of successful aging is influenced by this systemic discrimination, whereby individuals are encouraged to avoid functional decline in favour of remaining healthy, or able-bodied.

There is a strong need for successful aging studies to better examine the experiences of diverse groups (Romo et al., 2013). Successful aging stands to benefit greatly from intersectional analysis (Calasanti & Giles, 2018; Gibbons, 2016; Ziegler, 2012), where the unique experiences

of individuals can be examined from a holistic view of their cumulative journey throughout the life span to understand how and why some individuals are more likely to age successfully than others. That some encounter insurmountable barriers to inclusion in our society, inhibiting their capacity to prosper, is a significant problem in need of further attention at the macro-, meso- and micro-levels of society. Part of rectifying this involves deconstructing normative discourse surrounding aging and disability. Gibbons (2016) discusses a phenomenon of "compulsory youthfulness" where individuals subscribe to a socially constructed need to "remain youthful or stay young" (p. 74). Essentially, the notion of successful aging forces individuals to mask their true experiences in old age in favour of conforming to the image and expectations required of a youth-centric society. This message is further reflected in aging policies that promote the goals of active and independent living for older adults, emphasizing strategies to retain the more socially engaged persona of one's youth.

The dominant discourse in the field of aging supports a strong desire to remain free of disability and continue in an active social capacity that is similar to younger years. This is despite the inevitable differences associated with health status, body, productivity, or overall lifestyle that are likely to arise in later life years. Socially constructed body norms support neoliberal perceptions of the idealized productive body. Calasanti and King (2015) describe bodies in a cultural context, which "allows people not only to differentiate but also to include or exclude groups and thereby justify and maintain inequalities" (p. 195). More specifically, they highlight the extent to which ageism is fed by constructs of aging bodies, which ultimately contributes to intersectional inequalities (ibid). Giving more attention to the life course as a holistic experience, life course theory adds yet another analytical layer to this study by extending the discussion to include consideration for experiences in earlier years and their cumulative

effect in later years. To do so involves accounting for the influence of interdependent relationships with others, as well as defining milestones reached over many life stages.

## Life Course Theory

Using life course theory in studies of later life examines individual history, personal development, and the culmination of occurrences over many years and life stages. Individuals are a product not only of who they are in the present, but also of who they once were in the past. As an analytical framework this theory highlights human development, including the extent to which people evolve along certain "trajectories," or variances in lived experiences and social roles (Elder Jr., Johnson, & Crosnoe, 2003, p. 3). These occurrences nearly always intersect with key life transitions that are generally accepted as normative outcomes transpiring at different stages. Normative transitional milestones may include marriage, having a child, beginning a career, or retirement from paid working life (Daly & Grant, 2008; Elder Jr., 1998; George, 1993). Here I explore the paradigm of life course theory with particular emphasis on the value of an intersectional perspective in combination with this paradigm. I further examine the concept of equity between generations, highlighting the philosophical argument of Callahan (1987), as well as that of distributive justice and the allocation of scare resources in neoliberal society.

### *A Life Course Perspective*

Life course theory suggests scholars include several factors in the examination of complex life experiences. According to Elder Jr. (1994), a founder in the development of this paradigm, life course theory encompasses four key components: "the interplay of human lives and historical times, the timing of lives, linked or interdependent lives, and human agency in choice making" (p. 5). This approach to aging allows for the equal and inclusive consideration of each generational stage, encompassing the varied lived and social experiences of numerous

groups and individuals (Kennedy, 2000; Minkler & Fadem, 2002; Priestley, 2003). It is a perspective that fixates on the extent that human relations and individual autonomy, histories and places are interrelated, influenced by continuous interactions with macro-level structures and organizational forces (Carpentier, et al., 2010; Daly & Grant, 2008). The aging process is thus intertwined with many factors that do not necessarily align with the restrictive expectations of normatively constructed life stages.

This approach is highly applicable to studies about older adults because it highlights the extent to which late life is not a fixed state. In the study of people and successful aging, there is a tendency to examine lived experiences as static or "in the moment" (Hagestad, 2003; Stowe & Cooney, 2015). Instead, a life course perspective propels researchers to look at a complete picture of the lifespan, with the goal of understanding the long-term implications of certain events and choices (George, 1993; Johnson, Crosnoe, & Elder Jr., 2011). While life course theory is strong as a holistic approach to aging study, it is further enriched by intersectional and feminist perspectives that give attention to layers of identity as they manifest over time (Daly & Grant, 2008). In this way, these theories together lend themselves well to studying the complexities of social locations and manifestations of the intricate self, furthering the discussion around gendered lived experiences of later life.

Ziegler (2012) describes intersectional life course theory. On the subject of complex identities across the life course, she writes:

> In contrast to other markers of difference (e.g. gender and race) chronological and socially constructed aspects of age are continuously changing throughout the life course, which necessitate an on-going process of re-positioning of the self. This complex process is partially dependent on dominant and other discourses available for constructing subjectivities, but also on the accumulative life course experience of the individual which helps to interpret those discourses and give meaning. In that way we can consider being 'old' as an emergent, fluid and negotiated process rather than a static identity. (p. 1299)

Older adulthood is unique from other social identities, occurring with the fluidity described by Ziegler. As a result, intersectional life course theory extends well beyond its biomedical roots, which examine more limited function-based perceptions of the self. Where life course theory on its own does not give sufficient attention to power dynamics and relations, the added layer of intersectionality addresses this gap, particularly through its inclusion of gender (Daly & Grant, 2008). The complex modes of identity explored through these frameworks means acknowledging the role of structural forces as a pervasive presence throughout the life course. As described in Chapter 2, the autonomous choices made by individuals throughout the life span occur within the restrictive parameters of larger social contexts and power structures. Here the interactions of traits such as age, disability, gender, class, etc., exist as highly complex sources of vulnerability and oppression that affect individuals as they enter old age. The life choices made by individuals are hence heavily influenced by their identities and the macro-level systems surrounding them, both of which are highly influential to life chances and outcomes (Elder Jr., 1998). Certainly, this dynamic plays a significant role in the examination of later life and understanding the position of older adults as it transpires through an evolutionary process.

Dannefer (2012) deems the life course a feature of a "constructed social reality," inclusive of diverse meanings and influences, and serving as part of the larger "social structure" (p. 221). As established throughout this study, the social order is in many ways dictated by neoliberal ideology, where the extent to which individual agency is inhibited by structural power is obscured in favour of a model where people are responsible for themselves and their own well-being. In accordance with the theories described in this chapter, socially constructed norms and meanings are very much determined by marketization and neoliberal interests in Western society. An expanded definition of successful aging has led to expanded discussion of influences

on later-life circumstances that extend beyond the individual (Stowe & Cooney, 2015). As has already been established in earlier parts of this dissertation, the goals of successful aging fail to account for the influence of larger structural forces by supporting a model of individualism, where people are mostly responsible for their own destiny in later life (Callero, 2013; Rubinstein & de Medeiros, 2015). The model of successful aging could be further improved by incorporating intersections of age, gender, disability, and other such sources of inequity across the life course (Minkler & Fadem, 2002). An intersectional life course-based approach addresses the need to further examine these sources of oppression as they occur and impact life experiences over time. For this reason, some theorists have applied an intersectional life course frame of analysis to that of the successful aging debate, to better evaluate its intricacies, particularly with regards to gender.

In examining what it means to age successfully, life course theory adds value to the concept of successful aging by highlighting the presence of disadvantage and inequality and their fluidity over time (Stowe & Cooney, 2015). While feminist theories may give an initial focus to the experiences of women, they also highlight general inequalities as they manifest among people and groups across the life span, among which gendered aging experiences must be included. Hooyman, Browne, Ray, & Richardson (2002) write that feminist perspectives on life course theory “help us to understand both women’s and men’s privilege, oppression, diversity, and abilities along with their similarities in meeting life’s challenges” (p. 4). Feminist scholars speak to multi-layered disadvantage facing women, where dominant patriarchal norms serve to exclude and devalue their contributions throughout the life course (Armstrong & Armstrong, 2010; Armstrong & Braedley, 2013). This ultimately results in heightened disadvantage in the

later lives of women. This study hence employs a feminist approach with life course theory to highlight systemic barriers to successful aging.

From a neoliberal perspective, successful aging is defined as a goal that is realized through personal contribution and preservation of biological health. This definition is supported by complex constructions of life course stages. Key periods over the life course tend to be constructed in a "normalized" way, where age categorizations are described by the parameters of early-, middle- and later-life, further presenting a source of intersectional marginalization for women. Societal expectations of what is to occur at each life stage are well-established. For instance, it is largely expected that years of youth are spent in education and training towards a productive career path in the subsequent stage of middle age. Those who are defined by experiences with disability, gender-based oppression, and/or other such traits are marginalized for the extent that they veer from the idealized body constructs that allow one to pursue these anticipated tasks of a "normal" and productive life course (Priestley, 2000, p. 424).

In such cases, multiple categories of difference ultimately result in further social devaluation of those marginalized by identity-based systems of oppression, and less acknowledgement of deeply personal and unique needs that may require accommodation (Esqueda, 2011; Overall, 2006). The life course has been intentionally constructed in this way, breeding sources of inequality and difference, particularly in regard to how work and labour is divided and constructed. Daly and Grant (2008) write that "tasks are gendered across the lifecourse [sic]" (p. 18). Because women assume the majority of unpaid work roles over the course of their lives, much of their contribution is valued differently compared to that of paid work efforts. This acculturation holds implications for women's health and wellbeing, particularly as they assume the often-depleting role of informal caregivers in familial contexts of

every life stage (Martinengo, Jacob, & Hill, 2010; Moen, Robison, & Fields, 1994). This most certainly has a strong impact on the aging experiences of older women, whose life path is distinct from men. As a result, inequitable circumstance manifests strongly across generational groups, and impacts the ways in which we ascribe value to those defined by youth versus people who are of old age.

*Equity Between Generations*

A life course perspective is of particular importance to discussions of equity, as people experience the market and social life in different ways depending on their numerical age (Popay et al., 1998; Raphael 2009). Disparities between age groups manifest in both treatment and access to health services. Kane and Kane (2005) speak to differential access, where ageist practices indicate unequal care/treatment decisions between younger and older generations. In this regard, they suggest that treatments which are not generally acceptable for a younger person are often commonplace for older adults. One such example is the widespread adoption of institutionalized living for older adults with disabilities, a method that is often used as a last recourse for younger people with comparable disability experiences (p. 117). Nelson (2005) similarly writes of "healthism," in reference to an ongoing trend where older adults receive different treatment from health care professionals than their younger counterparts with similar health needs (p. 212). This apparent age bias in the delivery of care is likely to equate with poor health outcomes. When one becomes older, it is assumed that their health needs will grow. Older individuals are also likely to require increased social welfare support as they have retired from paid working life. This increased need for care and resources requires further attention. Some scholarly voices encourage the adoption of privileging the health and wellness of those in a position to contribute, arguing that this is in fact equitable and just.

Callahan (1987) is one such theorist, for example, who argues for the allocation of scarce health resources using age as the principal criteria. He proposes a model that provides equity between generations, where youth and middle-aged people are afforded the same access enjoyed by now-older adults when they were younger. Callahan uses equity in a fairness context, arguing that it is fair and just to provide health services and resources to a younger person, allowing older people to live a natural and "normal" life course. In his fixation on a static length of life, however, Callahan fails to account for the fact that the extent of one's life years is highly dependent on cultural, social, environmental, geographical, and economic factors (Clarke, 2001). Callahan's (1987) model favours neoliberal ideology; resources are thought to be limited, and privilege is assigned to the presumably more productive years of younger and middle age. This model elevates the economic contribution of youth, while devaluing later life as a stage of dependence rather than one of enrichment (Glass et al., 1995). Ultimately, the argument fails to account for the numerous ways in which older adults encounter inequitable treatment through their exclusion from the market and/or social life (Esping-Andersen, 1990).

The impact of inequity in later life is essential to consider when examining inequalities facing vulnerable minorities, women, and others outside of the privileged class (Priestley, 2003). While disability and later life can be supported through the removal of social barriers, increased access, and a reduction in ageist/ableist attitudes and practices, the resultant poor health conditions caused by widespread disadvantage are far more challenging to overcome (Verbrugge & Yang, 2011). In order to resolve the significant inequities facing older adults, the focus must therefore be placed on systemic societal changes, and not on the individual. This is particularly applicable to women, who not only comprise the majority of the oldest adult population, but are also more likely to have lower socio-economic status, higher rates of disability, and are less

likely to receive gender-based supports for their unique needs in a system that fails to recognize and address them (Nussbaum et al., 2005; Seeley, 2012; Sharpe, 1995). It is clear that women have historically struggled to attain equitable circumstances and continue to do so in a society fraught with bias and barriers to inclusion. Positive change will not only entail systemic action at the level of policy and the state, where gender is given focused attention, but also action to address how women, particularly older women, often internalize a feeling of acceptance towards their systemic disadvantages. Sharpe (1995) suggests this situation can be remedied using a multi-layered approach to not only educate professionals, but also to empower women to advocate for themselves. Such changes will no doubt involve an attitudinal shift from a very early age and throughout the life course so that ageism, ableism and sexism are no longer at the forefront of older adult exclusion.

To address older adult exclusion, the SDOH add value in the examination of long-term life course outcomes, particularly in later life. Deprivation in earlier life is likely to impact later life and throughout the life course in significant ways. Overall (2006) deems old age and disability to be material constructions, where the ways in which individuals age and their overall health or well-being, are very much dependent on social factors outside of their control, such as poverty or the onset of disability in earlier life. Poor living conditions can therefore impede access to needed social resources, while potentially compromising health and safety. For example, if one lives in poverty throughout their youth and middle age, it is very likely that they will also enter later life in a severely disadvantaged socioeconomic position compared to their wealthier counterparts. Priestley (2003) and Ng (2002) cite the need for a framework of intergenerational equity, placing value on the consideration of all age cohorts and their unique perspectives. Such broad consideration requires closer examination of key later life experiences,

such as removal from paid (or unpaid) work participation, movement into some form of institutionalized living arrangement, and the loss of active engagement with social life. A life course perspective supports the study of these occurrences across the lifespan, allowing for the development of new scholarly understandings. This involves deeper investigation of changing life circumstances, identity interactions, life events, power structures, and other such life-long factors across time. In these ways, life course theory makes an important contribution to the analysis in later chapters of this study.

## Conclusion

Throughout this chapter, I explore the three primary theories that comprise the conceptual framework of this study. The lenses of feminist political economy, intersectionality, and life course theory shape the discussion of the themes identified in this dissertation, including successful aging, disability and gender in late later life, and the lived experiences of the oldest old. Green (2014) writes of the extent to which generating a theoretical framework is not only an important purpose of all qualitative study, but also a necessary mechanism that gives structure to scholarly work. He further contends that it allows for deeper meanings to be derived from research findings, ultimately making conclusions more generalizable to the field at large. The theoretical concepts described here guide the dialogue of this work. While theory informs how concepts are understood, analyzed, and conveyed in this study, in the succeeding chapter I further describe my research methodology, as well as the methods used and my rationale for these selections.

# Chapter Four: Research Methodology and Methods

## Introduction

As previously established, in this study I pursue an entirely qualitative research process. My methodology draws from the theoretical models outlined in Chapter 3 and uses the approaches of critical ethnography and case study to inform the research design, the scope of the inquiry, and my interpretation of the findings. In later chapters of this dissertation, these models are wholly intertwined with this study's main purpose: to convey and understand the experiences of the oldest old as they relate to the aging-, health-, gender-, and disability-related themes of this study.

In recent years, gerontology and health studies have seen a shift from the dominance of positivist inquiry informed by clinically-based studies, to the increased inclusion of qualitative investigation which aims to critically capture highly subjective personal perspectives (Green & Britten, 1998; Vesperi, 1995). Biomedical models of health and aging tend to conceal important cultural and personal perspectives that are more richly contextualized through "insiders' perspectives on aging and the elderly" (Luborsky & Rubinstein, 1995, p. 90). Medical models of aging fail to adequately capture how "individuals at every level of cognitive and physical functioning personally experience and shape their lives" (ibid). Qualitative investigation is hence an appropriate choice in this dissertation study, as it illuminates how the oldest old perceive their own aging experiences.

As identified in preceding chapters, a vital aim of this dissertation is to address the need for further empirical investigation of the oldest old and their personal expressions about successful aging. In doing so, I seek to treat older adults as active participants who shape their own realities through "talk and interaction, stories, and narrative," rather than simply acting as

objective subjects (Gubrium, 1995, p. 24). Critical ethnography is used in tandem with elements of case study to meet these goals. These approaches call for rich interpretation of the data, and highly descriptive results (White, Drew, & Hay, 2009; Willis, 2007; Yin, 2009). In this chapter, I explore these methodological concepts, speaking to their relevance in both the research design and in addressing the main questions posed in this thesis. I also outline the methods used for the purposes of data collection, data coding and final analysis, as well as the ethical protocols I followed. Finally, as central to enhancing the validity of my findings, I outline the ways in which trustworthiness was measured and established in this study.

## Research Methodology

In scholarly work, methodology is understood as the "the science and philosophy behind all research" (Adams, Khan, & Raeside, 2014, p. 5). It represents a guiding path through which knowledge and research questions are shaped and realized by forming the rationale of a study, the interpretation of its data, and the conclusions that are drawn (Bailey, 1994). In this section, I explore the qualitative approaches of critical ethnography and case study, both of which provide methodological context for this work.

### *Critical Ethnography*

Before examining critical ethnography, it is important to first understand its predecessor. Conventional ethnography supports a dialogue of engaging with people and studying the lives and social interactions of individuals and groups, as they occur in cultural settings and contexts. It often involves investigating the experiences of members of marginalized populations, sometimes known as the "other" (Wolcott, 1999, p. 12). Ethnography is particularly valuable in gerontological work, as researchers seek to understand the lives of the "othered" so that they can better convey the ways in which older people perceive of their social world and interactions

within it (Victor, Westerhof, & Bond, 2007). Participant observation and in-depth interviews are particularly valuable tools which inform this dialogue. To adequately capture subjective understandings of successful aging in the oldest old of adults, I use critical ethnography as a primary research approach in this work.

Madison (2012) describes the methodology of critical ethnography as one that is closely intertwined with critical theory, allowing for "critical theory in action" (p. 16). Unlike broad ethnographic work, critical ethnography is the "performance of critical theory" with a "political purpose" (Madison, 2012, p. 16; Thomas, 1993, p. 4). It embraces the participant voice alongside normative assumptions and pre-existing biases, with goals of emancipation and empowerment (Thomas, 1993). Critical ethnography is transformative, as it strives to engage with disadvantage and the direct experiences of individuals. It lends itself very well to research concerning older people, those who identify with disability, and others who may be characterized by sources of societal oppression. With its transformative aims, critical ethnography supports a dialogue that strives to alter power relations and resultant social norms that may not otherwise be sufficiently explored or questioned (Simon & Dippo, 1986). As established in Chapter 2, the oldest old are vulnerable to systemic ageism and ableism, or a lack of voice in scholarship, policy, and community contexts. The resultant higher risk of societal disadvantage facing people in this group make the need to learn their direct views more acute.

In his critical ethnographic study, Diamond (1986) speaks to the usefulness of this process in gerontological and health research. He writes, "it is a method for exploring macropolitical forces in the micropolitical moments of their everyday execution" (p. 1287). Diamond refers to the larger contexts in which individual actions occur and can be studied. It pertains to the relationship between the autonomy of actors, and the extent to which systemic

forces impact their personal choices and situations. In contextualizing the lives of older people according to larger political and economic structures, one can identify the impact of these systems on those who are silenced and/or marginalized. This aligns with the feminist aims of transformative research, which move away from dominant paradigms where privilege is ascribed to the perspective of the White, able-bodied, male (Mertens, 2005). Together with these facets of critical ethnography, case study methodology also contributes to this work.

*Case Study*

Case study is a unique, though somewhat contested, qualitative methodology, albeit one in which disparities exist among researchers about its precise parameters and protocols (Mertens, 2005; Yazan, 2015). As a result, the case study approach allows for some flexibility in its interpretation and use. As Merriam (2009) states, "case study is a term used by many different people in many different ways to mean many different things" (p. X). In her work, which draws a comparative analysis between the seminal pieces of three prominent case study scholars, Yazan (2015) provides an insightful guide which illuminates key points of methodological dissonance between Yin (2009), Stake (1995), and Merriam (2009). This dissertation most closely follows elements of the case study method described by Merriam (2009), who writes of an exclusively qualitative inquiry through a constructionist lens.

Social constructionists posit that reality is socially created, where what is taken as "fact" is the result of social interactions and how these encounters are interpreted by individuals (Bourgeault, 2006). This paradigm is most concerned not only with the knowledge that is generated as a result of social experiences and interactions, but also how this knowledge comes to be accepted as part of larger social contexts. Merriam (2009) anchors her epistemology in this framework, noting that a "case" can be represented by a person, group, or other unit of analysis

which is bound by certain conditions (p. 40). She explains that "Anchored in real life situations, the case study results in a rich and holistic account of a phenomenon. It offers insights and illuminates meanings that expand its readers' experiences" (p. 52). Merriam's definition aligns well with this thesis, which limits its scope to a specific group of older adults who visit the same community-based organization over a fixed period of time. Here I investigate a case of the oldest old, a group presumed to be most vulnerable to age-related decline, seeking to understand how they experience the phenomenon of successful aging while living independently and visiting a site that supports the goals of Active Living in later life.

Where critical ethnography is employed to develop a richer understanding of the individual lived experiences of participants in this dissertation, case study is used for the purpose of binding its context to a particular time and place. As Ziegler (2012) writes, "the presentation of results in the form of case studies enables a focus on complex relationships and processes within and between categories which reflect the unique yet common experiences of individuals" (p. 1299). Given the specificity of its focus, the findings of this study are not generalizable to the larger population of oldest old. Instead, the scope of this work is bound by more restrictive parameters specific to the setting and group under study. In alignment with a social constructionist framework, the experiences shared by the older adult participants in this study are reflective of their deeply personal, extensive, and rich social experiences throughout the life course. This study does not account for the perspective of those who may be less "active" and is limited only to those who access or attend one specific community-based facility. The lives and experiences of these respondents is hence very much constructed through their subjective reality and the meanings that they derive from it (Merriam, 2009). This is not without implications. As Yin (2009) states, the objectives of case studies tend to make a greater contribution to theory

than other wider contexts and dialogues. Though this obvious limitation speaks to the challenge of drawing universally applicable results from a single case study, the method does present an opportunity to identify and explore research gaps, as well as to determine future areas of research in its calls for further study. In this way, it might be said that the very strength of a case study may lie in its representation as a singular, limited piece of a larger theoretical puzzle.

## Research Methods

Where methodology is the guiding framework for how research is performed, research methods refer to the techniques and tools used to collect empirical data (Jennings, 2009). One strength of conducting this work as an ethnographic case study is the stipulation that varied forms of data collection are utilized. Of particular relevance to this study, the combined use of data sources is important for triangulation purposes, where relying on multiple sources of information to examine the same phenomenon produces more credible results (Bowen, 2009; Mertens, 2005; Yin, 2009). In this dissertation, data triangulation allows for a variance of older adult perspectives to be more extensively captured. In alignment with the three primary data sources of case study identified by Merriam (2009): semi-structured in-depth interviews, observational field notes, and document analysis together provide evidentiary support in this work. Multiple in-depth interviews, where discussion is semi-structured in nature, allows for a rich, in-depth conversation where new themes and concepts can emerge (Dearnley, 2005). Interviews partner well with researcher observations, where a dynamic process, one that is "continually moving and evolving," can be explored through direct experience in the environment (Mulhall, 2003, p. 308). Finally, document analysis adds foundation and context to the lived experiences garnered through interviews and observation. Each of these three modalities, which complement and build upon one another, is subsequently described below.

*Qualitative Semi-Structured Interviews*

One tool frequently used in health and aging research is the qualitative interview. Often, the engaging conversation developed through such discussion leads to much richer understandings of subjective lived experiences (Von Faber et al., 2001). As previously stated, this dissertation primarily relies upon interviews that are semi-structured in nature. Although a question guide is used, there is room for flexibility in how the conversation evolves. It is distinct from structured interviews where identical questions are asked of all participants. In semi-structured interviews, it is often the case that there is significant potential for variance in participant responses (Fylan, 2005).

The use of semi-structured qualitative interviews is a particularly useful approach in discovering how older people experience certain phenomena. One such strength lies in its potential to garner a unique and in-depth narrative from respondents. Low (2013) indicates the value of learning “new details” that may otherwise be missed in more planned discussion (p. 91). She further suggests that probing or prompting participants throughout the interview, based on their responses in the moment, is an effective approach where “themes can be pursued in the context in which they emerge” (ibid). This notion is well-aligned with the interviews conducted in this dissertation, where participant responses were often based on improvised follow-up questions. These discussions frequently reflect an element of fluidity. Through this method, the researcher’s pattern of thinking directly impacts points of elaboration and subject matter raised in the interview. This speaks to the extent that the responses of participants, coupled with decisions made by the researcher, play a critically important role in shaping the theoretical context and overarching themes identified from the interview data.

Language is central to the qualitative interview in gerontology, including the language which is conveyed by study participants and the language employed by the researcher to interpret these expressions (Victor, Westerhof, & Bond, 2007). In this way, the task of the ethnographic researcher requires acknowledgement of one's own inherent biases and other limitations that will inevitably impact the analysis and elucidation of findings (Whiting, 2008). Every effort must therefore be made to consider "reflexivity" so that the researcher can avoid making assumptions, based on their own knowledge, that are unwarranted or inappropriate in the context of the interview (Low, 2013, p. 92). In this study, although careful interpretation was conducted to the greatest extent possible, I am consistently cognizant of such limitations and their impact on the validity of my findings.

When relying upon qualitative semi-structured interviews, notions of validity and reliability prominently emerge as a source of dissonance for researchers. A debate around the "trustworthiness" of qualitative research data as compared to that of quantitative positivist measures is consistently part of methodological dialogue (Golafshani, 2003, p. 600). Here a primary criticism of qualitative methods lies in the ambiguity of the often varied and in-depth responses given by participants. In response to such criticism, Pope and Mays (1995) argue that the value and validity of personal narratives is not to be underestimated. They state that "qualitative methods score more highly on validity, by getting at how people really behave and what people actually mean when they describe their experiences, attitudes, and behaviours" (p. 43). It might be argued, then, that the value of the semi-structured qualitative interviews used in this study lies in their revelation of what might be obscured by more limited positivist measures opening the door to new ideas that may not have been previously considered. This, in combination with other sources of data, only serves to enhance the validity of research findings.

*Observations*

In a complimentary relationship to semi-structured qualitative interviews, observations are another useful methodological tool that enhance understandings of research participants and the environment in which they are being studied. This allows the researcher to engage with numerous elements of the site, its function and operation, as well as those who use the space. Such observational work is captured through the development of detailed field notes, which document the carefully noted experiences of the researcher in the field. As Mulhall (2003) discusses, recorded observations allow the researcher to capture and convey "the whole social setting" (p. 308). The strength of this form of field notes data, Mulhall emphasizes, is that more than with interviews, observations focus on a larger picture of what occurs in the physical environment being studied, as well as the ever-changing processes within it (ibid).

Similar to that of semi-structured interviews, however, the subjectivity of field notes also faces criticism. Researcher impressions of a particular space, its activities and the actions of its inhabitants, will inevitably reflect a personal bias. An individual researcher's world view is informed by the multitude of factors unique to their everyday and scholarly experiences. This unique stance will then bleed into the interpretation of results. Merriam and Tisdell (2016), emphasize the role of transparency in research, encouraging scholars to clearly state their biases and indicate, in depth, their specific approach. Sangasubana (2011) notes that the researcher must be particularly aware of the extent to which their own values or perspective will produce partiality in their results. She further posits that this occurs more frequently in qualitative field work studies, which are often performed in a far less controlled environment than a laboratory-type setting where objectivity can be more easily maintained. Observations are hence a valuable

tool when used in a complimentary fashion, alongside other sources of data such as participant interviews and/or analysis of assistive documents.

Among varied forms of data collection, the value of researcher field notes is that they provide important insight into the positionality of the researcher. Ultimately, it is the researcher's constructed interpretation of the situation and participants under study that informs the final interpretation of results (Yazan, 2015). In a small-scale study such as this one, written entirely by the primary researcher, field notes are salient in illuminating this voice and showcasing the unique lens through which the study has been conducted.

*Document Analysis*

The third and final form of data utilized in this dissertation is that of official documents and reports. This method involves the assessment of texts that are relevant to the topic of study (Boadu & Higginbottom, 2015). Unlike the precise and calculated measures of quantitative research, document analysis in qualitative inquiry is less structured in nature. Its focus lies "more on uncovering the richness of meanings and interpretations embedded within the text" (Hewson, 2008, p. 557). Documents are useful for triangulation purposes because their content is entirely free of intervention by the researcher (Bowen, 2009). Unlike interviews and observations, this form of data are therefore more likely to be objective in their meanings, adding another element of complexity and validity to the final analysis.

This is not to say that the process of document analysis is free of limitations. Certainly, similar to the other methods described here, there is the potential for partial selection and analysis of the documents that are used. Though this is unavoidable to a large extent, being aware of it and knowing that documents are produced independent of the researcher ensures that a different voice is heard in the research. Another limitation that Bowen (2009) describes is that

documents, which are often not produced for the purposes of research work, may lack the detail necessary to sufficiently answer a research question. It is here that using document analysis as a supplementary method holds value.

Overall, the diverse methods of interviews, observations, and document analysis together present a more complete picture of the subject being explored. As a theme throughout this work, the dichotomy between structure and agency is reflected in the chosen methods of data collection described here. Where government policy documents convey the discourse of macro-level institutions and structures, interview respondents represent the unique voice of individuals at the micro-level and what it means to age within the confines of these larger frameworks. Both perspectives are important to understanding societal experiences of aging and disability among the oldest old.

## Research Design

Aging and later life experiences, particularly as they intersect with disability have always been a source of strong personal and scholarly interest to me. As a scholar of health equity, much of my research orientation resonates with a feminist political economy perspective. After extensively reviewing the relevant scholarly literature (see Chapter 2), I identified both the theoretical frameworks for this study (see Chapter 3) and the primary research gaps (see Chapter 1) being addressed in this work. Namely, the need for further empirical investigation of the oldest old as a distinct group among older adults. Through these processes, the foundation for the design of this research was established.

This study broadly explores personal expressions of the oldest old in relation to models of successful aging, critically examining these perspectives in larger neoliberal contexts. Through knowledge gained from reviewing the pertinent scholarship in these areas, my principal research

questions were formed. Swanson (2005) emphasizes that research questions are developed through a learned process that allows for “deeper understanding of the phenomenon” (p. 23). As outlined in Chapter 1, the main questions posed in this thesis seek to discover how successful aging is understood by the oldest old, as well as how these perspectives align with that of the successful aging discourses in both scholarship and policy. I also investigate how gender and disability influence aging experiences among those in this age cohort, and the ways in which the oldest old are supported while aging at home via formal aging policies and community-based supports. The formulation of research questions serves an important purpose in leading a researcher to their choice of methods (Donalek, 2005). While my selection of case study highlights the exploratory nature of the “how” and “what” research questions I ask (Yin, 2009, p. 10), critical ethnography aligns with my goal of investigating the subjective voices of society’s oldest members, many of whom are considered vulnerable for reasons discussed in other chapters of this work (Madison, 2012). In this section, I outline key elements of my research process, detailing how my chosen methods were enacted in the field as I endeavoured to investigate my research questions. Here I include a detailed description of the research site, recruitment, data collection, data coding and analysis, and the ethical procedures I followed.

*Site of Study*

This study was conducted in North York, part of the City of Toronto, which comprises a significant segment of the northern Greater Toronto Area (GTA). With a population of nearly 700,000, this centrally located urban area is highly diverse in population. Data were exclusively collected, over a period of approximately 3 months, at a centre for older adults offering a variety of recreational activities and other services. The centre provides programs which aim to promote a healthy active lifestyle and the overall well-being of community-living older adults who are

largely independent in their living circumstance. Programs are offered seven days per week, and include fitness classes, group card games, art courses, and culturally specific or special interest activities. The centre operates as a non-profit organization and is funded through a number of different mechanisms. Among its most prominent funding sources are fundraising campaigns. In addition to this, funding is also supported by the nominal umbrella fees required of each program registrant, and annual membership fees which are occasionally subsidized for those who demonstrate financial need, and complimentary for individuals who are 90 years of age and older.

The centre was described as highly accessible by those involved in this study. Though some participants spoke about difficulties accessing the facility by car, citing the complexities of parking in the area, access through public transport services was described more positively. This is not surprising given that the centre is located in very close proximity to the Toronto subway system and is highly accessible by bus or by the government-subsidized Wheel-Trans service. The centre also offers its own transportation service similar to Wheel-Trans, though at a higher cost, more limited hours, and within a smaller metropolitan area.

In addition to its varied programs and transportation services, the centre assists clientele with securing limited in-home services, including light housekeeping and personal care, and provides general information about available older adult supports and services when met with inquiries. In this regard, it is an information resource hub for people who find it difficult to navigate available older adult services on their own. As a prominent older adult community-based organization in the area, this site was chosen for several reasons.

First, the rapidly growing number of people among the oldest old in North York make issues of concern to this particular group an increasingly important priority. Table 1 shows a

dramatic increase of nearly 37% in North York's aged 85+ population occurring between 2006 and 2016 (City of Toronto, 2018). This significant rate of growth represents the third highest increase of any age group over an equivalent period of time in the same area—second only to that of the aged 60 to 64 and 65 to 69 cohorts.

**Table 1**

*North York population profile over 10 years (2006-2016), by age group*

| Age Group | 2006 | Percentage | 2016 | Percentage | Percentage Change |
|---|---|---|---|---|---|
| 0-4 | 30,975 | 5.2% | 32,165 | 5.0% | 3.8% |
| 5-9 | 31,320 | 5.3% | 33,790 | 5.2% | 7.9% |
| 10-14 | 33,975 | 5.7% | 32,820 | 5.1% | -3.4% |
| 15-19 | 36,580 | 6.2% | 37,625 | 5.8% | 2.9% |
| 20-24 | 39,905 | 6.7% | 44,410 | 6.9% | 1.3% |
| 25-29 | 40,655 | 6.9% | 46,730 | 7.2% | 14.9% |
| 30-34 | 42,760 | 7.2% | 45,960 | 7.1% | 7.5% |
| 35-39 | 46,435 | 7.9% | 44,615 | 6.9% | -3.9% |
| 40-44 | 49,090 | 8.3% | 43,775 | 6.8% | -10.8% |
| 45-49 | 45,645 | 7.7% | 47,025 | 7.3% | 3.0% |
| 50-54 | 39,570 | 6.7% | 47,765 | 7.4% | 20.7% |
| 55-59 | 35,375 | 6.0% | 42,930 | 6.7% | 21.4% |
| 60-64 | 26,065 | 4.4% | 36,015 | 5.6% | 38.2% |
| 65-69 | 22,945 | 3.9% | 32,010 | 5.0% | 39.5% |
| 70-74 | 21,180 | 3.6% | 23,300 | 3.6% | 10.0% |
| 75-79 | 19,800 | 3.3% | 19,765 | 3.1% | -0.2% |
| 80-84 | 15,915 | 2.7% | 15,765 | 2.4% | -0.9% |
| 85 plus | 13,320 | 2.3% | 18,210 | 2.8% | 36.7% |
| **Total** | **591,515** | **100.0%** | **644,685** | **100.0%** | **9.0%** |

*Note.* Reprinted from *North York: City of Toronto community council area profiles*, by City of Toronto – City Planning Strategic Initiatives Policy & Analysis, retrieved from https://www.toronto.ca/wp-content/uploads/2019/01/9710-City_Planning_2016_Census_Profile_2018_CCA_NorthYork.pdf. Copyright 2019 by City of Toronto.

Second, as an entity with significant membership of older, English-speaking individuals, the chosen site was highly convenient for recruitment and sampling purposes. As the sole researcher conducting this project and residing in North York myself at the time that data collection occurred, this site was not only easily accessible, but well-aligned with the funding and practical limitations of pursuing a project of this scope. The recruitment of oldest old

participants who live independently is far more feasible through a centrally located organization like the one used in this study. At the time that data collection occurred, of its approximately 1200 active older adult members, 21% of all users at the facility were represented by people 85 years of age and older (Interview 19, 2016). In qualitative research, feasibility is a critically important factor in research design and execution. Morse (2004) identifies "evidence of access to the setting and participants" in a research study to be a key component in the completion of a project as it is described (p. 501). In other words, an accessible research site plays an important role in allowing the researcher to accomplish their goals within a reasonable timeframe. As a conveniently located urban hub for the oldest old of adults to regularly convene, the centre therefore aligned well with the main objectives of this project.

Finally, in selecting the research site, my intention was also to observe health in a non-clinical setting, where a multiplicity of socioeconomic factors impacting one's health could be explored first-hand in both aging and disability contexts. With the increasing expense of older adults living in an institutionalized long-term care environment, policies and rhetoric in support of aging in place has made it an increasingly attractive option as the aging population grows and sustainability becomes a significant concern for Canada's health care system. An entity like the older adult centre used in this study, which in many respects seems to operate in support of this cause, promotes a dialogue of "healthy" and "active" lifestyle choices that are well-aligned with normative successful aging discourse. Much of this involves accommodating the needs of older adults so that they can continue to live independently for as long as possible. Older people living in the community are also more likely to encounter and/or be impacted by various SDOH in their everyday lives, where they are more vulnerable to a circumstance of precarious access to

resources. In the initial conceptions of this project, these health equity contexts were an anticipated valuable component identified from the data.

*Study Design & Recruitment*

Upon completion and approval of the dissertation study proposal, the design and execution of this work was conducted in several phases. Following a review of relevant literature, the results of which are found in Chapter 2, I began the processes of recruitment and collection of primary data. Before field work could begin, the research site required several administrative tasks to be performed. These procedures provided important introductory information that would later assist me in understanding the organizational structure of the centre. In the first step of this process, I reached out to a member of the management staff, one who would eventually become a key informant in this study. [4] I first contacted this individual via e-mail. This was followed by two telephone conversations, during which introductions were made and details of the study were discussed. In this initial exchange of communication, my proposed work was received with enthusiasm.

Bernard (2000) describes the value of key informants in ethnographic research as “people you can talk to easily, who understand the information you need, and are glad to give it to you or get it for you” (p. 346). In this dissertation study, the key informant on the management staff proved to be an invaluable ally during recruitment efforts and throughout the data collection process by providing significant assistance in recommending potential interview candidates and answering general questions that arose during the work. Logistically, I was required to complete

[4] It is important to note that though the key informant offered invaluable assistance through the provision of logistical information concerning the centre and its function, this voice remains largely secondary to that of the oldest old participants throughout this work. More specifically, the personal expressions of older adult respondents, both inside and outside the context of the research site, is the primary concentration of this study and the dominant perspective conveyed and explored in succeeding chapters.

and sign a volunteer application form, which included my personal background and contact information. I was also given a 2-hour site visit tour of the facility, where the key informant provided me with general information and explained the activities occurring in each wing of the facility. Finally, I was required to read and familiarize myself with Workplace Safety and Insurance Board (WSIB) policies, a process that took approximately 3 hours, before I was permitted to officially begin data collection at the site.

In this study, sampling was purposive, where elements of both homogeneous and snowball techniques were utilized for recruitment. Purposive sampling infers that the primary researcher, using their own judgement, seeks to select participants based on their capacity to share knowledge and experiences that are most relevant to the study (Etikan, Musa, & Alkassim, 2016). First, where homogeneous sampling was utilized, the majority of study participants were selected for interviews on the basis of a shared trait: in this case, their age (Onwuegbuzie & Leech, 2007; Ritchie et al., 2014). Most individuals in the sample were among the oldest old of adults (85+ years), English-speaking, and members or visitors of the centre. This allowed me to contextualize first-hand perspectives of successful aging as they are perceived by the oldest members of this organization. Interview candidates were comprised of both male and female participants for the purpose of enriched gender analysis, a theme explored in Chapter 6. Though other intersectional commonalities, such as race, were indicated through interview conversations, my primary focus remained on age, gender, and disability. In Chapter 8 of this work, I recognize that varied intersectional perspectives—particularly race—are compelling areas for future research.

Exceptions to those represented by the homogeneous age sample of the oldest old included the four key informant staff members, and one respondent family member. These

respondents were interviewed to better understand the varying roles assumed by different individuals at the centre. As reflected in both observational field notes and interviews, these participants were also in a unique position to provide insight and make recommendations based on their personal interactions with the oldest old who frequented the centre. Connecting with these respondents was therefore very helpful during recruitment and data collection.

In addition to homogeneous sampling, snowball sampling techniques that rely upon the recommendations of participants and key informants to suggest potential interview candidates were also a key element of recruitment in this study (Check & Schutt, 2012; Cohen & Arieli, 2011; Noy, 2008). This evolved through early conversation during observations and interviews where members of the centre and the staff frequently and voluntarily proposed suitable interview candidates to me as the work progressed. Check and Schutt (2012) speak to the valuable role of snowball sampling in identifying “hard-to-reach” populations that may otherwise be difficult to recognize (p. 105). For this, I often engaged in casual conversation with potential research participants, staff, and volunteers, many of whom would suggest candidates based on their own personal associations after learning about my study and its focus.

Recruitment efforts also included a poster placed on an informational bulletin board at the centre, briefly describing the study and providing my direct contact information. Additionally, members of management offered to include a message about this study in the centre’s electronic newsletter one month prior to commencing data collection. While these efforts served well as advertisement, nearly all candidates were successfully recruited by spending prolonged hours at the centre and fostering relationships over time. A significant amount of this observation time meant engaging in casual conversation and speaking directly to people about the project and its purpose. On many occasions I spent upwards of six hours per

day at the research site, two to three days per week, over the months that data collection took place. Substantial time was spent in both the lobby area of the facility, where guests consistently arrived and departed, as well as in the food café where numerous members gathered for affordable meals and socialization. This not only served the important purpose of establishing a rapport with people, but also in gaining their trust and assistance with recruitment efforts. A fair number of participants were recruited over a shared meal with various older adult members during the lunch hour. It was often the case that after learning about this project several older adult members and staff at the facility, many of whom did not fit the criteria of the sample group, enthusiastically suggested friends and acquaintances at the site that did qualify.

During observations, I was continually mindful of the possibility that individuals might feel some sense of discomfort from my surveillance, as their actions and activities were subject to increased scrutiny. Initially, it did seem as though a number of older adults were somewhat distrustful of my approaching them. Dwyer and Buckle (2009) refer to the complex perspective of the "outsider," when one is conducting research with a population that they themselves do not belong to (p. 57). Though this can mean some level of difficulty in gaining the trust and understanding of certain individuals, the authors suggest that "the core ingredient is not insider or outsider status but an ability to be open, authentic, honest, deeply interested in the experience of one's research participants, and committed to accurately and adequately representing their experience" (ibid, 59). In this study, I strove to develop and foster this type of trusting dialogue with those I regularly encountered on my visits to the site. This meant acknowledging my outsider status and remaining mindful of it as I openly sought insight from others. Spending a significant amount of time speaking to the volunteer staff at the main reception desk, many of whom were also older adult members of the centre, helped immensely in this endeavor. It was

often the case that these volunteers would not only suggest appropriate interview candidates, but also willingly served as intermediaries by personally introducing me to potential participants. Such introductions from "insiders" at the facility significantly enhanced the reception of my work by many in the target population. In this way, insiders also assume the role of allies in ethnographic work, particularly when working with a population that are more likely to be distrustful of outsiders performing research.

*Participant Data*

Data collection took place over a period of three and a half months. Together with the recruitment methods described above, observations and in-depth interviews began in January of 2016 and concluded in mid-April of the same year. In the months following, each interview was transcribed, and subsequently coded to assist with final analysis. At the conclusion of each interview, participants were asked to complete a brief and confidential survey containing basic demographic information (see Appendix A). When paired with the rich interview data, survey responses were particularly useful in providing context and informing critical analysis during the writing phase. For each question in the survey, participants were expected to simply place a checkmark beside the answer that most applied to them and their circumstance. The results of this survey provide a demographic profile of the older adults interviewed, including their age, marital and family status, racial/cultural group, disability, and health status (see Table 2).

**Table 2**
*Demographic profile of oldest old participants (N = 18)*

| Characteristic | n | Percentage |
|---|---|---|
| Age Group (years) | | |
| 85 years to 89 years | 10 | 55.5 |
| 90 years and over | 8 | 44.4 |
| Gender | | |
| Male | 9 | 50 |
| Female | 9 | 50 |
| Marital Status: | | |
| Married (legal and common law) | 6 | 33.3 |
| Separated | 1 | 5.5 |
| Widowed | 11 | 61.1 |
| Children | | |
| Yes | 16 | 88.8 |
| No | 2 | 11.1 |
| Racial/Cultural Group | | |
| White | 14 | 77.7 |
| East Asian | 1 | 5.5 |
| South Asian | 2 | 11.1 |
| Don't Know | 1 | 5.5 |
| Health Condition | | |
| Yes | 10 | 55.5 |
| No | 7 | 38.8 |
| Don't know | 1 | 5.5 |
| Disability (Self-Perceived[5]) | | |
| Yes | 6 | 33.3 |
| No | 12 | 66.6 |
| Disability Type (Self-Perceived) | | |
| Sensory (hearing, vision/sight, smell, etc.) | 3 | 16.6 |
| Mobility (walking, bodily movement or pain, etc.) | 3 | 16.6 |
| Intellectual (memory, thought, etc.) | 1 | 5.5 |
| Sensory and Mobility | 3 | 16.6 |
| Mobility and Intellectual | 1 | 5.5 |
| Refused | 2 | 11.1 |
| Not applicable | 5 | 27.7 |

Table 2 shows that of the participants in this study who were aged 85 years and older, an equal number of men and women were interviewed. The majority of the participants also indicated being widowed and/or without partners, a factor I examine more extensively in Chapter

[5] Self-perceived disability status was determined by asking participants whether they considered themselves to have a disability. This is distinct from a medicalized diagnosis of disability through some form of clinical assessment.

6 of this thesis. A lesser number of participants identified with having a disability than those who considered themselves to have some form of health condition. This suggests that not all participants who expressed experiencing a disability felt that this was equivalent to having a health condition and vice versa. Among those who participated in this study, the two spheres of disability and health-related illness are therefore not necessarily synonymous, as many dominant biomedical models tend to support.

It is also important to provide details concerning the study participants in this work, as it allows readers to consider the relevance of the present findings to their own situation and the oldest old with whom they may be interacting either personally and/or professionally in other settings (Lincoln and Guba, 1985). Box 1 provides a description of the class-based locations of these participants based on information gleaned from the demographic surveys, qualitative interviews, and my observations.

Box 1: Description of Study Participants

In order for readers to assess the validity of these findings, and the extent to which they may be applicable in other circumstances, it is important to provide what Lincoln and Guba (1985) describe as a "thick description" of the attributes within the sample group of the oldest old in this study. These older adults were residents of a relatively affluent neighbourhood of Toronto and their racial/cultural composition was predominantly of European or Caucasian decent – where nearly 78% identified as belonging to this category. Most of these individuals either lived in houses or condominiums that they themselves owned, while two electively resided in privately funded retirement homes. Of note, very few participants expressed serious concerns about their financial situation. A number of interviewees further indicated that they had planned and budgeted for the potential possibility of personally funding their relocation to some form of long-term care circumstance, should it arise in the future. This ultimately suggests that amongst this particular group of the oldest old, this sample is likely represented by those situated in more advantageous social locations.

*Interview Data Collection*

Interviews were semi-structured in nature, allowing for a dialogue that, though dictated by prepared questions, produced some improvisation where participant responses to some degree guided the flow and direction of the conversation. This improvisation was conducted in a "careful and theorized way" (Wengraf, 2001, p. 5), while occasionally allowing the conversation to flow in a direction that was desirable to the respondent. In the case of two participants, the need for a second conversation arose. In these instances, a subsequent interview was conducted for clarification and member checking purposes.[6]

Interview questions covered a variety of areas relevant to investigating this study's main purpose and research questions. Please see Appendix B1-B3 for the comprehensive interview protocol developed and used for this study. The interview guide concentrates on five general areas, including living circumstance, life satisfaction, the research site facility, disability, and government services. In formulating the interview questions and probes, I strove to make them "brief and unambiguous and, at the same time, sensitive to the feelings of participants" (Donalek, 2005, p. 124). Between 5 and 10 questions relating to each category were explored during interviews. With respect to their *living circumstance*, participants were asked to describe their present living situation, as well as how they felt about the arrangement. Under *life satisfaction*, respondents were prompted to speak to this in the context of their current age compared to their earlier years, their financial situation, their relationships with family and friends, their health, and finally, the way that they were generally treated by others in daily life.

[6] In qualitative research, member checking refers to a process of validating the response and/or intended meaning of participants through follow up discussion and engagement (Goldblatt, Karnieli-Miller & Neumann, 2011). This concept, as it is used in the context of this study, is more extensively discussed in a subsequent section of this chapter entitled, "Trustworthiness."

Regarding questions about the centre, I sought to learn which needs participants felt were being fulfilled by the facility, what was involved in a typical visit to the site, the importance of partaking in the programs offered, the activities that they elected to join, and the extent to which their accessibility needs were being met in this setting. In the realm of *disability*, prepared questions delved in to both physical barriers and emotional challenges faced in day-to-day life, as well as how respondents felt towards these factors. I asked interviewees to speak about the extent to which they felt any personal challenges or needs were being accommodated, if at all. I also questioned how people understood the phrase and concept of "successful aging," including the role played by disability, if any, in this status. With respect to *services*, I inquired about the formal government supports and programs that participants had either used themselves or were familiar with, as well as how they felt about receiving and/or accessing any such services to accommodate their specific needs.

The variance in questioning described above produced rich interview data targeted at satisfying the guiding research questions of this study. The broad probes concerning living circumstance, for example, garnered significant responses with respect to my question about the oldest old aging in place or at home: a main theme in this study (see Chapter 7). By asking participants about the factor of disability in their lives and their experiences at the centre, I gained perspective about their subjective views with respect to successful aging and other important social facets and services present in their everyday lives. The flexibility of semi-structured dialogue generated during these conversations further allowed for several follow up inquiries that together addressed a number of relevant aspects pertaining to each of my research questions (Bailey, 2018). In these ways, interview discussions produced responses that were appropriate to the scope of this inquiry.

Nearly all interviews took place at the research site, often in the library room on the main floor. This was typically an unoccupied and quiet space. In four exceptional instances, participants requested an interview in their home because their time at the centre was bound by inflexible transportation. In these cases the preference was always accommodated, and the interview was scheduled at an agreed-upon time and place that was most convenient for the participant. To the best extent that was possible, given that this project involved participants who identified with some form of disability, efforts were made to meet the accessibility requirements of any participants who indicated accommodative needs.

Through the interview process, all study participants were given an informed consent form that they were required to read and sign prior to beginning the interview conversation (see Appendix C). Participation was entirely voluntary, and interviewees were permitted to cease or withdraw their participation at any time, although no participants elected to do so. All interviews were tape-recorded on two devices, as a precautionary measure to protect against lost data if the primary recorder failed.

During interview conversations some participants were brief in their responses, which presented little opportunity for follow-up questions. In these instances, I remained very close to the questions outlined in the prepared interview guide. In other cases, the opposite phenomenon occurred, where participants were extensive in their responses and would often veer away from the topic and subject matter. Here, I would gently direct conversation toward dialogue that was more relevant to the scope of this study. One interesting element I encountered here is the extent to which many of the older people who were interviewed, primarily those who were either widowed or living alone, implied a desire for comradery or friendship beyond the parameters of this research project. In the time spent together, I also found it difficult not to become attached or

feel compelled to pursue a friendship with some participants after the study was complete. This is a noted struggle that some ethnographers acknowledge. That of the friendship which can occur between the "outsider" researcher and the "insider" informant, as well as the ethical dilemmas that may arise from it (Smith, 2016; Taylor, 2011). Ultimately, in this research process, no such post-data collection contact or further conversation came to fruition, though the intent was often present and felt during and immediately after the time that interviews took place.

As already mentioned, a total of 24 interviews were conducted in this study, of which eighteen were with individuals 85 years of age and older, four were members of the facility's staff, and one was a family member. Upon completion of this set of interviews, a point of saturation had been reached. That is, as the latter interviews took place, it became clear that "no new themes, findings, concepts or problems were evident in the data" (Francis et al., 2010, p. 1229). In determining the final sample size for this study, effort was made to ensure that the participant group being studied was large enough for saturation in results to be reached, but not so small that it could not (Onwuegbuzie & Leech, 2007). Ultimately, I determined that the final number seemed appropriate for the scale and parameters of this study.

*Observational Field Notes*

In addition to the rich data elicited by semi-structured interview conversations, I captured researcher impressions in the hours preceding and proceeding interviews, as well as during the times that activities and programs were held at the site. Field notes were recorded at least twice a week. As most recruitment was done through significant time spent at the older adult centre, this allowed me ample opportunity to capture and engage in casual conversation with interviewees, staff and others who frequented the facility for various purposes.

All observational field notes were electronically recorded on an iPad tablet device during visits to the research site. These notes complement the interview data and provide an opportunity for greater understanding of the research site and how the site was both used and experienced by participants. In order to capture a complete picture of the centre, I not only spent significant time in the communal social areas of the facility, but also observed several of the activities that took place. On multiple occasions, I spent time in art classes, knitting groups, card and game social gatherings, and other programs at the site. As I attended these classes, I was met with mixed reception. In the art and knitting groups, for example, I certainly felt an increased trust between myself and those who participated in these activities. These members seemed to become accustomed to seeing me in the space regularly and enjoyed getting to know me. In the card and game groups, however, where the atmosphere was generally more competitive, my presence garnered the opposite response, and I felt that I was received with suspicion. Merriam et al. (2001) support that this is typical of scholarly work, where researchers are likely to assume the persona of both an outsider and insider in the course of a study. Hence, I experienced first-hand the dichotomous balance between the researcher insider/outsider during my time observing these activities.

*Supplementary Documents*

In this study, along with researcher observations, I used documents to supplement the findings from the primary interview data. There are a number of ways in which documents are used in qualitative ethnographic approaches. While document analysis can provide needed background information, and aid in the verification of research findings, it is also a method that can "complement another in an interactive way" (Bowen, 2009, p. 30). Connell, Lynch, and Waring (2001) write that the criteria for evaluating documentary sources involves "authenticity,

credibility, representativeness and importantly the establishment of the meaning of the document and its contribution to the issues researchers are hoping to illuminate" (p. 4). In selecting appropriate documents for this project, I aimed to abide by these conditions by using sources that are both significant in Canadian/Ontario aging policy discussions and that speak to the broadly identified themes and sub-themes of this work.

This component of the research design involved the collection and review of various official document materials from resources such as Canadian (federal), and Ontario (provincial) government websites. I also consulted some WHO (global) aging report literature for context. All documents were accessed using online search engines such as Google and Google Scholar, by targeting key search phrases related to the main research questions posed in this study. Most of the documents collected are government policy reports, institutional/organizational policy analysis documents, and reports generated via Statistics Canada—specifically those that draw upon most recent 2016 Canadian census data. For a list of notable documents used in this study, and my key interpretations of these materials, please see Appendix D (Table 5). I read and reviewed each document, highlighting relevant passages for thematic congruence. Some of the documents I consulted include:

- *Aging with Confidence: Ontario's Action Plan for Seniors* (Government of Ontario)
- *Canada's Aging Population: The Municipal Role in Canada's Demographic Shift* (The Federation of Canadian Municipalities)
- *Time for Action: Advancing Human Rights for Older Ontarians* (Ontario Human Rights Commission)
- *Ageing Alone: The Impact on Poverty and Social Exclusion* (Quebec Advisory and Monitoring Committee)
- *A Framework for the Law as it Affects Older Adults: Advancing Substantive Equality for Older Persons through Law, Policy and Practice* (Law Commission of Ontario)
- *Expanding Caregiver Support in Ontario* (external advisory report to the Government of Ontario)
- *Portrait of Caregivers* (analytical report produced for Statistics Canada)

- *An Evidence-Informed National Seniors Strategy for Canada* (2nd ed.) (Alliance for a National Seniors Strategy)
- *Report on the Social Isolation of Seniors* (National Seniors Council)
- *Diversity, Aging, and Intersectionality in Ontario Home Care: Why We Need an Intersectional Approach to Respond to Home Care Needs* (Wellesley Institute)
- *Canada's Aging Population: Seizing the Opportunity* (Special Senate Committee on Aging)

Reviewing these supplementary documents allowed me to gain a stronger understanding of macro-level aging policy dialogues and situate these findings within the context of the micro-level perspectives shared by participants. Together, these forms of data allowed for a more holistic picture of the issues being examined.

*Data Coding & Analysis*

Upon completion of data collection, subsequent methodological steps involved the transcription, coding, and analysis of materials. As the sole researcher on this project with a limited budget, I elected to personally transcribe the interviews conducted, as opposed to outsourcing this task to a transcription professional. Doing so was helpful as a means of immersing myself in the data, and this process was an important first step in imagining important themes that would later inform the final analysis. A basic computer program called InqScribe was used to transcribe the audio recordings. Each audio file was loaded into this software application, which was explicitly designed for transcription purposes. The interface of the program allowed me to listen to the interview recordings while simultaneously translating them to verbatim typed text. Transcribed text files provided tangible/readable data for coding and analysis purposes.

During the coding of interview data, I relied upon the constant comparative method to develop the thematic-categories and sub-categories used in this work (Lincoln & Guba, 1985; Powell, 2004). Having derived the major research questions in the proposal phase of this work,

and having conducted an extensive review of scholarly literature (see Chapter 2), I relied upon this knowledge base to inform the empirical approaches of this study and its themes. A method of constant comparison supports the identification of codes/themes from the data themselves, where main concepts are established during the coding process. More specifically, rather than embarking upon data collection with a preconceived notion of anticipated categories that might be identified, or analyzing the data independent of the coding, the researcher develops salient themes from the data, as they are being coded, through comparative means (Boeije, 2002; Glaser, 1965). As a result, the rich content of the data were regularly re-evaluated in the context of identified themes that organically arose among the many different voices represented in this study.

In this project, coding was performed in two phases. In the first phase, I carefully read each transcribed interview and manually wrote code/category names beside applicable quotes in the margins of these documents. Evaluating the hard copies in this way allowed me to easily identify and review key ideas, classifying common links and patterns between different accounts. Points of repetition were comparatively identified between interview quotations and related back to my principal research questions, a process through which the major themes and sub-themes of this work were identified. In the second phase, I subsequently utilized the NVivo computer software program to manually input each piece of coded data determined in the first phase. Wiltshier (2011, January) explains that "nodes in Nvivo allow users to represent specific themes, places, people or other area of interest, and where appropriate, to gather data together that is relevant to the theme the node represents." This program is known to be highly user-friendly and a valuable assistive tool in qualitative inquiry. The software enabled me to generate

comprehensive document reports, itemizing all similarly grouped quotations according to the categories and sub-categories I identified.

Throughout the coding/analysis process, I evaluated participant responses as independent entities and then comparatively against one another as part of a larger whole. During this process I identified three clearly defined main themes and nine sub-themes, all of which are fully explored in subsequent discussion chapters of this dissertation. Please see Appendix E (Table 6) for a full list and summary of the identified themes and sub-themes in this study. The prepared questions asked of participants informed these surfacing themes greatly, as similar questions posed across the sample population are more likely to inspire a common thread or link among respondents. This interview guide was a necessary tool in providing structure and context, as well as ensuring that the subject matter was aligned with the larger conceptual goals of this work. At the same time, the semi-structured nature of participant conversations, where discussions are less rigid, leaves room for areas of focus that may otherwise be hidden by a more structured guide. A great benefit of this method is that while a necessary amount of uniformity is maintained in the data, there is also an opportunity for unforeseen elements to be identified.

Also worthy of note in my methodological process was my choice to revisit the data after a nearly two-year absence from this project for an extended maternity leave. Following this interruption, I embarked upon a process of refamiliarizing myself with the data. I approached this task by re-listening to the audio recordings of all interviews and re-reading my detailed observational field notes. I also conducted an updated search for supplementary documents, to discover more recent aging policy-related documents that had been released during my hiatus from this work. By immersing myself in the data this way, for the second time, I felt as though I was transported back to the research site and able to visualize my field work experience.

I reflexively acknowledge that my positionality has been somewhat altered through the significant changes to occur in my personal life during this interruption. My thinking about the feminist/familial elements of this study, in particular, now resonate with me on a more personal level. I also hold a stronger emotional response to participants who indicated experiences such as managing the loss of their spouse and balancing a relationship with their children: a concern I am more acutely aware of after becoming a parent myself. It occurs to me that it is not uncommon for researchers to update their studies, sometimes years after their original works, with follow-up reports. Not only is new scholarship continuously being presented, but personal and professional experiences undoubtedly intersect with the evolution of a research career throughout the life course. Trepal, Stinchfield and Haiyasoso (2014) speak to the extent that doctoral students convey and grapple with their experiences of motherhood amidst their scholarly work. In their work, participants indicated that the dual roles of parenthood and pursuing their doctorate was an enhancing factor in their work. Just as research work is continually evolving, I embrace my return to this work in my newer location as a mother.

*Ethical Considerations and Processes*

In addition to the potential methodological implications of my changing positionality and life circumstance, it is important to also be mindful of ethical dilemmas encountered in qualitative research involving older adults. I am acutely aware of concerns associated with vulnerability when involving older adults, and particularly issues of capacity and consent regarding those with disabilities in research. These concerns can impact research, particularly because some older people are subject to a higher likelihood of experiencing certain chronic conditions or illness, rendering them more vulnerable (Covey, 1985). Hatch (2002) cautions researchers to be particularly mindful of power relations, and to have an increased awareness of

placing vulnerable individuals at risk. This includes recognizing the extent to which the research itself could "disturb the site and potentially (and often unintentionally) exploit the vulnerable populations we study" (Creswell, 2013, p. 55). This research was hence conducted with a particular sensitivity towards the ethical concerns associated with research studies involving human participants.

All collected data will be stored on a secure database for an indefinite period of time, only for the purposes of publication and to potentially provide needed background for any future research that may build upon this work. To the greatest extent possible, anonymity and confidentiality are strictly preserved for all participants during the processes of data collection, data analysis, and dissemination of results.

## Trustworthiness

The concept of "trustworthiness" was first established by Lincoln and Guba (1985). The methods of this protocol are widely used as a means of validating qualitative research findings (Elo et al., 2014; Rolfe, 2006). In this study, trustworthiness is measured in three ways. The first occurs through prolonged engagement. This refers to the researcher spending adequate time at the research site fostering relationships with research participants, and deriving cultural meaning from this process (Henry, 2015; Onwuegbuzie & Leech, 2007). It also involves the deep understandings gained by the investigator through persistent observation (Erlandson et al., 1993). In the three and a half months I spent in the field collecting data, I established a strong rapport with the respondents in this study. Extensive time at the research site was beneficial in allowing me to observe participants in multiple settings and numerous contexts beyond that of formal interviews. During this time, I also took extensive field notes where my reflections about my personal interactions were comprehensively documented. These detailed observations not only

informed my thinking with respect to the thematic conclusions that would later be drawn, but also allowed me to witness and identify recurrent operational trends at the research site.

The second criteria of trustworthiness fulfilled in this study occurs through a process of informal member checking. Member checking refers to the sharing of findings with those involved in the research to verify answers and elucidate meaning (Harper & Cole, 2012). In this study, two interviewees were asked to partake in a second, follow up interview based on a need to clarify and expand upon statements made in our initial conversations. Additionally, on two occasions during the data collection process, I communicated my identified findings and key observations to the key informant manager at the research site for the purpose of resonance. Extensive reflexive notes were taken after each of these discussions. While the participants in this study spoke to their subjective personal experiences, I note in my observations that the perspective of this manager provided context through a "bird's eye view" of the centre, its members, and its operations at multiple levels (observation, March 23, 2016). Through her professional role and daily engagement with the oldest members of the facility, the manager was a particularly valuable resource and ally who could speak to my findings through the process.

Finally, trustworthiness is preserved in this study through triangulation of data sources. On this subject, Shenton (2004) writes that "the use of different methods in concert compensates for their individual limitations and exploits their respective benefits" (p. 65). As discussed earlier in this chapter, three primary modes of data inform this work. Here, participant interviews convey subjective experiences of the oldest old, observations inform my knowledge and thinking in reflexive ways, and consulted documents, the contents of which are free of researcher intervention or bias, situate my analytical findings in a policy context. The congruence between these selected sources of data are a critical piece of validity in the findings of this work.

## Conclusion

In this chapter, I describe the research methodologies of critical ethnography and case study as the primary guiding approaches of this work. I also outline the detailed methods of data collection, coding techniques, and final analysis employed in this doctoral study. Finally, I contend with ethical procedures and the trustworthiness of this research. In this study, as I seek to explore the lived experiences of the oldest old, in one specific community, the choice to pursue an entirely qualitative method was made because of its strength in capturing the rich lived experiences of the oldest old of adults. Romo et al. (2013) write that "successful aging involves subjective criteria and has a cultural context that is not captured in objective measurements" (p. 939). Qualitative study seeks to address this gap in knowledge, which may occur when objective quantitative methods overlook important social and personal experiences in favour of examining later life through a lens of biological determinism. In each of the three subsequent discussion chapters of this thesis, I present my research findings and analysis according to the main themes and sub-themes I identified.

# Chapter Five: Aging Interdependently – Examining the Complexities of the Independence/ Interdependence Dyad among the Oldest Old

> *"If the older individual perceives aging as an isolated existence, the individual will isolate itself and begin to fail; however, if the older individual perceives aging as an integral part of the social structure in which he or she lives, he or she will thrive. Social support and perception has a very powerful influence on adaptation to physical and cognitive limitations."*
>
> (Hansen-Kyle, 2005, p. 50)

## Introduction

This is the first of three chapters in this dissertation study to focus on the findings and themes identified from the research data. For the purposes of this work, a "theme" is defined as a topic or concept used as a means of answering research questions, as well as to organize similar ideas that repeat across data sets (Vaismoradi, Jones, Turunen, & Snelgrove, 2016). Using participant data, in this chapter I explore the first major theme of an independence/interdependence dyad as it is reflected in the research findings of this study. Interview data suggest that while the notion of independence was identified as a most significant mechanism for successful aging by respondents, an underlying more complex necessity for interdependence is also revealed. Here, I argue that the essential role of interdependence in facilitating successful aging requires stronger presence in aging policy discussions and the dominant discourse through its support for strengthened formal services, while opposing the goals of supreme independence endorsed by neoliberalism.

In relation to this theme, my findings and analysis are presented through a discussion of three primary sub-themes: sustained autonomy, familial/intergenerational connections and support, and the avoidance of disability along with living an active lifestyle. In a subsequent

discussion section, connections are then made to the theoretical models of feminist political economy, life course theory, and intersectionality in relation to the data. When asked what successful aging means to them, many participants identified a preference to maintain their sense of individualism and remain autonomous. This sentiment is consistent with that of dominant neoliberal ideology, the discourses of successful aging and Active Living, as well as policies concerning aging and the aged. Independence, as described by the oldest old in this study, is complex in its meaning. During interviews, participants discussed a number of key measures that were necessary to maintaining their independence with advancing age. Though many participants were explicit in indicating a preference to remain productive and actively engaged through continued social participation, they also suggested that this process did not occur in isolation. Rather, interviewees emphasized a reliance on others in social, familial, and support-centered contexts. This is consistent with a model of interdependence, involving reciprocity, interrelationships between people and external support from formal government services (Beeber, 2008; White & Groves, 1997). White and Groves (1997) suggest that independence and interdependence are related concepts, writing "the ideal image of the aged should be of healthy independence, supported by family, friends and community – in essence, interdependence" (p. 85).

In addition to findings from the participant data, in this chapter I also draw upon policy documents focused on aging well and Active Living. For example, *Ontario's Action Plan for Seniors* (2017) is comprised of several components in support of an independence model for older adults. The Federation of Canadian Municipalities (2013), the Conference Board of Canada (Dinh, 2014), and the IRPP Task Force on Aging (2015) all released reports consistent with the message of maintaining good health through community-based services targeted at educating

older adults in individual lifestyle factors that facilitate positive and active aging. While these policy dialogues do describe many avenues of support for older adults, they also seem to shift responsibility away from that of the welfare state. Canadian/Ontario aging policies further tend to allocate services in later life based on an age category of 65 years and beyond, giving little attention to the distinctions that may occur between the needs of older adults and the oldest old of adults.

In this chapter and the two that follow I present participant narratives from interview data, exploring these voices in the context of the theoretical and policy-centered frameworks used in this study. In examining the personal stories of multiple informants, “it should be possible to distil the tellers’ perspectives on the events recounted or on particular themes or processes” (Cortazzi, 2001, p. 385). The aim of conveying narratives in qualitative research is to portray a full context of the experiences and the culture of the research participants as they are observed and analyzed. In alignment with this, it is through the first-hand accounts of the participants in this study that the themes/sub-themes of this work are identified and explored.

## Findings and Analysis

In this study I identified three primary sub-themes from participant data in relation to this chapter’s main focus of complex independence/interdependence as essential to successful aging. Findings are here presented according to each of the following sub-themes: sustained autonomy, familial/intergenerational connections and support, and finally, avoidance of disability and living actively. In this section, I examine these interrelated sub-topics through participant expressions, field note observations, and the dialogue found in aging policy-oriented documents. I further draw connections with the theories that comprise the analytical framework of this thesis as outlined in Chapter 3.

*Sustained Autonomy*

In an aging context, autonomy is defined in various ways by both scholarly literature and policy frameworks. From a policy perspective, the World Health Organization (WHO) (2017) identifies the need to "foster older people's autonomy" as an important strategic objective in its *Global Strategy and Action Plan on Ageing and Health.* The report states: "Older adults have the right to make choices and take control over a range of issues, including where they live, the relationships they have, what they wear, how they spend their time, and whether they embark on a treatment" (p. 11). Here, autonomy is named as a critical component in maintaining several core values that are intrinsic to the human condition. In scholarship, a similar understanding of the freedom to make choices in later life is given particular emphasis. Hansen-Kyle (2005), for example, describes autonomy as an individual's capacity and personal desire to make decisions regarding their own care (p. 51). Clark (1988) takes this further, noting that personal autonomy also involves control over one's life, as well as the freedom to pursue a life plan of one's choosing, and living by one's own inclinations and preferences (p. 284). Consistent with these definitions, interview data indicate that a number of participants in this study held a strong preference to be as self-sustaining as possible. For many respondents, their autonomy was preserved through both their ability to freely spend their time as they desired (something that was particularly felt at this current stage of their lives) and their general resistance to accepting state-level supports, preferring to avoid dependence on external aid to the greatest extent possible.

One 90-year-old woman expressed feeling fortunate to be able to pursue basic tasks at her own pace and on her own terms. She said "I'm so used to being by myself, or going to sleep if I want to, eat when I want to, whatever. So far, I've been able to, which is pretty lucky. Very lucky" (Interview 13, 2016). Though clearly satisfied with this freedom to do as she chose, she

later alluded to how this autonomy over her time was socially devalued by drawing a comparison to her earlier paid working life:

> I(nterviewer):[7] Do you have any comment on how your age might affect your happiness now? Would you say that you feel differently now, versus when you were younger?
> R(espondent): Well, you don't feel very useful because you're not working and you know, if you go to sleep and nobody cares whether you're up or not, you can spend your time as you wish - except if you've made commitments. You're pretty free to choose your own lifestyle, which is quite nice. (ibid)

Herein lies one complex element of pursuing an "unproductive" path in later life, and the feelings it evokes in one who has aged in a free-market oriented society. Market-driven neoliberal models tend to devalue unpaid activities that are not visible or directly obvious in their economic contribution to society. In stating that she did not feel "useful" because she was no longer "working," this woman seemingly held on to continued beliefs regarding economic activity and its connection to her worth even at 90 years of age, decades into her formal retirement. At the same time, she still spoke positively about her autonomy and sense of freedom to dictate her own time, calling it "quite nice."

A more positive sentiment about no longer partaking in productive working life was expressed by another participant. For this woman, the autonomous freedom to choose how she spent her time at this age was a welcome change from the experience of her working years:

> I: Can I ask if there are things that are more or less important to you now than when you were younger? How have your priorities changed?
> R: Art has been wonderful for me.
> I: Is that something that you did when you were younger?
> R: No, I couldn't.
> I: So, when did you pick that up?
> R: At 81. I always wanted to do it, but I couldn't.
> I: So, you've made the time since being in your 80's to pursue your passions?
> R: Yeah. Well that was one of the greatest things I did. It did so much for me in other respects. It gave me a really strong sense of confidence, and well they said that when you stop working you lose your identity. I don't believe that. It didn't for me.

[7] In interview transcriptions, the interviewer is labelled "I," while respondents are labelled "R."

> I: It didn't for you? How would you define it then? Would you say your identity can be defined in what way?
> R: I have a strong sense of who I am now, whereas I didn't before. (Interview 22, 2016)

In freely pursuing art as a hobby only after the age of 81 this respondent, who was 85 at the time of our interview, described the benefits of increased flexibility with her time that allowed her to pursue something she genuinely enjoyed. She also suggested that her identity was not connected to her paid work path of earlier years, and that she had in fact gained a stronger sense of self at this particular point in her life. Having the autonomous freedom to pursue a creative passion became possible only long after the productive expectations of her time had ceased. Here the extent to which individual autonomy is constrained under neoliberalism, through the demands of a free market system, is demonstrated.

Though the capacity to make autonomous choices was suggested as a preferred path by some participants in this study, another perspective conveyed in the data was a feeling of resignation and negativity associated with losing one's freedom at this life stage. This threat to independence tended to converge with health- or disability-related experiences. For example, one participant expressed acceptance of his circumstance with an acquired disability in his oldest old years as something that he felt powerless to change, yet he still clung to his capacity to do things for himself and retain his independence. He said "Well, you don't have a hell of a lot of choice, you really don't. Take it from me, you don't have a lot of choice. You have to adapt" (Interview 21, 2016). In this case, he spoke to the difficulties that arose from his acquired health condition, and the associated constraints to his autonomy. As a result, his capacity to make choices and do for himself had been compromised. Despite his more limited sense of autonomy, this participant, like others in this study, was adamant that he did not want to become a burden to the state by utilizing government-funded services. In fact, he considered this type of assistance to be a last

resort. At one point he said: “If I don't really think I need it, I'm not going to go out and ask for it. If I can do it myself, I'm going to do it” (ibid).

Self-reliance was articulated not only as a source of pride for many participants in this study, but also as a means of avoiding becoming a burden to the system by utilizing services to which they did not feel entitled. Research suggests that independence is “one dimension or contributing factor to personal autonomy,” where pursuing daily tasks or activities without aid from external forms of assistance is essential to the cause of preserving autonomy in later life (Davies, Laker, & Ellis, 1997, p. 409). Many of the participants considered it a sign of successful aging and sustained autonomy if they could manage without overly relying on others, whether it be their family/children or the government. The following excerpts from two different participant interviews illustrate a negative attitude towards receiving public assistance. The first is the account of a 90-year-old woman:

> I: Can you describe any services that the Ontario government provides for seniors? Or any that you’re familiar with that you might use?
> R: Well, I don’t know if there’s any I could use. Depends if there’s – you know – sometimes they have a monetary, you know how much money you make and are bringing in.
> I: A pension?
> R: Oh, I know there’s quite a few services. There’s one I know I could avail myself of, but I don’t bother. My hubby was a veteran, and they said that veteran’s wives could get some help. But at the moment, I don’t need it. I was just reading in the paper today, two thousand and some veterans are homeless?
> I: That’s so sad.
> R: It is. I don’t know – and they have a good support group here, too. Although, I’m not in the area. I can’t avail myself, they said they’d make an exception, but I said no, it wouldn’t be right to make an exception for me because then for other people – they would say, well you do it for her why can’t you do it for me. We have a lot of people that are in the area, that are not covered. We don’t go south of the 401.
> I: Right. Are you talking about the service for veteran’s wives?
> R: No, I’m talking about the services here.
> I: At the centre, here. Oh okay.
> R: Because I could use the home help.
> I: Yes, and you don’t use those services?
> R: No, it’s not available.

> I: Even though you can?
> R: Well, they'd have to make an exception. See it ends south of the 401. Then they only go north to Steeles. I'm past there. I'm not in their area. I'll put it that way.
> I: Oh, so are there any services like that in your area?
> R: Yes, there is a different group, but so far, I haven't bothered. I haven't needed it. Well, as long as I'm able to do it, let them serve someone else. (Interview 1, 2016)

In the above, this participant acknowledged that while she could benefit from public assistance, she felt less entitled to services than others who may be in greater need. As a result, she was hesitant to accept any benefits she may be eligible to receive. On the subject of receiving welfare benefits in general, another woman expressed a highly negative view of pursuing state-provided assistance. From her perspective, welfare support was something that many should not be entitled to receive. She told me:

> I: So, the last few questions that I had are about services offered to seniors by the government. Do you use any? Can you describe them?
> R: Well, I know of people. Have met one a couple of times. It drives me insane. Her doctor describes her as a depressed - she suffers from depression and alcoholism. Well, tough apples, that's my outlook. I think she got into drinking and she lost a very good job. That's probably how it happened. It just bugs me that everybody else is paying for that. She's only in her late 50's, maybe, but this has been going on for a long time. Who's the doctor signing, and you know you see so much abuse of the privileges that we do have. My husband for a while had a handicap card for the car. Of course, he had emphysema - he smoked. A lot of people have it and you think how come you have that handicap thing, and then go off to an exercise class where you're really working hard. That sort of thing, I think there needs to be more check up there. I think a lot of people, they just know how to get around. I know a lot of people that know how to get around the rules and get on welfare and sit on welfare, whereas I grew up in an age when you didn't go on welfare. There's an awful lot of that done now… (Interview 10, 2016)

These perspectives align with an independence model of neoliberal ideology. As discussed above, the idea of depending on the welfare state is often viewed as becoming a burden on the system and society at large. Callero (2013) writes that the capitalist economy relies on a model of individualism which feeds a belief that the economy performs better for everyone in society if people "are left alone without government intervention" (p. 25). Within capitalist societies, independent self-interest is hence valued while dependence on welfare support is devalued (ibid).

For other participants in this study, the desire to remain free of support extended further than government reliance. Some expressed a negative view of accepting assistance in the context of family support. Stated with a sense of pride for not causing any difficulties to her family or the state, one 90-year-old participant said: “If you reach this age and you haven't caused any great trouble for anybody. I guess it's successful. I haven't caused the government or my children any problems” (Interview 16, 2016). In another instance, a 90-year-old man who lived alone and described himself as someone whose sense of autonomy was largely intact, spoke about feeling that he might become a burden to his son. He said, “But the situation – the son here – he does really take the burden of looking after me, in case something happens to me. You know I could fall and break a hip and die tomorrow. Or I could fall and get run over. Pedestrians are vulnerable in this town” (Interview 3, 2016). This participant viewed accepting assistance from his son as a transition to becoming burdensome in his own self-assessment, a result with a more negative connotation than remaining independent by not requiring his son’s help.

The neoliberal model is one that advocates for increased independence in a self-sustaining manner. Many Canadian aging policies encourage doing for oneself and remaining independent. The *Ontario Action Plan for Seniors* (OAPS) (2013) identifies the goals of “independence,” “activity” and “good health” to assist older adults in living as independently as possible. This report supports that adults in later life can thrive by remaining actively engaged in their communities. While the OAPS does propose several government support programs and services, the objectives of productivity, continued activity, and maintaining good physical health are described in a context that empowers people to achieve these goals on their own. Overall, it seems that these participants felt their autonomy and sense of independence were related to the

extent that they dictated their own time and day-to-day activities, as compared to the extent upon which they relied on the state and family members to help them.

*Familial/Intergenerational Connections and Support*

Despite the indicated desire to preserve their autonomous independence shown in the preceding section, a number of respondents in this study spoke about diverse experiences related to family and social supports. Reflected in the data are a complexity between the desire to remain independent of aid, the necessity to connect socially with others, and the need to receive assistance at a time when productive life in an entirely economic sense has ended. Members of neoliberal society are resistant to the notion of accepting help. Yet, the desire for a sense of community and belonging is innate, despite relationships and life roles inevitably changing with age. A life course model supports that the lives of individuals are linked through complex associations over the continuum of the life span (Elder Jr., 1994; MacMillan, 2005). As a result, interdependence, where people are intimately connected or desire connection, is an inevitability of the human condition. Participant dialogue about this sub-theme speaks to the complexities of connecting with others in meaningful and needed ways while also maintaining one's independence.

The following two participants acknowledged that while they needed people in their lives, there was a balance between doing things for themselves and relying on others for assistance:

> "The best thing you can do for an old person is to have an understanding of the person and when he falls, pick him up. Don't try and help him to save him from falling, let him fall and then pick him up. It's important that the person does as much as he possibly can, at least I think so, for himself." (Interview 12, 2016)

> "Everybody will go, and new people will come always. The people to me, is all the same. I met all the kinds of people. It's the same. There's no difference, if it's this country or that

> country. It doesn't matter. I love people... It's all the same. I've met them. They need the same what you need. Everybody wants to be better. If you can give them, they want what they can do. But you have to do yourself. You have to do what you can do, not what they can do for you. It's about what you can do for yourself." (Interview 19, 2016)

Despite the overt preference for independence in the above statements, there was still a clear need for connection with external support. The first account in particular, shows that while doing as much as possible for himself was essential, the help of others was still necessary. White and Groves (1997) mention the ways in which social networks are formed in later life, writing that "many older individuals rely on helping networks often made up of family, friends and neighbours in an interdependent life-style supporting and providing the opportunity for activity and contact with others…" (p. 85). For the oldest old in this study, a strong reliance on familial connections, particularly one's children, was described as a most significant factor in their well-being.

One 91-year-old woman who told me she had eight children who provided her with assistance whenever she needed it said "It's nice to have a family. I feel sorry for those that don't. I know it's not their own fault, but I am blessed" (Interview 11, 2016). In a similar vein, two others also spoke positively of the extensive support that they received from their children:

> I: How about cleaning and grocery shopping and that kind of thing?
> R: I'm fortunate, my daughters get the groceries, because I don't go to grocery stores and I don't have the stamina to do it. They do my errands and my shopping. Once a week, I go out with them on a Saturday morning, and we do groceries and have lunch. That's about all. I can only stay out two, maybe three hours and I get tired. That's the end of my energy, I have to go home. But they're good. (Interview 7, 2016)

> I: How important are family and friends right now at this age for you?
> R: The older we get, the more important the family. They know they are helping more and more. Luckily, she has her family and I have mine and whatever we ask, they are glad to do it right away. (Interview 15, 2016)

These participants highlighted family assistance as a critical dimension in their lives. They acknowledged that with increasing age they required additional help, and therefore they relied on

their children to fulfill this growing need. In many ways an increased reliance on familial care serves the interests of the neoliberal state, as it shifts the burden of support away from macro-level structures, leaving this responsibility to the informal network of the family.[8]

A feminist political economy lens strives to illuminate the private domain of the home as distinct from the realm of more formal work. The assistive support provided by families to their aging members is a function that is not often seen or adequately recognized by the dominant discourse. The informal connections that occurs between familial generations may be considered part of a meso- or intermediate-level system: a support network that is situated between the individual and the state (Dykstra, 2013). Family support in the form described by the above respondents bridges service and care gaps at the systems level. As demonstrated by the tone of their statements, it is also a form of assistance that these two participants seemingly felt positive about accepting.

Interview data also demonstrate an added dimension of familial interdependence that arises for the oldest old whose children are older adults themselves and may therefore be managing their own personal aging concerns. In a situation that is likely far more unique to the population of adults among the oldest old, a 95-year-old man indicated that he found it difficult to rely on his daughter for assistance when she herself was also an older adult:

> I: Are you satisfied with the government's programs for Seniors?
> R: I think, that the government does many things to help old people.
> I: Do you think there's anything they could do that would help you more at this age?
> R: Yes.
> I: Yes? Okay, what things?
> R: I think my daughter is gradually old. Also, a senior. So, she also needs help. So, she cannot do everything for me. So, government must help us more, than usually.
> I: So, your daughter takes care, and helps you?
> R: Yes. Because the age is same. We are same…
> I: Seniors?

[8] Contexts of interdependent care between and among individuals and generations are further explored in Chapter 6 of this work, where gender is a principal focus.

> R: Seniors. So, she cannot do everything to help me, as usually. So, that time, I need more help from government [sic]. (Interview 5, 2016)

This respondent suggested that while government supports were helpful, they were inadequate to his family's needs. More specifically, he wanted his daughter, who was over the age of 65, to benefit from formal assistance as she continued to help him and who required additional support to do so.

An added complexity that is not well described in policy or scholarship is that of intergenerational assistance between older adults and their aging parents. Children typically begin their lives from a position of dependence on their parents, only to have the reverse occur in adulthood as their parents become older (Van Gaalen & Dykstra, 2006). The life course relationship between children and parents is highly complex and fraught with interdependencies, as this close relationship deeply transpires over the life span (Hagestad, 2003). The phases of dependence, independence, and interdependence are cyclical throughout the life course. In *Ontario's Action Plan for Seniors* (2017), the report acknowledges the importance of family supports in the lives of older people, stating that this is essential to the goals of older adults remaining independent and in their communities. Yet this unique dynamic of those who are aging together with their parents and striving to do as much as possible without adequate formal assistance remains under-acknowledged.

Another notable area revealed in the data, with respect to social connections in the lives of the oldest old, is the matter of their social network aging alongside them. The oldest old are unique from other older adults because they are also much more likely to have experienced significant losses in their social circles. This can have a negative impact on their connections with others. In one instance, a woman told me about the phenomenon of anticipating the loss of people in her life, something that had only manifested in this very late stage of her life:

> "Well everyone I've known are dead. You know, the friends I had have died. I have a new friend now, and she hasn't called me for a couple of days. It occurred to me, what if she died? You know, like normally you never ever think this, but when you know somebody - how much older? I'm 90, so she's 84. She hasn't phoned me. She could have died. She lives alone, a couple of streets over. So, I thought, gosh she hasn't phoned me or anything. I wonder if I should phone her again. Then I don't want to be bothering her if she doesn't want to talk. Then I said, gosh she might have died. You know, you never think about that when you're your age, but it's not so bizarre if I think that somebody I just recently met couldn't be around because they haven't called me." (Interview 16, 2016)

Her account is indicative of the unique social circumstance facing the oldest old, and the greater likelihood of a rapidly shrinking social network. Another participant also referred to losing people over time, as well as the immense emotional struggles that arose from feeling increasingly abandoned and alone as she became older:

> "It's terrible. One of the worst things about getting old is losing all of your friends and your family. I've lost two sisters, two nieces, and a nephew. It's just unbelievable. Cousins. Mind you, I was one of the younger ones, granted. But still, it's just shocking and it happens one at a time and you just don't think anything of it, then all of a sudden you think, my god there's only me. There's only me. It is. It's tough. There's something that I didn't expect in my 80's. I really didn't." (Interview 8, 2016)

Both of these accounts suggest that the oldest old are more vulnerable at their advanced age to a dramatically smaller system of family, friends, and other social connections. To cope with such losses, one man in this study spoke of a necessity to actively seek out more friendships, saying "You had friends and you used to socialize with those friends. Half of them are dead, so you have to find alternatives. So, I found alternative friends" (Interview 12, 2016). This reality of losing family members and friends, coupled with a more pronounced need to form new social bonds to replace former connections demonstrates the important role of community-based organizations, such as the older adult centre used in this study, in the lives of older adults.

The research site facility represents an avenue through which new social connections in the lives of the oldest old, who may have lost their social network, become possible to create. In

my observation of an art class at the centre, I noted the role of this facility in the formation of new relationships or bonds:

> The dynamic through which friendships are formed here seemingly occurs with both grace and fluidity. In most cases, the older adults I observe are seeking companionship more than anything else at this centre. It is here that they can enjoy conversation and bond over a shared hobby with a newfound acquaintance, fulfilling an apparently innate need for connection. Halfway through this art class, I overhear one woman say to another, "It would be nice if we could meet on Saturday. The kids are all busy this weekend." For the duration of this session, it is clear that these two women (one of whom earlier told me that they met one another in this class) enjoy each other's company. (Observation, February 22, 2016)

Though many Canadian aging policy initiatives emphasize an essential need to address social isolation and loneliness with older adults, more study is needed with regards to the social isolation of the oldest old. Of particular importance is a clear and precise policy plan to address the increased social losses incurred by the very old so that new connections can more easily be realized. Bould, Smith, and Longino Jr. (1997) propose an "interdependent helping network" to address the increased needs of the oldest old, who are more likely to have experienced a shrinking of their friend/family network due to death and loss (p. 28). They suggest that services should be created which specifically cater to the needs of this population. Certainly, with the rapid growth of the oldest old population in the coming years, it will become more urgent to do so.

*The Avoidance/Acquisition of Disability and Living Actively*

As discussed at length in Chapter 2, the absence or avoidance of disability in later life is perceived in a positive light within biomedical models of successful aging (Rowe & Kahn, 1997). This perspective obscures lived experiences and the role of larger systemic forces in favour of physicality and function (Fagerström & Aartsen, 2013; Rubinstein & de Medeiros, 2015). Health and health experiences are far more complex than the clinical lens perceives,

especially for those in later life. In this section, I explore participant responses that suggest the complexity with which disability is described and experienced by the oldest old. I also consider the notion of living an active lifestyle, including its relationship to the acquisition of disability in later life, and the role of Active Living-focused older adult centres such as the research site used in this study.

A number of unique perspectives are shown when participants described the role of disability with respect to successful aging. For some, the experience was aligned with that of function-based biomedical models that equate poor health with disability. In one case, for example, a participant conveyed an understanding of disability as decline:

> "…if a person doesn't have things in life that keep their brain going and keep their body going – and some don't – their normal aging process is going to be on a decline. I don't want to be like that. Because these are the people that end up in wheelchairs and walkers and stuff like that. A lot of people around here are like that. That's not my target. So, I've been fit enough to stay up at this level, you know? Sort of. Then, unfortunately, for some reason my legs just let me down one day. But I'm working hard." (Interview 3, 2016)

In the above statement, the respondent mentioned a genuine desire to maintain his activity level so that he could delay the acceleration of an acquired physical disability. A similar sentiment of disability and function as a limiting factor in the latest life years is echoed in the two cases below:

> I: What's changed in your life since your 80's, compared to your younger years?
> R: Everything is changing. It's a very big change for me, because I must have been 70 years old when I started playing tennis. Three years ago, I had to stop because my balance wasn't so good. (Interview 15, 2016)

> I: When I ask you what you think successful aging means, what comes to mind? In your words, what does it mean to successfully age?
> R: That's a tough one, in the sense that I don't know whether you mean healthy aging - like most people - or invalid aging like me. I just have to sit there and let the years go by, whereas a healthy person can do things. Volunteer, or go to church or whatever. I just have to sit there and let the days go by. I have no choice.
> I: Do you feel that successful aging is mainly physical, then?

> R: Not necessarily physical, but the mental and physical I think go together. You decide that you want to do such and so, or volunteer here or volunteer there or do something or help somebody. Whatever. You've got to have the physical means to do it. I don't. I could not do anything for anybody. As I said, it's very recent - a few years - and sudden. So, it was suddenly hard to get used to. (Interview 21, 2016)

Both of these participants clearly expressed frustration with adapting to the onset of disability in their late lives, relaying the extent to which it has had a limiting impact on their capacity to participate in volunteer work or the leisure activity of playing a sport. When the second of these interviewees said, “a healthy person can do things” the inference of social norms that equate productivity with what is considered to be a “healthy” body is also a present sentiment in the dialogue. As discussed in Chapters 2 and 3, body norms are represented in how privilege is ascribed in neoliberal society.

Social model research indicates that perceptions of acquired disability in later life are highly complex. Such perceptions hold that health, illness, and disability are social constructs that are “a product of attitudes and the organization of our social world” (Kelley-Moore, Schumacher, Kahana, & Kahana, 2006, p. 135). In essence, the social, economic and health-related disadvantages experienced by people with disabilities are the result of socially constructed barriers. Many aging policies do not adequately address the support needed to cope with newly acquired intersecting identity formations like disability and old age, particularly with the complexities that arise through the life span.

Disability is a named social determinant of health. Of Canadians over the age of 65, more than 40% identified as having a disability (Mikkonen & Raphael, 2010). Yet, in Canadian aging policies, disability support mechanisms for older adults are not well-described in later life contexts, with even less attention being given to the oldest old as a distinct group with unique needs. Rather, most disability-centered programs cater to people in their productive or middle

years of life, a time when disability is viewed as an unexpected or non-normative occurrence. Not only are public support mechanisms less frequently allocated to older adults with disabilities when compared to their younger counterparts, but Mikkonen and Raphael (2010) also point out that Canada ranks among the lowest of OECD countries in what it publicly invests in its overall disability support programs.

In this study, and in contrast to the participant perspectives described above, there were a number of participants who did not subscribe to the view of disability as a limiting and entirely function-based facet of their very late lives. These respondents indicated a higher level of life satisfaction despite their encounters with health or disability-related experiences. One participant said of the role of disability in successful aging: “Aging is being able to connect with people, whether you're disabled or not, and interact with them” (Interview 14, 2016). In this case, social relationships with others were considered more important than health status or function:

> I: So, are there things that you do now that you didn't do since turning 85? Are there things that you do now that you didn't do before? Or things that you feel better about now, or different about now than when you were younger?
> R: Well, I see myself as satisfied with what I can still do. It's getting less and less important, what to do.
> I: Can you elaborate and speak a little about that?
> R: Well, gradually every year is a little bit slowed down. But so far, I cannot expect at my age, to be the same. To be the same, like two or three years ago. So, I feel it pretty well, the difference.
> I: You feel the difference?
> R: Yeah.
> I: Is there anything that you would say about physical barriers? What I mean by physical is, walking or getting around. Is that harder for you now?
> R: It's mainly physical. Of course, that means I need more to lay down or sit-down watching television. The less we can walk or work, the more we are doing watching television, and the bridge we are using a lot. It keeps at least our health going, and with other old people. (Interview 15, 2016)

This participant was clearly accepting of the differing lifestyle that arose with an acquired disability. Similar to the participant account before his, there was less focus on disability as a

limitation and more focus on finding alternative life-enhancing avenues for adaptation. Both respondents also emphasized that a network of support and social outlets had become an integral part of their altered life circumstances, specifically speaking to the examples of playing card games and increased social connections.

Other respondents spoke about personal fears associated with aging alone and meeting health/disability-related barriers in the absence of a community or network. One woman told me: "I'm not happy entirely with being old…I don't know what else I could do. It's not like anybody would ever come here and live with me…the disability is being old (Interview 16, 2016). In another interview, a similar expression was made concerning acquired health difficulties and being alone:

> I: So, I guess that somewhat leads into my next question. Which is, how does your current state of health effect your happiness on a regular basis or in your life?
> R: It's a worry. It's a worry. Health is always a worry… I do worry because I'm alone and I think, oh God. I've got all kinds of little things that bother me, you know? (Interview 8, 2016)

In both cases, these participants indicated age-related anxieties around their lack of connection and living alone, alongside concerns about the possibility of declining health. The genuine need for mutual relationships with others was evident, as support and social connections were highlighted. Kelley-Moore et al. (2006) argue that the maintenance of a strong social system of support for the oldest old has a mitigating effect on self-perceived negativity surrounding disability and poor health. They further contend that the oldest old are less likely to even consider themselves as having a disability with the presence of strong social relationships in their lives.

Maintaining an active lifestyle to avoid disability is another theme present in the data. The older adult centre used in this study is an entity that promotes a goal of Active Living

through its mandate. It is a place where members can congregate and remain engaged in unique ways. Such a facility is clearly vital to the camaraderie and connection required to spare people from the isolation and loneliness that comes with advancing age. Here interdependent connections were discussed when participants communicated a strong reliance on specific mechanisms and people in their lives as critical to their aging success at this very late stage of their life journey. Various participants spoke to the value added by this community resource. When asked about how important this type of centre was in her life, one participant told me, "Vital. Vital. I cannot imagine life without doing that. I just can't." (Interview 8, 2016). Similarly, in the following excerpts, other participants described the services provided by the centre as essential to their active participation:

> "I think it's very important. Very important. A lot of people laugh, saying they would never join a senior's centre. You hear that all the time. I wouldn't do that and I wouldn't volunteer and that sort of thing, but there's an awful lot. You see the people here, and they enjoy themselves. They come bustling in and really enjoy their classes. If not, they just switch to something else. It's very important. I think that to have somewhere to go to, where you know you're more or less accepted and whatever your faults and everything else, you know. I think it's great. It's a great place." (Interview 10, 2016)

> "About four years ago, we discovered [the centre] and we see it's so well-organized, so many volunteers are here and it's a pleasure. We are coming here and feel like being home." (Interview 15, 2016)

> "Well, I don't have to say anymore because you'll see the environment, people-wise, that I'm into here. I love it. For the last 10 years, I love it and I'm not going to change. I'm not gonna go anywhere else. I mean, I want to get here every day. I mean, every day that I'm programmed to come here. I don't want to stay home and say, it's too cold out or too hot out, or too lazy. I don't want to stop my lifestyle. My lifestyle is not being risky or stupid or spending money or stuff like that, my lifestyle is quite conservative, I guess. I'm not normally a terribly social person, but this is an easy place to get along with people. We're all in the same space, not necessarily the same diseases, but the same space. People appreciate the fact that I can't see too well now, and stuff like that now. I've had all sorts of things, you know? Eyes, ears, everything. Anyway, I won't go into the medical side of my life, but I'm here, and I want to keep this going. I'm glad to tell you why I'm here, and tell you that I'm going to keep this way. If you come back in 10 years, you're going to find me here." (Interview 3, 2016)

These participants clearly saw the centre as a resource that ultimately allowed them to both connect with others and actively engage in ways that were meaningful to them. The final participant specifically mentioned feeling accepted in this space despite his acquired disability, stating that "people appreciate the fact that I can't see too well." His statement speaks to the notion of inclusion, a central feature of progressive disability discourse. This aligns with the goals of a social model of disability, described in Chapter 2, where disability requires accommodation through the removal of socially constructed barriers to inclusion. In my time spent at the research site, I felt a similarly inclusive sentiment during my observation of the food café as a central social hub for members to congregate at the centre:

> More than a place to eat, this is a place where a sense of community is felt. I can see people continually bonding over food and conversation, as many engage in casual discussion around me. In my time here people have expressed to me, in various ways, that the interactions they have here are often their only means of social contact in a given day. One woman, in particular, told me that this level of connection is sufficient for her to feel "a sense of belonging." It also occurs to me that through the subsidized cost of food here, the issue of food insecurity among older people is another concern being addressed by this communal dining space. For the oldest old, even the effort of preparing food for themselves can be difficult. In these ways, this centre helps to bridge important social needs that most certainly impact health and wellness in late later life. (Observation, February 1, 2016)

Consistent with these themes, the value added by a facility like the centre, as an entity that visibly promotes a mission of inclusion for older adults of diverse backgrounds and circumstance, is something that is also acknowledged at the policy level.

Upon release of *Ontario's Action Plan for Seniors* (2017), the provincial government pledged to invest $8 million over the course of three years to develop an additional 40 Active Living-oriented centres for older people. This would ultimately result in the creation of over 300 facilities similar to the research site used in this study, across the province (Ministry for Seniors and Accessibility, 2017). This policy piece fails to mention the oldest old, however, and a

specific plan to accommodate the potentially unique needs of this population is absent. There is also an underlying neoliberal message in the mission of Active Living that is hard to ignore in the emphasis placed on the actions of the individual. Bercovitz (1998) writes: "To a large extent, Active Living is essentially the 'old' lifestyle rhetoric in a new guise. Driven by a political climate of rationalization and economic restraint, independence and self-discipline emerge as dominant themes" (p. 322). The doctrine of Active Living in later life is a present message throughout Canada's aging policy dialogue. Here, the balance between empowering individuals to retain their desire for independence and engaging them in active ways, requires careful attention to the resultant adverse health outcomes and social isolation that can arise from an overly strong message of doing for oneself.

## Discussion

The concepts of independence and interdependence are highly relevant fixtures in the later lives of the oldest old. These concepts are intensely intertwined with notions of productivity and the neoliberal system at large. For clarity, a *systems* perspective implies the extent to which ideology is "embedded in social institutions" (Calasanti & Kiecolt, 2012, p. 264). Despite the message of individualism that is strongly promoted by a free market system, the capacity to be productive involves strong links with other people and entities. Aligned with principles of interdependence that manifest at the micro- and macro-levels of society, and despite a widespread belief that these spheres are distinct, the individual and society are wholly intertwined (Callero, 2013). While the effects of aging and health outcomes are felt at the micro-level, the lens of feminist political economy supports a macro-level analysis that accounts for the role of structures in individual agency and life paths.

The individualistic model supported by neoliberal ideology obscures the impact of larger macro-level influences and constructs as they manifest at a micro-level (Rubinstein and de Medeiros, 2015). It is clear that the impact of this "myth of individualism" (Callero, 2013, p. 3) runs deep, as it continued to resonate with many of the participants in this study. Although many respondents had long ago exited the paid work force, their responses suggested that they continued to feel the strong legacy of these values. Participant dialogue included complex feelings about the desire to remain independent and autonomous amidst societal expectations to be productive in contributive ways.

By design, the economic system is constructed in a way where people are awarded or refused privileges and therefore forced into positions of perceived dependence or independence by numerous social factors beyond their control (Nussbaum et al., 2005; Overall, 2006). These factors tend to be located in complex disadvantage rooted at a systems level. Intersectionality theory postulates that this deeply overlaps with interrelated social identity contexts that are often a source of this disadvantage. Under neoliberalism, locations of the self are lost amidst inequitable circumstances that do not adequately account for the greater disadvantage experienced by some individuals and groups more than others. In essence, individuals are often considered in a way that assumes they are similarly situated, obscuring unique differences and identity locations that may require additional support at the state level.

What is missing from the dominant discourse is the extent of health and age-related disparities that occur among the oldest old, many of whom have unique life course histories and experiences. Also obscured is the notion that all people, irrespective of their age, require the support of others in order for their needs to be sufficiently met (Plath, 2008). If this support is not realized it is possible for older people to feel alienated, isolated, and socially excluded under

strong societal expectations of independence (ibid). In many instances, despite the expressed desire to remain independent the participants in this study also emphasized the need for social connections and community-based supports in leading a fulfilled later life. It is here that the function and role of interdependent support is most clearly demonstrated within the data.

Interdependence is a cornerstone of life course theory, in which people's lives inevitably overlap in unique and essential ways and where relationships among kin and friends are a deeply embedded necessity over the life span (Elder Jr., 1994; MacMillan, 2005). Plath (2008) writes of an independence model that embraces interdependence in its frame, similar to the Independent Living movement of people with disabilities. She states that this model is "contrary to a medical view of independence as the physical capacity to manage alone, but supports a view of independence as accessing resources in order for needs to be met" (p. 1355). Socially constructed barriers imposed on the intersecting identities of aging and disability in later life must be removed, and resources must be made available in an inclusive way so that people can "realize their full potential" (Callero, 2013, p. 29). To do so is to move away from a negative perception of dependence on welfare state provisions, in favour of an interdependence model where the notion of utilizing support services is highlighted and embraced.

A life course perspective dictates that an adequate depiction of human lives can only occur with consideration for the strong sense of partnership and cooperation between people and groups, as life experiences continually evolve across numerous social contexts (Elder Jr. et al., 2003). An adequate examination of later life therefore requires historical context that is best captured through a life span analysis that considers individual experiences over multiple life stages. Many aging policies support a model of individualism but do not give enough mention to earlier life years and their impact in later life. The SDOH model emphasizes the potentially

profound impact of early life circumstances on later life years, especially for those who experience systemic inequalities and disadvantage in their earlier lives (Braveman, Egerter, & Williams, 2011; Raphael, 2009). For such individuals, it is much more difficult to overcome barriers and advance in the social hierarchy to a point of prosperity. Aging policies hence need to examine the roots of inequity and difficulties between generations by tracing back to earlier times, an endeavour that is logistically difficult and expensive. In many respects, as life course theory observes, the histories of people matter immensely in the study of lives (Bengtson & Allen, 1993; Elder Jr. et al., 2003). This includes strong consideration for the impact of intersecting social identity locations, particularly disability and age, as supported by an intersectionality lens.

Throughout the life course, individuals encounter varying stages of dependence, independence, and interdependence. It is presumed that people tend to be viewed as more dependent on others in their early and later lives. These phases are distinct from middle-aged years of adulthood, when the expectations for independence and economic production are most acute. Townsend (2006) argues that dependence of older adults is a socially constructed concept born from circumstances of "retirement, poverty, institutionalisation and the restriction of domestic and community roles" (p. 165). He further contends that that this is a human rights issue. It serves the interests of the free market to place much of the responsibility for one's health and well-being in later life on individuals themselves. The capitalist system also benefits from a pervasively negative attitude towards dependence and the stages of life during which people do not typically partake in productive paid labour. While dependence in childhood may be perceived as a time with great potential for the coming years of productivity, later life does not have the same sentiment of hope attached to it. This is largely because older adults are often

viewed as having served their productive time, and it is presumed that they will not return to the realm of paid work. Such ideals relieve the state from responsibility while promoting a message of falsified empowerment by encouraging aging individuals to fend for themselves.

Neoliberal ideology is visibly enacted at a systems level. In societies where free market capitalism is less pronounced, the notion of independent self-interest is not emphasized as strongly (Callero, 2013). It is virtually impossible to be completely independent and, in fact, part of the human condition is to rely on others for support. Essentially, lives are inherently linked through overlapping networks of interdependence (ibid). In this study, participants expressed a strong desire for connection and support, especially from members of their family, despite voicing a continued need to sustain themselves on their own.

Participant data also indicate that the presence of familial relationships in the lives of the oldest old may have a mitigating effect on the extent to which respondents perceived acquired disability to be a limiting factor in their later lives. Kelley-Moore et al. (2006) suggest that the oldest old of adults who have children and are very satisfied with their social network are less likely to consider themselves to have a disability at all. This phenomenon largely supports the social models of disability and aging that highlight the extent to which these locations of disadvantage are socially constructed. In this sense, systemic ideologies that situate responsibility for maintained health, wellness and prosperity with the individual need significant adjustment. As a number of the participant accounts in this study highlighted, the support of family and other such mechanisms and entities, including the older adult centre itself, have had a largely positive impact on their aging experiences. In this way, interviewees very much embraced a sense of interdependent reliance on an external network for their continued well-being.

The false sense of independence supported and promoted by the system of neoliberalism results in the devaluation of unpaid activities within the private realm. This applies to actions that occur outside of paid work endeavours and are most certainly applicable to the oldest old, who have long since retired and no longer participate in this capacity. Within a framework of dependence, there is little or no recognition of what long-retired older adults can contribute to the socioeconomic system. Rubinstein and de Medeiros (2015) write that "there is no actual plan for transforming the cultural value of volunteer, unpaid work among retirees or other older adults so that it becomes equivalent to the value granted to paid work" (p. 37). Transforming the way that work is defined, viewed, and valued plays an important role in perceptions of successful aging and late life experiences of the oldest old.

In addition to the ways in which we define and value work and labour, part of the negative thinking applied to the oldest old comes from a widespread belief that we are heading towards a time of rapid growth in this population that will result in an unsustainable economic burden. As a result, it is assumed that this largely "unproductive" group is likely to present an increased liability to the health care system and society at large. Yet, upon closer examination, the perceived economic burden of caring for the presumably dependent oldest old may be unsubstantiated. Some suggest that this misconception results from larger deeply embedded messages in favour of individualism and free market schemes (Bould, Smith, & Longino, 1997; McDaniel, 1987). Certainly, decline, disability and poor health are all anticipated outcomes of later life, but they are not necessarily true of everyone in the highly diverse spectrum of older adulthood. It is clear that many of the participants in this study, for example, found ways to adapt to their circumstances with as little public assistance as possible. The strongly indicated desire of

respondents to avoid reliance on system supports suggests a view that is not considered by dominant frameworks, which portray later life as a time of likely dependence on the state.

The policy response to the perceived dependence burden of older adults has largely been seen in the development of initiatives that are strongly focused on the promotion of Active Living. For example, a briefing report from the Conference Board of Canada identifies the Active Living goals of continued physical activity for older adults, as well as healthy behavioural factors, as a priority for this population (Dinh, 2014). The report's proposed plan of action speaks to changes through a multi-layered approach, including interventions from the state, the meso-level of communities and institutions, and individual action. Yet, the language within the report conveys a tone valuing productivity and economic agendas. It postulates that "now is the time… to foster a healthier, happier, and more productive population, which will ultimately contribute to a more resilient society and stronger economy" (p. 3). Similarly, the IRPP Task Force on Aging (2015), identified the continued sustainment of healthy and active lives for as long as possible as a significant aim for the Canadian aging population. The IRPP report proceeds to outline mechanisms through which Canadians can be educated on health literacy and planning in earlier stages of the aging process, thereby providing them with the means to remain engaged upon reaching later life. A third report, produced by the Federation of Canadian Municipalities (2013), highlights the role of meso-level community-based services for older adults, and carries a parallel message of providing optimal conditions and opportunities for the enhancement of "Active Aging" mechanisms (p. 4). Here too, the goals of well-being and community engagement are critical focus areas to ensure that older adults age "well" in their communities (ibid). Though there is agreement between all three of these policy-driven accounts, claiming that increased government assistance is an essential mechanism to better prepare people

for later life, through a rhetoric of Active Living the onus remains on the individual to age independently and take responsibility for their own success in aging. Hence, the message of Active Living that resonates in these policy documents contributes to an overall perception that aging, and its associated spectrum of unique experiences, is a responsibility of the individual more so than the state.

## Conclusion

Despite a strongly stated desire for independence from the oldest old of adults who participated in this study, an inherent implication of interdependence emerges as an intrinsic part of thriving in late later life. In this first of three discussion chapters in this dissertation, I explore this main theme along with three related sub-themes of sustaining personal autonomy, familial relations/support, and the avoidance of disability alongside the promotion of an Active Living model. Participant accounts of these ideas are here revealed as highly complex, and consistent with neoliberal ideology that is intertwined with notions of productivity and the ways in which we define and value or devalue societal contributions from elders. From a policy perspective, it seems that "seniors" are not a uniform homogeneous group of adults over the age of 65, and an additional distinction must be drawn to accommodate and recognize the needs of those who are 85 years of age and older. One initiative to support the oldest old might be a focus on the ways in which a positive perception of interdependence can enable people in this group to maintain greater levels of autonomy and independence. Participant data show that for the oldest old to prosper, emphasis must be placed on communal support rather than on a more solitary state of self-sufficiency. In the chapter that follows, I turn my attention to the second key theme identified from the data: that of gender relations in the contexts of care, partnership, and socioeconomic circumstance.

# Chapter Six: Interdependent Care Contexts of the Oldest Old – Examining Gender Relations as an Intrinsic Part of Late Later Life

> *"With respect to gender there is a*
> *noticeable misbalance especially in*
> *the oldest old stage of life, the majority*
> *of the old people being women...*
> *There is little doubt that old strategies*
> *regarding employment and retirement,*
> *health and social care, social inclusion,*
> *housing etc. are no longer adequate."*
> (Pahor, Domajnko, & Hlebec, 2006, p. 157)

## Introduction

In this chapter, I explore gender relations among the oldest old as the second major theme identified within the data. As in the preceding chapter's discussion of independence, autonomy, and disability in the aging experiences of participants, interdependence also arises as a key feature in a gendered context and primarily with respect to care. Gender is a fixture across the life course, as it strongly intersects with health, disability, and aging. Gender is also a known and prominent SDOH (Mikkonen & Raphael, 2010; Phillips, 2005; Sen & Östiln, 2009): which significantly intersects with all other social determinants (Armstrong, 2006).

By many statistical findings, women tend to live longer than men. In Canada, the most recent census data indicate that the gap between men and women grows exponentially with increasing age, where 6 out of 10 in Canada's population of oldest old (or 62.2%) between the ages of 85 and 89 are women (Statistics Canada, 2016). This number increases dramatically to 88.4% females among all Canadians who are 100 years of age and older (ibid). As a result, it is important to consider gendered life course experiences when exploring successful aging perspectives of the oldest old. The diversity within this group also requires greater attention for the largely different life course paths and trajectories followed by women and men.

In this study, an equal number of men and women aged 85 years and older were interviewed. This ratio was intentional so that a balanced conceptualization of gender among the participants could be captured. Knodel and Ofstedal (2003) support this type of work, arguing that a "gender-sensitive approach should consider the special needs of both sexes" (p. 679). While gendered studies in this area tend to focus on women, there is much to be gained from a perspective of relational dynamics between the sexes, where understanding the concerns and situation of men is important to understanding that of women and vice versa (Armstrong, 2006). In this chapter, I examine how female and male participants identify with notions of care, spousal/partnership relations, and issues related to work and income inequality. Findings are presented according to these three identified sub-themes.

The first sub-theme of care and care contexts involves the provision and reception of care by both informal and formal resources. Care work is highly gendered and linked with interdependent support mechanisms from the state and community at large, as well as from familial and other informal connections. The second sub-theme of partnership is explored through spousal/partner relationships in very late years and the loss of a spouse or companion as a significant life course event for many of the participants in this study. Finally, under the sub-theme of income and work, gendered life course experiences of productivity and economic compensation are also identified as an important consideration from the data.

In earlier parts of this dissertation, I discussed the unique gendered experiences associated with the public and private spheres of neoliberal society, with a particular focus on the dichotomous relationship between the two. In Chapter 5, I suggested that models of productivity and individualism offered by a neoliberal agenda fuel the resistance and devaluation of relying on external supports for aid through a lens of dependence. In this chapter, I argue that a

strengthened framework of interdependence in care and gendered contexts represents a vital addition to dominant discourses applied to the oldest old seeking formal public assistance in a society governed by the neoliberal ideology of self-reliance.

In addition to the interview data, findings are also drawn from relevant policy documents. Specifically, report documents are used from the Alliance for a National Seniors Strategy and the Ontario Human Rights Commission (OHRC), among others, that highlight gender in policy discourse, service provision, and income supports for those who are aging. These policy documents add context as I explore the interview responses provided by participants in this study. Findings are subsequently discussed using the paradigms of feminist political economy, life course theory, and intersectionality, all of which provide a valuable contribution to the analysis.

## Findings and Analysis

Pertaining to the main theme of gender relations and successful aging among the oldest old, three related sub-themes were identified in the data. They are care and care contexts, the complexities of partnership (including the loss of a spouse), and gendered notions of work and income. While there were clear and overarching differences among participant responses, there were also a number of commonalities. In this section, I explore each of these sub-categories in depth using the personal accounts of both older adult participants and staff member respondents, drawing on content from relevant policy documents throughout.

### *Care & Care Contexts*

For the purposes of this study, care is defined as “the needs for help and support that can arise in old age, and to the care which is provided by formal welfare services and, informally, by relatives and others” (Fine & Glendinning, 2005, p. 602). It is a multifaceted concept which is

made even more complex within a free market system that supports and endorses independence and a minimal role for the state. Within this framework, the desire and need for care in the contexts of aging and disability are often interpreted under a negative subtext of burden or dependence (ibid). As explored in earlier chapters, Rowe and Kahn's original model of successful aging supports this premise by privileging physical health through individual strength and action, implying that those who require care-related assistance in their later lives are "unsuccessful" agers. Tesch-Römer & Wahl (2017) counterargue that in many senses becoming older and requiring additional care should instead be viewed in a more positive light, as a necessary and anticipated component of what it means to successfully age in the very late stages of the life course. Prevailing neoliberal ideology therefore fails to account for interdependent care needs that are an often-intrinsic part of later life.

Throughout the life span, most care work begins and ends in the domestic sphere of the home. It is here that the bulk of familial care work is performed, taking place through early and middle age years, and well into the later stages. It is also in this realm that much of the work performed is not visible, recognized, or adequately compensated (Feo & Kitson, 2016; Kemp, Ball, & Perkins, 2013). Women have also historically dominated as primary caregivers in the domestic realm, an experience that is consistent with the accounts of female participants in this study (Bracke, Christiaens, & Wauterickx, 2008; England, 2010). According to interview data in this study, both female and male participants spoke about three types of care: informal and self-directed care, formal care through government services, and reciprocal models of care among peers.

In the first area of informal and self-care, the experiences of participants in this study reveal themselves to be unique in terms of following distinctly different life course paths.[9] Some female participants, for example, referred to the impact of a notable legacy of care over many years spent performing this type of work for others in the domestic sphere. In these cases, a reduction in familial care obligations during their very late years was described as a positive change that allowed them to finally care for themselves. On this matter of self-care, one woman said:

> I: Would you say that you are more actively social now than when you were younger?
> R: Well it's different. When you're younger you have different responsibilities. You have kids that you have to look after, the husband, after a house, or whatever you're living in. It's a different life all together. Now I can really please myself to do what I want to do and what I don't want to do. Once you get older, you don't care that much about what people think. (Interview 13, 2016)

In a similar vein, another woman told me:

> R: I had gotten very fat before my husband died, because I was with him and he had heart trouble and everything, and he was miserable and so on. That ruined my health at the time. So, then I had a re-birth, in a sense, with going to Sunnybrook there and doing that program.
> I: So, you've really taken care of yourself differently in this later stage?
> R: Sure, because I didn't have to go to work and I didn't have a husband that's sick - in and out of the hospital - mental problems and everything else that he had. So, yeah, so you know my reason that I never get interested in another husband, one was enough [Laughs]. I was seventy-six, you know, not likely that I'd be interested in any other relationship. I had enough. I never had any interest. (Interview 16, 2016)

In both cases, these women made reference to domestic care work performed throughout their earlier lives, conveying a feeling of relief and freedom in being able to care for themselves after many life years spent caring for loved ones. This increased capacity for self-care is a notable avenue of care work identified from the data. It has been suggested that older people with a

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[9] Self-care applies to the everyday tasks and activities that one performs for themselves and their own well-being. This includes efforts made to ensure personal physical and emotional needs are fulfilled. To achieve this, many older individuals, especially those who experience disadvantage for reasons of systemic marginalization, require the assistance of others through supportive interdependent mechanisms of care.

diminished capacity for self-care may in turn have lower levels of life satisfaction (Borg, Hallberg, & Blomqvist, 2006). The all-consuming nature of performing care can be personally depleting for caregivers and may compromise their capacity for self-care, as was clearly the case in earlier life stages for the women quoted above.

In a report suggesting policy reform, Torjman (2018) states that many caregivers experience physical and mental health difficulties given the immense toll of performing this task combined with a lack of adequate caregiver support and respite. According to a *Portrait of Caregivers* analytical report produced for Statistics Canada, nearly 8.1 million Canadians provide some form of informal care to an older adult family member, person with a chronic condition, or person with a disability (Sinha, 2013). The realm of informal caregiving is vast and difficult to navigate, and there is a need for some form of reprieve for those who provide it. Aligned with this need, one female participant spoke of caregiving responsibilities becoming more than she could cope with when her spouse was in his final years:

> R: My husband was still alive, and he had Alzheimer's after a while, so that's not wonderful. It takes time to look after him and all kinds of stuff.
> I: Right, that's really hard.
> R: Yeah, it is difficult for sure.
> I: Do you mind if I ask if he eventually went to a nursing home?
> R: The last three months, we put him into Valley View Nursing home, they're very good there. It's very close to where I live.
> I: Because it's very hard to care for somebody at home without the right supports.
> R: But we did get that support from CCAC. They were very good and sent me help ten hours a week or something like that. It was very helpful, for control. They took him for a walk, because he loved walking, gave him a shower, and that was very nice. But the last three months, I just couldn't cope anymore. (Interview 16, 2016)

Though not an ideal choice, the pressures involved with intense informal care work warrant further state-funded assistive mechanisms. This particular woman noted the help that publicly funded care services provided her for the purposes of respite from caring for her husband. When she could no longer cope, she utilized a long-term care facility for this purpose. Torjman (2018)

states that a shift to residential or institutional care for a partner or relative is often a last resort that arises from caregiver depletion and compromised well-being. In such cases, a stronger emphasis on external supports and caregiver reprieve may allow additional time at home with a spouse or loved one, rather than pursuing an often less-preferred path of institutional care.

For male participants in this study, their experiences with informal care provision seemed to be concentrated in the very late stages of life. In this regard, their perspectives were distinct from the preceding female narratives of heavier care work responsibilities throughout the life course. In fact, no men in this study mentioned caregiving responsibilities in their earlier lives. Two of the men who raised the issue of taking on a caregiving role in their current life stage seemingly did so out of necessity, as a result of their wives becoming ill and requiring help. Both of the male participants below expressed a genuine desire to care for their wives. In the first case, this 95-year-old man described a scenario in which he would prefer to move to some form of assisted living facility for older adults, but he was prevented from doing so because he continued to provide care for his wife:

> I: So, how do you feel about moving from here to another place? To a long-term care facility, for instance?
> R: I think, I can go to the senior house every time, but my wife cannot. Because she has a bad habit. So, I worry about that.
> [*Participant speaks in another language. Translation occurs at this point, with the child of this participant – who was present at the interview for this purpose. Her translation follows.*]
> R: [Translator: My dad, he's easy to adjust to his environment, but my mom is a little bit spoiled. She has a lot of bad habits. She's not a very tidy person. She's very emotional, and she's also depressed. So, with long-term depression my dad is helping her all the time. That's why he's very tired, and we can't help because I can't accept my mom doing things like that. My dad's patient enough to do all the things for her.]
> I: You mean he's patient to provide her with emotional support?
> R: [Translator: Emotional support, yes.] (Interview 5, 2016)

In another instance, a man expressed heartbreak over the forced interruption in care he once provided for his wife. He emphasized that he felt pressured to allow her to move to a long-term

care facility, and he regretted the decision, when his preference would have been to continue to look after her himself. In our interview he said:

> R: I was thinking my wife will come back. I believed that for three years. Then, nurses came, they told me you can't take care of your wife. So, I had to put her in a home. After three years I decided to sell the apartment.
> I: When you said you regret the decision a little bit, are you saying that seeing your wife now - you could have managed to care for her yourself?
> R: I think so. I think so, yeah. It would have been better for her.
> I: For her. Okay, interesting. Absolutely.
> R: Because I don't like it now. I saw other people as well, even worse than my wife, at home. That's why. (Interview 18, 2016)

Both these accounts suggest that with age, care duties extend to men when there is a need. Among the male participants in this study, the performance of care work primarily arose at this very late life stage, long after the duties of their productive working years had ceased. A growing, yet less-acknowledged, realm of male caregiving therefore occurs in the context of providing care when required for a loved one, particularly a spouse, among the oldest old. Older male caregivers are likely to encounter the same stressors and needs as women do in this role, even if their life course pathway to caregiving is distinct from that of most women (Bookwala & Schulz, 2000). As a result, both groups require strong caregiving supports in the very late years, particularly through formal measures provided by the state.

The second mode of care raised in the data manifests through external government-funded support services for the oldest old of adults. Formal care provision was raised among the participants who spoke of utilizing public care services. Participant responses pertaining to care-focused support programs suggest that the system is fraught with discrepancies concerning who is entitled to or excluded from receiving care. Difficulties and inconsistencies in accessing formal care services was something that affected a number of participants in this study. The following different encounters with a similar care service provider illustrate these

inconsistencies. One participant expressed deep satisfaction with the personal bathing assistance that she received following a difficult episode with her health:

> I: So, you are satisfied with your current living situation, in terms of support and accessibility?
> R: Yes, it is accessible. I live in that building because it is. I have a care person that comes in twice a week to give me showers, which I'm not able to do alone.
> I: Very nice. Is that government-funded?
> R: Government sponsored, yes.
> I: Okay, so you don't have to pay for that.
> R: For seniors. It is, and one needs a shower [*Laughs*]. You're allowed to have them twice a week, which is great.
> I: Fantastic. So, was it a long process to apply for that person to come in?
> R: Yes, it is now, apparently, but I've had my girl for quite a number of years. I'm told now that it's quite a wait, which I don't really know. I have the same girl.
> I: Right. How long have you had that service?
> R: Long. I'm trying to remember when I came out of hospital. I needed help. I'm okay now. Five or six years, I'm guessing. (Interview 7, 2016)

In a second example, a participant who experienced a broken hip spoke about her struggle in losing the same service, despite her continued need for this care. She also referred to another older adult friend in her social circle who encountered similar barriers to accessing formal care:

> R: I just finished on Saturday and CCAC said they realized I needed more care, but there's such a long waiting list and with all the cutbacks, CCAC doesn't have the money now.
> I: So, they won't send anybody now?
> R: No. They'll keep the case on file.
> I: So, it sounds like in your case you feel that you need more care?
> R: Yes, and the PSWs are upset because they've stopped it when I can't get into the tub yet on my own. Because they have to put my legs in. I've got a bench, like my bathtub is low and it's got a grab bar here, and a bench here, but only in between because there's a curve in the tub. I don't know how I'm going to manage.
> I: So, they're not coming at all?
> R: They won't be coming at all.
> I: So how is that decision made? You started off at seven days, twice a day. So, who decided that it should be reduced?
> R: Well they did an assessment. See what happened at the beginning, when I was in hospital, CCAC was on strike. So, it was regional nursing that sent the PSWs in and the physiotherapists and the pharmacists and all that. They were excellent. I only have one girl, that didn't do more than she had to. I didn't say anything about it, because well, I didn't. But anyway, the others were excellent. This girl was great with what she did, but

> she did the minimum and that was it. I don't know how I'm going to manage because my legs are getting worse from the other health conditions.
> I: Did they do an assessment recently?
> R: Well, they did two or three weeks ago, and she said unfortunately it has to stop. I've had it over a year. From February of last year to February of this year. So, she says you've been very gracious about it. So, I can't do anything about it. She made a couple of recommendations that I would have to pay for.
> I: Do you know how much it would cost you?
> R: I know my friend who hasn't been able to get CCAC or any help and she has Parkinson's. She's in her 60's and she's my friend who's a flute player. Her Parkinson's is getting worse. She had both knees done last year and she's got other conditions. Her husband is Japanese. He has motor neuron disease. It's a wasting disease and he falls and she can't pick him up. He's fed by a tube in his abdomen. They said she could pay $28 an hour. She's finally now getting once a week help, for a short period of time. He's on a waiting list, 2-4 years for long-term care. (Interview 22, 2016)

This participant referred to an existing gap in formal home care services which occurs upon discharge from a hospital stay after acquiring a disability or experiencing an impactful health event. The above demonstrates a scenario in which acute health care services released an older individual from formal care when she was still in need of additional aid upon returning home. Her experience suggests that the system does not sufficiently support this type of transition for all who require it. Research shows that many older people in similar situations are left in a highly disadvantaged position where they are unlikely to be able to heal and advance without assistive extended care upon hospital discharge (Svanborg, 2001). Yet, constraints within the current system force a circumstance whereby older individuals who are prematurely sent home from a care facility may feel abandoned or fearful for their future without adequate home care.

It is not just assistive care which causes anxiety among the oldest old. Sometimes, the non-availability of supports is itself the cause of stress. One participant spoke of not qualifying for care services at all, due to a medicalized assessment deeming him to be too physically “healthy” to receive them:

> I: Is there anything that you wish the government would offer you that they may not at the moment? Cleaning or any other kind of assistance?

> R: They won't give it to me. Cause I told you, I was in the service, and everybody kept telling me to apply for a pension, so I applied for a pension and they sent me a notice that I qualify - just send my income tax data, and then they phoned and said sorry you're above the poverty line. So that was the end of that. So, they said would you like to apply for overseas service. I said yeah, I was overseas, so I'll apply. So, I applied and what was the answer? Oh yeah, we'll send a nurse around to check your health out. She comes and checks my pulse and checks my bathroom and I got a phone call; sorry you don't qualify because you're too healthy. So, okay.
> I: So, which service was this that you don't qualify for?
> R: House cleaning, and stuff like that. Cutting the grass and stuff like that.
> I: So, you tried to get those services?
> R: Yeah.
> I: They told you...?
> R: I'm too healthy. (Interview 12, 2016)

In all three of these cases, it is clear that receipt of formal care provisions is not necessarily a smooth process for recipients. Nor are these provisions comprehensive in how they are allocated and provided to older adults in need. As the second of the above three participants stated, she felt powerless to change the outcome of no longer qualifying to receive the care support services she believed she needed. These participant accounts demonstrate that that there are several care gaps not being sufficiently met by the current system. The last participant, in particular, who mentions he was labelled as "too healthy," shows the extent that policies tend to have limiting criteria that are often based on clinical/physiological standards.

This type of model fails to account for heterogeneity among the oldest old and the vast spectrum of gendered aging and disability-related experiences in society. It is also often the case that the biomedical criteria to qualify for such services are inherently ageist and gender-blind in their limited assessment of the patient, rather than the person who is subject to a multitude of social factors impacting their health and wellness. This lens also tends to misunderstand the unique gendered needs of men and women, as discussed in Chapters 2 and 3. Gender differentials are important to consider when examining the ways in which health is assessed and care services are allocated. The neoliberal agenda is evident here once again, as the retrenchment

of public care services is the by-product of a shrinking welfare state, thereby placing a greater responsibility on informal care measures and the individual themselves to fulfill the increased needs (Braedley, 2006; Rosenthal, 1997).

It is often the case that a community-based older adult resource centre, such as the research site, serves as an ally with regards to accessing formal home care services. These types of organizations act as intermediaries by linking older people with publicly funded supports. The centre used in this study partners with other organizations that provide care-related needs, including caregiving respite services. In an interview, the manager at the site explained the ways in which the organization provided access to care assistance through formal and informal networks:

> "I think we offer the support. Again, if it's something that's out of our scope, or if it's something that's a little more specific, then our intake department would guide that person to another resource or group. I think a lot of it, though, is kind of informally done. When you meet someone in an art class, for example, and you get to talking and you become friends. Then you both realize, maybe you're both widowers at this point. Or maybe someone's husband isn't doing well. You just build these networks and friendships that are informal, and you know there's always that question going around in the industry of how important is informal caregiving? Oh my god, it's huge compared to doctors, nurses and other formal care that you think of. If you're at home with a sick husband for 10 years, well that's going to take a toll on you. I know a lot of people come here to sort of escape that for a little bit. So, they'll leave another caregiver at home and they'll come and do their exercise class, to do something for themselves." (Interview 19, 2016)

This shows that community-based organizations have a role in guiding people towards appropriate services, connecting them with others on an informal basis, and providing caregiver respite.

Along with self-care and government-funded care services, reciprocal care relationships are also shown in the data as a third noteworthy type of care. Reciprocal care involves care that is provided for and by the oldest old of adults themselves, in a communal fashion. Both men and women in this study discussed feeling a greater sense of purpose and fulfillment in helping

others who would in turn help them. An 85-year-old woman described the following scenario as a time that she received and provided help:

> “I've asked this one girl that has all the confidence in the world with her limited abilities, and she came over last week and did some helping me with getting the move straight. Because my daughter's, when I was out in the hospital, they took my art stuff and everything and they just tossed it in the library. I couldn't find anything. They had a bin with all different things. I couldn't even get into the room because I couldn't move the bin. So, she was wonderful because she moved it back and forth. Everything's done except two bins and the room looks lovely. She's going to come over next week to help again. I offered her a reasonable price and gave her lunch and supper, so she was delighted with it. She's retired now, and she's not getting much of a pension. So, it's helping her and helping me.” (Interview 22, 2019)

Here, this participant spoke to enjoying a mutually beneficial and harmonious helping relationship in a reciprocal care context, in which she benefitted from the assistance provided to her, and also felt like she was making an equal contribution by helping in return.

In another case, an 85-year-old male participant described reciprocal care as a type of helping network. The following is an illustrative selection from our interview:

> R: Friends I have now, we had a very wide circle that slowly came down after a while. It's become a smaller circle, but that is good because the friends which I have, I can depend on them.
> I: They're from here? They live nearby?
> R: Near condo and other places. So, once in a while we see each other. I also have, in my condo building, three very good friends. Like if I want to go to the airport, they take me. They want to go to the airport, I take them. We help each other. So, if you are good to somebody, naturally they will not be bad to you. (Interview 9, 2016)

Based on the two responses above, reciprocal care was positively perceived as self-fulfilling by these participants. Lingler, Sherwood, Crighton, Song, & Happ (2008) refer to these types of associations as “mutual care relationships” where “such phenomena may be manifested by simultaneous caregiving and care receiving” (p. 369). The capacity to contribute to the lives of others in some way may also serve as a means of combating the notorious social isolation that often accompanies very late life, as I discuss in Chapters 5 and 7.

*Complexities of Partnership – Spousal/Companion Loss and Relationships*

Within the participant group in this study, a number of complexities arose when one lost a partner or encountered a chronic diagnosis that changed the dynamic of a spousal relationship. Marriage and the death or loss of a spouse are among the most significant life course transitions one can experience. From a gendered perspective, women who perform most of their earlier life's work in the unpaid domestic sphere are more likely to have relied on the economic support of their spouse throughout their middle age years and into their later lives. Hence, losing a spouse at this late stage, when income is likely to be more precarious, renders many women more vulnerable to conditions of poverty, thus compromising their capacity to age successfully and fulfill important SDOH.

Many dynamics involving partnership and widowhood/widowerhood arose in conversations with study participants. As shown in Table 3, at the time that data were collected all but one of the women I spoke to were widowed—and many had been for years. Only one female participant in this study was living with her spouse. D'Epinay, Cavalli, & Guillet (2010) state that grieving the loss of a spouse tends to be "more typical among the young-old than the old-old. Beyond the age of 80, women greatly outnumber men and most of them are already widows" (p. 302). By comparison, also specified in Table 3, only three of the male respondents in this study were widowers while one was single due to separation from his life partner. The remaining five were married, although two respondents were in a second marriage and the wife of a third was diagnosed with advanced Alzheimer's and was living apart from him in a long-term care facility. The partnership attributes in this group were diverse, particularly among the men in this study who had a much higher ratio of living partners than the women.

**Table 3**
*Marital/partnership profile of oldest old participants by gender (N = 9)*

| Marital Status | Male | | Female | |
|---|---|---|---|---|
| | n | Percentage | n | Percentage |
| Married | 5 | 55.5 | 1 | 11.1 |
| Separated | 1 | 11.1 | 0 | 0 |
| Widowed | 3 | 33.3 | 8 | 88.8 |

In the following two cases, where a female and a male participant both seemed highly content with their spousal bonds, notions related to losing their partners were considered. In the first case, an 85-year-old married woman who lived in a retirement residence with her husband told me that at this stage in her life, the loss of her spouse was something she thought about and had to prepare for. She said:

> "No complaints, we're together… quite often, I've thought that if anything happened to my husband, what would I do. Of course, I did talk to some of my friends here. They're a little bit older than me and their husbands have passed away in the last few years. I talk to them and see how they coped with it. So, I realize that it's not the end if you yourself, you're still here. You've got to accept that your husband or spouse is gone. Carry on as best as you can... I suppose it would be an emotional upheaval." (Interview 17, 2016)

In the second example, a former widower spoke about marrying a widowed former friend for the sake of companionship. He stated:

> "My common-law wife, her husband passed away nineteen years ago. My wife passed away about seventeen years ago. We were friends with the husbands and wives. We came from Hungary together, her family and my family together. Ever since my wife passed away, I got together with my common-law wife. Since then we are no problems, even one day. We are satisfied…" (Interview 15, 2016)

In both these cases, elements of continued partnership bonds into late later life were expressed. For those who are married in later life, a close interdependent bond between spouses can serve as a critical avenue of social support (Arber, 2004).

In contrast to the sentiment of the attached participants described above, the experiences of those who had lost partners was distinctly different and more complex. When speaking of the loss or death of a spouse, the male participants described the impact of losing their partners more

emotionally than did the women. In contrast, women instead discussed the socioeconomic aspect of being married and losing their spouse. In the following three cases, all of which are male perspectives, the adjustment to losing a spouse was described as very difficult. In the first two excerpts, the respondents spoke about a meaningful and impactful loss in their lives:

> I: What are your experiences with emotional challenges in your daily life now?
> R: Now, because two years ago my wife passed away and before that I was more happy because we were two, and we were living 62 years together. So, suddenly it is a challenge to live alone. What can I do? [*Sobbing*].
> I: I'm so sorry. It's very, very, hard.
> R: So, that is the only thing because, as such, I don't have any stress about anything else. (Interview 9, 2016)
>
> R: But things happen in life, so… oh well, this was a major thing when my wife died when I was 55, roughly. Okay, so that's a major blow in life, but anyway, you have to overcome that. Oh, actually, that lasts, they say that trauma lasts a few years, like five years. For me, it lasted about seven years. It took about seven years to get over that.
> I: The loss of your wife, you mean?
> R: Yes, it was an adjustment. Not, oh boy what am I going to do, I gotta go drink alcohol. No, no, no, just the adjustment. (Interview 3, 2016)

A third man also described the pain of losing his wife, who was still living but residing in a nursing home due to intense care needs. He referred to this as a significant emotional loss after many years of marriage:

> R: My wife, as I say, was born in South Africa. She was a schoolteacher here, and now she has Alzheimer's, and this is the worst part of my life. [*Sobbing*].
> I: That sounds incredibly hard. Very, very, hard. I can't imagine it.
> R: Very hard. Sixty years married.
> I: Sixty years. Wow.
> R: Thank you. Sometimes, I can't sleep.
> I: I can imagine. I'm so sorry.
> R: Anyway, that's in life, whatever it comes, you can't control this. (Interview 18, 2016)

While the men above all referred to the emotional component of losing their wives, some women participants in contrast focused on the economic stability that being married afforded them.

In the following two cases, female respondents spoke directly of the economic implications of marriage and losing their spouses. For them, their very sense of financial security

was intertwined with the marital aspect of their lives. In the first case, the participant indicated financial security came solely as a result of having married someone with privilege:

> I: So, is money a source of stress for you?
> R: It would have been. It would have been absolutely terrible if I hadn't remarried when I did.
> I: Okay.
> R: Right. It would have been. I was working, so I was making ends meet. But obviously, at my age I'm not still working. So, I'd be up the creek with the proverbial paddle, as they say. Or without the paddle. So, I thank the almighty for that aspect of my life. (Interview 8, 2016)

In the second case, another woman mentioned the financial insecurity that came from having lost her spouse, and hence having to divide her financial resources:

> I: So, in terms of stress, would you say that finances are a source of stress for you?
> R: Of course. Of course, it is. One of the problems is, you have half of an income. Your husband, of course, had an income. Mine happened to work for the federal government, so I get only half of the pension. So, you're concerned about money because the problem is there's none coming in. Only the wee bit, and you don't work, of course. (Interview 7, 2016)

The differing perspectives of the men and women participants above reflect the gendered complexities that arise through partnership status in late later life. In a document released by the Ontario Human Rights Commission (OHRC) entitled *Time for Action: Advancing Human Rights for Older Ontarians* (2001), the unique barriers and concerns of both gender groups are described. The report speaks to the disproportionately higher levels of socio-economic disadvantage that are more likely to be faced by older women for reasons of longer life expectancy and greater chances of widowhood. Widower men in late later life, however, often encounter greater difficulties coping with their personal care needs after the loss of their wives, particularly in cases where their spouses took on most of the caregiving and domestic responsibilities (ibid).

The following is the statement of an 89-year-old male who spoke about the impact of his wife's care of him after acquiring a disability at this very advanced stage in his life:

> "Because of her, I have these thoughts every once in a while, rarely but once in a while - you can't help it - what it would be like to have something happen to her. God help us, please. You know? I don't know what it would be like. Where I would end up. The kids would all have to get me into something. I couldn't do it by myself... She's an angel, she's a miracle worker. Takes care of me, feeds me right. I guess she does it because she loves me, but I'm not just saying that. Others might say, put your own shirt on. But no, not her." (Interview 21, 2016)

This interviewee's wife was clearly a critical lifeline for him, so much so that he questioned where he would live and how he would cope without her. In general, the loss of a spouse is identified as a significant threat to successful aging (Bergstrom & Holmes, 2000). The extent to which one establishes other interdependent supports and strengthened relationships around them has a significant impact on their capacity to recover from this traumatic life event (ibid).

Regarding interdependent bonds, a widower quoted earlier in this section spoke of the friendships/connections he had formed with others who resided in the same building and were of a similar age and circumstance to himself:

> I: Do you find that people treat you differently at this age than when you were younger. Just, generally, people that you meet and in what ways?
> R: No, I feel this depends on you, not on age. Because when you are younger, you have younger friends and so if you are 18 or 20 years, you don't have a friend who is 40 or 50. If you are 40, you don't have friends who are 18 or 80 years old. But when you are like myself, then we move in the circle of others who are in that age group. Except our grandchildren and family, of course. So, I have no problem with that. People, where I live, 70% of them are seniors.
> I: In your condo building?
> R: Yeah, they own the condo. They are the original buyers of this condo and either their husband died, or wife died, so they are living maybe 30 or 40% alone. So, we have a friendship and I meet them. I have no problem with that. (Interview 9, 2016)

As discussed in Chapter 5, the formation of new bonds is essential to the well-being of the oldest members of society to overcome the dramatic reduction in one's social network which comes with advancing age. The circumstance described by this man is one where the loss of a spouse

was a common link between the very old seeking companionship in his social circle. Unfortunately, social bonds among the oldest old are difficult to establish outside of spaces that facilitate this. The living arrangement of this participant in a condominium building where most occupants were of a similar age, was obviously one such social mechanism. Another possible avenue for connection is concentrated in community-based social networks and hubs for older adults.

The facility used in this study is one such community resource, serving an important intermediary function as a helping network that facilitates social connections for the oldest old who have lost their spouse. On this subject, a program coordinator at the centre told me:

> "I think on the best side it's seeing the relationships that people are able to build here. Because we see people when they first come in, for example, if they're a new widow or something like that, and they're looking to become more social. We introduce them to people, or they just decide - I'm going to play euchre. As a result of that, they build long-lasting firm relationships, and yeah, I think that's really rewarding to be helping in the facilitation of that." (Interview 23, 2016)

Community-based resources like this entity play an important role in combatting the social isolation that is often encountered after spousal loss. This type of resource, along with more extensive government-funded social supports, are hence critical to fulfilling very old adults' need to create and foster newer social bonds.

*Work and Income*

The work and income status of participants is a third and final gendered sub-theme revealed in the data. Gender and income inequality intersect differently for men and women, through diverse paid and unpaid work experiences over the life course. Both gender and income are identified as key SDOH which play a critical role in health and age-related inequities across the life course (Mikkonen & Raphael, 2010). This is largely because efforts in the paid work

domain, where men have historically dominated in patriarchal society, are ascribed tangible monetary compensation and given a higher social worth. In contrast, unpaid work that has more often been performed by women in the home not only garners less financial benefit but can also be personally depleting and socially devalued (Nordenmark, 2004). These gendered elements of work were discussed by several participants in this study, as the legacy of economic activities in middle age continued to have an impact in their very late life years.

During most of the interviews with male participants, respondents opted to provide an extensive descriptive background of their paid work careers in earlier life. Their connection to productivity was far more pronounced than for the women I interviewed. Unlike the men, female participants more often focused on their present-day circumstances, their hobbies and their earlier life work performing care and domestic labour. Interestingly, few participants in this study referred to financial support from government resources. Instead, nearly all focused on their independent financial capacity or that of members of their immediate informal network (i.e. their children) upon whom they might rely for socioeconomic support.

The men that did refer to the issue of financial status nearly always did so by indicating high levels of satisfaction in this area. For example, this man spoke about the ability to focus on his own well-being, given that he was free of financial stresses at this late stage:

> I: So, the priority now, at this age, what would you say is your biggest priority in terms of goals?
> R: To stay healthy and to stay active, and I'm not too concerned about money. The house is paid for, and I have enough. (Interview 14, 2016)

In a second case, another man alluded to the additional costs associated with acquired disabilities or health-related issues that one might encounter in later life, none of which he personally experienced. Hence, economic privilege correlates with the ability to sustain personal health and wellness. Our exchange was as follows:

> I: So, in terms of financial stresses, is this a source of stress for you?
> R: No.
> I: Like it is for many seniors…
> R: Like I said, a lot of seniors have problems with diabetes, heart, health conditions, this and that. They have problems with their money also, then they cannot walk or something or need some help cleaning and all. So, they have more expenses than me. I have no other expenses myself. (Interview 9, 2016)

These perspectives are aligned with that of many of the men I interviewed in this study, who discussed their financial privilege in similar ways.

In a third case, a 90-year-old man I spoke to was unconcerned for his financial future, despite feeling as though he could be in a better position with more funds. The retirement benefits garnered from his earlier-life career had seemingly allowed him to support himself without significant distress up to this point in his life. In the following interview excerpt, he discussed these issues and also referred to the state-provided pension benefits he received:

> I: Is money a source of stress?
> R: No, no it isn't. Of course, the money that I retired with, back in 1980, is less than the starting salary for anybody in a good engineering job today. Starting out of college today, they get more than I ended up with 35 years ago. But, no, it hasn't, it's fine. I have a RRIF now, which is running out, of course, and OES and CPP. Things happen, you know? I took them out early, by the way, because I didn't know how long I was gonna live. I figured the earlier you get them, the more money you get. Now I wish I hadn't taken them out, I would have been getting 20 or 30% more. But anyway, there's a story. I guess my assets were bringing in enough to live on. I never worried about it. I did my charitable work, and stuff like that, no problem. When I moved down here, of course, selling the house naturally provided me with the funds for investing to live where I am now, which bites off a lot of money. I don't know, it's gonna run out some day. If it does run out, I don't know, I'll be on the street downtown there. You can visit me [*Laughter*], by the Salvation Army. I'll be sleeping by that vent over there [*Laughter*]. Anyway, I'm still not worried about it. (Interview 3, 2016)

He also considered income to be a central facet of successful aging. In the following statement, he conveyed the point that food and income security are linked factors necessary for successful aging. He told me:

> "What's successful aging? Somebody who doesn't fall apart when they get older, I guess. Somebody who's doing something. Not necessarily a celebrity, just somebody who's got

> a sufficient income – whether it's from a retirement plan or something like that… Oh yes, I don't think, if your cupboards are bare, I don't think that you're really able to age successfully because you're preoccupied with eating and getting enough food." (ibid)

As an identified SDOH, food security is an essential need that correlates with individual circumstance and position in the socioeconomic hierarchy (Mikkonen & Raphael, 2010). The statement above emphasizes this connection, making the case for income as a primary factor in aging success by providing the means to fulfill basic human needs in the latest life years.

Many of the perspectives about work and income relayed by the female participants in this study included narratives about a legacy of domestic work and responsibilities. When asked what it means to successfully age, one woman highlighted her earlier-life work contribution within the home. She said:

> I: At the age of 91, what do you think successful aging is. What does it mean to successfully age?
> R: I don't know, except my mother used to say, hard work never killed anybody. I haven't worked outside the house, but I have certainly worked inside.
> I: Which is a lot of work with eight kids.
> R: I know. I got them raised and had dinner on the table. I've sewed and I've cooked and been up at night. You know, the usual. Gone through everything. I don't know what it is. But probably it's something to do with your genes, I guess. Because my mother lived to be a hundred, and she didn't go to a nursing home until she was ninety-three. Of course, my father died at eighty-four. He lived quite a while too, in those days. I don't know, she always said she'll work hard. We had seven kids in our family. I think that's the secret. Keep busy. Always have something interesting, if it's not reading it's knitting. Something. Just keep going. (Interview 11, 2016)

This participant drew a clear distinction between the public and private spheres of work. Her sentiment is one where she took pride in the work she performed for her family. Another female participant also referred to concentrating most of her working efforts in the home, though she elected to partake in the paid work domain before and after the years she spent rearing her children:

> "I was working on a Friday, and I had my baby on the Sunday.... Never went back to work after that, because six months later I got pregnant again [Laughs]. That was the end

> of it. So I never ever went back to work until I was fifty when I got a secretary job, but I had been home because my husband worked for an American company and had to have a home office and part of the conditions was that he have the office in the house and for that I got compensated with trips. The company was in Berkeley, California, which is where we settled for some time." (Interview, 16, 2016)

These women expressed contentment with their earlier-life responsibilities in the home. At the time of their interviews both women lived alone and financially supported themselves. Some of the other women I interviewed, however, described a more precarious financial situation.

In the following examples, two women discussed the stresses that arose with financial insecurity in their late later lives. The first participant mentioned her worry and stress over financial issues, then alluded to the availability of financial support from her children should she need it. Once again, there was no mention of reliance on the formal benefits of the state:

> R: So, it's always a worry. You worry if you're gonna run out of money and you have bills to pay, of course. That's a bit stressful. That would be about the only thing I get stressed over, which my children tell me I shouldn't.
> I: Of course.
> R: They would, of course.
> I: I appreciate that perspective. Because it is a worry for a lot of people.
> R: I think most seniors would have that problem. Unless you're wealthy and you have lots of money, but otherwise, it is a bit of a problem. Well, yeah, because as I say, it's not like when you had a job. There's always a pay cheque coming in next week. There isn't now. But anyway, we manage. (Interview 7, 2016)

In the second example, another woman described the financial support that came to her through her marriage, but also mentioned the informal care work she provided to her late husband towards the end of his life. In her estimation, it was a reciprocal exchange comprised of the support she provided him through care, while he provided her with monetary security. On the subject she said:

> R: That [marriage] was just great for me. It was good for my late husband because he became very ill and he needed somebody to look after him and I think I did. He was very ill for seven years. So, yeah.
> I: That seems to be a source of stress for a lot of older people.

> R: Oh, I think so. I wouldn't say I'm wealthy, but I'm certainly able to make ends meet. My little house that I live in is worth a fortune. People always say, why don't you sell it and get a million dollars. Well, what would I do with a million dollars? You know? (Interview 8, 2016)

Reliance on marital support for financial security illustrates how gender roles and divisions remain distinct in the context of aging and later life. In a third example, an 85-year-old woman who had been widowed for many years at the time of our interview spoke of working with a limited budget at her age. More specifically, she mentioned that the lifestyle restrictions that arose from a health-related incident were what allowed her to sustain herself financially. She stated:

> I: Is money a source of stress for you at this point in your life? Do you find that it's something that causes you stress?
> R: Breaking my hip in one way, has been a blessing. Because I was going from cheque to cheque, you know.
> I: You were before?
> R: Now, the last few months, because of what I'm saving on all the things that I've cut - it's enabling me to save a little more.
> I: Right, but had you not broken your hip would it be different?
> R: Probably. I think so. Yeah, I'm sure it would. (Interview 22, 2016)

In this case, the highly individual model promoted by neoliberal society where people hold greater expectations of themselves than of the system at large to take care for them, is evident. One of the primary recommendations of the *Time for Action* (2001) report released by the OHRC is for gender to be made a priority in aging policies. This report discusses income inequality and gendered patterns of labour force participation as contributing factors to increased poverty, particularly among the oldest old of women. The report specifically recommends that "the public and private sectors consider the 'intersectional effect' of age and gender in policies and programs, especially with respect to the compounded disadvantage experienced by older women" (p. 24). Importantly, life-long income is a factor that must be considered when evaluating the socioeconomic circumstances faced by women and men in very old age.

The notion of access to community resources also arose through respondent narratives as a matter related to income and economic status. This was mainly discussed in the context of having the material means to access a community-based entity like the research site facility. All participants in this study were active members of the centre, and therefore had the means to afford a membership that allowed them this level of access. This was not only acknowledged during interview discussions but could also be deduced by the fact that they were frequent visitors at the site. In a discussion on the subject, the manager at the centre referred to the likelihood that its members represented a financially secure group of older adults:

> I: Are you aware of the financial position of the older adult group that accesses this centre?
> R: Sometimes. It's hard because at this particular centre, they're so independent. And people could and probably do present one way, versus what they might be living like at home. There's probably a substantial amount of our membership that is fine. They're financially okay. There's definitely a population that needs help, but they likely access other services. I don't know. It's kind of hard to think but I do think that subsidy is going to be more needed in the future. I don't know in how many years, to be quite honest, but I think that it will be needed, and maybe different models might have to be looked at. In terms of us offering subsidy. Not just for membership, but maybe also for classes or for drop-in. We do accommodate that now, but it's only for a handful or people. (Interview 19, 2016)

Economic privilege affects the oldest old by facilitating access to essential community-based services. Those with the capacity to visit a centre like this, and with the means to participate in the social and leisure activities it offers, can benefit in ways that the more vulnerable members of society's very old may not be able to. Knowing that most of the oldest old population in Canada are women, many of whom are more susceptible to income-based barriers related to access, means that greater attention must be given to gender-related disadvantage by both community organizations and policy makers in the future.

# Discussion

The interview data in this study reveal strong gender-based connections with life course experiences related to care, spousal loss/relationships, labour history and income inequality. Based on the responses above, neoliberal thought is evident through a strongly indicated drive to remain independent of public support for the fulfillment of essential needs. This includes the necessity to care for and support oneself, as well as the election to rely on unpaid informal resources and reciprocal informal care rather than the state. In large part, this perspective is strongly linked to how notions of dependence, independence, interdependence, and care are socially constructed within the free market system. As a society, we have come to assign a negative value to dependence on others, though it is an inevitability of life (Kittay, 1999). A framework of interdependence embraces a network of providers and recipients of care at different stages of the life course, particularly when it is most required in the latest stages (Daly, 2001; Kittay, 1999).

In Canada, where women generally assume most of the unpaid/informal caregiving responsibilities, care tends to be provided through family relations (Daly & Grant, 2008; Luxton, 2006). Contemporary Western models of care are distinct from societies where capitalist ideology is less pronounced and the welfare state has an expanded role (Callero, 2013). For instance, social democratic nations such as Sweden and Denmark have strengthened gender equity policies that provide social and health-related supports to those in caregiving roles (McAllister et al., 2019). Such benefits are likely to have a long-term socioeconomic impact for women well into their very old age. Braedley (2006) discusses care provision under neoliberalism as follows:

> In the case of the populace's need for care, decisions regarding who provides care and under what circumstances are reframed to conform to the market considerations regarding the costs of care and who pays for care. Thus state-funded involvement in care

> is not conceived as a social benefit of citizenship, or as a social safety net to buffer society from economic downturns, or as a stabilizing involvement in social reproduction. State-funded care has been transformed into a short-term residual social welfare measure that will manage individuals into taking up or resuming independence and self-sufficiency. (p. 222)

Care and interdependence have therefore been transformed under neoliberal ideology into a driving force for a system of individualism with detrimental effects upon the care work contribution of women in both the public and private spheres.

Care is an essential element in the lives of the oldest old. As described in Chapter 5, many of the oldest old are vulnerable to the loss of their core social network and more likely to encounter health or disability-related difficulties (Asla, Williamson, & Mills, 2006). Intersectionality furthers the discussion here by highlighting the impact of gender as an important layer of identity that often collides with acquired states of old age and disability. For many of the participants who identified with experiencing a disability in their very late life, this was almost always coupled with an increased need for assistance and care from others. Consideration for newly acquired identity contexts, as they overlap with existing ones, allows for a richer and more holistic understanding of aging experiences.

Because most people among the oldest old are women, and most caregivers are also women, it becomes increasingly important to examine these issues within a gendered context. Rather than placing the emphasis on individuals aging successfully and taking responsibility for their own prosperity and care in late later life as promoted by neoliberalism, the focus should instead be on the structure of the patriarchal system that perpetuates gender norms. One possible starting point could lie in assigning more value to the work of those who perform informal care for the aged, thus recognizing it as a truly vital contributing service to larger society. Beasley and Bacchi (2005) suggest that a political system that recognizes interdependence as a necessary

aspect of the human condition is essential to developing an appropriate and valued understanding of care. This would ultimately allow for a more holistic view of caring that accounts for the extent to which we all serve as givers and receivers of care at multiple stages of life (Beasley & Bacchi, 2005; Fisher & Tronto, 1990). Kittay (2005) refers to the extent that we each have our own intrinsic sense of self that is maintained through our "connection to others" (p. 117). In this sense, caring is a reciprocal, cyclical, necessary, life-enhancing, and complex process that aligns with the values of an interdependence model.

Part of realizing an enhanced vision of care lies in fulfilling a need for strengthened services in the formal system alongside informal care provision. Luxton (2006) aptly points out that "not everyone has family available to help, and access to care should not depend on having available family members; nor should family members be subject to 'compulsory altruism,' pressured to help loved ones because no alternative support is available" (p. 288). For the oldest old, it can be said that increased reliance on familial/informal care is the product of a failed public welfare system (Songur, 2019). While a strong reliance on family is identified as critically important to many of the oldest old who participated in this study, some respondents did not have such personal connections available to them. Many of the oldest old are vulnerable and without sufficient informal connections and resources they have few options but to seek the assistance of state-sponsored mechanisms for their survival. The data illustrate that many of the oldest old who required assistance live without the support of a spouse or partner. To address this need, Cammack and Byrne (2012) propose a "network model of care" as one that "recognizes that, to achieve the best outcomes, individuals require communication, problem solving, and collaboration among *and* between informal networks and formal care providers" (p. 27). Such a

proposal engages with interdependent facets of care where the needs of individuals are best met through multiple sources as a shared responsibility.

As of June 2017, many older adult home care services in Ontario are provided through Local Health Integrated Networks (LHINs) across the province. At the time the data were collected for this study, this task was left to the now obsolete Community Care Access Centres (CCACs). Aronson, Denton, and Zeytinoglu (2004) discuss the extent to which the CCACs attempted to meet the complex home care needs of older people with limited funds and resources. While further investigation is required to assess home care services under the much newer umbrella of LHINs, it is clear that "policy has not centered on addressing equitable access to home care based on need" (Yakerson, 2019, p. 270). The participant accounts of formal care services in this chapter suggest that more investigative work is needed in the realm of allocation and needs-based assessments for formal care delivery, especially in terms of ease of access for those trying to navigate a complex system fraught with inconsistencies.

In the realm of income inequality, my findings show differing experiences for both male and female participants in their very late lives, primarily as a result of distinct work histories between the genders throughout the life course. A feminist political economy lens strongly applies here. Over time, the unpaid work contributions of women through the life span is in large part what has allowed men to participate and advance in the public domain more easily by not sharing in domestic responsibilities to the degree that women have (O'Connor, Orloff, & Shaver, 1999). Social roles are hence constructed through the ideal male as a producer, and the female as a largely dependent individual whose work has been more contained to the private sphere (Doyal, 2000). Participant responses illustrate that the ramifications of these gender dynamics continue to play out well into late later life. Life course theory is also relevant to this analysis

because the historical experiences of women and men throughout their early, middle, and late years are highly gendered. As in feminist political economy, the life course paradigm aims to holistically examine individual lives amidst dynamics of macro- and micro-social levels of inquiry (Taylor & Bengtson, 2001). This is ultimately true of any age cohort, including the oldest old. As previous chapters of this study establish, socioeconomic status in earlier years plays an influential role in the advantage/disadvantage experienced in subsequent life stages, and therefore in the capacity to age successfully (Britton et al., 2008).

Many of the female respondents discussed the extent to which their socioeconomic position correlated with their marital status and/or financial relationship with a spouse, even for those who had lost a partner. While male participants did not mention significant financial concerns in a spousal context, women were clear about their perceived dependence in this regard. Some women participants even acknowledged that they would be in a far worse position without this support earlier in their lives. Research suggests that the gendered differences occurring through marital status patterns mirror that of gender relations across the life span (Arber, 2004). Many of the oldest women have hence been placed in a position of financial insecurity as a direct result of patriarchal constructions of labour and production value that transcends their lifetime. A system that provided adequate welfare supports targeted to the oldest women and their unique needs would leave fewer of them at risk of encountering socioeconomic disadvantage.

The removal of income-based barriers to accessing essential services and the promotion/acknowledgement of interdependent relationships and connections that are critical to vitality in very old age are an important area of investigation for policy makers and community-led organizations. Income is one of the most influential social determinants of health (Frohlich, Ross, & Richmond, 2006; Hofrichter, 2003; Raphael 2012). We know from a SDOH model that

chronic stress through insufficient social supports leads to poor health outcomes. This is a significant issue for society's oldest of adults, many of whom are women and particularly vulnerable to lower-income status. While income and financial well-being are acknowledged as primary factors of stress by the women participants in this study, many of the men indicated less concern in this regard. Kahana and Kahana (1996) write of the extent to which macro-level structural factors play a complex role in defining one's status in later life, which is largely determined by the resources made available to them. They further acknowledge that this is potentially much more damaging for women and minority groups, who are often even further constrained in terms of resources.

In Canada, policy documents centered on income supports for older adults most often refer to the particularly precarious financial situation of the oldest women, many of whom are widowed like all but one of the women interviewed in this study. Despite the varied tiers of public and private pension plans in Canada, income security and the threat of poverty are persistent concerns for widowed older women (Gazso, 2005). Gazso (2005) argues that though many older women pensioners are recipients of government-funded Old Age Security (OAS) and the Guaranteed Income Supplement (GIS), their continued place below the poverty line suggests that these income supports are insufficient.

The report by the Alliance for a National Seniors Strategy, *An Evidence-Informed National Seniors Strategy for Canada* recommends that the Canadian federal government prioritize finding ways to provide equitable access to post-retirement funds (Sinha et al., 2016). It further suggests that the current system is constructed in a way that favours those with higher than average life course incomes through personal retirement savings plans, while failing to provide an adequate income safety net for vulnerable populations, especially women. Feminist

political economy and life course theory together illuminate the life-long implications of labour market precarity for women who often experience significant interruptions or exclusion from the work force for reasons of care and domestic responsibilities. This has meant that their retirement income is at risk of being significantly compromised into their very late years.

As demonstrated by some of the personal accounts provided in this chapter, even though most of the widowed female participants in this study were managing in their current circumstance, some expressed a feeling of financial vulnerability, particularly in the absence of their spouse. In the older adult population at large, 30% of older Canadian women live in a circumstance below the poverty line, and they are twice as likely to be in this position than their older male counterparts (Sinha et al., 2016). A proposed solution to alleviating this problem is the Canadian federal government increasing its lowest tiers of retirement funding, specifically for the most vulnerable group of seniors who are single and living alone (Bazel & Mintz, 2014). Research suggests that a 15% increase in the GIS payment "would immediately lift all older adults out of poverty" (Sinha et al., 2016, p. 36). Strengthened public support in this area will also undoubtedly enhance trust and faith in the system to care for people in their latest years. In doing so, it would serve the important purpose of alleviating the stresses associated with an individualistic model of care in later life. It would also provide respite for an increasingly depleted informal network of family and other associations who absorb most of the caregiving responsibilities for our elders.

## Conclusion

Gender is a distinct feature of later life experiences worthy of considerable attention by researchers and policy makers alike. In this study, participant data revealed both similar and divergent narratives between gender groups. Findings in this chapter are demonstrated through

the sub-themes of care and caregiving, spousal relationships/loss, and income inequality, all of which correlate with market experiences under neoliberalism and across the life course. A policy framework that embraces interdependent supports is also proposed as critical to addressing concerns related to care provision and the threat of poverty among the oldest women. This means a model of care that occurs through balanced provision of both formal and informal resources in support of society's oldest women and men.

In what capacity and to what extent does the society in which people have contributed care work for so many years assume the role of taking care of them? This is a highly gendered and complex consideration that directly relates to how we approach, value, and construct care provision and productivity in relation to the life course path of our oldest members. As described by the OHRC (2001), observing the intersectionality of age as it interacts with numerous other locations of identity, particularly gender, highlights the most pronounced sources of systemic disadvantage and oppression in our society. This is perhaps the most significant starting point in developing gender-equitable support mechanisms for society's oldest old. In the succeeding chapter of this thesis I critically explore the third and final theme of living circumstance in the latest life years, and the policy goal of aging in place in relation to participant data.

# Chapter Seven: Aging in Place – Examining Interdependent Living among the Oldest Old

> *"… highlighting older people's contributions to places and communities emphasises the interdependence of support, and moves the focus beyond support between individuals to examine support between individuals and collectives. Moreover, it shows us that not only do older people derive wellbeing through attachment to place, but they actively contribute to the wellbeing of places as well."*
>
> (Wiles & Jayasinha, 2013, p. 100)

## Introduction

One of the most profound issues facing older people today is their living circumstances. More specifically, where one resides is intricately connected to their quality of life and numerous other aspects of their latest years. In this chapter, I explore the third major theme of aging in place, as an identified feature of successful aging in the lives of participants in this study. For the oldest members of society, who are often subject to a heightened risk of displacement from their original home for reasons of preference or capacity, a place of residence is intertwined not only with a sense of autonomy but also a sense of self. Policies in this area tend to focus strongly on the objective of aging in place, a concept promoted at the level of both national and international political platforms.

The World Health Organization (WHO) (2019) proposes a *Global Network of Age-Friendly Cities and Communities* in support of a unified goal across countries, by fostering barrier-free societies that sustain people through the life course and especially into their old age. In Canada, aging in place policy initiatives focus strongly on continued independence and autonomy as well as residence in a home of personal or individual preference. According to a Statistics Canada Census in Brief (2017) report, nearly one of every three people aged 85 years

and older in 2016 were "living in collective dwellings such as nursing homes, long-term care facilities and seniors' residences" (p. 4). This number increases rapidly with age, where two of every three centenarians reported living in such residences (ibid). The oldest old are more likely to be displaced from their original homes and relocated to some form of institutional living. Despite the increased likelihood of this occurrence, the desire to remain living in the community and age in place is overwhelmingly preferred by even the oldest members of society. This is supported not only for the explicit reason of preserving the autonomy of individuals, but also as an implicit goal of lowering fiscal costs incurred by the state (Wiles et al., 2012).

Consistent with previous chapters, an interdependence model also applies here, as the goals of community-living and prosperity are fostered through access to adequate multi-layered systems of care and support from formal and informal sources of aid. The research site used in this study, and other comparable community-based organizations facilitate aging in place by providing avenues for varied means of socialization, support, and connection with others. In this chapter I contend that an interdependent living model, comprised of both informal and formal service is critical to thriving while aging in place during the latest years of life. This is despite dominant neoliberal constructs in support of individualism alongside less pronounced welfare state supports across the life course.

My findings from the data show that the main theme of independent living elicits three related sub-themes. The first is that of place, which encompasses the preference of participants to remain in their communities and retain their independence for as long as possible. In doing so they avoid movement into a long-term care or institutional setting, an occurrence that often connotes a negatively perceived state of dependence. In many ways, relocating to this type of facility can signify a final resting place, or exit from active social life, especially for the oldest

old who are unlikely to leave such an institution until the end of their lives (Vesperi, 1995). The second related sub-theme of choice is also identified as critical for many in the respondent group. Aging in place, or at home, is very much allied with autonomous choice and sustained independence (Chan & Pang, 2007; Löfqvist et al., 2013; Wiles et al., 2012), whereas institutionalization in later life is often interpreted as tantamount to a loss of these capacities (Agich, 2003; Kane & Kane, 2001). Finally, I explore the third sub-theme of access, with an exclusive focus on transportation mechanisms and supports that are essential to aging in place. This theme is particularly relevant for those with acquired disabilities and adaptive needs in their latest years. In this chapter, I explore these sub-themes, using data from both participant interviews and relevant policy documents. Much of the analysis that follows is examined through the theoretical lenses of feminist political economy, life course theory, and intersectionality, all of which inform my discussion of these findings.

## Findings and Analysis

This section explores my findings from the data as they relate to this chapter's focal theme of community-based independent living or aging in place. The three related sub-themes of place, choice, and access to transport mechanisms are identified as the most significant areas of concentration from the data. Here, I explore these areas by drawing upon both interview data and supplementary policy documents to inform my analysis.

### *Place*

In this study, place is considered a multi-layered notion extending well beyond the bounds of a physical residence. Understanding place in the context of aging manifests as "a complex process, not merely about attachment to a particular home but where the older person is continually reintegrating with places and renegotiating meanings and identity in the face of

dynamic landscapes of social, political, cultural, and personal change" (Wiles et al., 2012, p. 358). Individualistic models of successful aging can inhibit personal capacity to age in place or at home by failing to adequately acknowledge the importance of an interdependent system of support. As highlighted in previous chapters, such a network is comprised of a balance between formal and informal channels of service and care that are essential to thriving in a community setting.

According to many of the participant narratives in this study, the strongly indicated desire to remain independent was synonymous with residing in a community-based dwelling, which was therefore their preferred path. Table 4 shows a profile of study participants with respect to both living arrangement and level of satisfaction with their living circumstance. Demographic participant data demonstrate that 11 of the oldest old respondents lived entirely alone, while 5 resided with a partner or spouse and 2 stayed in a dwelling with their children. All but two in this group deemed their living arrangement to be satisfactory, while the remainder indicated a circumstance that was adequate to their needs.

**Table 4**
*Living arrangement and living satisfaction profile of oldest old participants (N=18)*

| Characteristic | n | Percentage |
|---|---|---|
| Living Arrangement | | |
| Living with a partner or spouse | 5 | 27.7 |
| Living alone | 11 | 61.1 |
| Living with children | 2 | 11.1 |
| Satisfaction with Living Arrangement | | |
| Satisfactory | 16 | 88.8 |
| Adequate to needs | 2 | 11.1 |

In more detailed interview discussions with participants about their living situations, many spoke about aging in place in the context of avoiding all forms of institutional living at this very late stage in their lives. Of the 18 oldest old of adults who participated in this study, 16

continued to live in community-based homes, either alone or with family members. The remaining two, of which one was a widow and the other lived with her spouse, reported having moved to a private retirement residence by their own elective choice, both relying entirely on their personal funds to support their relocation.

According to interview data, movement into a nursing home or long-term care facility (the alternative to aging in place) was perceived in the highly negative light of presumed dependence and/or decline. The following interview accounts illuminate the varied negative perspectives associated with institutional living in later life:

> "Well, you don't have the freedom. It's an institution. You don't have the freedom and then also, I think too, once you're there you would deteriorate much more quickly… In a home, I think once you go in, you're kinda stuck." (Interview 10, 2016)

> "No, no no, absolutely not. I don't want to. I don't want to go to a home, if I can help it, but who knows what the future brings." (Interview 13, 2016)

> I: Any thoughts on living in a retirement or nursing home, compared to living independently as you are right now?
> R: I just think that retirement homes are horrible, I really do. I've never seen one that could take the place of my home. Some of them are very beautiful and very nice, but to put the name home on them is pretty tough for me. But these people, they like to play bridge. I don't play bridge. But these people like to sit and play bridge all day long. It's not for me. My house is a mess, in a way. A nice mess, because I've got craft projects and art projects going all the time.
> I: Do you think there's something that those environments could do to make them better, or do you think older people just need to remain at home?
> R: I would miss working in my garden, I would miss cooking in the kitchen, I would miss making my own bed. I would miss the things that I do every day. I would hate it. I would just hate it. Unless I was really really sick. Really really sick... I don't know what I would do. What the hell would I do? I'm busy all day, and when I'm not busy, I'm bored. Then the days get long when I'm bored. Boy would I be bored in an old age home. (Interview 8, 2016)

> I: Would you be open to living in one?
> R: No. The whole idea of being caged in and being with other old people doesn't appeal to me... They're all sitting there sleeping, you know? It's like a jail, I think, to be in any of those places. It would just be totally - I just couldn't feel that I'd want to put myself into a jail like that. That's awful. (Interview 16, 2016)

> "I don't want to be a liability to my sons and deteriorate in my old age… And if I did, you know, I'd be in a huddle at a home somewhere, a hospital or whatever. Or an old folks place, and they'd have to visit me and, you know, you get all the problems that you hear about. I don't want that. I'd soon rather collapse and go." (Interview 3, 2016)

The above responses demonstrate that these participants were highly resistant to the notion of residing in a long-term care facility for reasons including a compromised sense of freedom, decreased levels of activity or stimulation, social isolation, and boredom.

In general, admission into some form of long-term care is a particularly significant part of later life. It is most certainly a pronounced reality for the oldest old, who are more likely to face this possibility. In the lives of many older people, formal institutionalization tends to hold the largely negative connotation echoed by these respondents. In some ways, there is perhaps no greater symbol of societal ageist/ableist practice than institutionalization. The institutionalized space often represents a time of sadness and anxiety for older people, where they may be subject to dehumanization and are also particularly vulnerable to age or disability-based oppression (Nussbaum et al., 2005; Pasupathi & Löckenhoff, 2002; Sloan, 2009; Special Senate Committee on Aging, 2009). Framed by some as analogous to a prison, older adults' loss of autonomy and control in these settings represents a loss of freedom where they can no longer enjoy privacy, and worse, may not be able to leave a facility voluntarily once admitted (Agich, 2003; Kane & Kane, 2001).

Beyond the micro-level impact on individuals, the space of long-term care is also very much connected to the larger social and economic contexts, which it "furnishes and animates" (Vesperi, 1995, p. 13). This implies that larger systemic forces (to the extent that the state invests in long-term care) and the prevalence of social barriers in these settings influence the overall experience and negative association with living in an institutionalized setting. Kane and Kane (2001) suggest that long-term care is not a priority of politicians because there is little to gain

from the service. This view is aligned with ableist/ageist notions supported by neoliberal ideology which frown upon investment in social welfare services when there is little to no return in the form of productive capital. An increased shift towards the privatization of care can cause further damaging effects to arise. In such a system, rising competition between entities may put a potentially greater strain on care providers which would ultimately result in compromised care for recipients, and particularly for the disadvantaged (Armstrong, 2013).

Despite these aforementioned negative facets of nursing home care, some participants spoke of a more positive impression with regards to relocation to this type of facility. One woman in particular, who was living in a private retirement residence by choice at the time of her interview, revealed feeling more reassured about this type of environment after visiting a relative in such a space:

> R: Actually, a few nursing homes that we did tour around to look at, I always said I don't want to move into a place like that. But my husband's sister is now in a nursing home. We've been out to visit her, and I keep saying, if I gotta go in a nursing home that's where I want to go. She's treated well. She's got a lovely room, and there are activities that she participates in - to a certain degree.
> I: So, you don't necessarily have a negative perception of nursing homes that most people seem to?
> R: No. If I needed it, I'd find a good one. I guess that's about it. There are good ones that I know of. The woman who lived next door, she had to go into a nursing home. We still see her son occasionally and he says his mother's quite happy there and he thinks the place is lovely. So, you do hear these good things about nursing homes. They can't all be bad. (Interview 17, 2016)

In another positive account, a male participant whose wife was residing separately from him in a nursing home at the time of the interview praised the experience she had in this setting. Here he specifically focused on the quality of care his wife received in a nursing home environment:

> I: What is your opinion of nursing homes?
> R: I think they're making a terrific job… The way they treat them, it's amazing. That's why I told my son that we should do something for the nurses there. They trained especially for this kind of job to have there. Because one day we went out and she [his

> wife] make a mess. Then I took her back there… The nurses take her to the bath and everything, and so on. It was amazing.
> I: So, you are happy with the care?
> R: Amazing, yes. Very good. They have very good care for older people in this place. (Interview 18, 2016)

Of note in the two positive excerpts above is the role of socioeconomic privilege in the differing quality of private versus public care in an older adult facility. In the first interview, the woman and her spouse were residing in a private retirement residence that was fully paid for by their own personal funds. If needed, they may also have had the ability to apply their funds to another form of private or semi-private nursing home or long-term care environment. In the second case, though this participant referred to a partial subsidy from the government for his wife's excellent care in a nursing home, he also mentioned the high personal cost he incurred for her to stay there. At one point in our interview discussion, he said:

> R: I have a private room for her, but the government pays some. Myself, I have to pay twenty-six hundred dollars a month for her.
> I: Wow, that sounds like it could be a strain.
> R: It's a lot, yeah. The government also pays some. Yeah, expensive place. (ibid)

Here, the notion of economic privilege and access to enhanced care based on financial circumstance is another aspect of long-term care revealed in the data.

On the subject of private versus semi-private or publicly funded long-term care facilities, a 90-year-old male respondent stated that he believed a government-funded nursing home was likely to have compromised or inadequate care:

> "I guess I would like to look forward someday, if I ever had to go into a senior's residence that they had – and not a provincially funded one where you're a victim of abuse and no money and stuff like that. No, I want to go into a place that's reasonably respectable." (Interview 3, 2016)

The shrinking of the welfare state in favour of capital or economic gain, as supported by neoliberal ideology, will ultimately result in an overall diminished quality of publicly funded

care as well as an increased reliance on informal supports that are both unpaid and under-acknowledged.

It is clear from participant responses that the assistance provided through informal relationships, was essential to the well-being of the oldest of adults aging in place. Excerpts from discussions with two different interviewees demonstrate this point. In this first example, two selections are provided from the same interview where one participant emphasized the assistive care his wife provided him with on a daily basis. It was clear not only that her support was what allowed him to remain at home despite his acquired disability, but also that she viewed it as her duty to care for him so he could remain at home and avoid any forms of subsidized care or institutionalization:

> I: So, what would you say is the biggest barrier for you at the moment?
> R: The physical. Oh yeah. I can't do anything for myself. Physically. Do I look nice this morning?
> I: You look great.
> R: She helped me get dressed. I couldn't do it myself.
> I: So, all of your daily care needs, your wife helps you with?
> R: Absolutely.
> I: Have you thought about what you might do in terms of supports if it became difficult for her to do these things?
> R: I personally have not thought about it. I don't know. I guess we would have to get somebody in from somewhere, I don't know. Sitting at this moment. Somebody to give advice. Give me a good going over, examine me and find out what the problems are. What I need to do in my daily get up and go to bed. Get up in the morning, go to bed at night. In between, what I would need, they would recommend and that would be it. (Interview 21, 2016)

> I: Can you talk about whether, at any point, has your mind gone to the possibility of needing to live in a supported facility?
> R: Before this?
> I: I would say now, maybe.
> R: I think about it, but my wife doesn't. She wouldn't let me. As long as she's able to take care of me, there's no way.
> I: Right, okay. In what way do you think about it?
> R: Because it would give me care and support. Support in the sense of physical, medical.
> I: So, in some ways, do you think that there are things that you need that aren't provided at home?

> R: No, not at all.
> I: So, do you use any government services? Does anybody come in and help at all?
> R: Not at the moment. This pretty much is the decision of my wife, whether she wants to supplement what she does for me. But so far no. (ibid)

In a second example, an 85-year-old woman described the essential help she received from neighbours in her community:

> "One neighbour does the lawn and his son has his car in my driveway. My other neighbour is from Kenya. Lovely man. They're Portuguese and Indian, lovely man. When I was in hospital and we had the art show, his whole family came, because my daughters wouldn't come when I wasn't here. So, he came and took pictures and a video and brought some of my art supplies to the hospital. So, I did some rehab doing painting. He's always keeping a lookout for me and helping. If I need anything he's right there. If anybody is around the house outside that shouldn't be, he phones and lets me know. But he's been a really wonderful help. He takes the garbage and blue box out on Tuesday." (Interview 22, 2016)

The vital role of such informal, community-based connections is conveyed in these participant narratives. Informal supports for older people are in fact such a pronounced feature of aging in place that larger society may even perceive of movement into a nursing home or long-term care space as a failure by the family itself or others in the community to care for a loved one (Armstrong, 2013). This perception follows a neoliberal agenda in shifting responsibility away from the state. Under this model older persons who seek public assistance are perceived through a lens of dependence and therefore a liability to the prospering economic system.

Interview data also suggest that due to flaws in public service provision, the significant responsibility directed towards alternative informal supports can be unmanageable and depleting for those who have assumed a caregiver role. The plight of a 95-year old participant's daughter, an older adult herself by normative age-based standards, speaks to this dilemma and a prominent gap at the systems level of care. In the following excerpt, she referred to the toll that it took on her and her husband to help her aging parents:

> R: We can't help them, as we did before, because me and my husband are getting to the age. Right now, it's not very simple. Just taking the walker, getting into car. Anytime he goes out, we gradually got back problems. We got leg problems, too. I tell him "the walker's too heavy." I can't lift it [*Laughs*]. Now it gets to the point where they need a wheelchair, so it's even heavier. So, I applied for seniors Extendicare, but the difficulty with the two of them, they cannot get in at the same time. It will always be one person. So last time, there was an opportunity for my mom to go in, but my mom doesn't want to go in there by herself. No matter how hard we tried to convince her, that my Dad will be coming later, to her it's scary going to a strange place. So far, the system is not taking care of a couple, they only take care of a single. So that's difficult for them right now.
> I: Right. So, they won't allow them to go in together?
> R: The system is that each individual must apply separately. My dad has to apply by himself, my mom has to apply by herself. So, whenever a spot is available, they let one go in first. So, then you have to wait. They told me that the second person will be higher priority to go in, but the waiting time is still 6 months to a year.
> I: And they have to be apart?
> R: They have to be apart. It's very difficult for them, because they've been together all their lives. My dad says, "I want to see her every day." Then it's additional work for us to take him to see my mom, pick him up every day, and look after him and look after my mom emotionally. So, the thing was, the last year in December, my mom was accepted by one of the Chinese Extendicare, and she turned it down. We waited for 7 years, finally got a spot, and she refused to go in. At that time, my dad's leg was okay, so we say okay – we will stay home. Close to December, suddenly, he couldn't walk. That incident got him a little bit scared. He said, "What happens if I can't walk?" I can't come in to bathe him or take him to the washroom. I have to get my husband in here to take him to the washroom. Because he cannot stand up, for a couple of days. Finally, we saw the doctor, he gave him the injection. So, his leg is manageable right now. It was scary at that time. Saying to myself, what happens if I really can't do anything for him. So, they never really realize, it's a fact, we all get to the age that we need help. (Interview 6, 2016)

From this participant's perspective, several systemic failures culminated in the unique needs of her very old parents not being met.[10] She felt overburdened by the responsibility to look after her parents without adequate public assistance. The extent to which the system is not designed to handle the unique needs of "a couple," as this respondent emphasized, has a potentially depleting effect on the informal care providers who must step in to address the gap.

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[10] This individual represents the one case in which a family member was interviewed in this study. Though family members were not an identified focus in this dissertation, the perspective provided in this particular instance is both highly relevant and appropriate to this work. This woman served as a translator (when needed) in an interview I conducted with her 95-year-old father (interview candidate number 5). Both participants were present throughout my interview discussions with each of them, where her father made an active contribution to her dialogue while she translated and described their situation.

The manager at the research site spoke directly about the difficulties associated with caregiver exhaustion on the part of informal care providers who wished to keep their aging relatives at home, but needed stronger means of formal assistance to do so. Our interview exchange was as follows:

> I: Do you think it's better for people to remain in their homes? Or do you think a supported living environment is preferable?
> R: Depending on their needs. I'm Eastern European, so my culture is that you take care of that person till the end. You don't go anywhere, but now that I've seen the whole spectrum, I think there's a point when it's too much. A point when you cannot take care of them at home. So, I think it's on an individual basis. I think the longer you can stay at home benefits everybody, when manageable. When it becomes unmanageable, there are services out there to help. (Interview 19, 2016)

Formal assistance provisions, together with the help provided by an informal network, are a necessary component for the oldest old aging at home. While it is often not the preferred choice of many elders to move to a formal care facility, it may be the case that there is no other option if very old individuals do not receive the assistance required for them to remain in the community. As a result, the choice to relocate is often made out of necessity. In the following section, I critically examine this notion of choice as it is described in the context of place in the data.

*Choice*

The notion of choice is one that intersects strongly with the neoliberal ideology of individualism. The extent to which older people have a choice with respect to their living circumstances at the micro-level occurs under the constraints of the macro-level structural system and the resources available to them. Dalmer (2019) deems the element of choice associated with aging in place to be “illusory” (p. 46). While aging in place policies support the goal of assisting older individuals to remain in their homes, on careful examination she suggests that aging in place is truly the only option posed by such policy-oriented dialogues (ibid). An

underlying reason for this is that the ideals of individual choice and self-reliance are strongly intertwined with reducing dependency on state-funded welfare supports (Ilcan, 2009). This neoliberal motive is masked by a language of empowerment where older people are made to feel fulfilled and autonomous by their ability to manage independent of formal assistance while continuing to live in their community. Yet, as is discussed throughout this thesis, the prosperity of older individuals is very much linked to the SDOH as they manifest throughout the life course. For those who experience disadvantage in very late life, prospering in place without adequate access to resources and assistance is exceedingly difficult irrespective of whether they reside in a home of their choosing.

In this study, aging autonomously in a place of personal preference was described by respondents as it was influenced by two primary factors: economic privilege and social connections. According to *Ageing Alone: The Impact on Poverty and Social Exclusion* (2010), a report released by a Quebec advisory and monitoring committee*,* poverty and social exclusion are both identified as critical factors for consideration in aging policies and support programs because they can cause or exacerbate health difficulties that manifest in later life. Among older adults it is emphasized that

> The incremental damage caused by persistent poverty and social exclusion compromises this group's chances of an active old age and widens the disparities in accessing everything they need (e.g. healthcare, in-home care, adapted housing, recreation) to maintain their self-sufficiency and quality of life by limiting their choices in order to respond to age-related needs. (p. 11)

The above speaks to the extent that choice in very late life is governed by larger socioeconomic conditions that surpass the micro-level of individuals. Within the realm of economic privilege, where welfare resources are more limited in a free market system comprised of independent

actors, personal agency in a place context is largely dictated by structural dynamics occurring at the macro-level of society.

According to participant data, numerous respondents referred to the direct influence of their financial circumstance on where they resided in their advanced age. In nearly every case that the topic was raised, the cost of relocation was mentioned as the personal responsibility of the individuals themselves, with little to no mention or expectation of a state role for support. For example:

> I: So, how does your current state of health impact your stress, or is it problematic for you?
> R: I do the communist thing, where they have a five-year plan and a ten-year plan. So, I work out my finances on a five-year plan and a ten-year plan, and I look at my health and I do exactly the same thing…It's inevitable. So, I don't really concern myself about it. I plan for it. My finances are planned so that if I have to be institutionalized I've got my money according to that, and then I budget it. I budget the remainder, spend it travelling or whatever. (Interview 12, 2016)

> I: Do you find that money is a source of stress for you? Or are finances something that you worry about?
> R: Speaking for myself, I've always been a worrier about money. I'm a penny counter.
> I: Had you worried about this part of life, going into it in that aspect?
> R: No, we prepared for it. Both my husband and I, our thoughts were that we did want to move into a place like this. So, we set our finances up so that we'd be able to move into a place like this. Hopefully, not out-live our money. (Interview 17, 2016)

> "To get into something decent, it costs an awful lot of money. You know, these places are not cheap. I don't think. Somebody said to me, oh you can get in there for $3500 a month, but by the time you take on other things you're up to $4500 a month. That's a lot of money when you work it out over a year. Then income tax on top of that. So, the idea is to stay out of it as long as you can." (Interview 10, 2016)

> I: Would you say that money is a source of stress for you?
> R: I don't think it is in here. Because you wouldn't come here if you didn't have money. Because retirement homes are not cheap, no. It's a matter of using up what you had. I had a house to sell, too, so it made a big difference. Some of them don't. Some of them have a lot of pensions from their husbands and stuff like that. So, you couldn't live in here if you didn't have money.
> I: So that's, I guess, a barrier for some people.
> R: Oh yeah, because some people are just living on their old age pensions and maybe their Canada pension. I don't know. There aren't enough seniors. You know the

> subsidized senior's places? They aren't building enough of them and there's a big waiting list to get in. Those are apartments that they could afford to go by your income. There's so few of those around. I can't believe all these condo's that are going up. You know? They need more nursing homes. (Interview 11, 2016)

> "I still own this house, and I've given a lot of my money away to both daughters and to the grandchildren lately. I'm thinking, you know, what if all of a sudden, the real estate department or something calls, and this house is not sell-able. Like nobody wants this house, you know? Do I have enough money to go to an institution, or will I wind up totally unable to make any decisions for myself?" (Interview 16, 2016)

As these excerpts illustrate, cost and financial means is a significant part of aging in place. In the above narratives, being able to afford an acceptable living circumstance was clearly a most important concern for these respondents. For many of the oldest old, who are at an age where the possibility of institutionalization is a greater concern than it is likely to be at earlier stages of the life course, the place one resides is hence dictated by their position in the socioeconomic hierarchy. As discussed in Chapter 6, life-long income and financial status is a significant determinant in outcomes related to both health and aging. In this regard, the free choice dialogue associated with aging in place is a façade that very much depends on factors external to individual action.

Similar to that of financial status and poverty, the data suggest that aging in place alone or in isolation represents a significant source of vulnerability for members of this cohort. For many of the very old participants in this study, thriving through social relationships with others is a testament to the critical importance of a strong network of support. In this regard, it might be more accurate to say that for the oldest old where you live matters less than the network available to you in a particular place. Social isolation in later life years is an often identified and discussed problem in policy and literature (Cattan et al., 2005; Findlay, 2003; National Seniors Council, 2017; Newall & Menec, 2019). As noted in earlier parts of this thesis, the oldest old of adults are at a heightened risk of losing key social contacts as well as experiencing the loss of a

spouse or partner. Many in this demographic group are therefore widowed/widowered and vulnerable to being alone. In this study, several factors such as co-habitation with a child, movement into a retirement residence, and time spent at the centre were all identified as avenues that provided social fulfillment and alleviated loneliness. Hence, an acceptable living circumstance is not only about place in the literal context of a primary dwelling but also about a larger interdependent framework comprised of both informal connections and other system-level provisions.

The following accounts all speak to the importance of social connection when aging in place and what participants have gained from being around family as well as connecting with their peers in a setting like the site used in this study. In the first excerpt, a man referred to the essential social fulfillment provided by living with his son:

> I: Do you think it would be difficult for you to live independently now?
> R: Well, I mean I do my own cooking and I used to do my own laundry, and I still like to iron my own clothes - I guess from when I was in India. So, I could live independently, but I like the social aspect, you know? (Interview 14, 2017)

In another case, a woman identified social capacity as a prominent element when selecting a place to reside in her very late years:

> "Well, people choose. Some people just don't want to be bothered with cooking and shopping and all that and they like being in a retirement home. Other people feel that all their friends are unable to come around with them or go anywhere with them, so they have company in a place like that." (Interview 13, 2016)

The older adult centre was also often referred to as a major site for social inclusion through the connections and friendships formed between members:

> I: Is there anything that makes you particularly sad or distressed at this particular age, compared to earlier in time?
> R: Being alone. More than that, I don't think. Being alone is difficult. Not really, I guess because I'm lucky I have two good daughters.
> I: And you seek out the centre and places to be around people.

> R: Has helped, oh yeah. Coming here with people and having lunch and getting out of the apartment helps. If you didn't have that and you didn't have anywhere to go it would be depressing, and nobody wants to be depressed. (Interview 7, 2016)

> "People ask me from a social perspective. You don't have friends here? No, I don't have any friend here. I come here to have friends. To the [centre]. I have not sought to have a social circle outside. I didn't know anybody when I was here, I still don't know anybody out there – except my family and two or three other people. Important people like the doctor and the dentist and people like that. But my activities are pretty well confined to the [centre] here because I can do things that are good for me." (Interview 3, 2016)

> I: What needs do you think the centre helps you with?
> R: Oh, well, everyone will tell you the friendships that come.
> I: Do you see them outside of the centre, the people here?
> R: Yeah, definitely. You can form very close friendships with people once you find someone. More or less the same as yourself. You can form great friendships here. (Interview 10, 2016)

One of the two women in this study who chose to move to a private retirement residence attributed a significant part of her reasoning for this relocation to increased social connections, as well as ease of access to the older adult centre. The following two excerpts from our interview describe this:

> "Oh, it makes such a difference. That's one of the reasons why I said to my neighbour, at least I'll have somebody to talk to if I want to. I can go down and there's always somebody around." (Interview 11, 2016)

> R: I like going there [the centre], because we do the knitting and there's a nice group of girls there that I know and wanted to stay in touch with. Before that I took exercises there, that's how I got into there. So, I met a few people then. So, I didn't want to lose that, so that's why I chose to live here.
> I: So, you actually chose to live here because of that network you had at [the centre], originally?
> R: Yeah… There was a lot of factors that appealed to me. So that was one reason. (ibid)

Finally, the manager at the centre spoke to the important role of social engagement echoed by the narratives above. In her estimation, this is one of the primary purposes of the facility and a key aspect of supporting older people who wish to age in place:

> I: So, the reason that most people seem to come here? Do you have a sense of the reasons?

> R: Well, I mean like our mission, vision and values, is that people come here because they're 55 and older and they want to be socially engaged. I think that's what it does come down to. Social engagement. You have people who just come for lunch. It's lunch and a chat. It's lunch and seeing the volunteers who give you the lunch. It's sitting with your friend who always comes for lunch on Tuesday as well. So, I think that it is that, like you had sort of said it and that's just it. People can be lonely and get lonely. We are open. That's why we're open 7 days a week. (Interview 19, 2016)

It is clear from the above that social connection is inherent for many of the oldest adults in this study. The role of community-based organizations like the centre, and other informal social supports, cannot be understated in fulfilling this need.

In two separate documents released by the National Seniors Council (2014, 2017), the subjects of social isolation and loneliness among older adults are explored as distinct risk factors of concern for policy makers as well as a particularly pronounced problem in relation to the most vulnerable groups in society, including older women and older adults with disabilities. According to the *Report on the Social Isolation of Seniors* (2014), loneliness is a subjective feeling that older adults perceive with regards to a lack of interaction or contact with others. Social isolation, however, more objectively encapsulates other factors, including a lack of adequate social roles and fewer social contacts. It is also to some degree dependent on systemic factors and the level of support older adults feel within their communities. Ultimately, when an older person elects to age in place, means of support must be available to address the increased risk of loneliness and isolation, both of which have socially determinantal effects on health (Newall & Menec, 2019).

From the findings presented above, participants were clearly cognisant of the essential roles of economic resources and social connection to successfully aging in place. From an access perspective, these facets hold deeply systemic roots in neoliberal free market ideology, where the notion of freely choosing a satisfactory living circumstance is inevitably influenced by the larger

constraints that dictate the social order. This agency/structure dynamic renders the selection of a place to live in later life even more complex.

*Access: Transport Mechanisms*

In the context of this study, the sub-theme of access was discussed most often with respect to transportation. Transportation access is essential to aging in place because it helps to preserve the sense of independence respondents considered vital. In the sphere of transport, having the means to physically access the centre and other essential services was an important mechanism for remaining actively involved in the community. For the oldest old, a significant related threat to such access arises through the cessation of driving. This potentially significant event for older people tends to coincide with an increased reliance on external channels for support. As a result, several respondents described utilizing the public transit system, the transportation service provided by the centre, or relying on the assistance of family members and other people in their informal network as a means of transport access.

According to a document released by the WHO (2007) entitled *Global Age-Friendly Cities: A Guide,* urban spaces and centers become increasingly inaccessible in areas where public transportation services are not adequately provided. Accessibility is a required mechanism for aging in place. Participant data on the subject of transport access were somewhat conflicting. Some respondents indicated a strong reliance on public transit to embark on daily activities and tasks. Other respondents referred to barriers associated with the cost of transportation services, the complexities of driving and driving cessation at an advanced age, and finally, reliance on mechanisms like family or the older adult centre to assist with outings. In the following excerpts, participants spoke about utilizing various public transit services to meet their needs:

> R: When I go out, I have to go to several places because you can't go out every day. They only go from one place, you know, one thing on a trip. They don't take you all over. I have to time the bus. I go on the YRT bus, because they put the ramp down. If I need assistance on the bus, they do that. They're all very helpful to me. If they haven't seen me for three or four years and they're back, they're so happy to see me.
> I: And they take you to multiple places?
> R: Well, I phone the bus stop - my bus stop - which is a block from my home. I get the times for the next three buses. Then each place I have to go, I know how many minutes it is from my stop to where I'm going. I time it so I track the minutes from the time it takes to get from A to B, and if the next stop I have to make is maybe 15 minutes, I'll take another bus and so on. I time it right. So, I've got a system. I go down and take the bus to Shopper's at 16th and Bayview and get a few things there. They sell a few groceries because they're owned by Shopper's. So, I get that bag filled. Because I can't take too much with the walker and that. I get some that way, and the bell director, she gets me a few staples and the occasional item. I have to time it all so that I can do it all together, you know? They're all different… (Interview 22, 2016)

> R: When I'm on my own – which I am most of the week – I use Wheel-Trans bus.
> I: Okay. How do you find that service?
> R: I won't complain that it's not a good service, because we're happy to have it. For handicap people who don't drive. Without it we'd be locked in. So, they're really good, and they do their best. They have a lot of people and it's difficult, but I use them all the time. I've used them for 20 years. (Interview 7, 2016)

> I: Do you ever take public transit?
> R: I take it all the time. Because where I live, I take one bus to the subway and here I am. Unless I have other errands to do, I just take the bus or the subway or whatever, you know? (Interview 13, 2016)

> "They have their own transportation - Circle of Care. I use them… this is good. I like it. They're on time, always. Never been late." (Interview 21, 2016)

In these statements, the use of transportation services was described as a most important mechanism for achieving daily tasks. The second excerpt, in particular, makes reference to being "locked in" without this type of dedicated public transit service available. The enhanced mobility provided to these respondents by public transportation services was clearly a critical factor in accessing places that they may otherwise not have been able to.

With respect to access, the cost of transport services was identified by participants as a barrier to its use. According to two participants in particular, making transportation services affordable to older adults was an area that required improvement:

> R: Well, I would enjoy a taxi ride here and back every day, instead of using the bus, but I don't think anybody offers that. Except the politicians all have their own driver and Cadillac where they park under City Hall, and they go home with it. Well, yeah very nice. That doesn't even come out of their expense account, it's part of their perks. You don't even know how the other half lives, so don't tell me what I need for services, thank you very much. I don't think the counsellors are any use at all to us. The counsellors are no use at all. They come here and make a big noise once in a while, but they don't respond to any of our needs. My needs.
> I: So, you would like complimentary transportation?
> R: Yeah, complimentary would be nice. Of course, the centre has transportation but it's not complimentary. (Interview 3, 2016)
>
> R: I think sometimes the money goes on the wrong things like the TTC where kids who are twelve years old get on free. I don't think that's right. I just don't. Maybe for little babies and so on, but not for twelve-year-old boys. I think that's where they should consider seniors a little bit more. Definitely seniors, in a case like that.
> I: Transportation, access?
> R: I have a pass, but I'm lucky to be able to afford that. That's just gone up to $110 a month for a senior, and we sell the tickets here, but not the pass, of course.
> I: That's quite a bit. That's a lot for an older person.
> R: That's a lot. You have to make sure it's worth it… But yeah, I think of things like that, there could be a little bit more help. (Interview 10, 2016)

These participants spoke to the inhibiting role of economic disadvantage for older people who are often reliant on public means of transportation service. The WHO names an accessible transport system as critical to health equity by enabling people to physically access essential services in the community that are vital to maintaining important SDOH. In a report concerning guidelines to health and housing, the WHO suggests that the cost of public transit must be considered alongside the expense of housing, given that the need for both shelter and travel are so significantly intertwined (World Health Organization, 2018). This is especially the case for vulnerable populations including the oldest adults, many of whom are characterized by

disadvantage arising from intersectional locations of gender and/or disability where their ability to afford or utilize a personal vehicle may be compromised.

Regarding continuing to drive, the habits of participants in this study clearly evolved and changed with time. For many respondents in this study driving behaviours had either ceased or changed on account of advancing age and/or the onset of disability. On this subject, participants said:

> I: How do you feel about deciding not to get your license again? How do you feel about not driving anymore? That must have been hard.
> R: Yeah, it's strange after driving for about sixty years. But I gave it up because one early morning I was driving and I felt this pressure in my head and it affects my eyes also, so that's when I went home and I called up my daughter and I told her. (Interview 15, 2016)
>
> "I like to drive, but at the same time, I drive a small car purposely. That's why I learned to drive something small, because I'm not very comfortable driving big cars, although they say they are safer. But I think safety is that you have to watch out for the other people." (Interview 14, 2016)
>
> I: So, you don't drive, right? And you don't need to?
> R: No, I don't need to. No, I don't drive. The ones that I've known in here have given up their cars, because there's a lot in here with macular degeneration and their sight is gone. They can't read grocery labels. It's hard. There's quite a few in here like that, with bad vision. I mean I have bad ears, and they have hearing aids too, but it's not as bad as your vision. (Interview 11, 2016)
>
> "It's a great family, but I just don't get to see them enough. I won't drive on the highway now. I'm now 87. Well I'll be 87 in two weeks. And I just don't think it's a good idea. I have a very small car. It's new, it's in good shape, but I don't think that it's a good idea so I don't drive up there anymore." (Interview 8, 2016)

In all four of these cases, driving a personal car in late later life was clearly different from earlier years' experiences. The notion of community access for the oldest old may become more complex as this life stage often heralds modification to how one accesses modes of transport.

One participant in particular, who continued to drive, referred to the additional burden of the testing process required of older adults to maintain a valid driver's license. In the following

exchange, she also spoke about being cognisant of changes to her driving capacity, which would necessitate the need to learn about and utilize public transportation services:

> R: Yeah, as long as I can drive, I don't require transportation. But if I couldn't drive, certainly I would have to learn the ins and outs of whatever's available in the way of transportation.
> I: Like Wheel-Trans?
> R: Like Wheel-Trans or a number of services around, I understand.
> I: Okay. So, there's no age limitation on your license, right? It's just vision?
> R: That's right.
> I: Okay.
> R: And the test they give you is ridiculous. Just ridiculous.
> I: How often do you take that?
> R: Every two years, and the last time they asked me to draw a clock and set it at, I think it was ten after eleven. Whoopie. That took a long time to do that, but I've heard two people say that the person sitting next to them, drew the circle, drew the one at the top, and started putting in the numbers. By the time they got to twelve, they didn't have any more room. So, it does say something. But for somebody who's artistically inclined I thought, oh come on.
> I: So, when you take that test are you fearful about losing your license?
> R: Not because of the test. I'm a fairly confident driver.
> I: I'm sure. You've been driving longer than most people on the road.
> R: That's right, and I'm very careful. (Interview 8, 2016)

In all these participant accounts, it is clear that some form of transport is critical to accessing a number of outlets in the community and therefore to the goals of society's oldest adults aging in place. The government of Ontario's *Aging with Confidence* (2017) report claims that "older people tend to outlive their decision to stop driving by a decade" (p. 16). As a result, a named provincial policy goal is to expand public transportation in underserved areas so that older people can connect with more supports irrespective of their ability to drive. It remains to be seen whether this can be effectively achieved as transport systems are often costly to develop, implement, and maintain.

In the final component of transportation access raised by participants in this work, support mechanisms provided through an interdependent network of family, friends, and/or the formal services of the older adult centre were also indicated as essential to aging in place. In the

following two accounts, participants spoke about the dual roles of public transportation service and family for commuting purposes:

> I: You used to drive and don't any longer?
> R: Yes.
> I: So, you both just decided you didn't want to drive anymore?
> R: Actually, when we moved out here, I took a look at the traffic on Yonge. I said, I'm not driving. I guess I could have gotten used to it, but we just decided. We sat down one day, and we projected for three years - the cost of insurance, gas and parking. We thought, maybe once or twice a month we'd use it. So, what was the point? So, we sold the car and we've been using the TTC. A couple of times we've had to go out to Cambridge - one of my husband's nephews lives out there. The other nephew picked us up and drove us out there those times. When I had to visit my brother in the Kingston area, one of his sons drove us out there. So, it's interesting and working out alright. (Interview 17, 2016)

> I: Is there anything that you get help with at home, then, with your current living circumstance right now?
> R: When I have to go somewhere, I either go independently on a bus, and I don't use Wheel-Trans. If I have to go somewhere where my son wants to go with me, he comes and picks me up, and we drive. (Interview 3, 2016)

In both these responses, a network of support was mentioned as being critical to navigating the community and its services. Staff informants from the older adult centre further illuminated the importance of a centralized organization that facilitates access for older adults aging in place. A lead instructor of one of the programs offered at the facility, who also assisted in other areas including transportation, described the role and function of their internal transport service as follows:

> R: Our transportation was designed to service clients who aren't eligible for Wheel-Trans. So, they might still be too mobile for that service, but they also can't drive themselves anymore. So, if everyone were really honest about it, then our clients would likely be able to go on all the rides that they want. But I do know that we have some people who use Wheel-Trans and use ours as well. But I'm not going to be the one to say anything.
> I: Police that, you mean?
> R: Yeah.
> I: I didn't realize your system doesn't cater to the social.
> R: Yeah. Well I mean it does to an extent. Like if our schedule is really busy, or if someone's sick, or the weather is bad, it's the social rides that will always get cut first.
> I: How many vehicles do you have?

> R: Here, we have four in a given day. Then there's also the iRide. So, I think there's another 35 with iRide. I mean there's definitely vehicles out there.
> I: But a lot of people.
> R: Yeah. It's too bad about the social rides, because I get that it's important to get people to their medical appointments, but I just think that it's also important to get someone to their friend's house or to their daughter's house, or to the movies, because that's the biggest thing. Everyone loses their friends as they get older. (Interview 24, 2016)

The above references the limitations of this type of formal public transport system where availability can be a barrier to meeting the needs of older adults, especially the need for socialization. This staff member directly spoke to the extent that "social" endeavours were secondary to essential appointments and other such tasks that took precedence with the formal ride service. Here, the adverse effects of limited or insufficient transport resources are indicated, especially for those who are at heightened risk of being isolated when aging in place.

The manager of the centre also spoke to the role of transportation supports in fostering connection. In our interview, she referred to the extent that the centre assisted older members in learning about and accessing services that may otherwise be difficult for them to navigate on their own. She made the following two statements about this:

> "We try to help as much as possible. If there is the ability to pay for transportation then we would get them in touch, or we would let them know who to call at Wheel-Trans to set up a Wheel-Trans account. So, we try our best if we don't have the answer, to get the people to give them that answer. Always." (Interview 19, 2016)

> "At the end of the day, what we strive to achieve is to have that person who's coming, you want them to access as many of our services as possible. Right? That's kind of an end goal. So, you want them to use our transportation system to come, to play bridge, have lunch with us, and then go home…That's our goal." (ibid)

It is clear from the access goals described above that an important function of older adult resource centres like this facility lies in their role as a centralized hub for information and connection. While the participant responses shared here illuminate the complexities of fulfilling

the diverse transport needs of some among the oldest old aging in place, they also show that there is room for improvement with respect to personal cost and ease of access in transportation.

## Discussion

In many respects, the concept of aging in place can be viewed as neoliberal at its core (Dalmer, 2019). The aging in place model encourages older people to remain independent agents whilst continuing to live in their homes. The implications of this in the context of the larger capitalist system are twofold. First, it inevitably shifts a significant portion of care work to the highly gendered informal realm, as discussed extensively in Chapter 6. Second, it fails to adequately conceptualize inequitable circumstances of late life that manifest through lacking in essential SDOH. Consistent with a life course analysis, these social deficits tend to be more pronounced for older adults who experienced disadvantage in the earlier stages of their lives. The lens of intersectionality further provides that sites of identity, including gender, age, and disability, exist as markers of disadvantage that may exacerbate inequities between individuals and groups (Emmett & Alant, 2006; Pal, 2011). Policies targeted at all older adults (aged 65+) therefore obscure the need to allocate resources through an equity framework of distributive justice, even when some require increased supports over others to successfully age in place for reasons of more pronounced disadvantage.

Among a group of the oldest old aging in place, the findings of this study reveal the important function of interdependent supports. For participants in this study, this necessity is indicated through networks of informal assistance, economic resources, social connections, as well as transport mechanisms, and access to community-based services such as the older adult centre. According to the data, participants overwhelmingly wished to avoid relocation to a long-term care facility, preferring instead to remain in their original homes. In doing so, respondents

referred to critical factors that fulfill essential interdependent needs during their latest years, particularly with regards to socialization, service, and transport access. While most of the participants in this study indicated a capacity to support themselves and remain in their homes for the present time, many expressed a genuine fear of eventual relocation to an institutional setting and concerns with the associated cost. Those who did speak about the possibility of movement to a long-term care situation suggested a preference to reside in a privately funded facility as opposed to enduring what were often assumed as poorer living conditions in public government-funded nursing homes. The literature supports that it is due to widespread negative perceptions of long-term care that older adults may prefer the solution of aging in place where they can maintain a certain level of autonomy and independence (Boyle, 2008; Henderson & Vesperi, 1995). Overall, the likelihood of institutionalization is a reality that many respondents were acutely aware of. Some even mentioned having financially planned for moving to some form of long-term care facility. Certainly, this event is a known potential outcome in the lives of the oldest old.

While relocation can be a significant event at any age, it is difficult to imagine the feelings of displacement that arise through migration in the latest life years, and after a lifetime spent living in the community. Given the strong preference indicated in this study to age at home, it is clear that home- and community- based assistance must be prioritized by policy makers to facilitate this goal. To do so involves providing individuals with adequate supports and care mechanisms in the home environment that would ultimately allow them to remain engaged in their communities. Both the Special Senate Committee on Aging (2009) and the Law Commission of Ontario (2012) cite aging in place as an important priority for the aging population of Canada in the years to come. In some respects, the framework of aging at home

can be viewed as a social-model oriented endeavour. Here, the removal of societal barriers through home-based supports fosters inclusion, while the withdrawal from active society that arises with institutional living might be regarded as exclusionary.

Opposing perspectives, however, suggest that current home care solutions may further the goals of neoliberalism and marketization by indirectly shifting increased responsibilities of care away from the state and to individuals and families (Daly & Grant, 2008; Guberman et al., 2006). As a result, the burden of informal or unpaid care work performed in the home, which is highly gendered, shifts mainly to women who may themselves require additional support to sustain this assumed role (Day, 2013; Guberman et al., 2006; Seeley, 2012). Feminist political economy, in its recognition of unpaid work, can be applied here in the context of individual and family autonomy in care processes (Guberman et al., 2006). From this perspective, the solution of home-based care supports must consider the diverse experiences of women and women's work as providers and recipients of care if it is to truly serve the interests of individuals rather than the economic goals of larger systemic entities. It is here that Ontario falls short in its caregiver support mechanisms. In *Expanding Caregiver Support in Ontario*, Janet Beed (2018) outlines recommendations for the province to implement stronger supports for those who provide care to people aging at home. Beed emphasizes that Ontario's initiatives in this arena are inconsistent and do not extend to all areas in need. She emphasizes that the province should look to the example of countries with stronger formal caregiver support programs, such as Sweden and the United Kingdom, to address caregiver inequity. As an essential part of the aging in place model, disparities that manifest at the level of informal support networks may ultimately compromise the care of the oldest old choosing to remain in their communities to avoid movement to an institutional setting.

With regards to living circumstance, a life course perspective furthers understandings around the notion of aging at home by considering historical life-long experiences and their impact on how the oldest old acclimate to a new setting. The theory posits that significant transitions or milestones throughout the life course are often strongly connected with place. Robison and Moen (2000) find that older adults who experience relocation more frequently are likely to hold a greater openness to the possibility of moving to different settings in the future. In this sense, past place-oriented circumstances hold relevance in adaptation capacity during the latest life years. Research further suggests that examining migration patterns through a life-course perspective provides insight into the mobility tendencies of older adults (Uhlenberg, 1996), a notion that can potentially assist with identifying the unique place-based needs and preferences of older people. This is particularly applicable in a policy context, as it accounts for the diverse adaptation capacities of older adults by considering their histories with geographic movement. Here, social locations of identity also play an important role in shaping place-based experiences and patterns.

Intersectionality is another highly relevant lens when applied in a policy context of aging in place. A Wellesley Institute report suggests that meeting the service needs of older adults who are aging in place in Ontario requires an understanding of diversity, and the resultant inequities that arise through multiple identity interactions that fuel systemic oppression and disadvantage (Laher, 2017). The report further suggests that current home care-based policies do not adequately meet the diverse needs of the older adult population, an essential element in fostering equity in the latest life years. Reconciling this disadvantage involves recognition and appreciation by the state in the allocation of support services, to accommodate the varied needs of all individuals throughout each stage of the life course, all of which influence one another.

Policies that ignore difference in favour of a homogeneous approach to meeting the needs of the oldest community-living adults do a great disservice to numerous individuals who are aging in place with insufficient support.

The Ontario Home Care Association (OHCA) (2007) states that vulnerable older adults who are considered to be most "at risk" for a loss of independence while aging at home are those that require more assistance than the current system can provide. An OHCA report recommends that although it is not possible to meet every requirement and need of the oldest people, the province "can make strategic funding interventions for locally identified groups," which would "mitigate the risk factors for loss of independence so that living at home, even with significant challenges, can become a true reality for aging Ontarians" (p. 2). Those characterized by the locational identities of gender and/or disability, which the majority of the oldest old in Canada are statistically more likely to experience, require special attention from policy makers and society at large to foster age-friendly mechanisms of support at the community level.

As the highly individualistic perception of many participants in this study suggests, remaining at home or in place is coupled with a view of ultimately being responsible for oneself. Respondents did not believe in or possess a strong sense of the social safety net available through welfare state provisions. The neoliberal model of aging at home, in which the role of the state is diminished, resonates strongly with successful aging constructs that favour individual action. To some degree the dominant discourse may also discourage older people in need of assistance from seeking out external supports due to stigmatized impressions of dependence and widespread societal ageism and/or ableism. For several participants aging at home in this study the general hesitancy to rely on the state for support was indicative of the presence of this deeply entrenched belief system.

Strengthened social welfare programs and supports are consistently discussed as a necessary and enhancing component in supporting older adults to thrive in place. In an aging context, the welfare state impacts living circumstance in late life through the provision of adequate pension programs and other means of economic support (Madero-Cabib, Corna, & Baumann, 2019). Chen et al. (2018) comparatively examine a model of the successful "aging of societies" in 18 OECD countries and identify a strong social safety net as an important element in the capacity of nations to support their oldest members (p. 9169). As highlighted by participants in the present study, the affordability of housing and transportation mechanisms were critical to actively participating at the centre and accessing other essential resources in the community at large. The oldest old aging in the community require "a comprehensive range of services," many of which are non-medical and therefore at heightened risk of being overlooked amidst normative frames dominated by biomedicine (Bould et al., 1997, p. 28).

In a policy report, Torjman (2018) states that in their current form the aging at home policy initiatives of Canada's provinces and territories are largely insufficient. The report emphasizes that the oldest old population requires special attention as a group that is more likely to require home-based services and care for longer periods of time due to their advanced age. Torjman recommends that "future policy measures need to be more creative, community-based, and coordinated than they have been in the past" (p. 5). Along with the earlier-emphasized support of family and other informal assistance measures, the addition of strong formal home- or community- oriented programs are hence critical to supporting interdependence across generational groups (Liang & Luo, 2012). As suggested by several participant accounts in this chapter, there is still much to be desired in the scope of adequate supports that accommodate the place-related needs of the oldest old.

## Conclusion

As demonstrated by the findings in this chapter, factors that are most essential to participants aging in place include the avoidance of relocation to an institutional setting, the capacity to choose one's dwelling free of income-based, social or other systemic barriers, and accessible transport measures. To achieve these goals requires a multi-tiered approach that involves not only a stronger social safety net for older people themselves, but also adequate support for their informal care providers who may also be vulnerable to unmet needs. From the accounts shared here, a combination of both formal and informal service is needed for the oldest old to thrive while living in their community. Yet, to avoid a stigmatized state of "dependence" through an over-reliance on external support measures, adhering to a stricter neoliberal-esque model of "independence" was stated as preferable by many participants. To a large extent, a number of social and ideological limitations that may hinder the capacity of older adults to thrive while aging in place occur between the conflicting models of independence and dependence (Beeber, 2008, p. 21). Instead, it is through a two-pronged method of interdependence, comprised of both familial/informal and formal supportive services, that a more holistic approach to older adult community care is achieved. Beeber (2008) writes, "using interdependence as a way to conceptualize care of older adults reveals the significant support networks and strengths of individuals, which were not previously considered in the independence-dependence continuum" (p. 23). Hence, an attitudinal shift in belief at a systems level, is required from both the macro- and micro-levels of society.

In these endeavours, policy makers must consider the diversity that manifests through the intersectional identities among the oldest old, of which the majority are women and/or likely to experience some form of disability. To promote aging in place as a wholly inclusive ideology, part of this shift will therefore involve fostering and embracing the richness of interdependent

relationships that have the potential to "enhance well-being and quality of life for older people at home and as integral members of the community" (Thomas & Blanchard, 2009, p. 14). It is only through this lens of essential cooperation, mutuality, and support, that a truly equitable vision can be attained for the oldest of adults who are aging in place.

# Chapter Eight: Conclusion

> *"Successful aging at the societal level will obviously facilitate successful aging at the level of the individual… The challenges associated with the aging of our society urge that the concept of successful aging of the individual be complemented with a body of theoretical inquiry and empirical research at the level of society."*
>
> (Rowe & Kahn, 2015, p. 594)

## Introduction

Within the dominant discourse, perceptions of old age are often conflated with presumed disability and functional decline in the latest life years (Guan, 2008). For the oldest old in particular, personal experiences are at risk of being lost to decline-focused dialogues where it is assumed that the older one becomes, the less able and frailer they are likely to be. In this study, I have attempted to dispel negative connotations of later life through qualitatively derived personal expressions. A critical ethnographic approach was used, with case study, to collect and convey subjective narratives from a group of 18 community-living adults aged 85 years and older. As a research methodology, critical ethnography allows for the unique perspectives of the people under study to be captured. Drawing from this research approach and the theoretical frameworks of feminist political economy, life course theory, and intersectionality throughout this study's analysis, strengthened understandings of the themes and sub-themes identified from participant data were elicited.

This study supports the premise that the oldest old are a diverse group whose aging experiences are worthy of distinct empirical inquiry. In my analysis of the data, through perspectives shared by the participant group, an overarching theme of interdependence is revealed as an enhancing lens in the contexts of disability, service needs, gender, and aging in

place. I further critically examined successful aging as a notion that is limited by biomedical thought, supporting a view of late later life through a lens of decline/frailty and dependence. This perception aligns with the ideology of neoliberalism and is evident in both dominant aging discourse and policies that promote a strong message of independence in old age (Breheny & Stephens, 2009; Plath, 2009). In attributing individualism to aging success, a minimized welfare state places the onus of responsibility to provide care for the oldest old on familial and other informal sources of aid.

The implications of the welfare state's divestment of care responsibilities are problematic. As Plath (2008) writes, "Doing things alone and relying on one's own resources can lead to doing without, frustration, safety and security concerns, loneliness, boredom, minimal resources, lack of opportunities, feeling burdened by responsibilities and feeling isolated from society" (p. 1365). At all stages of the life course, and particularly in very late life years, a doctrine of individualism is limited in its scope, as the oldest old questioned in this study spoke to the beneficial need for social connection and service from others. Many respondents in this study also described a life circumstance that was satisfactory to their needs, and largely misaligned with normative biomedical impressions of old age as a negative state of degeneration. Scholarly literature in this area supports that models of successful aging should not be reduced to "simplistic normative assessments of success or failure" (Smith et al., 2007, p. 326). Hence, the notion of interdependence becomes an important tool in lifting older people out of a perceived dependence burden, empowering them to embrace the help of an available network of resources. The principles of health equity and the SDOH similarly support a model of increased formal assistance measures, accounting for the dual influence of structure and agency, where the equitable distribution of resources and welfare provisions are emphasized as integral to health

and wellness across generations. As discussed in preceding chapters of this work, interview data support the values of an interdependence model where the combined assistance of both the formal and informal networks of care in a number of service areas, are described as necessary for participants to thrive. These service areas include income support, transportation mechanisms, personal care, home care, disability supports, and social connections.

Additionally, the data highlighted the influence of productive life course histories on the late life circumstances of the men and women interviewed in this study. The distinct legacies of their earlier productive work, as a number of participants described, align with complex underpinnings of neoliberal ideology and individualism. Participant data also support that labour experiences are highly gendered and intricately connected with income as a primary and life-long social determinant of health. An adequate understanding of aging experiences among the oldest old must consider the influence of both larger systemic and ideological forces throughout the life course. It must also include historical experiences of the life course journey, as they intersect with and influence the agency and autonomy of the oldest men and women.

As I conclude this work, in this final chapter I speak to the main themes of this study and the implications of its findings. I first explore these topics by providing a research summary, where my interpretations of the data are collectively discussed in answer to the five central research questions posed in this thesis. This is followed by a second section outlining the notable scholarly contributions of this study to the larger field of aging research. Here I emphasize the contributive role of including the oldest old, a population that is both diverse and underrepresented in aging scholarship, as the subject of increased empirical inquiry. I further highlight the value of applying an intersectional analysis that explores both disability and gender in the context of very late life. In a third section, I subsequently acknowledge the limitations of

this study, many of which are methodological and bound by the parameters of a doctoral thesis project. This section is succeeded by a fourth in which I make recommendations for future aging research. Here I include a call for expanded intersectional study of the oldest old, where greater attention is given to identity contexts outside the scope of this thesis—particularly with respect to race. I also suggest the value of scholarly work that applies the issues discussed here in a rural Canadian context, as well as support that further investigation is needed to capture the unique circumstance of the oldest old and their older adult children aging alongside them. Finally, I close this chapter with brief concluding remarks that broadly advocate for the adoption of strengthened welfare state provisions by looking to the example of social democratic nations, where a more equitable circumstance for older citizens is demonstrated.

## Research Summary

As described in Chapter 4, critical ethnography and case study together inform the methodological foundation for this work. After collecting primary data at an urban older adult centre, resultant themes and sub-themes were derived from both personal interview accounts of a group of adults aged 85 years and older, and researcher observations. These data, triangulated with relevant supplementary policy documents, inform the final analysis.

Participant perspectives in this study varied with respect to successful aging in the latest life years. I identified three main themes, under which nine key sub-themes were found. In Chapter 5, I examined the first theme of independence, coupled with an underlying necessity for interdependence, to the extent that it was revealed by participants as a complex factor in perceptions of successful aging. Within this category, three sub-themes of sustained autonomy, familial/intergenerational connections and support, and the avoidance of disability along with living an active lifestyle, are indicated as most relevant in the data. In Chapter 6, I identified an

overarching theme of gender, examining commonalities and distinctions in the aging experiences of male and female respondents in my analysis. Here, the three sub-categories of care and care contexts, the complexities of partnership (including the loss of a spouse), and gendered notions of work and income are all identified as significant factors in the gender-based experiences of the oldest old questioned in this study. Finally, in Chapter 7 I explored aging in place as a main theme that is relevant in both participant discussion and policy dialogue. The primary sub-themes shown here are place, choice, and access to transportation mechanisms. Below I discuss the main findings of these themes and sub-themes in relation to the central research questions posed in this thesis.

*Research Question One*

The first research question in this study asks: "In what ways is successful aging understood by community-living older adults among the oldest old (aged 85+ years)?" Successful aging was described as a complex notion by participants. Interview data presented in Chapter 5 show that some respondents privileged their autonomy and held a certain level of resistance associated with accepting aid. This focus on sustained autonomy is aligned with neoliberal doctrine, whereby productivity and independence were identified by respondents as primary lifestyle goals even at their current late life stage. For the oldest old in this study, a strong desire to avoid becoming a "burden" to society by receiving formal assistance was described as vital to their continued independence and capacity to successfully age. Yet, despite this sentiment, interdependence is also a supported model within the data, where participants made reference to their reliance on the care and services of both informal networks and formal government assistance. This is reflected in the data where respondents discussed strong familial bonds, continued active participation through engagement with offerings of the older adult

centre, and access to essential care resources and services. Though the perspectives of some respondents were aligned with biomedical norms in naming the avoidance of disability as a factor in successful aging, others minimized the impact of this experience by focusing on the importance of social connection and adaptation in their very late years.

Within aging policy documents, it seems that many policies support a model of successful aging aligned with the goals of Active Living, individual lifestyle factors, and the continued independence of older adults. Amidst the strong focus on individualism in these documents, state-sponsored programs are described by respondents as inadequate to meeting the diverse micro-level needs of some participants in this study. Some interviewees, for example, mentioned the inadequacies of government service provision by way of insufficient resources and funding, as well as inconsistencies in care. It might be said that these deficiencies at the systems level act as barriers or inhibiting forces to the successful aging of the oldest old.

*Research Question Two*

The second research question of this thesis asks: "In what ways do community-living older adults (aged 85+ years) experience aging in their very late life years, compared to their earlier older adult years (aged 65+)?" In this study, participants described certain experiences that became more pronounced at their advanced age compared to their younger older adult years. These experiences were frequently mentioned in reference to significant losses to their social circles, the cessation of driving alongside navigating transportation services, acquired disability- and/or health- related experiences, as well as strengthened fears associated with possible relocation to some form of long-term care facility. Gendered themes are also evident here, where all but one of the women interviewed in this study was widowed—and had been for a number of years—a ratio that shows the absence of a partner was a more likely circumstance at this very

late life stage. For those in the participant group, a status of widow/widower may therefore require increased attention from policy makers with respect to support services.

Currently, a significant omission is present in many aging policy dialogues through a tendency to categorize or label all older adults as one singular group of individuals over the age of 65. Here the need for more customized policies and services, recognizing issues of importance to people who are 85 years of age and older as distinct among all older adults, should be a priority for future research and government policies.

*Research Question Three*

The third research question addressed in this study asks: “In what ways do disability and/or gender influence how the oldest old experience aging?” While a number of participants viewed disability as a physically limiting factor to avoid or overcome, others spoke about a strengthened capacity to adapt and accept disability experiences as a newer circumstance of their present life stage. Respondents indicated that their continued social engagement with others at the older adult centre, strong familial bonds, and support from informal care providers were all desired elements in coping with the adjustment of an acquired disability. On the subject of informal care provision, aging policy documents examined on this subject indicate deficiencies in government response to addressing the issue of respite for informal caregivers. In order to strengthen the informal care sector of those assisting the oldest old, there is a need for stronger policies that directly support caregivers so that they can in turn better help the oldest of adults with adaptive needs requiring assistance.

Participants expressed divergent views in some areas related to how gender influences the aging experience of the oldest old. For example, women and men participants spoke about their feelings towards economic security differently. For some women in this study, their

financial/income status was related to a life-long economic dependence on their former partners, while this factor was not nearly as present for men. Additionally, the majority of women participants in this study were widowed at the time of data collection, whereas a number of the men were not. Many of the women participants revealed partnership to be a strong factor in financial stability at their current life stage. Aging policy documents explored in this regard reveal a need for strengthened income supports for women among the oldest old, who are statistically more vulnerable to precarious circumstances in their very advanced years. Stronger consideration for gender as a primary identity location among the oldest old, the majority of whom are women, represents a potential avenue for policy reforms concerned with equity.

*Research Questions Four & Five*

The final two research questions in this study concentrate on aging in place, and community-based interventions in support of the oldest old aging at home. On these issues the fourth question asks: "In what ways are the oldest old supported while aging at home in their communities?" The fifth and final research question asks: "What are important resources for the oldest old who are aging in place, and to what extent are these needs being met by current policies?" In this study, aging in place was explored as a policy agenda aligned with an independence model reinforced by neoliberalism. Participants widely expressed a desire to avoid living in a long-term care institution, preferring to remain in a place of their own autonomous choice. Part of successfully aging in place, however, requires strong interdependent support from both informal and formal community-based resources. Transportation access was one such prominent resource named by participants as essential to successfully aging at home. The oldest old in this study stated that changes to their driving habits and privileges have meant an increased reliance on public transport services, family, or friends for transportation assistance.

Respondents also discussed concerns about perceived poor living conditions in publicly funded long-term care facilities, and the importance of personal financial circumstance/means and social connections needed to successfully age while remaining at home in their communities. The capacity to rely on their own personal income and funds to support their living circumstance was vital for many participants wishing to remain living independently in their communities. This included budgeting for a possible move to some form of private long-term care facility if required in the future. Overall, supporting the oldest old in a residence of their choosing requires inclusive policies associated with equitable access to important SDOH at both the macro- and micro-levels of society.

## Scholarly Contributions to Aging Research

In seeking to explore qualitative impressions of later life, this work has aimed to address noted gaps in the literature by investigating the experiences of the oldest old as a distinctive cohort. This type of research work contributes to discussions of aging policy and support services. In both areas, developing an understanding of successful aging that is largely informed by the views of older people themselves can "identify the types of interventions that are most appropriate to improve the experience of successful aging and respect elders' values" (Romo et al., 2013, p. 940). Clear identification of interventions needed to best support the oldest old will be necessary to the formation of effective policy that improves the outcomes/quality of life of those in this cohort.

One notable challenge facing many aging policies in Canada involves addressing the unique needs of older people at a micro-level. Potential barriers to achieving this include economic cost and sustainability, the time involved with developing and implementing customized programs, and the maintenance of consistent support provisions for individuals and

groups with varied needs. Despite the presence of such obstacles at a macro-state level, there are a number of areas where progress may be feasible. Many participants in this study, for example, called for improvements to income supports, transportation services, social connections, and access to adequate care. More effective policy reform must be based on an increased understanding of problems faced by those belonging to the target population, even if reforms only proceed incrementally. The personal expressions by the oldest old collected in this study add valuable insight by suggesting specific areas of focus for policy makers.

This study also contributes to conversations that dispel deeply entrenched age-based discrimination woven through the dominant fabric of society. There is a prevailing assumption, for example, that the oldest old will present a potentially significant fiscal cost to the health care system and the welfare state compared to their younger counterparts in the coming years (Bartels & Naslund, 2013; Mitchell, 2014). Yet, the presumed economic burden of supporting this population at a systems level is seemingly based on biomedical assumptions made about those in this growing cohort. Contrary to what associated fears of economic sustainability may imply about the needs of an expanding aging population, a perception of the oldest old as a dependence burden largely fails to consider the genuine and strong desire expressed by many participants in this study to *not* end up this way. The oldest old interviewed here expressed that they were doing everything in their power to avoid receiving public assistance of any kind. For example, the two participants who lived in retirement homes had planned and budgeted for this relocation from their own personal wealth, avoiding government assistance altogether. Other respondents suggested that they had a personal financial plan in place to independently support a possible move to a long-term care facility if needed in the future.

There is great value in conducting studies that extend beyond the common perception of the oldest old as an economic burden to society. Bould et al. (1997) caution against making ageist assumptions about the oldest old through learning about their unique circumstances:

> Fears concerning the cost of such programs, moreover, should be examined in the light of the extreme heterogeneity of the oldest old population. This is not a population in which everyone needs care or even help. A substantial minority are without limitations. The oldest old population should be studied carefully to allay fears and dispel stereotypes. (p. 29)

As Bould et al. suggest, a more accurate picture of those in this population can be captured by acknowledging the great diversity in this group. On this issue, McDaniel (1987) argues that it is a potential misconception of policy makers and economists to assume that a growing aging population is responsible for increased welfare state needs, suggesting instead that many in this group are actually self-sustaining. The findings of the present study are aligned with McDaniel's interpretation that older people are more likely to prefer independence or look to other informal supports before seeking public assistance. As participant data in this dissertation illustrate, formal aid was often described as a last resort, or one that was only acceptable if there was a significant need for it. Hence, the sense of societal "alarmism" associated with the fiscal cost of demographic aging may be misinformed (Gee, 2002, p. 750). An important contribution of this work lies in supporting this alternative view, which is often lost in the dominant, biomedical discourse.

Finally, this study contributes to the gerontology literature by expanding intersectional understandings of successful aging in the two identity contexts of disability and gender in very late life. On the subject of disability, Romo et al. (2013) write that "understanding how individuals make sense of successful aging in the context of disability and age-related changes gives voice to those who have to deal with the changes they are experiencing" (p. 940).

Gerontology studies will benefit greatly from the concepts offered by progressive disability theories that critique traditional medicalized concepts of decline. The social model of disability, for instance, is helpful as a counterpoint to the medical view. Putnam (2002) highlights a need for stronger presence of social model disability theories in gerontology, which will benefit aging discourse by highlighting social factors in the areas of work, family and health care access. Many disability rights discourses focus on the powerful influence of socially constructed barriers to inclusivity, many of which take place at an institutional level, and which also apply in an aging context (Dewsbury et al., 2004; Mulvany, 2000; Shakespeare, 2006). In this study, participants spoke to various sources of inclusion that mitigated the personal impact of an acquired disability or health state in their lives. This included factors such as social and familial connection or support, as well as using the services of organizations like the older adult centre. Here the relationship between macro- and micro-layers of society is demonstrated as state funding and the implementation of older adult centres, or other similar community-based resources, fosters accessibility and barrier-free participation for the oldest old.

In a gendered context the data in this study revealed that the financial status of women participants was strongly connected to the legacy of both their partnership status and their paid and unpaid work contributions in earlier life. In both areas, the life course experiences of many of these women continued to impact their financial security in their latest life years. Gender-based disadvantage is experienced by women, increasing the vulnerability of a group who statistically live longer than men and represent the majority of the oldest old population in Canada (Armstrong & Armstrong, 2010; Seeley, 2012). As a result, studies such as this one, that focus on the life course perspectives of both men and women in the latest life years, may provide valuable insight in to enhanced gender-specific accommodations at a policy level.

## Limitations of Study

Despite its strength in conveying the unique perspectives of community-living older adults, 85 years of age and older, there are several challenges and limitations that arose when conducting this study. The first is a common obstacle in qualitative research: the extent to which my own biases as a researcher may have influenced or interfered with the goal of representing the intended messages and lived experiences expressed by participants. In many senses, objectivity is a challenge of all qualitative research. All data are interpretative and based on researcher translation. Exploring my positionality as a researcher is a highly reflexive process. The process of reflexivity is one that is heavily discussed in qualitative research studies. It is concerned with the extent of researcher influence on study findings (Jootun, McGhee, & Marland, 2009).

In order to address this complexity, Hertz (1997) suggests a course of constant vigilance, where the researcher is mindful of their position within larger socioeconomic, theoretical, and identity contexts, and takes important steps to remain detached, self-aware, and careful when representing the unique views of informants. Having read about the importance of reflexivity in qualitative research, I remained particularly thoughtful of these factors during data collection, as well as during the succeeding steps of coding and analysis. As is more extensively explored in Chapter 4, I engaged with processes of prolonged engagement, informal member-checking and triangulation to enhance the validity and trustworthiness of the findings presented (Lincoln & Guba, 1985).

A subsequent limitation of this work lies in its scope. As a sole researcher collecting data at a single site, the very scale of this project holds its own restrictions. Smaller projects such as this have limited funding/resources and must be completed in accordance with the scholarly parameters and guidelines of the supporting institution, in this case, York University. At every

stage of the process, I was met with constraints I encountered as a solitary research agent. I often made informed choices that undoubtedly impacted the direction of the research. For example, my chosen recruitment methods of purposive and snowball sampling techniques are frequently criticized for fostering a small sample size that is unlikely to be representative of a broader social group (Oppong, 2013). In most qualitative cases, determining whether a particular sample represents an adequate depiction of others in the same category of identity is a widespread methodological challenge.

It is difficult also to defend against critics who might say that different findings would be generated by entirely different participants from the same social group. As the solitary researcher on this project, I was ultimately responsible for selecting all interview candidates. By contrast, the findings of a research project of a larger scale or level of funding, conducted at multiple sites with multiple researchers, has the potential to produce greater validity in its findings that might be more broadly generalizable to the group under study. That being said, such projects are expensive and time-consuming, often involving significant cost, and likely to present their own limitations. In conducting this smaller-scale research project, I acknowledge the scope of this work and I strove to ensure that the collected data were contextualized in an appropriate manner, avoiding generalizations where appropriate. Using triangulated sources of data was an important mechanism which operated in support of this goal.

Another difficulty that arises in qualitative ethnographic study concerns the choice of data used in analysis and presentation, and what they may reveal. Powers (1995) expresses struggling with this challenge in her study of institutionalization experiences from the perspective of nursing home residents, where she writes that anonymity was difficult to maintain despite her best efforts to use fictitious names and avoid particular details. Because ethnographic

research relies so heavily on presenting in-depth personal experiences, readers closely connected with the research setting or participants may be able to identify respondents based on verbatim statements they have made (p. 182). It is therefore a challenge for researchers to make decisions about what information to present, how much information should be presented, and to present information in the most respectful way possible.

Finally, the limitation of this study's intersectional contexts results in a number of perspectives being obscured. As I have endeavored to focus my analysis on the intersectionality of gender, age, and disability, I am acutely aware that other social locations are not present in the discussion. There is also a wide spectrum of experiences within each one of these categories of identity that could not be covered in great depth in this study. For instance, the experience of disability includes a vast array of types, including sensory, mobility and cognitive experiences. A similar spectrum is present in every social locational category of identity.

On this point, I acknowledge methodological difficulties associated with conducting expansive intersectional research, including gathering data linked with people representing different identity contexts. This includes a lack of funding, the difficulty of collecting qualitative data in a timely and expansive way, and finally, the ethical concerns associated with research involving vulnerable subjects. Despite these limitations, it is also the very macro-level structural constraints under which we live that impact micro-level health experiences by governing the access and distribution of resources between individuals and groups. Aligned with this, and in criticism of the dominant discourse, Rubinstein and de Medeiros (2015) write:

> There is no connection made between the individual and society, except that which relates to a perspective in which society is defined only by its varied constituent individuals, not by age-based, family-based, ethnic, cultural, social, gender, work-based, religious, economic, or other groupings and divisions… (p. 37)

It is only through expanded intersectional work that the multi-layered oppressions facing those most marginalized can be understood, particularly with respect to furthering aging studies that focus on the diverse and/or unique needs and expressions of older adults at different stages of later life. Though the parameters of this study did not allow for the inclusion of many of these experiences, in the section that follows I acknowledge their absence and recognize them as important areas for further research concerning the oldest old.

## Recommendations for Future Aging Research

A significant goal of this work is to convey the perspectives of the oldest old on what it means to successfully age—an understudied area of health and aging research. As with any study of this nature, there are a number of areas worthy of further scholarly investigation that build upon the scope of ideas explored here. This study concerns a group of people aged 85 years and older who visited and utilized the same older adult facility in a major urban center. However, the viewpoints of those in this age cohort who may face barriers to accessing this type of community resource, who are notably absent from this discussion, are also worthy of representation and acknowledgement. Learning the diverse perspectives of those in this group represents a rich area of study that future scholarship can redress: the reasons *why* people cannot age successfully and, perhaps more importantly, *who* is prevented from doing so. Here I turn my attention to a number of potential avenues for future research.

First, there is significant space for empirical and policy-related work that applies intersectional inquiry to the population of the oldest old. Hankivsky and Christoffersen (2008) indicate a lack of "consistent investigation" into the role played by multi-layered oppressions. Individuals who are characterized by a combination of their gender, age, disability, race, class and sexuality, among other locations, provide a strong lens through which researchers can

attempt to understand inequitable health circumstances. As discussed in earlier parts of this thesis, the life course influences upon the oldest old are based on the progression of multi-layered identity contexts over many years. Applying a framework of intersectionality to aging and life course studies will be an important contributor to dialogues concerning the oldest members of our society. While this study concentrates on the locations of age, disability and gender, future studies can benefit from expanded work that focuses on other social locations of inequity and oppression. Hofrichter (2003), for example, speaks of the relevance of race, in addition to class and gender when examining "hierarchies of power" (p. 8). Like disability, race is often perceived as a trait worthy of stigma, leading to subordination and inequality for certain individuals (Wilkinson, 2005). There is much to be discovered by studying race and other such identity locations in relation to the well-being of the oldest old.

In another important area for future research the urban/rural divide in Canada, as it relates to the aging experiences of the oldest old, is also a topic worthy of further study. According to Forbes, Morgan, and Janzen (2006), older Canadians living in rural areas are subject to a "lower life expectancy, greater proportion of oldest-old, lower income, less education, higher levels of impairment, fewer formal services, and greater distances to access health services" (p. 322). Older adults living in rural areas of Canada are at a heightened risk of lacking in essential SDOH, where place is a highly relevant factor in health outcomes. There is much more to be discovered in the circumstance of those who are severely deficient in access to essential resources and living in rural regions of Canada. As the value of a facility like the older adult centre used in this study was strongly indicated by participants in this work, and despite the fact that these types of organizations are highly beneficial to older adults in general, they remain largely inaccessible to those living outside urban centers. For a myriad of reasons based in both

fiscal and logistical factors, policies and state funding give a lesser priority to the creation of such services in rural areas. While it is true that fewer individuals are likely to access this type of older adult centre in more sparsely-populated rural regions of the country, this does not negate the fact that in order to thrive the oldest of adults living in these environments require similar measures of formal and informal assistance to their urban-residing counterparts. As participant perspectives shared in this study support, social connection and contact with others is essential to addressing the significant concerns of social isolation and loneliness facing many in the oldest old population. Over time, study of the specific needs of the growing number of oldest old in rural regions will be an increasingly important area for future research and policy work in Canada.

A final area for further investigation revealed in this study is the experiences of the oldest old whose children are also classified as older adults themselves. Here, a complex dynamic is shown through the overlapping service, care, and economic needs of both the older adult child and the oldest old parent. In this study, a number of the oldest old frequently referred to a strong reliance on their children for assistance and camaraderie, a situation that may be compromised if the older adult children of their aging parents do not have the capacity or resources to assume a supportive role effectively. Having spoken to one participant over the age of 65 in this study who was largely responsible for assisting her very old parents in a number of areas, it is clear that this unique group is worthy of attention in future policies. In policy, this attention must include the provision of increased caregiver supports, as has been identified as a pronounced service need in earlier parts of this thesis. It will also entail aid in other areas so that neither party is excessively depleted in providing care for the other. Ultimately, it is only through recognition of the distinct

needs among those of the oldest old population that appropriate mechanisms of support can be developed and realized.

## Concluding Remarks

As the role of the individual is emphasized in neoliberal society, the function of the state in supporting the oldest old becomes less pronounced, whereby increased responsibility shifts to informal sources of care and assistance. To a large extent, messages of sustained independence and Active Living reflected in the language of aging policy dialogues lead to diminished formal service provision. An expansion of system-level welfare support could resolve this imbalance. Many recommendations within aging policy align with neoliberal ideology in suggesting that the role of the state is not necessarily to *take care of aging citizens*, but rather to assist aging citizens so that they can *take care of themselves*. A neoliberal agenda consistently pushes even the oldest old towards striving to do more for themselves. In contrast, an equity perspective over the life span involves intervention through strengthened state welfare supports, and the removal of systemic barriers at the macro-level. Part of realizing this goal involves shifting the focus from a neoliberal model of individualism, towards embracing interdependence as a notion that supports a sense of community and reliance on others in mutually beneficial and reciprocal ways.

It is often said that it takes a village to raise a child, yet this mentality has not been sufficiently applied into the very late years of life where a negatively framed model of dependence has instead prevailed for those seeking formal means of support. With increasing age, one's supportive network is at greater risk of a dramatic reduction in size. As described by many of the participants in this study, an increasing vulnerability to the loss of one's spouse and/or others in their immediate social network leads to increased feelings of loneliness and social isolation. Given that many among society's oldest old are widowed women, and hence

more likely to have experienced gender-based disadvantage, it becomes increasingly important to embrace a community-based approach to aging policy in which the welfare state has a stronger presence and impact at the micro-level of aging individuals.

Changes in public policy at the government level may serve to combat neoliberal ideology through the adoption of stronger supportive measures provided by the welfare state (Raphael, 2008). Such expanded welfare provisions would potentially allow for greater consideration of both the unique health and life-long labour experiences of aging women (Armstrong & Armstrong, 2010; Doyal, 1995), as well as acknowledgement of the oldest old as a distinct group among older adults. Ultimately, achieving an equitable circumstance for the oldest old is likely to require action at both the autonomous level of the individual, and the systems level of political, economic, and social structures that influence health between and within societies.

One study argues that "A successfully aging society distributes resources equitably across the older population, thus lessening the gap between the haves and the have nots" (Chen et al., 2018, p. 9169). In this regard, the social democratic nations of Norway, Denmark, Finland and Sweden rank the highest in the equitable distribution of resources among their oldest citizens (ibid). These systems provide a positive model of social supports for aging which other societies can learn from and strive to emulate. Successful aging as an *individual* requires support for successful aging from one's *society* through the strengthened institution of a model of interdependent care. On this subject, Bengston & Putney (2006) use the examples of Western Europe and Japan when they say:

> There are several reasons why these countries are less concerned with the generational equity debate, the most important being the existence of social-welfare programmes that support elders as well as families, which in turn promote extensive public-private

> reciprocal transfers and support, reducing intergenerational inequalities within families as well as within society. (p. 27)

Thus, a stronger role taken by the welfare state in supporting the oldest old is both necessary to the reduction of intergenerational inequity and the least that they deserve. Our society's oldest old have earned this support, and more, for their contributions of visible and nonvisible societal service made over a lifetime. It is my hope that this work provides a strong case for the inclusion of oldest old voices in conversations about advancing aging research, policies, care, and services.

Bibliography

Adams, J., Khan, H. T. A., & Raeside, R. (2014). *Research methods for business and social science students* (2nd ed.). Thousand Oaks, CA: SAGE Publications Ltd.

Agich, G. J. (2003). *Dependence and autonomy in old age: An ethical framework for long-term care.* Cambridge, UK: Cambridge University Press.

Aldwin, C. M., & Gilmer, D. F. (2004). *Health, illness, and optimal aging: Biological and psychosocial perspectives* (2nd ed.). New York, NY: Springer Publishing Company.

Angus, J., & Reeve, P. (2006). Ageism: A threat to "aging well" in the 21st century. *Journal of Applied Gerontology*, *25*(2), 137-152.

Arber, S. (2004). Gender, marital status, and ageing: Linking material, health, and social resources. *Journal of Aging Studies, 18*(1), 91-108.

Armstrong, H. (2013). Neoliberalism and official health statistics: Towards a research agenda. In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 187-200). Toronto, ON: Canadian Scholars' Press Inc.

Armstrong, P. (2001). The context for health care reform in Canada. In P. Armstrong, C. Amaratunga, J. Bernier, K. Grant, A. Pederson & K. Willson (Eds.), *Exposing privatization: Women and health care reform in Canada* (pp. 11-48). Aurora, ON: Garamond Press Ltd.

Armstrong, P. (2001). Evidence-based health-care reform: Women's issues. In P. Armstrong, H. Armstrong & D. Coburn (Eds.), *Unhealthy times: Political economy perspectives on health and care in Canada* (pp. 121-145). Toronto, ON: Oxford University Press.

Armstrong, P. (2006). Gender, health, and care. In T. Bryant, D. Raphael & M. Rioux (Eds.),

*Staying alive: Critical perspectives on health, illness, and health care* (pp. 331-346). Toronto, ON: Canadian Scholars' Press Inc.

Armstrong, P. (2013). Skills for care. In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 101-112). Toronto, ON: Canadian Scholars' Press Inc.

Armstrong, P., & Armstrong, H. (1985). Political economy and the household: Rejecting separate spheres. *Studies in Political Economy, 17*(1), 167-177.

Armstrong, P., & Armstrong, H. (2010). *The double ghetto: Canadian women and their segregated work*. Don Mills, ON: Oxford University Press.

Armstrong, P., & Braedley, S. (Eds.). (2013). *Troubling care: Critical perspectives on research and practices.* Toronto, ON: Canadian Scholars' Press Inc

Armstrong, P., & Connelly, M. P. (1989). Feminist political economy: An introduction. *Studies in Political Economy, 30*, 5-12.

Aronson, J., Denton, M., & Zeytinoglu, I. (2004). Market-modelled home care in Ontario: Deteriorating working conditions and dwindling community capacity. *Canadian Public Policy/Analyse de Politiques, 30*(1), 111-125.

Asla, T., Williamson, K., & Mills, J. (2006). The role of information in successful aging: The case for a research focus on the oldest old. *Library & Information Science Research*, *28*(1), 49-63.

Asquith, N. (2009). Positive ageing, neoliberalism and Australian sociology. *Journal of Sociology, 45*(3), 255-269.

Avers, D., Brown, M., Chui, K., Wong, R., & Lusardi, M. (2011). Editor's message: Use of the term "elderly." *Journal of Geriatric Physical Therapy, 34*(4), 153–154.

Bailey, C. A. (2018). *A guide to qualitative field research* (3rd ed.). Thousand Oaks, CA: SAGE Publications Inc.

Bailey, K. D. (1994). *Methods of social research.* New York, NY: The Free Press.

Baltes, M. M. (1998). The psychology of the oldest-old: The fourth age. *Current Opinion in Psychiatry*, *11*(4), 411-415.

Bartels, S. J., & Naslund, J. A. (2013). The underside of the silver tsunami—older adults and mental health care. *New England Journal of Medicine*, *368*(6), 493-496.

Bazel, P., & Mintz, J. (2014). Income adequacy among Canadian seniors: Helping singles most. *The School of Public Policy Publications, 7*(4).

Beasley, C., & Bacchi, C. (2005). The political limits of 'care' in re-imagining interconnection/community and an ethical future. *Australian Feminist Studies, 20*(46), 49-64.

Beeber, A. S. (2008). Interdependence: Building partnerships to continue older adults' residence in the community. *Journal of Gerontological Nursing*, *34*(1), 19-25.

Beed, J. (2018). *Expanding caregiver support in Ontario: Advice from Janet Beed to the Honourable Eric Hoskins.* Toronto, ON: Queen's Printer for Ontario. Retrieved from https://files.ontario.ca/beed_report_2018_0.pdf

Bengtson, V. L., & Allen, K. R. (1993). The life course perspective applied to families over time. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of family theories and methods: A contextual approach* (pp. 469- 504). New York, NY: Plenum Press.

Bengtson, V. L., & Putney, N. M. (2006). Future "conflicts" across generations and cohorts? In

J. Vincent, C. Phillipson, & M. Downs (Eds.), *The futures of old age* (pp. 20-29). Thousand Oaks, CA: SAGE Publications Inc.

Bercovitz, K. L. (1998). Canada's active living policy: A critical analysis. *Health Promotion International*, *13*(4), 319-328.

Bercovitz, K. L. (2000). A critical analysis of Canada's 'Active Living': Science or politics? *Critical Public Health*, *10*(1), 19-39.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234.

Bergstrom, M. J., & Holmes, M. E. (2000). Lay theories of successful aging after the death of a spouse: A network text analysis of bereavement advice. *Health Communication, 12*(4), 377-406.

Berlin, J. (1988). Rhetoric and ideology in the writing class. *College English, 50*(5), 477-494.

Bernard, H. R. (2000). *Social research methods: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications Inc.

Blanck, P. (2011). Disability and aging: Historical and contemporary views. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 49-70). New York, NY: Springer.

Blommaert, J. (2005). *Discourse: Key topics in sociolinguistics*. New York, NY: Cambridge University Press.

Boadu, N. Y., & Higginbottom, G. M. A. (2015). Using malaria rapid diagnostic tests in Ghana: A focused ethnography. In M. D. Chesnay (Ed.), *Nursing research using ethnography: Qualitative designs and methods in nursing* (pp. 139-170). New York, NY: Springer Publishing Company, LLC.

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity, 36*(4), 391-409.

Bookwala, J., & Schulz, R. (2000). A comparison of primary stressors, secondary stressors, and depressive symptoms between elderly caregiving husbands and wives: The caregiver health effects study. *Psychology and Aging, 15*(4), 607-616.

Borg, C., Hallberg, I. R., & Blomqvist, K. (2006). Life satisfaction among older people (65+) with reduced self-care capacity: The relationship to social, health and financial aspects. *Journal of Clinical Nursing, 15*(5), 607-618.

Bould, S., Smith, M. H., & Longino Jr, C. F. (1997). Ability, disability, and the oldest old. *Journal of Aging & Social Policy, 9*(1), 13-31.

Bourgeault, I. L. (2006). Sociological perspectives on health and health care. In T. Bryant, D. Raphael & M. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness, and health care* (pp. 35-58). Toronto, ON: Canadian Scholars' Press Inc.

Bourgeault, I. L. (2010). Constructing disability and illness. In T. Bryant, D. Raphael & M. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness, and health care* (2nd ed.) (pp. 41-63). Toronto, ON: Canadian Scholars' Press Inc.

Bourke, B. (2014). Positionality: Reflecting on the research process. *The Qualitative Report, 19*(33), 1-9.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40.

Bowling, A. (2007). Aspirations for older age in the 21st century: What is successful aging? *The International Journal of Aging and Human Development*, *64*(3), 263-297.

Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *British*

*Medical Journal, 331*(7531), 1548-1551.

Bowling, A. (2006). Lay perceptions of successful ageing: Findings from a national survey of middle aged and older adults in Britain. *European Journal of Ageing*, *3*(3), 123-136.

Boyle, G. (2008). Autonomy in long-term care: A need, a right or a luxury? *Disability & Society, 23*(4), 299-310.

Bracke, P., Christiaens, W., & Wauterickx, N. (2008). The pivotal role of women in informal care. *Journal of Family Issues, 29*(10), 1348-1378.

Braedley, S. (2006). Someone to watch over you: Gender, class, and social reproduction. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neo-liberalism* (pp. 215-230). Montréal, QC: McGill-Queen's University Press.

Braedley, S. (2013). A gender politics of long-term residential care: Towards an analysis. In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 59-70). Toronto, ON: Canadian Scholars' Press Inc.

Braithwaite, V. (2002). Reducing ageism. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 311-338). Cambridge, MA: MIT Press.

Brandt, M., Deindl, C., & Hank, K. (2012). Tracing the origins of successful aging: The role of childhood conditions and social inequality in explaining later life health. *Social Science & Medicine*, *74*(9), 1418-1425.

Braveman, P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports* (Suppl 2), *129*(1), 5-8.

Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health, 32*, 381-398.

Braverman, P., Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health, 57*(4), 254-258.

Breheny, M., & Stephens, C. (2009). 'I sort of pay back in my own little way': Managing independence and social connectedness through reciprocity. *Ageing & Society*, *29*(8), 1295-1313.

Britton, A., Shipley, M., Singh-Manoux, A., & Marmot, M. (2008). Successful aging: The contribution of early-life and midlife risk factors. *Journal of the American Geriatrics Society, 56*(6), 1098-1105.

Brown, W. (2003). Neoliberalism and the end of liberal democracy. *Theory and Event, 7*(1). Retrieved from https://muse.jhu.edu/article/48659.

Bryant, T. (2009). Housing and income as social determinants of women's health in Canadian cities. *Women's Health and Urban Life, 8*(2), 1-20.

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9*(4), 243-246.

Butler-Jones, D. (2010). *The Chief Public Health Officer's Report on the State of Public Health in Canada, 2010: Growing Older – Adding Life to Years.* Ottawa, Ontario, Canada: PHAC.

Calasanti, T. (2005). Ageism, gravity, and gender: Experiences of aging bodies. *Generations, 29*(3), 8-12.

Calasanti, T., & Giles, S. (2018). The challenge of intersectionality. *Generations, 41*(4), 69-74.

Calasanti, T., & Kiecolt, K. J. (2012). Intersectionality and aging families. In R. Blieszner & V. H. Bedford (Eds.), *Handbook of families and aging* (pp. 263-286). Santa Barbara, CA: ABC-CLIO, LLC.

Calasanti, T. & King, N. (2015). Intersectionality and age. In J. Twigg & W. Martin (Eds.),

*Routledge handbook of cultural gerontology* (pp. 193-200). New York, NY: Routledge.

Calasanti, T. M., & Slevin, K. F. (2001). *Gender, social inequalities, and aging.* Lanham, MD: Rowman & Littlefield Publishers, Inc.

Callahan, D. (1987). *Setting limits: Medical goals for an aging society*. New York, NY: Simon and Schuster.

Callero, P. L. (2013). *The myth of individualism: How social forces shape our lives* (2nd ed.). Lanham, MD: Rowman & Littlefield Publishers, Inc.

Cammack, V., & Byrne, K. (2012). Accelerating a network model of care: Taking a social innovation to scale. *Technology Innovation Management Review, 2*(7), 26-30.

Carpentier, N., Bernard, P., Grenier, A., & Guberman, N. (2010). Using the life course perspective to study the entry into the illness trajectory: The perspective of caregivers of people with Alzheimer's disease. *Social Science and Medicine, 70*(10), 1501-1508.

Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing & Society*, *25*(1), 41-67.

Chan, H. M., & Pang, S. (2007). Long-term care: Dignity, autonomy, family integrity, and social sustainability: The Hong Kong experience. *Journal of Medicine and Philosophy*, *32*(5), 401-424.

Chatman, E. A. (1992). *The information world of retired women*. Westport, CT: Greenwood Press.

Check, J. W., & Schutt, R. K. (2012). *Research methods in education.* Thousand Oaks, CA: SAGE Publications, Inc.

Chen, C., Goldman, D. P., Zissimopoulos, J., & Rowe, J. W. (2018). Multidimensional

comparison of countries' adaptation to societal aging. *Proceedings of the National Academy of Sciences*, *115*(37), 9169-9174.

Chivers, S. (2013). Care, culture, and creativity: A disability perspective on long-term residential care. In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 47-58). Toronto, ON: Canadian Scholars' Press Inc.

Cho, J., Martin, P., Poon, L. W., & the Georgia Centenarian Study. (2015). Successful aging and subjective well-being among oldest-old adults. *The Gerontologist*, *55*(1), 132-143.

City of Toronto. (2018). *North York: City of Toronto community council area profiles*. Retrieved from https://www.toronto.ca/wp-content/uploads/2019/01/9710-City_Planning_2016_Census_Profile_2018_CCA_NorthYork.pdf

Clark, P. G. (1988). Autonomy, personal empowerment, and quality of life in long-term care. *The Journal of Applied Gerontology, 7*(3), 279-297.

Clarke, C. M. (2001). Rationing scarce life-sustaining resources on the basis of age. *Journal of Advanced Nursing, 35*(5), 799-804.

Clarke, L. H., Griffin, M., & PACC Research Team. (2008). Failing bodies: Body image and multiple chronic conditions in later life. *Qualitative Health Research*, *18*(8), 1084-1095.

Coburn, D. (2000). Income inequality, social cohesion and the health status of populations: The role of neo-liberalism. *Social Science & Medicine, 51*(1), 135-146.

Coburn, D. (2004). Beyond the income inequality hypothesis: Class, neo-liberalism, and health inequalities. *Social Science & Medicine, 58*(1), 41-56.

Coburn, D. (2010). Health and health care: Political economy perspective. In T. Bryant, D. Raphael & M. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness, and health care* (2nd ed.) (pp. 65-92). Toronto, ON: Canadian Scholars' Press Inc.

Cohen, N., & Arieli, T. (2011). Field research in conflict environments: Methodological challenges and snowball sampling. *Journal of Peace Research, 48*(4), 423-435.

Comité Consultatif de Lutte Contre la Pauvreté et l'Exclusion Sociale. (2010). *Ageing alone: The impact on poverty and social exclusion.* rue Saint-Amable, QC. Retrieved from http://www.cclp.gouv.qc.ca/includes/composants/telecharger.asp?fichier=/publications/pdf/Avis_Vieillir%20seul_ANG.pdf&langue=en

Connell, J., Lynch, C., & Waring, P. (2001). Constraints, compromises and choice: Comparing three qualitative research studies. *The Qualitative Report*, *6*(4), 1-15.

Cordingley, L., & Webb, C. (1997). Independence and aging. *Reviews in Clinical Gerontology*, *7*(2), 137-146.

Cortazzi, M. (2001). Narrative analysis in ethnography. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of ethnography,* (pp. 384-394). Thousand Oaks, CA: SAGE Publications Inc.

Côté, J., & Bynner, J. M. (2008). Changes in the transition to adulthood in the UK and Canada: The role of structure and agency in emerging adulthood. *Journal of Youth Studies*, *11*(3), 251-268.

Covey, H. C. (1985). Qualitative research of older people: Some considerations. *Gerontology & Geriatrics Education, 5*(3), 41-50.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford Law Review, 43*(6), 1241-1299.

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches.* Thousand Oaks, CA: SAGE Publications, Inc.

Crowther, M. R., Parker, M. W., Achenbaum, W. A., Larimore, W. L., & Koenig, H. G. (2002).

Rowe and Kahn's model of successful aging revisited positive spirituality—the forgotten factor. *The Gerontologist*, *42*(5), 613-620.

Cruikshank, M. (2013). *Learning to be old: Gender, culture, and aging* (3rd ed.). Lanham, MD: Rowman & Littlefield Publishers, Inc.

Cuddy, A. J. C., & Fiske, S. T. (2002). Doddering but dear: Process, content, and function in stereotyping of older persons. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 3-26). Cambridge, MA: MIT Press.

Dalmer, N. K. (2019). A logic of choice: Problematizing the documentary reality of Canadian aging in place policies. *Journal of Aging Studies*, *48*, 40-49.

Daly, M. (2001). Care policies in Western Europe. In M. Daly (Ed.), *Care work: The quest for security* (pp. 33-56). Geneva, CH: International Labour Organization.

Daly, T. (2013). Imagining an ethos of care within policies, practices, and philosophy. In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 33-46). Toronto, ON: Canadian Scholars' Press Inc.

Daly, T., & Grant, G. (2008). Crossing borders: Lifecourse, rural ageing and disability. In N. Keating (Ed.), *Rural ageing: A good place to grow old?* (pp. 11-20). Bristol, UK: The Policy Press.

Dannefer, D. (2012). Enriching the tapestry: Expanding the scope of life course concepts. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 67*(2), 221-225.

Darling, R. B., & Heckert, D. A. (2010). Orientations toward disability: Differences over the lifecourse. *International Journal of Disability, Development and Education*, *57*(2), 131-143.

Davies, S., Laker, S., & Ellis, L. (1997). Promoting autonomy and independence for older people within nursing practice: A literature review. *Journal of Advanced Nursing, 26*(2), 408-417.

Davis, L. J. (2006). Constructing normalcy: The bell curve, the novel, and the invention of the disabled body in the nineteenth century. In L. Davis (Ed.), *The disability studies reader* (pp. 3-16). New York, NY: Routledge.

Day, S. (2013). The implications of conceptualizing care. In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 21-32). Toronto, ON: Canadian Scholars' Press Inc.

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher*, *13*(1), 19-28.

de Rezende, L. F. M., Rey-López, J. P., Matsudo, V. K. R., & do Carmo Luiz, O. (2014). Sedentary behavior and health outcomes among older adults: A systematic review. *BMC Public Health*, *14*(1), 1.

Depp, C., A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry, 14*(1), 6-20.

Dewsbury, G., Clarke, K., Randall, D., Rouncefield, M., & Sommerville, I. (2004). The anti-social model of disability. *Disability & Society, 19*(2), 145-158.

Diamond, T. (1986). Social policy and everyday life in nursing homes: A critical ethnography. *Social Science & Medicine*, *23*(12), 1287-1295.

Diamond, T. (1992). *Making grey gold: Narratives of nursing home care.* Chicago, IL: The University of Chicago Press.

Dillaway, H. E., & Byrnes, M. (2009). Reconsidering successful aging: A call for renewed and expanded academic critiques and conceptualizations. *Journal of Applied Gerontology, 28*(6), 702-722.

Dinh T. (2014). *Moving ahead: Making the case for healthy active living in Canada*. Ottawa, ON: The Conference Board of Canada.

Dixon, J. (2000). Social determinants of health. *Health Promotion International, 15*(1), 87-89.

Dogra, S., & Stathokostas, L. (2012). Sedentary behavior and physical activity are independent predictors of successful aging in middle-aged and older adults. *Journal of Aging Research*, *2012*, 1-8.

Donalek, J. G. (2005). The interview in qualitative research. *Urologic Nursing*, *25*(2), 124-125.

Dovidio, J. J., Pagotto, L., & Hebl, M. R. (2011). Implicit attitudes and discrimination against people with physical disabilities. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 157-184). New York, NY: Springer.

Doyal, L. (1995). *What makes women sick: Gender and the political economy of health*. Chapel Hill, NC: Rutgers University Press.

Doyal, L. (2000). Gender equity in health: Debates and dilemmas. *Social Science and Medicine, 51*(6), 931-939.

Doyal, L., & Pennell, I. (1979). *The political economy of health*. London, UK: Pluto Press.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54-63.

Dykstra, P. A. (2013, September 27). Ties that bind: Families across time and space. *Uhlenbeck Lecture 31*. Retrieved from http://hdl.handle.net/1765/50355

Elder Jr, G. H. (1994). Time, human agency, and social change: Perspectives on the life

course. *Social Psychology Quarterly, 57*(1), 4-15.

Elder Jr., G. H. (1998). The life course as developmental theory. *Child Development, 69*(1), 1-12.

Elder Jr., G. H., & Johnson, M. K., & Crosnoe, R. (2003). The emergence and development of life course theory. In J. T. Mortimer & Shanahan, M. J. (Eds.), *Handbook of the life course* (pp. 3-22). New York, NY: Kluwer Academic/Plenum Publishers.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE open*, *4*(1), 1-10.

Emejulu, A., & Bassel, L. (2017). Whose crisis counts? Minority women, austerity and activism in France and Britain. In J. Kantola & E. Lombardo (Eds.), *Gender and the economic crisis in Europe: Politics, institutions and intersectionality* (pp. 185-208). Cham, CH: Springer International Publishing AG.

Emery, J. H., Fleisch, V. C., & McIntyre, L. (2013). Legislated changes to federal pension income in Canada will adversely affect low income seniors' health. *Preventive Medicine*, *57*(6), 963-966.

Emmett, T., & Alant, E. (2006). Women and disability: Exploring the interface of multiple disadvantage. *Development Southern Africa*, *23*(4), 445-460.

England, K. (2010). Home, work and the shifting geographies of care. *Ethics, Place and Environment, 13*(2), 131-150.

d'Epinay, C. J. L., Cavalli, S., & Guillet, L. A. (2010). Bereavement in very old age: Impact on health and relationships of the loss of a spouse, a child, a sibling, or a close friend. *OMEGA-Journal of Death and Dying, 60*(4), 301-325.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). *Doing naturalistic inquiry:*

*A guide to methods.* Newbury Park, CA: SAGE Publications, Inc.

Esping-Andersen, G. (1990). *The three worlds of welfare capitalism.* Princeton, NJ: Princeton University Press.

Esping-Andersen, G. (1999). *Social foundations of postindustrial economies.* New York, NY: Oxford University Press.

Esqueda, C. W. (2011). Cross-cultural perspectives on stigma. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 185-204). New York, NY: Springer.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics, 5*(1), 1-4.

Fagerström, J., & Aartsen, M. (2013). Successful ageing and its relationship to contemporary norms. A critical look at the call to "age well." *Recherches Sociologiques et Anthropologiques*, *44*(1), 51-73.

Fain, J. A. (2017). *Reading, understanding, and applying nursing research.* Philadelphia, PA: F. A. Davis Company.

Federation of Canadian Municipalities. (2013). *Canada's aging population: The municipal role in Canada's demographic shift*. Ottawa, ON. Retrieved from https://www.fcm.ca/Documents/reports/FCM/canadas_aging_population_the_municipal_role_in_Canadas_demographic_shift_en.pdf

Feo, R., & Kitson, A. (2016). Promoting patient-centred fundamental care in acute healthcare systems. *International Journal of Nursing Studies, 57*, 1-11.

Findlay, R. A. (2003). Interventions to reduce social isolation amongst older people: Where is the evidence? *Ageing & Society*, *23*(5), 647-658.

Fine, M., & Glendinning, C. (2005). Dependence, independence or inter-dependence? Revisiting the concepts of 'care' and 'dependency'. *Ageing & Society, 25*(4), 601-621.

Fisher, B. J. (1992). Successful aging and life satisfaction: A pilot study for conceptual clarification. *Journal of Aging Studies, 6*(2), 191-202.

Fisher, B. & Tronto, J. (1990). Toward a feminist theory of caring. In E. K. Abel & M. Nelson (Eds.), *Circles of care: Work and identity in women's lives* (pp. 35-62). Albany, NY: State University of New York Press.

Flatt, M. A., Settersten, R. A., Ponsaran, R., & Fishman, J. R. (2013). Are "anti-aging medicine" and "successful aging" two sides of the same coin? Views of anti-aging practitioners. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *68*(6), 944-955.

Forbes, D. A., Morgan, D., & Janzen, B. L. (2006). Rural and urban Canadians with dementia: Use of health care services. *Canadian Journal on Aging/La Revue Canadienne du Vieillissement*, *25*(3), 321-330.

Foster, L., & Walker, A. (2015). Active and successful aging: A European policy perspective. *The Gerontologist, 55*(1), 120-131.

Foucault, M. (2003). *The birth of the clinic*. New York, NY: Routledge.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health, 25*(10), 1229-1245.

Frohlich, K. L., Ross, N., & Richomnd, C. (2006). Health disparities in Canada today: Some evidence and a theoretical framework. *Health Policy, 79*(2-3), 132-43.

Fylan, F. (2005). Semi-structured interviewing. In J. Miles & P. Gilbert (Eds.), *A handbook of*

*research methods for clinical & healthy psychology* (pp. 65-78). New York, NY: Oxford University Press Inc.

Gallagher, D. P. (2012). *Aging successfully: How to enjoy, not just endure, the second half of life.* Eugene, OR: Wipf & Stock Publishers.

Gallagher, S., Bennett, K. M., & Halford, J. C. G. (2006). A comparison of acute and long-term health-care personnel's attitudes towards older adults. *International Journal of Nursing Practice, 12*(5), 273-279.

Gazso, A. (2005). The poverty of unattached senior women and the Canadian retirement income system: A matter of blame or contradiction? *The Journal of Sociology & Social Welfare, 32*(2), 41-62.

Gee, E. M. (2002). Misconceptions and misapprehensions about population ageing. *International Journal of Epidemiology*, *31*(4), 750-753.

George, L. K. (1993). Sociological perspectives on life transitions. *Annual Review of Sociology, 19*(1), 353-373.

Gerring, J. (1997). Ideology: A definitional analysis. *Political Research Quarterly, 50*(4), 957-994.

Gervais, S. J. (2011). A social psychological perspective of disability prejudice. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 249-262). New York, NY: Springer.

Gibbons, H. M. (2016). Compulsory youthfulness: Intersections of ableism and ageism in "successful aging" discourses. *Review of Disability Studies, 12*(2&3)*,* 70-88.

Gilleard, C., & Higgs, P. (2011). Frailty, disability and old age: A re-appraisal. *Health, 15*(5), 475-490.

Glaser, B. G. (1965). The constant comparative method of qualitative analysis. *Social Problems, 12*(4), 436-445.

Glass, T. A. (2003). Assessing the success of successful aging. *Annals of Internal Medicine, 139*(5_Part_1), 382-383.

Glass, T. A., Seeman, T. E., Herzog, A. R., Kahn, R., & Berkman, L. F. (1995). Change in productive activity in late adulthood: MacArthur studies of successful aging. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 50*(2), S65-S76.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, *8*(4), 597-606.

Goldblatt, H., Karnieli-Miller, O., & Neumann, M. (2011). Sharing qualitative research findings with participants: Study experiences of methodological and ethical dilemmas. *Patient Education and Counseling*, *82*(3), 389-395.

Gondo, Y., Nakagawa, T., & Masui, Y. (2013). A new concept of successful aging in the oldest old: Development of gerotranscendence and its influence on the psychological well-being. *Annual Review of Gerontology and Geriatrics, 33*(1), 109-132.

Gordon, A. A. (1996). *Transforming capitalism and patriarchy: Gender and development in Africa.* Boulder, CO: Lynne Rienner Publishers, Inc.

Gornick, J. C., Munzi, T., Sierminska, E., & Smeeding, T. M. (2009). Income, assets, and poverty: Older women in comparative perspective. *Journal of Women, 30*(2-3), 272-300.

Green, H. E. (2014). Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher, 21*(6), 34-38.

Green, J., & Britten, N. (1998). Qualitative research and evidence based medicine. *British*

*Medical Journal*, *316*(7139), 1230-1240.

Greenberg, J., Schimel, J., & Mertens, A. (2002). Ageism: Denying the face of the future. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 27-48). Cambridge, MA: MIT Press.

Guan, L. H. (Ed.). (2008). *Ageing in Southeast and East Asia.* Singapore: Institute of Southeast Asian Studies.

Guberman, N., Gagnon, É., Lavoie, J., Belleau, H., Fournier, M., Grenier, L., & Vézina, A. (2006). Families' values and attitudes regarding responsibility for the frail elderly. *Journal of Aging & Social Policy, 18*(3-4), 59-78.

Gubrium, J. F. (1995). Perspective and story in nursing home ethnography. In J. N. Henderson & M. D. Vesperi (Eds.), *The culture of long term care: Nursing home ethnography* (pp. 23-36). Westport, CT: Bergin & Garvey.

Hagestad, G. O. (2003). Interdependent lives and relationships in changing times: A life-course view of families and aging. In R. A. Settersten, Jr. (Ed.), *Invitation to the life course: Toward new understandings of later life* (pp. 135-159). Amityville, NY: Baywood Publishing.

Hamdan, A. K. (2009). Reflexivity of discomfort in insider-outsider educational research. *McGill Journal of Education, 44*(3), 377-404.

Hankivsky, O. (2004). *Social policy and the ethic of care.* Vancouver, BC: The University of British Columbia.

Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health, 18*(3), 271-83.

Hankivsky, O., Reid, C., Cormier, R., Varcoe, C., Clark, N., Benoit, C., & Brotman, S. (2010).

Exploring the promises of intersectionality for advancing women's health research. *International Journal for Equity in Health, 9*(5), 1-15.

Hansen-Kyle, L. (2005). A concept analysis of healthy aging. *Nursing Forum, 40*(2), 45-57.

Harper, M., & Cole, P. (2012). Member checking: Can benefits be gained similar to group therapy? *The Qualitative Report*, *17*(2), 510-517.

Hatch, J. A. (2002). *Doing qualitative research in education settings.* Albany, NY: State University of New York Press.

Henderson, J. N., & Vesperi, M. D. (Eds.). (1995). *The culture of long term care: Nursing home ethnography*. Westport, CT: Bergin & Garvey.

Henry, P. (2015). Rigor in qualitative research: Promoting quality in social research. *Research Journal of Recent Sciences, 4*, 25-28.

Hertz, R. (1997). Introduction: Reflexivity and voice. In R. Hertz (Ed.), *Reflexivity and voice* (pp. vii-xviii). Thousand Oaks, CA: SAGE Publications Inc.

Hewson, C. (2008). Internet-mediated research as an emergent method and its potential role in facilitative mixed methods research. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of emergent methods* (pp. 543-570). New York, NY: The Guilford Press.

Hofrichter, R. (2003). The politics of health inequities: Contested terrain. In R. Hofrichter (Ed.), *Health and social justice: A reader on ideology, and inequity in the distribution of disease* (pp. 1-56). San Francisco, CA: Jossey Bass.

Holstein, M. B., & Minkler, M. (2003). Self, society, and the "new gerontology." *The Gerontologist, 43*(6), 787-796.

Hooyman, N. R. (1999). Research on older women: Where is feminism? *The Gerontologist, 39*(1), 115-118.

Hooyman, N., Browne, C. V., Ray, R., & Richardson, V. (2002). Feminist gerontology and the life course. *Gerontology & Geriatrics Education, 22*(4), 3-26.

Hsiung, P. C. (2008). Teaching reflexivity in qualitative interviewing. *Teaching Sociology, 36*(3), 211-226.

Hsu, M., Anen, C., & Quartz, S. R. (2008). The right and the good: Distributive justice and neural encoding of equity and efficiency. *Science, 320*(5897), 1092-1095.

Humphreys, D. (2009). Discourse as ideology: Neoliberalism and the limits of international forest policy. *Forest Policy and Economics, 11*(5-6), 319-325.

Ilcan, S. (2009). Privatizing responsibility: Public sector reform under neoliberal government. *Canadian Review of Sociology/Revue Canadienne de Sociologie*, *46*(3), 207-234.

IRPP Task Force on Aging. (2015). *Designing a National Seniors Strategy for Canada*. Institute for Research on Public Policy. Retrieved from https://www.cma.ca/En/Lists/Medias/task-force- aging-report-e.pdf

Iwamasa, G. Y., & Iwasaki, M. (2011). A new multidimensional model of successful aging: Perceptions of Japanese American older adults. *Journal of Cross-Cultural Gerontology*, *26*(3), 261-278.

Izaks, G. J., & Westendorp, R. G. J. (2003). Ill or just old? Towards a conceptual framework of the relation between ageing and disease. *BMC Geriatrics, 3*(1), 7.

Jennings, G. R. (2009). Methodologies and Methods. In T. Jamal & M. Robinson (Eds.), *The SAGE handbook of tourism studies* (pp. 672-692). Thousand Oaks, CA: SAGE Publications Inc.

Johnson, A. G. (2005). *The gender knot: Unraveling our patriarchal legacy*. Philadelphia, PA:

Temple University Press.

Johnson, M. K., Crosnoe, R., & Elder Jr., G. H. (2011). Insights on adolescence from a life course perspective. *Journal of Research on Adolescence, 21*(1), 273-280.

Johnson, J. K., Sarkisian, N., & Williamson, J. B. (2015). Using a micro-level model to generate a macro-level model of productive successful aging. *The Gerontologist, 55*(1), 107-119.

Johnstone, M. J. (2013). Ageism and moral exclusion of older people. *Australian Nursing and Midwifery Journal, 21*(3), 27.

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: Promoting rigour in qualitative research. *Nursing Standard, 23*(23), 42-46.

Jones, A. (2007). *The role of supportive housing for low-income seniors in Ontario.* Toronto, ON: Canadian Policy Research Networks Inc. and Social Housing Services Corporation.

Kabanoff, B. (1991). Equity, equality, power, and conflict. *Academy of Management Review, 16*(2), 416-441.

Kahana, E., & Kahana, B. (1996). Conceptual and empirical advances in understanding aging well through proactive adaptation. In V. L. Bengtson (Ed.), *Adulthood and aging: Research on continuities and discontinuities* (pp. 18-40). New York, NY: Springer Publishing Co.

Kane, R. L., & Kane, R. A. (2001). What older people want from long-term care, and how they get it. *Health Affairs, 20*(6), 114-127.

Kane, R. L., & Kane, R. A. (2005). Ageism in healthcare and long-term care. *Generations, 29*, 49-54.

Kattari, S. K., Lavery, A., & Hasche, L. (2017). Applying a social model of disability across the life span. *Journal of Human Behavior in the Social Environment*, *27*(8), 865–880.

Katz, S., & Calasanti, T. (2015). Critical perspectives on successful aging: Does it "appeal more than it illuminates"? *The Gerontologist, 55*(1), 26-33.

Kearns, R. A. (1993). Place and health: Towards a reformed medical geography. *The Professional Geographer, 45*(2), 139-47.

Kelley-Moore, J. A., Schumacher, J. G., Kahana, E., & Kahana, B. (2006). When do older adults become "disabled"? Social and health antecedents of perceived disability in a panel study of the oldest old. *Journal of Health and Social Behavior, 47*(2), 126-141.

Kemp, C. L., Ball, M. M., & Perkins, M. M. (2013). Convoys of care: Theorizing intersections of formal and informal care. *Journal of Aging Studies, 27*(1), 15-29.

Kennedy, J. (2000). Responding to the disparities between disability research and aging research. *Journal of Disability Policy Studies, 11*(2), 120-123.

Kite, M. E., & Wagner, L. S. (2002). Attitudes toward older adults. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 129-162). Cambridge, MA: MIT Press.

Kittay, E. F. (1999). *Love's labor: Essays on women, equality, and dependency*. New York, NY: Routledge.

Kittay, E. F. (2005). Equality, dignity and disability. In M. A. Lyons & F. Waldron (Eds.), *Perspectives on equality: The second Seamus Heaney lectures* (pp. 95-122). Dublin: The Liffey Press.

Knight, T., Ricciardelli, L. A. (2003). Successful aging: Perceptions of adults aged between 70 and 101 years. *International Journal of Aging and Human Development, 56*(3), 223-245.

Knodel, J., & Ofstedal, M. B. (2003). Gender and aging in the developing world: Where are the men? *Population and Development Review, 29*(4), 677-698.

Krekula, C., Nikander, P., & Wilinska, M. (2018). Multiple marginalizations based on age: Gendered ageism and beyond. In L. Ayalon & C. Tesch-Römer (Eds.), *Contemporary perspectives on ageism* (Vol. 19) (pp. 33-50). Cham, Switzerland: Springer Open.

Kyvik, S., & Teigen, M. (1996). Child care, research collaboration, and gender differences in scientific productivity. *Science, Technology, & Human Values, 21*(1), 54-71.

Laher, N. (2017). *Diversity, aging, and intersectionality in Ontario home care: Why we need an intersectional approach to respond to home care needs*. Toronto, ON: Wellesley Institute. Retrieved from http://www.wellesleyinstitute.com/wp-content/uploads/2017/05/Diversity-and-Aging.pdf

Law Commission of Ontario. (2012). *A framework for the law as it affects older adults: Advancing substantive equality for older persons through law, policy and practice.* Toronto, ON: Law Commission of Ontario.

Lev, S., Wurm, S., & Ayalon, L. (2018). Origins of ageism at the individual level. In L. Ayalon & C. Tesch-Römer (Eds.), *Contemporary perspectives on ageism* (Vol. 19) (pp. 51-72). Cham, CH: Springer Open.

Levy, B. (2009). Stereotype embodiment: A psychosocial approach to aging. *Current Directions in Psychological Science, 18*(6), 332-336.

Levy, B. R. & Banaji, M. R. (2002). Implicit ageism. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 49-76). Cambridge, MA: MIT Press.

Levy, B. R., Slade, M. D., & Kasl, S. V. (2002). Longitudinal benefit of positive self-perceptions of aging on functional health. *Journal of Gerontology: Psychological Sciences, 57B*(5), 409-417.

Liang, J., & Luo, B. (2012). Toward a discourse shift in social gerontology: From successful aging to harmonious aging. *Journal of Aging Studies*, *26*(3), 327-334.

Lin, J. (2015). Life satisfaction among older adults in Taiwan: The effects of martial relations and intergenerational relations. In S. Cheng, I. Chi, H. H. Fung, L. W. Li, & J. Woo (Eds.), *Successful aging: Asian perspectives* (pp. 179-198). New York, NY: Springer.

Lin, N. (2001). *Social capital: A theory of social structure and action.* New York, NY: Cambridge University Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: SAGE Publications, Inc.

Lindauer, M. S. (2003). *Aging, creativity, and art: A positive perspective on later-life development*. New York, NY: Kluwer Academic/Plenum Publishers.

Lingler, J. H., Sherwood, P. R., Crighton, M. H., Song, M. K., & Happ, M. B. (2008). Conceptual challenges in the study of caregiver-care recipient relationships. *Nursing Research, 57*(5), 367-372.

Löfqvist, C., Granbom, M., Himmelsbach, I., Iwarsson, S., Oswald, F., & Haak, M. (2013). Voices on relocation and aging in place in very old age—a complex and ambivalent matter. *The Gerontologist*, *53*(6), 919-927.

Low, J. (2013). Unstructured and semi-structured interviews in health research. In M. Saks & J. Allsop (Eds.), *Researching health: Qualitative, quantitative and mixed methods* (pp. 87-106). Thousand Oaks, CA: SAGE Publications Inc.

Luborsky, M. R., & Rubinstein, R. L. (1995). Sampling in qualitative research. *Research on Aging, 17*(1), 89-113.

Luxton, M. (2006). Friends, neighbours, and community: A case study of the role of informal

caregiving in social reproduction. In K. Bezanson, & M. Luxton (Eds.). *Social reproduction: Feminist political economy challenges neo-liberalism* (pp. 263-292). Kingston, ON: McGill-Queen's University Press.

Macmillan, R. (2005). The structure of the life course: Classic issues and current controversies. *Advances in Life Course Research, 9*, 3-24.

Madero-Cabib, I., Corna, L., & Baumann, I. (2019). Aging in different welfare contexts: A comparative perspective on later-life employment and health. *The Journals of Gerontology: Series B*. Retrieved from https://doi.org/10.1093/geronb/gbz037

Madison, D. S. (2012). *Critical ethnography: Method, ethics, and performance* (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Marmot, M. (1999). Importance of psychosocial environment in epidemiologic studies. *Scandinavian Journal of Work, Environment & Health, 25*(Suppl. 4), 49-53.

Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *The Lancet, 370*(9593), 1153-1163.

Marshall, B. L. (2000). *Configuring gender: Explorations in theory and politics*. Toronto, ON: Broadview Press Ltd.

Martin, P., Kelly, N., Kahana, B., Kahana, E., Willcox, B. J., Willcox, D. C., & Poon, L. W. (2015). Defining successful aging: A tangible or elusive concept? *The Gerontologist, 55*(1), 14-25.

Martinengo, G., Jacob, J. I., & Hill, E. J. (2010). Gender and the work-family interface: Exploring differences across the family life course. *Journal of Family Issues, 31*(10), 1363-1390.

Martinson, M., & Berridge, C. (2015). Successful aging and its discontents: A systematic review

of the social gerontology literature. *The Gerontologist*, *55*(1), 58-69.

McAllister, A., Bentley, L., Brønnum-Hansen, H., Jensen, N. K., Nylen, L., Andersen, I., ... & Burström, B. (2019). Inequalities in employment rates among older men and women in Canada, Denmark, Sweden and the UK. *BMC Public Health*, *19*(1), 319.

McDaniel, S. A. (1987). Demographic aging as a guiding paradigm in Canada's welfare state. *Canadian Public Policy/Analyse de Politiques, 13*(3), 330-336.

McGibbon, E., & McPherson, C. (2011). Applying intersectionality and complexity theory to address the social determinants of women's health. *Women's Health & Urban Life, 10*, 59–86.

McGinnis, J. M., Williams-Russo, P., & Knickman, J. R. (2002). The case for more active policy attention to health promotion. *Health Affairs*, *21*(2), 78-93.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation.* San Francisco, CA: Jossey-Bass.

Merriam, S. B., Johnson-Bailey, J., Lee, M. Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International Journal of Lifelong Education, 20*(5), 405-416.

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.

Mertens, D. M. (2005). *Research and evaluation in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (2nd ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Mikkonen, J. & Raphael, D. (2010). *Social determinants of health: The Canadian facts.* Toronto, ON: York University. Retrieved from http://www.thecanadianfacts.org/

Mills, S. (2004). *Discourse: The new critical idiom* (2nd ed.). New York, NY: Routledge.

Ministry for Seniors and Accessibility. (2017). *Aging with confidence: Ontario's action plan for seniors*. Ontario Newsroom: Archived Backgrounder. Retrieved from https://news.ontario.ca/oss/en/2017/11/aging-with-confidence-ontarios-action-plan-for-seniors.html

Minkler, M. & Fadem, P. (2002). "Successful ageing": A disability perspective. *Journal of Disability Policy Studies, 12*(4), 229-235.

Misra, J., & Akins, F. (1998). The welfare state and women: Structure, agency, and diversity. *Social Politics: International Studies in Gender, State & Society*, *5*(3), 259-285.

Mitchell, G. W. (2014). The silver tsunami. *Physician Executive*, *40*(4), 34-38.

Moen, P. (1996). A life course perspective on retirement, gender, and well-being. *Journal of Occupational Health Psychology, 1*(2), 131-144.

Moen, P., Robison, J., & Fields, V. (1994). Women's work and caregiving roles: A life course approach. *Journal of Gerontology*, *49*(4), S176-S186.

Montross, L. P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., … & Jeste, D.V. (2006). Correlates of self-rated successful aging among community-dwelling older adults. *The American Journal of Geriatric Psychiatry, 14*(1), 43-51.

Morris, S. P., Fawcett, G., Brisebois, L., & Hughes, J. (2018). *A demographic, employment and income profile of Canadians with disabilities aged 15 years and over, 2017*. Statistics Canada. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-654-x/89-654-x2018002-eng.pdf?st=eLvSil6m

Morse, J. M. (2004). Preparing and evaluating qualitative research proposals. In C. Seale, G.

Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative research practice* (pp. 493-503). Thousand Oaks, CA: SAGE Publications Ltd.

Morse, J. M. & Field, P. A. (1996). *Nursing research: The application of qualitative approaches* (2nd ed.). Cheltenham, UK: Nelson Thornes Ltd.

Moschis, G. P. (2007). Life course perspectives on consumer behavior. *Journal of the Academy of Marketing Science, 35*(2), 295-307.

Mosco, V., McKercher, C., & Stevens, A. (2008). Convergences: Elements of a feminist political economy of labor and communication. In K. Sarikakis & L. R. Shade (Eds.), *Feminist interventions in international communication: Minding the gap* (pp. 207-223). Maryland, MD: Rowman & Littlefield Publishers, Inc.

Moss, N. E. (2002). Gender equity and socioeconomic inequality: A framework for the patterning of women's health. *Social Science & Medicine, 54*(5), 649-661.

Motta, M., Bennati, E., Ferlito, L., Malaguarnera, M., Motta, L., & Italian Multicenter Study on Centenarians (IMUSCE). (2005). Successful aging in centenarians: Myths and reality. *Archives of Gerontology and Geriatrics*, *40*(3), 241-251.

Mulhall, A. (2003). In the field notes: Notes on observation in qualitative research. *Journal of Advanced Nursing, 41*(3), 306-313.

Mulvany, J. (2000). Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health & Illness, 22*(5), 582-601.

Narayan, K. (1993). How native is a "native" anthropologist? *American Anthropologist, 95*(3), 671-686.

National Seniors Council. (2014). *Report on the social isolation of seniors 2013-2014*. Retrieved

from https://www.canada.ca/content/dam/nsc-cna/documents/pdf/policy-and-program-development/publications-reports/2014/Report_on_the_Social_Isolation_of_Seniors.pdf

National Seniors Council. (2017). *Who's at risk and what can be done about it? A review of the literature on the social isolation of different groups of seniors*. Retrieved from http://www12.esdc.gc.ca/ sgpe-pmps/servlet/sgpp-pmps-pub?lang=eng&curjsp=p.5bd.2t.1.3ls@-eng.jsp&curactn=dwnld&pid=55890&did=4970

Navarro, V. (1999). The political economy of the welfare state in developed capitalist countries. *International Journal of Health Services, 29*(1), 1-50.

Navarro, V. (2007). Neoliberalism as a class ideology; or, the political causes of the growth of inequalities. *International Journal of Health Services*, *37*(1), 47-62.

Nelson, T. D. (Ed.). (2002). *Ageism: Stereotyping and prejudice against older persons.* Cambridge, MA: MIT Press.

Nelson, T. D. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61*(2), 207-221.

Nelson, T. D. (2011). Ageism: The strange case of prejudice against the older you. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 37-48). New York, NY: Springer.

Newall, N. E., & Menec, V. H. (2019). Loneliness and social isolation of older adults: Why it is important to examine these social aspects together. *Journal of Social and Personal Relationships*, *36*(3), 925-939.

Ng, S. H. (2002). Will families support their elders? Answers from across cultures. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 129-162). Cambridge, MA: MIT Press.

Ng, T. P., Broekman, B. F., Niti, M., Gwee, X., & Kua, E. H. (2009). Determinants of successful aging using a multidimensional definition among Chinese elderly in Singapore. *The American Journal of Geriatric Psychiatry*, *17*(5), 407-416.

Nordenmark, M. (2004). Does gender ideology explain differences between countries regarding the involvement of women and of men in paid and unpaid work? *International Journal of Social Welfare, 13*(3), 233-243.

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology, 11*(4), 327-344.

Nussbaum, J. F., Pitts, M. J., Huber, F. N., Krieger, J. L. R., & Ohs, J. E. (2005). Ageism and ageist language across the life span: Intimate relationships and non-intimate interactions. *Journal of Social Issues, 61*(2), 287-305.

O'Connor, J. S., Orloff, A. S., & Shaver, S. (1999). *States, markets, families: Gender, liberalism, and social policy in Australia, Canada, Great Britain and the United States.* New York, NY: Cambridge University Press.

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability & Society*, *28*(7), 1024-1026.

Ontario Home Care Association. (2007). *Creating an age-friendly Ontario: OHCA position statement.* Retrieved from https://www.homecareontario.ca/docs/default-source/position-papers/aging-at-home-final.pdf?sfvrsn=4

Ontario Human Rights Commission. (2001). *Time for action: Advancing human rights for older Ontarians*. Toronto, ON. Retrieved from http://www.ohrc.on.ca/sites/default/files/attachments/Time_for_action%3A_Advancing_human_rights_for_older_Ontarians.pdf

Ontario Ministry of Finance. (2017). *Population counts: Age and gender.* 2016 Census

Highlights: Fact Sheet 3. Retrieved from http://www.fin.gov.on.ca/en/economy/demographics/census/ cenhi16-3.pdf

Ontario Ministry of Finance. (2019). *Ontario population projections, 2018-2046*. Toronto, ON: Queen's Printer for Ontario. Retrieved from https://www.fin.gov.on.ca/en/economy/demographics/projections/projections2018-2046.pdf

Ontario Provincial Government. (2013). *Independence, activity and good health: Ontario's action plan for seniors.* Toronto, ON: Queen's Printer for Ontario. Retrieved from https://www.homecareontario.ca/docs/default-source/publications-mo/ontarioseniorsactionplan-en.pdf?sfvrsn=10

Ontario Provincial Government. (2017). *Aging with confidence: Ontario's action plan for seniors*. Toronto, ON. Retrieved from https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf

Onwuegbuzie, A. J., & Leech, N. L. (2007). A call for qualitative power analyses. *Quality & Quantity*, *41*(1), 105-121.

Onwuegbuzie, A. J., & Leech, N. L. (2007). Validity and qualitative research: An oxymoron? *Quality and Quantity, 41*(2), 233-249.

Oppong, S. H. (2013). The problem of sampling in qualitative research. *Asian Journal of Management Sciences and Education, 2*(2), 202-210.

Ortbals, C. D., & Rincker, M. E. (2009). Fieldwork, identities, and intersectionality: Negotiating gender, race, class, religion, nationality, and age in the research field abroad: Editors' introduction. *PS: Political Science & Politics, 42*(2), 287-290.

Ory, M., Hoffman, M. K., Hawkins, M., Sanner, B., & Mockenhaupt, R. (2003). Challenging aging stereotypes: Strategies for creating a more active society. *American Journal Of*

*Preventive Medicine*, *25*(3), 164-171.

Overall, C. (2006). Old age and ageism, impairment and ableism: Exploring the conception and material connections. *NWSA Journal, 18*(1), 126-137.

Pahor, M., Domajnko, B., & Hlebec, V. (2006). Double vulnerability: Older women and health in Slovenia. In G. M. Backes, V. Lasch, & Reimann, K. (Eds.), *Gender, health and ageing: European perspectives on life course, health issues and social challenges* (pp. 157-174). Wiesbaden: VS Verlag für Sozialwissenschaften.

Pal, G. C. (2011). Disability, intersectionality and deprivation: An excluded agenda. *Psychology and Developing Societies, 23*(2), 159-176.

Palaganas, E. C., Sanchez, M. C., Molintas, M., Visitacion, P., & Caricativo, R. D. (2017). Reflexivity in qualitative research: A journey of learning. *The Qualitative Report, 22*(2), 426-438.

Pasupathi, M. & Löckenhoff, C. E. (2002). Ageist behavior. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 201-246). Cambridge, MA: MIT Press.

Pecchioni, L. L., Ota, H., & Sparks, L. (2008). Cultural issues in communication and aging. In J. F. Nussbaum & J. Coupland (Eds.), *Handbook of communication and aging research* (2nd ed.) (pp. 167-214). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Perkins, M. M. (2014). Resilience in later life: Emerging trends and future directions. *The Gerontologist, 54*(1), 138-142.

Peterson, N. M., & Martin, P. (2015). Tracing the origins of success: Implications for successful aging. *The Gerontologist, 55*(1), 5-13.

Phelan, E. A., Anderson, L. A., LaCroix, A. Z., & Larson, E. B. (2004). Older adults' views of

"successful aging" —How do they compare with researchers' definitions? *Journal of American Geriatrics Society, 52*(2), 211-216.

Phillips, S. P. (2005). Defining and measuring gender: A social determinant of health whose time has come. *International Journal for Equity in Health, 4*(1), 11.

Plath, D. (2008). Independence in old age: The route to social exclusion? *British Journal of Social Work, 38*(7), 1353-1369.

Plath, D. (2009). International policy perspectives on independence in old age. *Journal of Aging & Social Policy*, *21*(2), 209-223.

Poland, B., Coburn, D., Robertson, A., Eakin, J., & members of the Critical Social Science Group. (1998). Wealth, equity and health care: A critique of a "population health" perspective on the determinants of health. *Social Science and Medicine, 46*(7), 785-798.

Popay, J., Williams, G., Thomas, C., & Gatrell, T. (1998). Theorising inequalities in health: The place of lay knowledge. *Sociology of Health & Illness, 20*(5), 619-44.

Pope, C., & Mays, N. (1995). Reaching the parts other methods cannot reach: An introduction to qualitative methods in health and health services research. *BMJ: British Medical Journal*, *311*(6996), 42-45.

Powell, J. L. (2006). *Social theory and aging.* Maryland: Rowman & Littlefield Publishers, Inc.

Powell, R. R. (2004). *Basic research methods for librarians* (3rd ed.). Greenwich, CT: Ablex Publishing Corporation.

Powers, B. A. (1995). From the inside out: The world of the institutionalized elderly. In J. N. Henderson & M. D. Vesperi (Eds.), *The culture of long term care: Nursing home ethnography* (pp. 179-196). Westport, CT: Bergin & Garvey.

Powers, L. E. (2007). Stakeholder involvement in intervention, research, and evaluation. In M. Putnam (Ed.), *Aging and disability: Crossing network lines* (pp. 203-224). New York, NY: Springer Publishing Company, LLC.

Priestley, M. (2000). Adults only: Disability, social policy and the life course. *Journal of Social Policy, 29*(3), 421-439.

Priestley, M. (2003). *Disability: A life course approach.* Cambridge, UK: Polity Press.

Primeau, L. A. (2003). Reflections on self in qualitative research: Stories of family. *American Journal of Occupational Therapy, 57*(1), 9-16.

Pruchno, R. (2015). Successful aging: Contentious past, productive future. *The Gerontologist, 55*(1), 1-4.

Pruchno, R. A., Wilson-Genderson, M., & Cartwright, F. (2010). A two-factor model of successful aging. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *65*(6), 671-679.

Putnam, M. (2002). Linking aging theory and disability models: Increasing the potential to explore aging with physical impairment. *The Gerontologist, 42*(6), 799−806.

Putnam, M. (2015). Replacing the elderly with older adults in JGSW publications. *Journal of Gerontological Social Work*, *58*(3), 229–231.

Raphael, D. (1998). Public health responses to health inequalities. *Canadian Journal of Public Health, 89*, 380-81.

Raphael, D. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy, 88*(2-3), 222-235.

Raphael, D. (2009). Social determinants of health: An overview of key issues and themes. In D. Raphael (Ed.), *Social determinants of health* (2nd ed.) (2-19). Toronto, ON:

Canadian Scholars' Press Inc.

Raphael, D. (2009). Social structure, living conditions and health. In D. Raphael (Ed.), *Social determinants of health* (2nd ed.) (19-36). Toronto, ON: Canadian Scholars' Press Inc.

Raphael, D. (2010). Social determinants of health: An overview of concepts and issues. In T. Bryant, D. Raphael & M. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness, and health care* (2nd ed.) (pp. 145-179). Toronto, ON: Canadian Scholars' Press Inc.

Raphael, D. (2010). The health of Canada's children. Part 1: Canadian children's health in comparative perspective. *Pediatric Child Health, 15*(1), 23-29.

Raphael, D. (2012). Critical perspectives on the social determinants of health. In E. McGibbon (Ed.), *Oppression as a determinant of health*. Halifax, NS: Fernwood Publishers.

Raymond, E. (2019). The challenge of inclusion for older people with impairments: Insights from a stigma-based analysis. *Journal of Aging Studies, 49*, 9-15.

Reed, R. K. (2005). *Birthing fathers: The transformation of men in American rites of birth*. Piscataway, NJ: Rutgers University Press.

Regmi, K., Naidoo, J., & Pilkington, P. (2010). Understanding the process of translation and transliteration in qualitative research. *International Journal of Qualitative Methods, 9*(1), 16-26.

Reindal, S. M. (1999). Independence, dependence, interdependence: Some reflections on the subject and personal autonomy. *Disability & Society, 14*(3), 353-367.

Richardson, D. (2005). Desiring sameness? The rise of neoliberal politics of normalisation. *Antipode, 37*(3), 515-535.

Rioux, M., & Daly, T. (2010). Constructing disability and illness. In T. Bryant, D. Raphael & M. Rioux (Eds.), *Staying alive: Critical perspectives on health, illness, and health care* (2nd ed.) (pp. 347-370). Toronto, ON: Canadian Scholars' Press Inc.

Ritchie, J., Lewis, J., Elam, G., Tennant, R., & Rahmin, N. (2014). Designing and selecting samples. In J. Ritchie, J. Lewis, C. McNaughton Nicholls, & R. Ormston (Eds.), *Research practice: A guide for social science students & researchers* (2nd ed.). (pp. 111-146). Thousand Oaks, CA: SAGE Publications Inc.

Robb, C., Chen, H., & Haley, W. E. (2002). Ageism in mental health and health care: A critical review. *Journal of Clinical Geropsychology, 8*(1), 1-12.

Robertson, A. (1997). Beyond apocalyptic demography: Towards a moral economy of interdependence. *Ageing & Society*, *17*(4), 425-446.

Robison, J. T., & Moen, P. (2000). A life-course perspective on housing expectations and shifts in late midlife. *Research on Aging*, *22*(5), 499-532.

Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, *53*(3), 304-310.

Romo, R. D., Wallhagen, M. I., Yourman, L., Yeung, C. C., Eng, C., Micco, G., ... & Smith, A. K. (2013). Perceptions of successful aging among diverse elders with late-life disability. *The Gerontologist*, *53*(6), 939-949.

Rosenthal, C. (1997). The changing contexts of family care in Canada. *Ageing International, 24*(1), 13-31.

Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful. *Science*, *237*(4811), 143-149.

Rowe, J. W. & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*(4), 433-440.

Rowe, J. W. & Kahn, R. L. (1998). *Successful aging.* New York, NY: Pantheon Books/Random House.

Rowe, J. W., & Kahn, R. L. (2015). Successful aging 2.0: Conceptual expansions for the 21st century. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 70(*4), 593-596.

Rubinstein, R. L., & de Medeiros, K. (2015). "Successful aging," gerontological theory and neoliberalism: A qualitative critique. *The Gerontologist, 55*(1), 34-42.

Sangasubana, N. (2011). How to conduct ethnographic research. *The Qualitative Report, 16*(2), 567-573.

Sargent-Cox, K. A., Butterworth, P., & Anstey, K. J. (2015). Role of physical activity in the relationship between mastery and functional health. *The Gerontologist, 55*(1), 120-131.

Scambler, G. (2007). Social structure and the production, reproduction and durability of health inequalities. *Social Theory & Health, 5*(4), 297.

Scambler, G., & Higgs, P. (1999). Stratification, class and health: Class relations and health inequalities in high modernity. *Sociology, 22*(2), 275-96.

Schneider, E. L., & Guralnik, J. M. (1990). The aging of America: Impact on health care costs. *The Journal of the American Medical Association, 263*(17), 2335-2340.

Schwab, S. J., & Glissman, G. (2011). Age and disability within the scope of American discrimination law. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 145-156). New York, NY: Springer.

Seeley, M. (2012). Women, aging and residential long-term care. In P. Armstrong, B. Clow & K. Grant (Eds.), *Thinking women and health care reform in Canada* (pp. 107-138). Toronto, ON: Women's Press Inc.

Selmi, M. (2011). The stigma of disabilities and Americans with disabilities. In R. L. Wiener & S. L. Willborn (Eds.), *Disability and aging discrimination* (pp. 123-144). New York, NY: Springer.

Sen, G., & Östiln, P. (2009). Gender as a social determinant of health: Evidence, policies, and innovations. In G. Sen & P. Östiln (Eds.), *Gender equity in health: The shifting frontiers of evidence and action* (pp. 1-46). New York, NY: Routledge.

Settersten, R. A. (2003). Propositions and controversies in life-course scholarship. In R. A. Settersten (Ed.), *Invitation to the life course: Toward new understandings of later life* (pp. 15–45). Amityville, NY: Baywood Publishing.

Sewell Jr, W. H. (1992). A theory of structure: Duality, agency, and transformation. *American Journal of Sociology, 98*(1), 1-29.

Shakespeare, T. (2006). The social model of disability. In L. Davis (Ed.), *The disability studies reader* (pp. 197-204). New York, NY: Routledge.

Sharpe, P. A. (1995). Older women and health services: Moving from ageism toward empowerment. *Women & Health, 22*(3), 9-23.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology, 7*(3), 233-243.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63-75.

Sidanius, J., & Pratto, F. (1999). *Social dominance.* Cambridge, UK: Cambridge University Press.

Simon, R. I., & Dippo, D. (1986). On critical ethnographic work. *Anthropology & Education Quarterly*, *17*(4), 195-202.

Sinha, M. (2013). *Analytical paper: Portrait of caregivers.* (Catalogue No. 89-652-X — No. 001). Retrieved from https://www150.statcan.gc.ca/pub/89-652-x/89-652-x2013001-eng.pdf. Accessed 14 January 2020.

Sinha, S. K. (2012). *Living Longer, Living Well. Report: Ontario's Seniors Strategy.* Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/ seniors_strategy/ docs/seniors_strategy_report.pdf

Sinha, S. K., Griffin, B., Ringer, T., Reppas-Rindlisbacher, C., Stewart, E., Wong, I. … Anderson, G. (2016). *An evidence-informed national seniors strategy for Canada* (2nd ed.). Toronto, ON: Alliance for a National Seniors Strategy. Retrieved from http://nationalseniorsstrategy.ca/wp-content/uploads/2016/10/National-Seniors-Strategy-Second-Edition.pdf

Sloan, J. (2009). *A bitter pill: How the medical system is failing the elderly.* Vancouver, BC: Greystone Books.

Smith, D. (1987). *The everyday world as problematic: A feminist sociology.* Toronto, ON: University of Toronto Press.

Smith, J. A., Braunack-Mayer, A., Wittert, G., & Warin, M. (2007). "I've been independent for so damn long!": Independence, masculinity and aging in a help seeking context. *Journal of Aging Studies*, *21*(4), 325-335.

Smith, S. (2016). Intimacy and angst in the field. *Gender, Place & Culture, 23*(1), 134-146.

Sofaer, S. (1999). Qualitative methods: What are they and why use them? *HSR: Health Services Research, 34*(5_Part_2), 1101-1118.

Songur, W. (2019). Older migrants' use of elderly care in Sweden: Family affects choice

between home help services and special housing. *European Journal of Social Work*, 1-11. doi: https://doi.org/10.1080/13691457.2019.1639628

Sousa, I. (2013). *New technologies and concepts of care.* In P. Armstrong & S. Braedley (Eds.), *Troubling care: Critical perspectives on research and practices* (pp. 129-142). Toronto, ON: Canadian Scholars' Press Inc.

Special Senate Committee on Aging. (2009). *Canada's aging population: Seizing the opportunity.* Retrieved from http://www.parl.gc.ca/40/2/parlbus/commbus/senate/ com-e/agei-e/rep-e/AgingFinalReport-e.pdf

Stake, R. E. (1995). *The art of case study research.* Thousand Oaks, CA: SAGE Publications, Inc.

Statistics Canada. (2016). *Women in Canada: A gender-based statistical report. Senior women.* (Catalogue No. 89-503-X). Retrieved from https://www150.statcan.gc.ca/pub/89-503-x/2015001/article/14316-eng.pdf. Accessed 10 January 2020.

Statistics Canada. (2017). *A portrait of the population aged 85 and older in 2016 in Canada.* (Catalogue No. 98-200-X2016004). Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016004/98-200-x2016004-eng.pdf. Accessed 25 January 2020.

Statistics Canada. (2017). *Census in brief. A portrait of the population aged 85 and older in 2016 in Canada.* (Catalogue No. 98-200-X2016004). Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/98-200-x/2016004/98-200-x2016004-eng.pdf. Accessed 11 November 2019.

Statistics Canada. (2019). *Annual demographic estimates: Canada, provinces and territories*

*2018*. (Catalogue No. 91-215-X). Retrieved from https://www150.statcan.gc.ca/n1/en/pub/91-215-x/91-215-x2018002-eng.pdf?st=mwocDMOw. Accessed 17 April 2020.

Stowe, J. D., & Cooney, T. M. (2015). Examining Rowe and Kahn's concept of successful aging: Importance of taking a life course perspective. *The Gerontologist*, *55*(1), 43-50.

Strawbridge, W. J., Wallhagen, M. I., & Cohen, R. D. (2002). Successful aging and well-being self-rated compared with Rowe and Kahn. *The Gerontologist*, *42*(6), 727-733.

Suzman, R. M., Manton, K. G., & Willis, D. P. (1992). Introducing the Oldest Old. In R. M. Suzman, D. P. Willis & K. G. Manton (Eds.), *The oldest old* (pp. 3-16). New York, NY: Oxford University Press, Inc.

Swanson, R. A. (2005). The process of framing research in organizations. In R. A. Swanson & E. F. Holton III (Eds.), *Research in organizations: Foundations and methods of inquiry* (pp. 11-26). San Francisco, CA: Berrett-Koehler Publishers, Inc.

Svanborg, A. (2001). Biomedical perspectives on productive aging. In N. Morrow-Howell, J. Hinterlong, & M. Sherraden (Eds.). *Productive aging: Concepts and challenges* (pp. 81-101). Baltimore, MD: The Johns Hopkins University Press.

Tarlov, A. (2000). Coburn's thesis: Plausible, but we need more evidence and better measures. *Social Science & Medicine, 51*(7), 993-995.

Taylor, B. A., & Bengtson, V. L. Sociological perspectives on productive aging. In N. Morrow-Howell, J. Hinterlong, & M. Sherraden (Eds.). *Productive aging: Concepts and challenges* (pp. 120-144). Baltimore, MD: The Johns Hopkins University Press.

Taylor, J. (2011). The intimate insider: Negotiating the ethics of friendship when doing insider research. *Qualitative Research, 11*(1), 3-22.

Tesch-Römer, C., & Wahl, H. (2017). Toward a more comprehensive concept of successful aging: Disability and care needs. *Journals of Gerontology: Social Sciences, 72*(1), 310-318.

Thomas, C. (2006). Disability and gender: Reflections on theory and research. *Scandinavian Journal of Disability Research, 8*(2-3), 177-185.

Thomas, J. (1993). *Doing critical ethnography.* Newbury Park, CA: SAGE Publications, Inc.

Thomas, W. H., & Blanchard, J. M. (2009). Moving beyond place: Aging in community. *Generations, 33*(2), 12–17.

Tong, R. (2009). *Feminist through: A more comprehensive introduction*. Boulder, CO: Westview Press.

Torjman, S. (2018). *Policy innovations for an aging society.* Retrieved from https://maytree.com/wp-content/uploads/Policy-Innovations-for-an-Aging-Society.pdf. Accessed 14 January 2020.

Townsend, P. (2006). Policies for the aged in the 21st century: More 'structured dependency' or the realisation of human rights? *Ageing & Society, 26*(2), 161-179.

Trepal, H., Stinchfield, T., & Haiyasoso, M. (2014). Great expectations: Doctoral student mothers in counselor education. *Adultspan Journal, 13*(1), 30-45.

Uhlenberg, P. (1996). Mutual attraction: Demography and life-course analysis. *The Gerontologist*, *36*(2), 226-229.

Vaismoradi, M., Jones, J., Turenen, H., & Snelgrove, S. (2016). Theme development in qualitative content analysis and thematic analysis. *Journal of Nursing Education and Practice, 6*(5), 100-110.

Van Gaalen, R. I., & Dykstra, P. A. (2006). Solidarity and conflict between adult children and

parents: A latent class analysis. *Journal of Marriage and Family, 68*(4), 947-960.

Van Wagenen, A., Driskell, J., & Bradford, J. (2013). "I'm still raring to go": Successful aging among lesbian, gay, bisexual, and transgender older adults. *Journal of Aging Studies, 27*(1), 1-14.

Verbrugge, L., M. & Yang, L. (2002). Aging with disability and disability with aging. *Journal of Disability Policy Studies, 12*(4), 253-267.

Vesperi, M. D. (1995). Nursing home research comes of age: Toward an ethnological perspective on long term care. In J. N. Henderson & M. D. Vesperi (Eds.), *The culture of long term care: Nursing home ethnography* (pp. 7-22). Westport, CT: Bergin & Garvey.

Victor, C., Westerhof, G. J., & Bond, J. (2007). Researching ageing. In J. Bond, S. Peace, F. Dittmann-Kohli, & G. Westerhof (Eds.), *Ageing in society* (pp. 85-112). Thousand Oaks, CA: SAGE Publications Ltd.

Von Faber, M., Bootsma–van der Wiel, A., van Exel, E., Gussekloo, J., Lagaay, A. M., van Dongen, E., ... & Westendorp, R. G. (2001). Successful aging in the oldest old: Who can be characterized as successfully aged? *Archives of Internal Medicine*, *161*(22), 2694-2700.

Walker, A., & Maltby, T. (2012). Active ageing: A strategic policy solution to demographic ageing in the European Union. *International Journal of Social Welfare*, *21*(S1), S117-S130.

Ward, K., & Wolf-Wendel, L. (2004). Academic motherhood: Managing complex roles in research universities. *The Review of Higher Education, 27*(2), 233-257.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods.* Thousand Oaks, CA; SAGE Publications Inc.

Werner, M., Strauss, K., Parker, B., Orzeck, R., Derickson, K., & Bonds, A. (2017). Feminist political economy in geography: Why now, what is different, and what for? *Geoforum, 79*, 1-4.

Western, M., Baxter, J., Pakulski, J., Tranter, B., Western J., Van Egmond, M., ... & Van Gellecum, Y. (2007). Neoliberalism, inequality and politics: The changing face of Australia. *Australian Journal of Social Issues, 42*(3), 401-418.

Wharton, A. S. (1991). Structure and agency in socialist-feminist theory. *Gender & Society*, *5*(3), 373-389.

White, A. M., & Groves, M. A. (1997). Interdependence and the aged stereotype. *Australian Journal on Ageing*, *16*(2), 83-89.

White, J., Drew, S., & Hay, T. (2009). Ethnography versus case study: Positioning research and researchers. *Qualitative Research Journal*, *9*(1), 18-27.

Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing Standard*, *22*(23), 35-40.

Wiles, J. L., & Jayasinha, R. (2013). Care for place: The contributions older people make to their communities. *Journal of Aging Studies*, *27*(2), 93-101.

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. (2012). The meaning of "aging in place" to older people. *The Gerontologist*, *52*(3), 357-366.

Willis, J. W. (2007). *Foundations of qualitative research: Interpretive and critical approaches.* Thousand Oaks, CA: SAGE Publications, Inc.

Wilkinson, J. A., & Ferraro, K. R. (2002). Thirty years of ageism research. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 339-358). Cambridge, MA: MIT Press.

Wilkinson, R. G. (1997). Health inequalities: Relative or absolute materials standards? *British Medical Journal, 314*, 591-595.

Wilkinson, R. G. (2000). Deeper than neoliberalism. A reply to David Coburn. *Social Science & Medicine, 51*(7), 997-1000.

Wilkinson, R. G. (2005). *The impact of inequality: How to make sick societies healthier.* New York, NY: The New Press.

Wiltshier, F. (2011, January). Researching with NVivo. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* (Vol. 12, No. 1).

Wolcott, H. F. (1999). *Ethnography: A way of seeing.* Lanham, MD: AltaMira Press.

Wong, P. T. (1989). Personal meaning and successful aging. *Canadian Psychology/Psychologie Canadienne*, *30*(3), 516-525.

World Health Organization. (2007). *Global age-friendly cities: A guide.* Retrieved from https://www.who.int/ageing/publications/Global_age_friendly_cities_Guide_English.pdf

World Health Organization. (2011). *Social determinants approaches to public health: From concept to practice*. Retrieved from http://whqlibdoc.who.int/publications/2011/ 9789241564137_eng.pdf

World Health Organization. (2017). *Global strategy and action plan on ageing and health.* Retrieved from https://www.who.int/ageing/WHO-GSAP-2017.pdf?ua=1

World Health Organization. (2018). *WHO housing and health guidelines.* Retrieved from http://apps.who.int/iris/bitstream/handle/10665/276001/9789241550376-eng.pdf?ua=1

World Health Organization. (2019). *Membership in the global network of age-friendly cities and communities (GNAFCC)*. Retrieved from https://www.who.int/ageing/age-friendly-environments/GNAFCC-membership-en.pdf?ua=1

Wright, S. D., & Lund, D. A. (2000). Gray and green?: Stewardship and sustainability in an aging society. *Journal of Aging Studies*, *14*(3), 229-249.

Yakerson, A. (2019). Home care in Ontario: Perspectives on equity. *International Journal of Health Services, 49*(2), 260-272.

Yazan, B. (2015). Three approaches to case study methods in education: Yin, Merriam, and Stake. *The Qualitative Report*, *20*(2), 134-152.

Yin, R. K. (2009). *Case study research: Design and methods* (4th ed.). Thousand Oaks, CA: SAGE Publications, Inc.

Young, I. (1990). *Justice and the politics of difference*. Princeton, NJ: Princeton University Press.

Ziegler, F. (2012). “You have to engage with life, or life will go away”: An intersectional life course analysis of older women’s social participation in a disadvantaged urban area. *Geoforum, 43*(6), 1296-1305.

Appendices

## Appendix A: Demographics Survey

**1. How old are you?**
16 years to 19 years
20 years to 24 years
25 years to 34 years
35 years to 44 years
45 years to 54 years
55 years to 64 years
65 years to 74 years
75 years to 84 years
85 years to 94 years
95 years and over

**2. Marital status:**
Single – never married
Married (legal and common law)
Separated
Widowed
Divorced
Other – specify: ______________________________

**3. What is your gender?**
Male
Female
Other – specify: ______________________________

**4. Do you have children?**
Yes
No
Other – specify: ____________________________

**5. Do you have grandchildren?**
Yes
No
Other – specify: ____________________________

**6. Were you born in Canada?**
Yes - Skip to Question 10
No
Don't know
Refused

**7. What country were you born in?**
Specify: ______________________________
Refused

**8. How old were you when you came to Canada?**
Specify: ______________________________
Refused
Don't know

**9. Are you a …. [Check one]**
Canadian Citizen
Landed Immigrant
Convention refugee
Temporary status
Other – specify: ______________________________
Don't know
Refused

**10. With which racial or cultural group do you most identify? [Check all that apply]**
White, Caucasian
Black, African-Canadian
Black, Caribbean-Canadian
First Nations/Aboriginal (e.g. Cree, Micmac, Métis or Inuit)
East Asian (Chinese, Japanese, Korean, Taiwanese, Mongolian, Pacific Islander, etc.
South Asian (Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)
Southeast Asian (Cambodian, Filipino, Vietnamese, etc.)
West Asian (Persian, Arab, Afghan, Iranian, Iraqi, Turkish, etc.)
Hispanic, Latin American
Other – Specify: ____________________________________________
Don't know
Refused

**11. What is your religious affiliation, if any?**
Buddhist
Christian
- Anglican
- Baptist
- Catholic
- Christian Orthodox
- Lutheran
- Pentecostal
- Presbyterian
- United Church
- Other Christian

Hindu
Jewish

Muslim
Sikh
Traditional (Aboriginal) Spirituality
No religious affiliation
Other – Specify: ____________________________________________
Don't know
Refused

**12. Which of the following best describes your current living arrangement?**
Living with a partner or spouse
Living alone
Living with children or grandchildren
Living with other relatives
Living with non-relatives
Other– specify: ___________________________________

**13. Is your living arrangement (check those that apply):**
Satisfactory
Unsatisfactory
Adequate to your needs
Inadequate to your needs
Other– specify: ___________________________________

**14. Do you have any health conditions that are of concern?**
Yes
No
Refused
Don't know
Other– specify: ___________________________________

**15. Do you consider yourself to have a disability or chronic illness?**
Yes
No
Refused
Don't know
Other– specify: ___________________________________

**16. If you consider yourself to have a disability or chronic illness, in which of the following areas do you have difficulties (check all that apply):**
Sensory (hearing, vision/sight, smell, etc.)
Mobility (walking, bodily movement or pain, etc.)
Intellectual (memory, thought, etc.)
Refused
Don't know
Not applicable
Other– specify: ___________________________________

## Appendix B1: Interview Protocol (semi-structured) for older adults

*Script*

Hello! It's a pleasure to meet you. Let me start by thanking you for your participation today. My name is Vishaya and I'm a graduate student from York University, conducting a study about aging experiences in later life. Mainly, I would like to learn more about factors important to aging in the community. Before we start the interview, I'd like to ask you to please read and sign this informed consent form, which outlines more detailed information about your participation in this study. If you prefer, I would also be happy to read the form aloud to you. Please let me know if you have any questions before you sign it.

Before we begin the interview, know that you are free to answer with as little or as much detail as you are comfortable with providing. I would like your permission to tape record this interview, so that I can more accurately document our conversation today. Know that your responses will be kept completely confidential. At the end of the interview, I will ask you to complete a brief written survey, used only for the purposes of my research analysis. The total time commitment asked of you today is approximately one hour. If at any time you would like to stop or take a break, please let me know. Do you have any questions for me before we begin the interview?

**GENERAL QUESTIONS:**

→ Can you tell me a little bit about yourself?
(**Prompts**: Perhaps you could talk about your interests? How do you generally spend your time in a given week (e.g. volunteering, participating in community events and programs, with family, etc.)?)

→ How would you describe your current living situation?
(**Prompts**: For instance, where do you live? Do you live alone or with another person or persons? How long have you lived there?)

→ How do you feel about your current living situation?
(**Prompts**: Do you feel that your needs are being met where you are living? Are there things you would change if you could?)

**QUESTIONS ABOUT LIFE SATISFACTION:**

→ Can you describe how your age currently affects your life satisfaction, if at all?
(**Prompts:** What makes you happy or sad at this stage of life? In what ways do you feel differently at this age than in your younger years?)

→ Are there things that have become more or less important to you at this particular stage in your life, compared to earlier parts of your life?
(**Prompts:** Have you found that your priorities have changed as you've aged? Do you spend your time doing different things than when you were younger? Have your interests changed or stayed the same?)

→In what ways does your current financial situation affect your life satisfaction, if at all?

(**Prompts:** Is money a source of stress, or does it reduce stress, in your life? How, if at all, has your financial circumstance changed from when you were younger?)

→Do your current relationships with family and/or friends affect your satisfaction in life?
(**Prompts:** Do your relationships with relatives and/or friends make you happy or sad? Are they a cause of stress or do they reduce stress?)

→In what ways does your current state of health affect your daily life satisfaction?
(**Prompts:** How, if at all, has your health changed as you've become older? How do you feel about this?)

→Can you describe what things, if any, have increased or decreased your life satisfaction at this age?
(**Prompt:** Are there things you currently find particularly enjoyable or unenjoyable in your life?)

→Do you find that people treat you differently, or the same, as you've become older?
**(Prompts:** Do people speak to you in a different way? Are different things expected of you? Are you treated differently by acquaintances and people close to you? How are you treated or spoken to by people who are younger than you compared to people who are the same age as you?)

**QUESTIONS ABOUT THE OLDER ADULT CENTRE:**
→What needs do you feel that this centre helps you with?
(**Prompts:** What are some of the reasons you visit this centre? To socialize with others? For information? Through encouragement from people in your life?)

→Can you describe a typical visit to the centre?
(**Prompts:** What do you do when you are here? How did you feel about it? How long is each visit? Do you attend by yourself or with other people?)

→How important has your participation in the programs and activities at this centre been to your level of life satisfaction?
(**Prompts:** How has spending time at the centre been helpful or unhelpful to you? In what ways has it had a positive or negative impact on your life?)

→What activities do you participate in at the centre?

- Can you describe them?
- Why did you choose those particular programs?

→ Can you describe how accessibility needs are handled at this facility?
(**Prompt**: How are any needs or special preferences that you might have, accommodated here?)

**QUESTIONS ABOUT DISABILITY:**
→What are your experiences with physical challenges or barriers, if any, in your daily life?

→What are your experiences with emotional/mental challenges, if any, in your daily life?

→ How do you feel about any physical or emotional/mental challenges you are currently facing? (**Prompts:** Have you found any new challenges in your later life to be difficult or easy to adapt to? Have any of these challenges helped or stopped you from doing certain things?)

→ Can you think of ways that any daily challenges you face could be better accommodated? (**Prompt:** In other words, are there ways that any difficulties you experience in your life could be made easier for you?)

→ When you hear the phrase, "successful aging", what does that mean to you?

→ There are a number of sources that claim, acquiring some form of disability in later life is an important factor in preventing older people from aging successfully. What is your opinion of this?
(**Prompt:** In other words, in your opinion, is disability in old age – whether it be a loss of sense (eyesight, hearing, smell, etc.), mobility, or mental function – a good measure of whether a person is aging successfully or not?)

**QUESTIONS ABOUT SERVICES:**
→ Please describe any current services being offered to seniors in Ontario that you use yourself, or that you are familiar with.

- How do you feel about these services? Are you satisfied or dissatisfied with them?
- When you first wanted to access these services, where did you go to find this information?
- Did you find it easy or difficult to access these services?
- What has been your experience with these services?
- How well do you think these services are meeting your needs at this stage of life?

→ Are there any other services you feel would help to better meet your needs?

**CONCLUSION:**
Thank you for all of the valuable information you've provided today. Are there any questions that you feel I've missed, or anything you'd like to add before we end?

I will leave you with my contact details, should you wish to get in touch with any questions or concerns about the study.

## Appendix B2: Interview Protocol (semi-structured) for staff & volunteers

*Script*

Hello! It's a pleasure to meet you. Let me start by thanking you for your participation today. My name is Vishaya and I'm a graduate student from York University, conducting a study about aging experiences in later life. Mainly, I would like to learn more about factors important to aging in the community. Before we start the interview, I'd like to ask you to please read and sign this informed consent form, which outlines more detailed information about your participation in this study. If you prefer, I would also be happy to read the form aloud to you. Please let me know if you have any questions before you sign it.

Before we begin the interview, know that you are free to answer with as little or as much detail as you are comfortable with providing. I would like your permission to tape record this interview, so that I can more accurately document our conversation today. Know that your responses will be kept completely confidential. At the end of the interview, I will ask you to complete a brief written survey, used only for the purposes of my research analysis. The total time commitment asked of you today is approximately one hour. If at any time you would like to stop or take a break, please let me know. Do you have any questions for me before we begin the interview?

**GENERAL QUESTIONS:**

→ Can you tell me a little bit about yourself?
(**Prompts**: What are your interests? How do you spend your time?)

→ Can you describe your work and responsibilities at this centre?

→ How did you become involved in the work that you do here?
(**Prompts**: How long have you worked here? What drew you to this field of working with seniors?)

**QUESTIONS ABOUT THE OLDER ADULT CENTRE:**

→ In what ways has time spent at a centre like this shaped or changed your views of aging and later life, if at all?
(**Prompts**: In other words, after having worked here, do you feel more positively, negatively, or neutral about this life stage?)

→ Can you describe the activities, services and programs offered at the centre?

→ How would you describe the differences or similarities, if any, in the ways that younger seniors versus older seniors use this centre? By younger seniors, I mean those who are 65 and over, versus those who are over 85.

→ What type of feedback do you receive from younger and older seniors about the programs/activities offered at this centre?

**QUESTIONS ABOUT DISABILITY AND LIFE SATISFACTION:**
→ Can you describe how accessibility needs are handled at this facility?
(**Prompt**: How are older adults with disabilities accommodated for any needs they might have?)

→ When you hear the phrase, "successful aging", what does that mean to you?

→ There are a number of sources that claim, acquiring some form of disability in later life is an important factor in preventing older people from aging successfully. What is your opinion of this?
(**Prompt:** In other words, in your opinion, is disability in old age – whether it be a loss of sense (eyesight, hearing, smell, etc.), mobility, or mental function – a good measure of whether a person is aging successfully or not?)

→ What factors, in your opinion, are important to aging successfully for younger seniors (who are 65 and over) compared to those who are over the age of 85?

→ Have you found the needs of younger and older seniors to be different or similar to each other?

→Can you comment on how seniors might be spoken to or treated by people younger than them, whether it be workers or visitors that they interact with at the centre? How about people their own age?
**(Prompts:** How do younger people interact with older people? How do older people interact with others in their age group?)

**QUESTIONS ABOUT SERVICES:**
→ Are you familiar with any services available to seniors in Ontario?

- How would you describe the effectiveness of these services?
- Have older people suggested to you that it has been easy or difficult for them to access these services?

→ How well do you think current services are meeting the needs of older people, particularly older seniors over the age of 85?

→ Are there any other service needs you can think of that might better accommodate older people, particularly older seniors over the age of 85?

**CONCLUSION:**
Thank you for all of the valuable information you've provided today. Are there any questions that you feel I've missed, or anything you'd like to add before we end?

I will leave you with my contact details, should you wish to get in touch with any questions or concerns about the study.

## Appendix B3: Interview Protocol (semi-structured) for family members & caregivers

*Script*

Hello! It's a pleasure to meet you. Let me start by thanking you for your participation today. My name is Vishaya and I'm a graduate student from York University, conducting a study about aging experiences in later life. Mainly, I would like to learn more about factors important to aging in the community. Before we start the interview, I'd like to ask you to please read and sign this informed consent form, which outlines more detailed information about your participation in this study. If you prefer, I would also be happy to read the form aloud to you. Please let me know if you have any questions before you sign it.

Before we begin the interview, know that you are free to answer with as little or as much detail as you are comfortable with providing. I would like your permission to tape record this interview, so that I can more accurately document our conversation today. Know that your responses will be kept completely confidential. At the end of the interview, I will ask you to complete a brief written survey, used only for the purposes of my research analysis. The total time commitment asked of you today is approximately one hour. If at any time you would like to stop or take a break, please let me know. Do you have any questions for me before we begin the interview?

**GENERAL QUESTIONS:**

→ Can you tell me a little bit about yourself?
(**Prompt**: What are your interests? How do you spend your time?)

→What is your relationship to a member of this centre? How is it that you've come to spend time here?

**QUESTIONS ABOUT THE OLDER ADULT CENTRE:**

→ In what ways has time spent at a centre like this shaped or changed your views of aging and later life, if at all?
(**Prompts**: In other words, do you now feel more positively, negatively, or neutral about this life stage?)

→ How would you describe the activities, services and programs offered at the centre?

→ What type of feedback do you receive from your [relative/client] about the programs/activities offered at this centre?

→ Have you found that the needs of your [relative/client] have changed or stayed the same as they become older?

**QUESTIONS ABOUT DISABILITY AND LIFE SATISFACTION:**

→ How are any accessibility needs of your [relative/client] handled at this facility?
(**Prompt**: In other words, how well are disabilities accommodated for those participating in programs at this centre?)

→ When you hear the phrase, "successful aging", what does that mean to you?

→ There are a number of sources that claim, acquiring some form of disability in later life is an important factor in preventing older people from aging successfully. What is your opinion of this?
(**<u>Prompt</u>:** In other words, in your opinion, is disability in old age – whether it be a loss of sense (eyesight, hearing, smell, etc.), mobility, or mental function – a good measure of whether a person is aging successfully or not?)

→ What factors, in your opinion, are important to aging successfully for younger seniors (who are 65 and over) compared to those who are over the age of 85?

→Can you comment on how your [relative/client] is spoken to or treated by younger people, whether it be other family members, or workers and visitors that they interact with at the centre? How about people their own age?
**(<u>Prompts</u>:** How do younger people interact with older people? How do older people interact with others in their age group?)

**QUESTIONS ABOUT SERVICES:**
→ Please describe any current services being offered to seniors in Ontario that you are familiar with.

- What is your experience in the effectiveness of these services?
- Has your [relative/client] suggested to you that it has been easy or difficult for them to access these services?
- Has your [relative/client] suggested to you that these services are adequate?

→ How well do you think current services are meeting the needs of older people, particularly older seniors over the age of 85?

→ Are there any other service needs you can think of that might better accommodate older people, particularly older seniors over the age of 85?

**CONCLUSION:**
Thank you for all of the valuable information you've provided today. Are there any questions that you feel I've missed, or anything you'd like to add before we end?

I will leave you with my contact details, should you wish to get in touch with any questions or concerns about the study.

## Appendix C: Informed Consent Form

**Study Name:** Aging Interdependently: A Critical Ethnographic Study of Successful Aging and the Oldest Old

**Researcher Name:** Vishaya Naidoo, PhD candidate
**Institution:** York University **Graduate Program:** Health
**E-mail address**: vishayan@yorku.ca **Office Phone:** (905) 717-5884

**Purpose of the research:**
The purpose of this research is to explore the personal aging experiences of older people. More specifically, I am seeking to learn the self-perceived positive and negative elements of what it means to successfully age in the community. This research will be conducted, presented and reported in a respectful manner to all participants involved.

**What you will be asked to do in this study:**
After signing this form of consent, you will be asked to participate in an interview with the researcher. Questions are open-ended, and you are free to answer with as little or as much detail as you are comfortable with providing. At the conclusion of the interview, you will be asked to complete a brief written survey. The total time commitment asked of you in this process is approximately one hour.

**Risks and discomforts:**
Your participation in this study will not involve any foreseen risks or potential discomforts; if it does we can stop and take a break, resuming when you feel comfortable, or we can stop altogether.

**Benefits of the research and benefits to you:**
Your participation in this research may provide a number of benefits, including; an opportunity to openly discuss your opinions; the chance to make a valued contribution to social sciences research; and the potential to advance societal knowledge/conversations about issues relevant to the study.

**Voluntary participation:**
Your participation in this study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the relationship you may have with the researchers or study staff or the nature of your relationship with York University either now, or in the future.

**Withdrawal from the study:**
You can stop participating in the study at any time, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event that you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

**Confidentiality**
All of the information you provide will be documented through audio, digital recording and handwritten notes taken by the interviewer. All documentation/recordings made in this study will not be associated with any of your personal or identifying information. All electronic data collected in

this study will be stored on a secure home office computer that is protected by a unique password and is the sole property of the researcher. All hardcopy data collected in this study will be kept in a locked filing cabinet of the researcher's home office. Only the researcher, as well as her academic advisors, will have access to this information. The protected data will be stored for the duration of the study, as well as for a 3-year period following the publication of the research results. After this retention period, the electronic and hardcopy data will continue to be archived both on a password-protected home office computer, and locked filing cabinet in the researcher's home office. The data will be stored indefinitely only for the purposes of publication, and to potentially provide needed background for any future research conducted by the researcher that may build upon this work. Confidentiality will be provided to the fullest extent possible by law.

**Questions about the research?**
If you have any questions about the research in general or your role in this study, please contact Vishaya Naidoo (PhD candidate, Principle Investigator) by e-mail at vishayan@yorku.ca or her research supervisor Dr. Nancy Viva Davis Halifax at nhalifax@yorku.ca. You may also contact York University's Graduate Program in Health offices at gradhlth@yorku.ca.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, you may contact the Senior Manager and Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone 416-736-5914 or e-mail ore@yorku.ca

**Legal rights and signatures:**
I_________________________________, consent to participate in *Aging Interdependently* conducted by Vishaya Naidoo. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

**Signature** ________________________ **Date**
Participant

**Signature** ________________________ **Date**
Principal Investigator

**Appendix D: Table of Documents**

**Table 5**

*Notable supplementary aging policy documents used for content analysis*

| Document Name | Location URL | Access Date | Key Interpretations in this Study |
|---|---|---|---|
| *Aging with Confidence: Ontario's Action Plan for Seniors* (2017) | https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf | November 13, 2019 | - Informal family supports play a critical role in older adults remaining independent and in their communities.<br>- The government of Ontario will increase its investment in older adult centres provincewide.<br>- An active lifestyle in later life is key to the avoidance of acquired disability and health conditions among older adults.<br>- As older people cease driving, public transportation is an increasingly important service in age-friendly communities. |
| *Canada's Aging Population: The Municipal Role in Canada's Demographic Shift* (2013) | https://data.fcm.ca/documents/reports/Canadas_Aging_Population_The_Municipal_Role_in_Canadas_Demographic_Shift_EN.pdf | January 25, 2016 | - This report highlights the role of meso-level community-based services for older adults and carries a parallel message of providing optimal conditions and opportunities for the enhancement of "Active Aging" mechanisms (p. 4).<br>- The goals of well-being and community engagement are critical focus areas to ensure that older adults age "well" in their communities (ibid). |

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| *Ageing Alone: The Impact on Poverty and Social Exclusion* (2010) | http://www.cclp.gouv.qc.ca/includes/composants/telecharger.asp?fichier=/publications/pdf/Avis_Vieillir%20seul_ANG.pdf&langue=en | December 15, 2019 | - Both poverty and social exclusion require stronger consideration in aging policies and support programs, as both are named factors in the cause or exacerbation of health difficulties that manifest in later life.<br>- Poverty and social exclusion in late life years compromise independence, autonomy, and equity. |
| *Expanding Caregiver Support in Ontario* (2018) | https://files.ontario.ca/beed_report_2018_0.pdf | January 3, 2020 | - This report outlines recommendations for Ontario to implement stronger supports for those who provide care to people aging at home. The province's current initiatives are inconsistent and do not extend to all areas in need.<br>- It is recommended that the province look to the example of countries with stronger formal caregiver support programs, such as Sweden and the United Kingdom, to address caregiver inequity. |
| *Time for Action: Advancing Human Rights for Older Ontarians* (2001) | http://www.ohrc.on.ca/sites/default/files/attachments/Time_for_action%3A_Advancing_human_rights_for_older_Ontarians.pdf | March 4, 2016 | - A key recommendation of this report is that gender be made a priority in aging policies, where the unique barriers and concerns of both gender groups are described.<br>- The report speaks to the disproportionately higher levels of |

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| | | | socio-economic disadvantage that are more likely to be faced by older women for reasons of longer life expectancy and greater chances of widowhood.<br>- Widower men in late later life, however, often encounter greater difficulties coping with their personal care needs after the loss of their wives, particularly in cases where their spouses took on most of the caregiving and domestic responsibilities in earlier years. |
| *Diversity, Aging, and Intersectionality in Ontario Home Care: Why We Need an Intersectional Approach to Respond to Home Care Needs* (2017) | http://www.wellesleyinstitute.com/wp-content/uploads/2017/05/Diversity-and-Aging.pdf | November 21, 2019 | - Meeting the service needs of older adults who are aging in place in Ontario requires an understanding of diversity, and the resultant inequities that arise through multiple identity interactions that fuel systemic oppression and disadvantage.<br>- Current home care-based policies do not adequately meet the diverse needs of the older adult population, an essential element in fostering equity in the latest life years. |
| *A Framework for the Law as It Affects Older Adults: Advancing Substantive Equality for Older Persons through Law, Policy and Practice* (2012) | https://www.lco-cdo.org/wp-content/uploads/2012/07/older-adults-final-report-framework.pdf | March 6, 2016 | - The framework proposed in this report offers an evaluative approach to aging policies and practices. One that seeks to understand the unique experiences and circumstance of older adults. |

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| | | | - Disability, a source of marginalization at any life stage, is most prevalent among the older adult population and therefore worthy of increased attention—in the context of aging—from policy makers.<br>- Systemic ageism in laws and policies must be acknowledged and adequately addressed. |
| *Portrait of Caregivers* (2013) | http://healthcareathome.ca/mh/en/Documents/Portrait%20of%20Caregivers%202012.pdf | January 14, 2020 | - According to this analytical report produced for Statistics Canada, nearly 8.1 million Canadians provide some form of informal care to an older adult family member, person with a chronic condition, or person with a disability. |
| *An Evidence-Informed National Seniors Strategy for Canada* (2nd ed.) (2016) | http://nationalseniorsstrategy.ca/wp-content/uploads/2016/10/National-Seniors-Strategy-Second-Edition.pdf | November 30, 2019 | - This report recommends that the Canadian federal government prioritize finding ways to provide equitable access to post-retirement funds.<br>- The current system is constructed in a way that favours those with higher than average life course incomes through personal retirement savings plans, while failing to provide an adequate income safety net for vulnerable populations, especially women.<br>- In the older adult population at large, 30% of older Canadian women |

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| | | | live in a circumstance below the poverty line, and they are twice as likely to be in this position than their older male counterparts. The report suggests that a 15% increase in the GIS payment "would immediately lift all older adults out of poverty" (p. 36). |
| *Report on the Social Isolation of Seniors 2013-2014* (2014) | https://www.canada.ca/content/dam/nsc-can/documents/pdf/policy-and-program-development/publications-reports/2014/Report_on_the_Social_Isolation_of_Seniors.pdf | December 5, 2019 | - Loneliness is a subjective feeling that older adults perceive with regards to a lack of interaction or contact with others. Social isolation, however, more objectively encapsulates other factors, including a lack of adequate social roles and fewer social contacts. It is also to some degree dependent on systemic factors and the level of support older adults feel within their communities. |
| *Canada's Aging Population: Seizing the Opportunity* (2009) | https://sencanada.ca/content/sen/committee/402/agei/rep/agingfinalreport-e.pdf | March 28, 2016 | - In examining equality in an aging context, poverty, income inequality, gender, and disability are identified as particularly significant social facets of concern in later life.<br>- Aging in place is a preferred option to institutionalized living for older adults and is therefore a mandate that should be supported by the state. |

**Appendix E: Table of Themes and Sub-Themes**

**Table 6**

*Summary of themes and sub-themes*

| Main Theme | Sub-Theme | Sub-Theme Description | Example of Illustrative Quotation |
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| Independence/ Interdependence in Successful Aging | Sustained Autonomy | • For many respondents, personal autonomy was preserved through both their ability to freely spend their time as they desired (something that was particularly felt at this current stage of their lives) and their general resistance to accepting state-level supports, preferring to avoid dependence on external government aid to the greatest extent possible.<br>• Though the capacity to make autonomous choices was suggested as a preferred path by many participants, another perspective conveyed in the data was a feeling of resignation and negativity associated with the increased likelihood of losing one's autonomy at this late life stage. This threat to independence was primarily described in the context of acquired health- or disability-related experiences. | "Well, you don't feel very useful because you're not working and you know, if you go to sleep and nobody cares whether you're up or not, you can spend your time as you wish - except if you've made commitments. You're pretty free to choose your own lifestyle, which is quite nice" (Interview 13, 2016). |

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| Familial/Intergenerational Connections and Support | • Reflected in the data are an inner conflict that arises between the desire to remain independent of aid, the necessity to connect socially with others, and the need for assistance at a time when productive life in an entirely economic sense has ended. Here, participants also highlighted family assistance as a critical dimension in their lives.<br>• The oldest old in this study spoke about their social network aging alongside them, and the emotional toll of losing those closest to them. Those in this cohort are unique from other older adults because they are much more likely to have experienced significant losses to their social circles. As a result, respondents identified a more pronounced need to form new social bonds. The older adult centre was named as an entity that facilitated this process through the positive interactions between members. | "The older we get, the more important the family. They are helping more and more. Luckily, she has her family and I have mine and whatever we ask, they are glad to do it right away" (Interview 15, 2016). |
| Avoidance/ Acquisition of Disability and Living Actively | • While some respondents spoke about acquired disability as a limiting factor in their very late lives, others focused on finding alternative life-enhancing avenues for adaptation. These included a strong network of support and social outlets, as well as active | "Aging is being able to connect with people, whether you're disabled or not, and interact with them" (Interview 14, 2016). |

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| | | participation in the offerings of the older adult centre. Making use of these resources had a seemingly mitigating effect on the impact of disability in their lives. | |
| Gender | Care & Care Contexts | • According to interview data, both female and male participants spoke about three types of care: informal and self-directed care, formal care through government services, and reciprocal models of care among peers.<br>• Both men and women described inconsistencies and insufficiencies in government-provided care services. Participants also discussed fostering care relationships in which they received and provided assistance in turn. These mutually beneficial helping relationships provided a greater sense of purpose and fulfillment for some participants.<br>• In alignment with an interdependence model of support, part of realizing an enhanced vision of care lies in fulfilling a need for strengthened services in the formal system alongside informal care provision. | "When you're younger you have different responsibilities. You have kids that you have to look after, the husband, after a house, or whatever you're living in. It's a different life all together. Now I can really please myself to do what I want to do and what I don't want to do. Once you get older, you don't care that much about what people think" (Interview 13, 2016). |

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| Complexities of Partnership – Spousal/ Companion Loss and Relationships | • When speaking of the loss or death of a spouse, male participants described the impact of losing their partners more emotionally than did the women. In contrast, women instead focused on the socioeconomic aspect of being married and losing their spouse. For some of the women, their very sense of financial security was intertwined with the marital aspect of their life course.<br>• All but one of the female participants in this study was widowed at the time data was collected, whereas more than half of the men interviewed had partners.<br>• For some widowed/widowered participants, the need to form new relationships and bonds became more acute after the loss of their spouse. The older adult centre was named as a community resource that serves an intermediary function as a helping network that facilitates social connections. | "One of the problems is, you have half of an income. Your husband, of course, had an income. Mine happened to work for the federal government, so I get only half of the pension. So, you're concerned about money because the problem is there's none coming in. Only the wee bit, and you don't work, of course" (Interview 7, 2016). |
| Work and Income | • Gendered elements of work and income over the life course were discussed by several participants in this study. Here the legacy of economic activities in middle age continued to have an impact in their very late life years. | "You worry if you're gonna run out of money and you have bills to pay, of course. That's a bit stressful. That would be about the only thing I get stressed over, which my children tell me I |

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| | | • The men in this study more often indicated high levels of satisfaction in this area. Having primarily held paid work positions for the years prior to their formal retirement, a number of the male participants refer to having financially planned for this stage of life.<br>• The perspectives relayed by female participants were more varied than that of the men. Some included narratives about a legacy of unpaid responsibilities in the domestic sphere. Other women discussed the stresses associated with financial precarity, particularly because of a previous reliance on marital support in earlier life stages. | shouldn't. They would, of course. I think most seniors would have that problem. Unless you're wealthy and you have lots of money, but otherwise, it is a bit of a problem. Well, yeah, because as I say, it's not like when you had a job. There's always a pay cheque coming in next week. There isn't now. But anyway, we manage" (Interview 7, 2016). |
| Aging in Place | Place | • According to interview data, movement into a nursing home or long-term care facility (the alternative to aging in place) was perceived in the highly negative light of presumed dependence and/or decline for reasons including a compromised sense of freedom, decreased levels of activity or stimulation, social isolation, and boredom.<br>• A number of participants held the perception that a privately funded living circumstance was preferable to that which is provided by the state in | "I guess I would like to look forward someday, if I ever had to go into a senior's residence that they had – and not a provincially funded one where you're a victim of abuse and no money and stuff like that. No, I want to go into a place that's reasonably respectable" (Interview 3, 2016). |

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| | the public system. Here, the notion of economic privilege and access to enhanced care based on financial means is another aspect of long-term care access revealed in the data.<br>• The assistance provided by one's informal network of family and friends, while continuing to live independently, was described as an enhancing and necessary component for the oldest old aging at home in this study. | |
| Choice | • In this study, aging autonomously in place was described by respondents as it was influenced by two primary factors: economic privilege and social connections.<br>• For many participants, access to a residence of their own choosing, whether it was a personal home or a communal retirement residence, was dictated by their financial means with little to no expectations of the state for assistance.<br>• As the oldest old are at an increased risk for social isolation and loneliness, building strong connections with others was identified by respondents as vital to successfully aging while living in their community. | "Well, people choose. Some people just don't want to be bothered with cooking and shopping and all that and they like being in a retirement home. Other people feel that all their friends are unable to come around with them or go anywhere with them, so they have company in a place like that" (Interview 13, 2016). |

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| Access: Transport Mechanisms | • Accessibility is a required mechanism for aging in place. Participant data on the subject of transport access was somewhat conflicting. Some respondents indicated a strong reliance on public transit to embark on daily activities and tasks. Others referred to the barriers associated with the cost of transportation services, the complexities of driving and driving cessation at an advanced age, and finally, reliance on mechanisms like family or the older adult centre to assist with transport needs.<br>• While the participant responses shared here illuminate the complexities of fulfilling the diverse transportation needs of some among the oldest old aging in place, they also show that there is room for improvement with respect to personal cost and ease of access. | "Actually, when we moved out here, I took a look at the traffic on Yonge. I said, I'm not driving. I guess I could have gotten used to it, but we just decided. We sat down one day, and we projected for three years - the cost of insurance, gas and parking. We thought, maybe once or twice a month we'd use it. So, what was the point? So, we sold the car and we've been using the TTC. A couple of times we've had to go out to Cambridge - one of my husband's nephews lives out there. The other nephew picked us up and drove us out there those times. When I had to visit my brother in the Kingston area, one of his sons drove us out there. So, it's interesting and working out alright" (Interview 17, 2016). |

## Appendix F: List of People Interviewed

| | Role | Age[11] | Sex | Date |
|---|---|---|---|---|
| Interview 1 | Older Adult | 93 Years | Female | January 6, 2016 |
| Interview 2 | Volunteer | 78 Years | Female | January 6, 2016 |
| Interview 3 | Older Adult | 90 Years | Male | January 7, 2016 |
| Interview 4 | Older Adult | 87 Years | Female | January 8, 2016 |
| Interview 5 | Older Adult | 95 Years | Male | January 11, 2016 |
| Interview 6 | Family Member | 68 Years | Female | January 11, 2016 |
| Interview 7 | Older Adult | 85 Years | Female | January 13, 2016 |
| Interview 8 | Older Adult | 87 Years | Female | January 18, 2016 |
| Interview 9 | Older Adult | 85 Years | Male | January 18, 2016 |
| Interview 10 | Older Adult | 86 Years | Female | January 18, 2016 |
| Interview 11 | Older Adult | 91 Years | Female | January 19, 2016 |
| Interview 12 | Older Adult | 91 Years | Male | January 21, 2016 |
| Interview 13 | Older Adult | 90 Years | Female | January 25, 2016 |
| Interview 14 | Older Adult | 87 Years | Male | January 28, 2016 |
| Interview 15 | Older Adult | 88 Years | Male | February 1, 2016 |
| Interview 16 | Older Adult | 90 Years | Female | February 3, 2016 |
| Interview 17 | Older Adult | 85 Years | Female | February 4, 2016 |
| Interview 18 | Older Adult | 96 Years | Male | February 4, 2016 |
| Interview 19 | Staff – Manager | N/A | Female | February 23, 2016 |
| Interview 20 | Older Adult | 86 Years | Male | February 24, 2016 |
| Interview 21 | Older Adult | 89 Years | Male | February 25, 2016 |
| Interview 22 | Older Adult | 85 Years | Female | February 29, 2016 |
| Interview 23 | 2 Program Coordinators | N/A | Female/Female | March 2, 2016 |
| Interview 24 | Program Lead | N/A | Female | March 17, 2016 |

[11] The age of each participant listed in this column reflects their numerical age at the time that they were interviewed.