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Ageing in Place: The Experiences of Older Adults Accessing Health Services in the Wakatipu

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Abstract

Access to health services is vital for maintaining the quality of life for older people. Older people living in rural and remote areas often have specific barriers to accessing good quality and timely health services. Poor health service access can make it difficult for older people in remote communities to 'age in place'. This research explored the experiences of older residents accessing health services in the Wakatipu area of New Zealand, to provide the opportunity for older people in the area to have their voices heard, and to inform service provision in the area. The experiences of older people accessing health services in rural or remote areas are pivotal to formulating policies and building communities founded on wellbeing. A qualitative framework was chosen to record and analyse the rich and detailed experiences of the participants. Eight people aged over 75 years, who currently live in the Wakatipu basin, were interviewed. The interviews were analysed using Interpretative Phenomenological Analysis (IPA), which enables detailed attention to people's lived experiences. Two superordinate themes of the places that people age, and strategies to maintain the positive ageing ideal, were identified. The results indicated that older adults view health services not in the narrow sense of provision of traditional GP and hospital services, but in the context of all the components required to age well in the location of their choice. This highlights the need to actively include older adults in the planning and decision making process for civic amenities, environmental design, transport, and health services.

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Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Introduction.....	1
Study purpose	1
The Wakatipu Basin	1
Chapter 1: Review of the literature.....	4
Ageing in place	4
Ageing in place in New Zealand	6
Accessibility of services	9
Chapter 2: Methodology	11
Embodiment.....	13
Interpretative phenomenological analysis	14
Chapter 3: Method and data analysis.....	16
Participants	16
Procedure	17
Data analysis.....	18
Chapter 4: Results.....	20

Overview.....	20
The places that people age.....	21
Ageing in bodies.....	22
Ageing in one's own home.....	27
Moving through spaces and to places	31
Ageing in communities: Invisibility.....	38
Ageing in communities: Health services.....	42
Ageing in unequal places: Lack of resources.....	45
Ageing in lonely places: Vulnerability and fear	47
Ageing in social relationships	50
Ageing in many places	54
Maintaining the positive ageing ideal	55
Ageing as a competent actor	56
Ageing with the resources I need	59
Ageing without 'giving in'	61
Staying visible	63
Ageing without becoming a burden	64
Ageing without complaining	66
Ageing with a strong network	68

Case study: Abbeyfield retirement home	74
Chapter 5: Discussion	80
Limitations	83
Implications and recommendations	84
Conclusion	86
References.....	87
APPENDIX A.....	101
APPENDIX B	104
APPENDIX C	105

Introduction

Study purpose

The purpose of this study is to highlight the subjective experience of older adults accessing health services in the Wakatipu basin. The researcher will describe the experiences of health service access among this group, and add to the data currently utilised by the recently formed Southern DHB (a merger of the Otago and Southland DHBs). In the current political climate in New Zealand there appears to be a drive towards basing important policy decisions around economics. One of the purposes of this study is to explore the human experience of ageing, how older adults make sense of their experiences of accessing health services, and what is required to age well in the location of choice, in the hope that the findings will contribute to policy development in terms of service provision.

The Wakatipu Basin

In order to understand the experience of ageing in place in the Wakatipu, it is necessary to provide background information on the demographic, geographic, and social aspects of the area, as well as an outline of the available relevant civic amenities. The Wakatipu Basin is a geographical area in the South Island of New Zealand, encompassing the areas Queenstown, Frankton, Arrowtown, Garston and Glenorchy. Total permanent population in this region at the last census was 29,000 (Statistics New Zealand, 2011), but this belies the actual population visiting or living temporarily in the area, which may reach levels of around 70,000 during peak tourist season.

The climate in the Wakatipu is very seasonal, with summer temperatures reaching thirty degrees, whilst in winter the area experiences often freezing temperatures and snowfall. Being out and about in the coldest months can be difficult, with increased risk of falls on icy pavements, and the real possibility of weather related driving accidents. Although not a common occurrence, snowfall in residential areas can leave residents housebound.

The basin is geographically isolated, as it is surrounded by mountains, and the nearest hospital currently used for major surgery, oncology, and many diagnostic procedures, is Southland Hospital in Invercargill, two and half hours away. It is, however, often the case that people have to travel almost four hours to Dunedin for some medical services, such as radical oncology treatments. There is a large hospital an hour away at Dunstan, but currently Wakatipu residents are rarely able to access services here, due to historically separate DHB structures.

Local health services are designed for the census population and consist of a small hospital with twenty two beds (six of which are set aside for medical care of older adults with age related, non-urgent conditions, such as a persistent chest infection), three medical practices, several pharmacies, and a rest home with thirty six beds (Foley, Pitchford, Ardagh, & Russell, 2011; Southern District Health Board, 2012). Whilst superficially, this indicates adequate service levels, there are several areas of concern. Firstly there is considerable anecdotal evidence for older people having to move away to Dunedin and Invercargill due to lack of health service availability, especially lack of dementia care facilities (Lynch & Boulay, 1999), and families are reluctant to move their ageing parents to the area due to the lack of services. Secondly driving becomes very treacherous during the winter months and people are often reluctant or unable to make the trip to Invercargill or Dunedin for treatment (Foley, et al., 2011). Whilst patients are transported by ambulance in an emergency they are often required to transport themselves to hospital for non-urgent treatment (Lynch & Boulay, 1999).

There is a public bus transport service, which has been operating for several years. It is free to access for superannuitants, and the frequency of service has recently been increased for the Frankton to Queenstown routes. Other areas, such as Kelvin Heights and Arrowtown have a reduced level of service, with the bus operating hourly outside of the rush hour periods (Connectabus, 2013).

The Wakatipu area is also known as an expensive place to live, with the cost of groceries, for example, being over 10% higher than in Auckland (Numbeo, 2013, February 13). GP fees are 15% higher than the New Zealand average (Foley, et al., 2011), and the current average house price is \$520,000 (Enz.org, 2013, February 13). For older people, especially those who do not own their own home, these costs can prohibit them from ageing in place. There are few affordable housing options in the Wakatipu, with just four council-owned pensioner units in Arrowtown, and a lack of affordable quality rental accommodation. Abbeyfield, a local aged care facility, costs \$350 per week, including meals, but requires residents to be independently mobile. A prohibitive cost of living, and poor access to both health services and quality affordable housing are major barriers to ageing in place in areas such as the Wakatipu (Adams, 2009; Age Concern, 2013).

The Wakatipu is experiencing rapid population growth, contrary to most of rural New Zealand (Foley, et al., 2011), yet its elderly population is suffering the same difficulties in accessing health services as if they lived in a declining population area (A. E. Joseph & Cloutier-Fisher, 2005; Lynch & Boulay, 1999). The perception in the past has been that the Wakatipu area is often ignored in terms of health service provision (Lynch & Boulay, 1999), and the most recent report on recommendations for hospital services does not have a strong focus on older people's needs or perspectives (Foley, et al., 2011).

Chapter 1: Review of the literature

Ageing in place

One of the terms that have become associated with ageing well is ‘ageing in place’. Geography and health are intrinsically linked, and specifically access to health services has been shown to be a vital aspect of the ideal neighbourhood for older adults (Carp & Carp, 1982; Curtis, 2004; Dummer, 2008). Ageing in place is often especially challenging in rural communities, due to a variety of factors, such as lack of public transport and lack of services (Dye, Willoughby, & Battisto, 2011). Older adults describe a strong desire to ‘age in place’ to maintain cultural connections and access to social support networks (Rioux, 2005; Vandeskog, Vandeskog, & Liddocoat, 2012), and access to services is strongly linked to wellbeing (Windley & Scheidt, 1980).

The term ‘Ageing in Place’ has its roots in human geography but now crosses a number of disciplines including sociology, psychology and social policy, and therefore warrants clarification (Andrews & Philips, 2005). Both ageing and place have significant impact on the wellbeing of older people in our society. Much of the academic, political and media focus around ageing and place is dominated by a focus on reducing reliance on institutionalised care, often rendering the wider perspective and experiences older people invisible (Findlay & McLaughlin, 2005; Kearns & Andrews, 2005). It is therefore important to research the lived experiences of older people.

In the Western world most elderly people express the desire to live at home for as long as possible, and there is a link between attachment to place in later life and the ability to continue being and feeling competent (S. M. Peace, Holland, & Kellaher, 2005; Rioux, 2005). One of the reasons for this may be that older people are more able to manage a familiar environment, so their feelings of accomplishment, control, and self-efficacy are enhanced (Cutchin, 2003; Findlay

& McLaughlin, 2005; Twigger-Ross & Uzzell, 1996). Rowles' exploration of the geographical experience of older people identified the psychological investment in place, and how this increases with the ageing process (S. M. Peace, et al., 2005).

From a social policy perspective, attention is increasingly shifting towards the definition of ageing in place as ageing at home, supported by the provision of community support services (Dye, et al., 2011; Kearns & Andrews, 2005; Ministry of Social Policy, 2001; Vandeskog, et al., 2012). The proponents of this approach cite the benefits of ageing at home, such as increased choice and control over one's environment, the ability to stay in touch with one's identity through attachment to place, feeling safer and more secure due to familiarity with one's surroundings, and it being the preferred choice of most older people (Davey, 2006; Milligan, 2009; Robinson, 2007; Tanner, 2010).

Although ageing in place has benefits for older people, and reflects the preferences of many older people, these policies have also drawn criticism. Critics are concerned that this policy is more about cost effectiveness and neo-liberal philosophy than a genuine desire for people to age well in the place of their choice (Milligan, 2009). They opine that there is an over-emphasis on individual responsibility for looking after oneself in old age, and 'home' being the ideal place to age (Tanner, 2010; J. Wiles, 2011).

Ageing in place can only succeed if well-resourced, high quality community based care services are available, which is often not the case in rural areas (Age Concern, 2013; Milligan, 2009; Sims-Gould & Martin-Mathews, 2008; Tanner, 2010; J. Wiles, 2005). Many older adults in New Zealand live in poor quality housing and their only source of income is New Zealand superannuation, which makes ageing in place a less than attractive option (Adams, 2009; Age Concern, 2013). There is also the tendency to ignore the decreases in privacy, autonomy and control, as older people become more reliant on home care services (Katz,

2005; Milligan, 2009). Despite its growing popularity, there is little critical gerontological research about the home as space in which to age (Binstock, 2000; Cutchin, 2003), but for budget-constrained health service providers it has assumed social policy ascendancy as a model of care, primarily as more cost-efficient alternative to residential care facilities (Cutchin, 2003; Vandeskog, et al., 2012; J. Wiles, 2005).

Ageing in place in New Zealand

Discovering more about individuals' experiences of accessing services and ageing in place, and the potential challenges they face, is a valuable exercise in planning for the future wellbeing of our ageing population (Dye, et al., 2011; Ministry of Social Policy, 2001; Vandeskog, et al., 2012). Several New Zealand studies highlight issues of health access and/or ageing in place (Butcher, 2012; Davey, 2006; Keeling, 2001; Vandeskog, et al., 2012; Walker, 1994; J. Wiles, 2011) although research is still sparse (Lidgard, 2006; Robinson, 2007).

Studies conducted in the North Island, Golden Bay, Auckland, East Cape, Mosgiel, and a New Zealand wide study focusing on older Chinese immigrants, highlighted a theme of the desire for autonomy, illustrated by a strong desire to age in place at home, with access to quality local medical care, social and familial supports, sufficient finances, and decent transport services (Butcher, 2012; Davey, 2006; Keeling, 2001; Li, 2009; Robinson, 2007; Vandeskog, et al., 2012; J. Wiles, 2011).

The need to address inequalities was also raised in a number of the studies, particularly with regards to health service access, income distribution, and differences between ethnic groups (Li, 2009 ; Walker, 1994; J. Wiles, 2011). Some researchers focused on the need for greater equality for older people, recommending a more collaborative approach by communities, working in partnership with its older residents, so that their views could contribute to building age-friendly neighbourhoods (Li, 2009; J. Wiles, 2011). Finally, the

theme of the importance of social relationships to enable older people to continue to age in place emerged in a number of the studies, highlighting that independence and autonomy need to be considered within the greater social support network (Butcher, 2012; Keeling, 2001; J. Wiles et al., 2009).

Whilst the studies outlined above indicated that ageing in place in the context of considerable support is preferred by most older people, there were also issues unique to geographical areas, and the characteristics and experiences of the participants, highlighting the need for research in other regions of New Zealand. For example the need to establishing a personal space, and the importance of dismantling language barriers were important for the elder Chinese immigrants (Li, 2009). Challenges to ageing in place for the residents of Mosgiel centred around shrinking familial supports, due to people having smaller families, and individuals moving to live further afield for work opportunities (Keeling, 2001).

Although much of the research highlighted independence and autonomy as central factors to ageing well in place, the Māori participants in the East Cape study acknowledged the importance of dependence on family for support, and the land for nourishment, without which autonomy is not achievable (Butcher, 2012). Other studies acknowledged the need for support to age in place: quality home support services were evidenced by Presbyterian Support as being a key factor for enabling elderly people to continue ageing in their homes, especially those with high and complex needs (Robinson, 2007). Presbyterian Support is a major provider of home care for the elderly in New Zealand, which might explain the focus on provision of these services in this study. Whilst acknowledging the importance of home care services, the Mosgiel study cautioned that home-based care services need to take privacy and intimacy barriers into account (Keeling, 2001).

Appropriate local facilities were identified as lacking for some research participants. For example, Golden Bay residents identified the need for a

quality, affordable retirement village, covering all stages of functioning (Vandeskog, et al., 2012), whereas the Auckland and Chinese immigrant studies highlighted the importance of considering and endorsing a broad range of alternative locations to one's own home for ageing in place (Li, 2009 ; J. Wiles, 2011). In some studies, such as the one focused on the Northland area, the issues were focused on access as opposed to choice, highlighting the powerful combination of poverty and remote location in preventing older residents from accessing basic health services (Walker, 1994).

It is clear that whilst there are some universal aspects to ageing in place and accessing health services, different issues arise depending on geographical location, demographics and characteristics of the participants. Consequently areas such as the Wakatipu, with its unique combination of geography, climate, and demographic profile, require dedicated research to uncover specific experiences and issues of its older inhabitants in relation to ageing in place and accessing health services.

Recognising the need for a location specific study in the Wakatipu, in 1999 the Wakatipu Health Development Committee produced a detailed report entitled 'Elderly Health Needs in the Wakatipu' (Lynch & Boulay, 1999). The purpose of the report was to survey national availability and standards of care to the elderly, aged over sixty five, and to compare this with the situation in the Wakatipu. Following presentation of the national data to interested service providers and community groups, they distributed questionnaires and collated the findings. The findings highlighted a number of issues, including a lack of access to services such as outpatient clinics, hospital care, and relevant health professionals. Cases were highlighted of people having to move away to access long stay psychiatric and secure dementia beds, as well as affordable, staged rest home facilities. Home help services were described as fragmented and there was no dedicated co-ordinator to inform, advise, and action access to appropriate services. It was also noted that the return of home visits by GPs would be

particularly welcomed by older people. In summary the availability and quality of health services for older people in the Wakatipu was described as inadequate (Lynch & Boulay, 1999).

The National Health Board recently revisited the challenges of providing health services in the Wakatipu. The report outlined the projection that the over 75 age group will increase by 147% by 2026, increasing pressure on current services (Foley, et al., 2011). A positive change that was noted was the presence of an Age Concern fieldworker, who helps to coordinate support and ensure that older people ageing in their own homes have a dedicated communication channel for new and changing services (Foley, et al., 2011; National Health Board, 2012). One of the continuing challenges, however, for people ageing at home is the high turnover of home care support staff (Foley, et al., 2011). Notably, the issue of lack of dementia care in the region, highlighted in the 1999 report, is recorded in the summary of feedback from the community, but given no attention in the main body of the report (Foley, et al., 2011; Lynch & Boulay, 1999). It is therefore timely to revisit the issue of access to health services for older people in the Wakatipu.

Accessibility of services

In Lawton's ecological model of ageing inaccessibility of services is one of the four key factors in exerting environmental demands on older adults (Glass & Balfour, 2003; S. M. Peace, et al., 2005). However there are few studies on the experience of receiving or accessing services by the elderly in rural areas, along with few studies on neighbourhood influences on ageing in rural areas (Glass & Balfour, 2003; Windley & Scheidt, 1980). There is considerable sociological literature around the importance of access to healthcare, but this literature often focuses at the macro level, using for example aggregate data to highlight issues such as poverty within ageing populations (Zablotsky, Scheid, & Roberson, 1999), and may not succeed in eliciting the emotional engagement to understand

the experience of health services from the patients perspective. Patients' experiences are often ignored in health psychology research and subsequent policy making (Radley, 1999), despite evidence to suggest that the experiences of older people accessing health services in rural or remote areas are pivotal to formulating policies and building communities founded on wellbeing (Bourgeault, Sutherns, Haworth-Brockman, Dallaire, & Neis, 2007; Ministry of Health, 2002a, 2002b, 2004, 2006). It also appears that the policy research literature is largely silent on the issue of equity of intergenerational access, and largely ignores rural based populations of older adults (Daniels, 2008; Lidgard, 2006).

Whilst information about people's experiences of health services may often be gathered in the form of aggregate data, surveys or questionnaires (Dummer, 2008; Rioux, 2005; Vandeskog, et al., 2012; Walker, 1994), there is evidence to suggest that meaningful information about health experience is best gathered in the form of talk with others (Chamberlain, Stephens, & Lyons, 1997; Cloutier-Fisher & Joseph, 2000; Murray, 1999; Radley & Billig, 1996). Those who are accessing health services are the experts with regards to their own experiences, and are able to provide detailed and rich accounts that contribute to a deeper understanding of the complexities involved in health service access and accessibility (Tanner, 2010).

Chapter 2: Methodology

The hegemonic health research paradigm remains biomedically dominated, experimental, enshrined in dualism, with the focus on stripping out the personal and the experiential (Eatough & Smith, 2008; Lyons, 1999; Morgan, 1999).

This research attempts to shift the argument away from a purely biomedical/economic debate around health access, to consideration of holistic wellbeing, hearing the voices of the experienced, and shedding light on the meaning that consumers ascribe to the challenges faced when accessing health services (Marks, 2002). In this sense this research contributes to the domain of health experience that is not controlled by the economically, politically, and ideologically dominant medical profession (Spicer, 1995). Specifically, qualitative psychological research has a significant part to play in contributing to the field of humanistic gerontology, where the meaning and experience of ageing is studied (Kontos, 2005).

There is a wealth of sociological literature on the topic of ageing in place (Bourgeault, et al., 2007), but limited psychological coverage. Within the context of place, time and culture (Lyons, 1999), psychology can highlight the personal, and the focus on wellbeing and beneficence. In line with current trends in critical gerontology, this research assumed a framework that would maximise the participation, and provide the potential for voices not only to be heard, but for real change to be a possibility (M. Bernard & Scharf, 2007; Gilleard & Higgs, 2000). As the research aimed to explore the lived experience of participants, the framework required an epistemological approach that embraces subjectivity through personal interpretation of both the participants and the researcher in a double hermeneutic process. The goal was to capture the experience of what it is like to age in the Wakatipu. This included the rich sense-making contributions of the participants (Holstein & Minkler, 2007; Ray, 2007).

Ontologically, the notion of ‘what is’ was examined entirely in context, in line with Heidegger’s notion of ‘dasein’, person-in-context. The research sought to know how people cope and make sense of their experience through their world of relationships, language and ‘things’ (Coyle, 2007; Eatough & Smith, 2008; J. A. Smith, Flowers, & Larkin, 2009). Within this framework, reality, or what ‘is’, is not static, out there waiting to be discovered, but is instead formed by interactions between beliefs, goals and activities of all the participants, including the researcher. These interactions are both constrained and facilitated physical, socio-historical, geographical, and linguistic contexts (Denzin & Lincoln, 2005a; Eatough & Smith, 2008; Stake, 2005; Yardley, 1999). It is not possible, therefore, to separate personal experiences of accessing health services from the power structures that lie behind our current systems (Popay, Williams, Thomas, & Gatrell, 1998).

In this study the role of the researcher was not of an outsider looking in, but a participant seeking to ‘be’ in the research process with the participants on an interpretative journey of meaning-making (Ashworth, 2008). It was not necessary to be seen as objective and impartial: rather the role of researcher was the catalyst for interpretation by the participants themselves to enable a greater understanding of their own world (Eatough & Smith, 2008; J. A. Smith & Osborn, 2008). The research facilitated the co-construction of knowledge between the researcher and participants, as opposed to a hierarchy of knowledge, where the researcher is seen as the expert (Ashworth, 2008; Denzin & Lincoln, 2005a; Guba & Lincoln, 2005; Lyons, 1999; Mathieson, 1999; Spicer, 1995; Yardley, 1999). No knowledge paradigm was seen as universally less valid than another: for example, in this research the participants may not have had a medically accurate view, but their views were valid experientially (Yardley, 1999).

To succeed within this framework the researcher needed to adopt a reflexive approach, being prepared to shelve conventional, or personally held views of the

world. In conclusion, this research did not seek epistemological dogma, but to create a flexible environment that gave a voice to those often not heard, and that potentially provides the opportunity to make an experiential contribution to the debate of health service access and ageing in place (Popay, et al., 1998).

To achieve the ontological and epistemological aims outlined above, the design required a qualitative, idiographic approach that allowed for the gathering of data from talk (Ashworth, 2008; Eatough & Smith, 2008), and the subsequent interpretation of the phenomena that emerged. It is important to continue to build a body of psychological research that focuses on human experience (Nelson & Prilleltensky, 2005), and how a person's behaviour, cognitions and emotions are more clearly understood in the context of place (S. M. Peace, et al., 2005). In line with the qualitative framework, validating this research incorporated sensitivity to context, commitment to a rigorous process, reflexivity, authenticity, and transparency and coherence of data collection, storage and analysis (Finlay, 2002; Fontana & Frey, 2005; Guba & Lincoln, 2005; Lyons, 1999; Mathieson, 1999; J. A. Smith, et al., 2009; Yardley, 1999, 2008).

Embodiment

The design needed to facilitate the study of people's experience in a non-dualist fashion. The concept of embodiment was key to this research, as the experiences of the body of being ill, and interacting with services are intertwined (Eatough & Smith, 2008; Kearns & Andrews, 2005; Sampson, 1996). Including the body in health related research can be challenging, and may fall into the trap of the object-body approach, where the body's role is viewed in a third person, observational way. The body may not only be challenging to research, but may be excluded altogether using certain methodologies. Finally, the embodied, lived experience may be perceived as too idiosyncratic to be useful (Polkinghorne, 1994). From the participants' perspective, it might be difficult to

think of services they may need in the future if they are not currently experiencing illness (Sampson, 1996), or they may try to ignore what is going on at the bodily level, as it reminds them they are ageing and declining (Higgs & Rees Jones, 2009). Another challenge is the inability of a younger interviewer to completely empathise with the participants' experiences, due to the age difference. It is important to remember that a subjective epistemology means that whilst one can be empathetic, it is not possible to completely share another person's experience, because the body fundamentally shapes how and what people know about the world (J. A. Smith, et al., 2009). Within this paradigm, all knowledge can be seen as experiential and therefore perspectival (Yardley, 1999).

Embodiment was core to this research firstly because it helped to raise questions during analysis about the nature of participants' responses. How had they absorbed the social and political constructions of old age, which have entwined with their own experiences of their ageing bodies, and how did this then influence their talk about their experiences (Butt, 1998; Higgs & Rees Jones, 2009)? Secondly, ageing affects our body, and this in turn will affect the experiences we have (Finlay, 2006; Laz, 2003): if embodiment is recognised as a key aspect of people's experiences, then it may lead to more inclusive decision making on matters important to the ageing population (Becker, 1994).

Interpretative phenomenological analysis

Due to the experiential and embodied focus of this research, Interpretative Phenomenological Analysis (IPA) was chosen for its epistemological fit (Eatough & Smith, 2008; J. A. Smith, et al., 2009; J. A. Smith, Jarman, & Osborn, 1999). IPA is a methodological approach specifically created for psychological research (Eatough & Smith, 2008; J. A. Smith & Eatough, 2007; J. A. Smith, et al., 2009; J. A. Smith & Osborn, 2008), and is particularly appropriate for health related studies, where embodiment plays a central part in

participants' sense-making activities (J. A. Smith & Eatough, 2007). Based on Merleau-Ponty's assumption that we gain understanding through the lived experience of entwined body and mind, IPA takes a holistic approach to embodiment, allowing for the collection and interpretation of data in physical, cognitive, and emotional domains (J. A. Smith, et al., 2009). In summary we perceive, are perceived, and communicate through our bodies (Finlay, 2006; Polkinghorne, 1994).

IPA suited the aim of this study, namely to explore how individuals make sense of life experiences, through a joint venture of interpretation by both researcher and participant (Mathieson, 1999; J. A. Smith, et al., 1999). IPA facilitated the search for insights into the talk of participants at a deeper level than their uninterpreted answers provided (J. A. Smith, et al., 1999). The design of this study utilised multiple participants to allow for the emergence of themes across a relatively homogeneous group, as well as weaving data with psychological theory (J. A. Smith, et al., 2009; J. A. Smith, et al., 1999).

As people's talk communicates the social, the historical and the contextual (Spink, 1999), the design required an approach that provided a platform for talk to predominate. Building on this premise, talk becomes meaningful with the interaction of two or more voices (Spink, 1999), which drives the choice of method, outlined below. IPA celebrates and highlights variability through the idiographic focus of participants' experiences (Yardley, 1999), and from the outset it was accepted that participants' responses were context dependent, and were therefore, by nature, shifting (Yardley, 2008).

Chapter 3: Method and data analysis

Semi-structured interviews were used to facilitate the collection of thick descriptions that provide the richness of data required, as well as to enable flexibility, deviation, and greater influence on the process and content by the participants (Eatough & Smith, 2008; Fontana & Frey, 2005; Guba & Lincoln, 2005; Mathieson, 1999; J. A. Smith & Eatough, 2007; J. A. Smith, et al., 2009). The aim was to focus on existential aspects of participants' lives, and this could not be accomplished within a highly structured interview (Nelson & Prilleltensky, 2005). The flexibility and interactivity of a semi-structured interview also provided participants with the opportunity to reflect and actively interpret their experiences, something that more naturalistic, observational data collection methods would have failed to achieve.

Participants

For the purposes of this research the participants were selected from the group of older adults aged 75 or over, currently resident in the Wakatipu, with intact memory and speech to enable full interview participation. Whilst acknowledging that the onset of old age is variable, dependent on multiple factors, and is partially socially constructed (Findlay & McLaughlin, 2005; Levy, 2009), the reasoning behind choosing this age group is that they may have increased challenges around ageing in place and accessing health services. They are more likely to be experiencing age-related ailments; their mobility and ability to drive is often compromised; and they are more likely to be widowed, with a decreasing network of social supports to call upon (Daniels, 2008; Findlay & McLaughlin, 2005). The sample needed to be relatively homogeneous, in the sense that participants were required to have had sufficient recent experience of accessing health services (J. A. Smith & Eatough, 2007; J. A. Smith, et al., 2009; J. A. Smith & Osborn, 2008). To this end, sampling was purposeful to ensure

that participants were able to provide suitably detailed talk around the topic of interest (Denzin & Lincoln, 2005b; Nelson & Prilleltensky, 2005; J. A. Smith, et al., 2009; Stake, 2005).

In line with IPA requirements, the sample was small, consisting of eight participants. This enabled the research process to focus on detail and richness (Eatough & Smith, 2008; J. A. Smith, et al., 2009; J. A. Smith & Osborn, 2008) and allowed time for in-depth interviews, transcription, and hermeneutic interpretation (J. A. Smith & Eatough, 2007; J. A. Smith & Osborn, 2008).

Potential participants were made aware of the research project through an information sheet flyer (see Appendix A), which was distributed in community locations, such as the Queenstown Citizens Advice Bureau, Age Concern, a not-for-profit housing project for the over 55s, and community centres. Individuals who were interested contacted the researcher either directly, or through an advocate. Recruitment ceased once the desired number of participants had been reached.

The research was conducted in accordance with the ethical principles of the Massey University Human Ethics Committee. The information sheet and informed consent documents (see Appendices A and B) were designed to educate and inform participants about the process (Fontana & Frey, 2005).

Procedure

As previously outlined, the method of data collection was through individual semi-structured interviews, which enabled guidance without restriction, and was flexible enough to work with, not against the participant's account (Eatough & Smith, 2008; J. A. Smith, et al., 2009; J. A. Smith & Osborn, 2008). Prior to interviewing, the interview schedule was rehearsed to improve the fluency of the interview. The interview schedule consisted of eight open questions (see Appendix C), designed to build on the strength of the participant's views

(Mathieson, 1999; J. A. Smith, et al., 2009), supplemented with probes where appropriate. All the participants chose to be interviewed in their own homes. The researcher was aware of their own power status, and encouraged the participants to share control of the process, asking questions, requesting clarification, or suggesting other issues or topics that might require investigation (Coyle, 2007; Finlay, 2002; Guba & Lincoln, 2005). The researcher was also sensitive to discomfort during the interview and did not proceed with a line of questioning that was distressing (J. A. Smith, et al., 2009).

Interviews were recorded using a digital sound recorder, which was placed in open view during the interview. It was outlined at the beginning of the process that the recorder could be switched off at any time at the interviewee's request, and this did occur on several occasions, to take phone calls for example. In addition to this, notes were made directly after the interviews to capture some of the memorable bodily reactions to questions.

All the names of the participants, health professionals, and any other identifiable individuals or details were changed to protect anonymity.

Data analysis

The first phase of the data analysis involved full transcription of each interview, followed by qualitative interpretative analysis, utilising hermeneutics to elicit a deep level of interpretation of the participants' sense-making processes (Ashworth, 2008; J. A. Smith & Osborn, 2008). For example, as a healthy individual, the interviewer's talk likely influenced the responses of the participant experiencing ill health in the face of someone else's healthy world (Lyons, 1999), and the participants may have sought to portray themselves as well, in the face of a younger, healthy individual; or they may have felt the need to provide stories expected from 'old people', as they had already been singled out as different and worthy of study (Gilleard & Higgs, 2000). Combined with

respectful probing during the interview, diligent analysis worked to identify strategies that conveyed a certain image, and highlighted contradictions and admissions that told a different story.

The analytical approach incorporated the principles of IPA, taking specific and descriptive information from individual interviews through an interpretative process to develop shared themes (Eatough & Smith, 2008; J. A. Smith, et al., 2009). Analysis started at the transcription phase (Denzin & Lincoln, 2005a; J. A. Smith, et al., 2009), keeping a record of initial thoughts, and paying attention to context throughout; focusing on a variety of normative, ideological, historical, linguistic, and socio-economic influences (Coyle, 2007). Following transcription and notes, emergent themes were identified and developed, reducing volume whilst maintaining complexity, utilising Atlas qualitative analysis software (J. A. Smith, et al., 2009). In order to capture the richness of the emerging themes the researcher utilised several recommended analysis techniques: for example, abstraction, to identify the super-ordinate themes of the ‘places that people age’, and ‘maintaining the positive ageing ideal’ (Storey, 2007); and contextualisation, where a pattern emerged around the role of the Abbeyfield affordable housing project for a number of interviewees. The Abbeyfield data was organised as a case study to provide analytical clarity.

After all the above analysis and interpretation had been completed this data was then linked to external theories to illustrate or provide further interpretation. It was appropriate here to generalise, based on current thinking about the topic, and the researcher’s and others’ own thoughts and experiences (J. A. Smith, et al., 2009).

Chapter 4: Results

Overview

Initially the aim of this research was to explore older adults' experiences of accessing health services. As the study progressed and interviews were completed, it became clear that the understanding of accessing health services needed to be broadened to encompass the concept of ageing in place, as the participants placed a strong emphasis on their efforts to remain in their own home for as long as possible. What emerged was a wealth of information about the strategies and sense-making processes that participants employ to age in place (Baltes & Baltes, 1990; Bartlett & Peel, 2005).

The central concept of embodiment permeates the results, and highlights how participants can only make sense of accessing health services, and ageing in place, when they are actually in the process of ageing. Two of the participants, James and Maureen, express the view that people do not think about environmental challenges until there is a problem or a need. James actually advises against engaging in this kind of thinking, as he believes that it is not healthy, and could cause unnecessary anxiety.

James: I think when you're younger you don't think about getting crook or you really don't. You think you're fireproof. I think if you start worrying about that sort of stuff too early you'll worry yourself into an early grave (laughs).

Maureen: yes well, you never, you never anticipate yourself being ill, erm it's only when you get ill because we were always quite well, reasonably well anyway.

James' and Maureen's ageing bodies are a daily reminder that they may need to access health services at any time. These speakers highlight the limitations of

younger members of the community trying to speak for, or make decisions on behalf of older people. Even the participants themselves admit that they were unable to foresee the difficulties they would experience in older age (Becker, 1994; Findlay & McLaughlin, 2005).

It is also important to highlight the broad definition that participants gave to health services, as it often assumed that the services required to keep people healthy are medical centres and hospitals. However, in this research, participants included a variety of services that are not related to primary health care. They interpret 'health services' as the services one needs to stay healthy and ageing in the place of their choice (Means, 2007; Tanner, 2010; Victor, 2010).

During the initial analysis a number of themes emerged, including visibility, maintaining relationships, managing risk and vulnerability. However, as the process unfolded and the researcher became more deeply familiar with the participants' experiences, the themes began to subsume under two superordinate themes: the places people age, and what they do to maintain the positive ageing ideal.

The places that people age

The notion of ageing in place is pervasive in the literature regarding older people. This is conventionally used to describe the process of remaining in one's own home as one ages. Through careful and close analysis of the interviews it became apparent that older people age in many places. These places include their physical bodies, their homes, their communities, and their social relationships. Consequently, the results have been structured to illustrate how people age in each of these different places and the implications of this for access to health services for older people.

Ageing in bodies

In this first section the analysis examines ageing in place as an embodied experience. Older people describe the ways that ageing involves decline and loss of function. In the face of ever increasing pressure to age well and positively, in the place of your choice, and look after one's health proactively, the participants spoke about their limitations. These limitations were often framed in terms of acceptance that the body is ageing and declining, but that does not mean that it is an enjoyable experience, as articulated in this next extract.

Denise: you know they just don't, d d that's that the thing about getting old you know, it takes a damn long time to die, it takes bloody years to die (laughs), it's awful isn't it?

For participants like Denise, who have experienced serious illness in recent times, it is hard to avoid the reality of ageing, living in a body that is a daily reminder of frailty. Experiencing illness exacerbates the difference between being old and feeling old, the latter being much more closely related to illness experience (Becker, 1994). The honesty expressed about ageing and decline illustrates that it is not a pleasant process and is a reminder of the lack of balance in the positive ageing literature and its preoccupation with ageing successfully (Becker, 1994; Jacoby, 2011; Ministry of Social Policy, 2001).

In line with the expectation that health and wellbeing is dependent upon individual health behaviour, several of the participants took responsibility for their poor health in later life. They accepted that previous lifestyle choices were detrimental to their bodies, but they accepted that there was little they could do and, in Denise's case, whilst medication can slow the decline, no amount of health service provision is going to repair the damage done.

Denise: I mean I've done the damage to my heart and now it's the medication, just living on that, but I'm quite happy to do that.

For Denise, acceptance of her declining body is important so that she can get on with the business of living. Accepting that one of the places you are ageing is in your own body may be one of the key factors to ageing in place: older people work hard to adjust to and accept decline, whilst maintaining the ability to retain a sense of general wellbeing (Lazarus & Lazarus, 2006).

Another issue around ageing in the body is living with uncertainty about what the body is doing. Although the 'body' is one of the places that people age, it is not separate from the mind, the community or social relationships that older people have. The body is present at all times and cannot be understood separately within IPA analytic terms. Uncertainty is a key aspect of the embodied experience of later life, whether related to accessing health services or ageing in place. For example, Denise describes her experience of uncertainty around her health status.

Denise: We can't find out what's wrong with it, just the one foot... still a mystery, so I mean we've tried everything. The doctor's put me on pills, taken me off pills, yes, no (quietly).

Whilst it is possible to experience diagnostic uncertainty at any age, the older person is living in a body in decline, and so a persistent health problem without diagnosis and treatment is likely to cause greater anxiety and preoccupation (Higgs & Rees Jones, 2009). Denise trails off into silence at the end of her sentence, at a loss for words, which reflects the silence around discussing the embodied experience in old age (Hillyer, 1998). In old age, even when one is well, there is uncertainty about how long this physical state will last, and there are often nagging reminders of decline, such as age related loss of function, generalised discomfort, or undiagnosed conditions. This contradicts the notion of positive ageing, which attempts to draw the focus away from frailty and illness

towards autonomy, resilience and resistance (Becker, 1994). In the face of poor health, the speakers take responsibility for their poor choices and current limitations. To varying degrees the participants all accepted that, the body does things that are out of our control, and that ageing and decline is not a pleasant process, contrary to the positive ageing literature (Becker, 1994; Jacoby, 2011; Laz, 2003; Ministry of Social Policy, 2001; Pond, Stephens, & Alpass, 2010).

An additional challenge of living in an ageing body in the Wakatipu is the sometimes hostile climate. For some participants the combination of climate, remote location, and a declining body made for very risky scenarios, and forced them to acknowledge that continuing to age in place was either becoming difficult, or was no longer a viable option. Participants described how they had to restrict their movements to the absolute necessities when the external environment becomes unsafe and threatening during the winter.

Interviewer: and what do you do, because we had that couple of weeks where it was really really frosty?

Deborah: O god, that was terrible, just terrible, my shower froze.

Interviewer: How does that affect you, did you go out?

Deborah: Well, I went and did my shopping, but erm I didn't sort of venture out, it was so cold, and er, but the house was nice and warm, I've got a heat pump, and it's just it's just great.

Deborah reduces her space mainly to home where she feels safe and in control. Being out in icy conditions in a frail body will increase the risk of falling and fracturing bones (Phillips, Siu, Yeh, & Cheng, 2005). In some cases participants were unable to complete the necessary tasks for ageing in place, due to an increasingly frail body. Derek describes his challenge around being able to

continue to fit snow chains, an activity he would have done many times through the Wakatipu winters, but finds that he no longer has the strength to undertake.

Derek: Yes, snow, I must admit, whenever it snowed I had to put my chains on, but in the last couple of years or so it's it's, I couldn't do it. I had to get my one and only neighbour down the road to come and put my chains on.

Derek had a deep attachment to his home of many years and, until recently, ageing in place was more important to Derek's wellbeing at that time than easy access to health services, and he was prepared to put up with the challenges posed by a remote location. His sense of self is deeply entwined with his home and sense of place (Chapman & Peace, 2008; S. M. Peace, et al., 2005; J. Wiles, et al., 2009). His experience highlights the additional challenges that living in a harsh climate in a remote area pose (Rozanova, Dosman, & de Jong Gierveld, 2008).

It is worth noting that the interviews were conducted at the end of what would be considered a 'mild' winter in the Wakatipu: although there were a couple of weeks where the ground was frosty, there were no heavy snowfalls in the residential areas. There may have been more talk from the participants about weather difficulties if they had experienced more severe conditions that winter.

The residents of the Wakatipu lack easy access to essential services. In remote locations people are often required to travel long distances to access major centres for medical treatment. Participants described the exhaustion and discomfort that traveling these distances, exacerbated by their ageing and declining bodies. Denise expresses her frustration at having to make such long trips, and provides an account of her experiences accessing hospital services in Dunedin, following a heart attack.

Denise: You break your leg and you've got to suffer erm that ride to Invercargill to have your leg plastered or whatever x-rayed and put in, you know it's it's a

long way and when I went from here to Dunedin we could do with some more specialists here, we need more money, that's what we need. We need our own scans.

Denise: It was tiring. I think it was, er, it didn't seem so bad coming out, (in a quiet voice) seemed a hell of a long way on the way up but erm, the first time I came home it seemed to take for ever to get home, that was but I wasn't very well I, I'd just had the first heart attack.

For Denise the journey is uncomfortable and is made interminable by to her poor state of health. A health care system that is organised over a large geographical area, as it is in Southland and Otago, affects older people differently (Kane, 2000). One's concept of time is altered, as the frail body feels the bumps and turns, making the journey seem so much longer and intensifying the negative experience (Sampson, 1996). The area between Dunedin and Queenstown is very sparsely populated, with only one hospital in between the two destinations, which are almost four hours apart, so in addition to the physical discomfort there is the risk of a health incident occurring far from the necessary medical facilities (A. E. Joseph & Cloutier-Fisher, 2005; Rozanova, et al., 2008).

As well as the issues of isolation from major centres, some participants voiced concern about the location of their homes within the community, particularly during times of illness, when their frail body reminds them of their vulnerability. For example, Maureen describes how her perception of where she lives changes during a severe bout of the flu.

Maureen: So, you know being a way out in the, being away from er townie things cos it's er a wee bit out...and I couldn't have driven, I couldn't have driven that day.

Interviewer: So it hit home a little bit then doesn't it?

Maureen: It does hit home when you're a wee bit further out like this.

Experiencing severe illness can make home feel more remote and isolated from medical services, especially when one is also unable to drive. Frail and unwell bodies force the consideration of the suitability of continuing to age in place (J. Wiles, 2005).

The participants in this study provide salient reminders that one of the core places of ageing is the body, and that this affects older people's ability to remain in their own homes. Living in a remote location exacerbates the experience of frailty and discomfort.

Ageing in one's own home

The majority of participants lived in their own homes, and they expressed the desire to stay there for as long as possible. However, this can become increasingly difficult as people age. For some, the home becomes too big. Maureen recognises the need to reduce the size of area that she is ageing in, and hers is a decision about the home she and her husband share. She precedes the comment about contemplating leaving with several phrases that illustrate the layers of attachment to the home and the area, through family ties, the building of their house, and pleasant memories of holidays.

*Maureen...*and erm we probably wouldn't have come here, we built the house, we bought the section, we had this section earlier, because my parents were down there and we'd been on holiday and the section, all sections along here were for sale (...) it's been great, erm, the thing is we hardly like to leave it and we're getting past looking after ourselves in a bigger area.

Maureen can see that the large house and section will soon become too much of a burden for her and her husband to cope with. Although, in practical terms, it is an option to reduce one's living space within the home, say to a single floor

(Loe, 2011), this does not attend to the home as an intrinsic part of the identity of its occupants, and the role of space to enable small changes through the day (S. M. Peace, et al., 2005).

For Maureen, the prospect of having to cleave themselves from the Wakatipu almost makes her wish they had never come here in the first place. Having come to a place that it is becoming difficult to age in, she knows there is a real possibility of having to leave the area and the house that they have become so attached to. It would have been difficult for her to envisage the house and garden being too hard to manage when they arrived, fit and well from the farm, thirty years ago. Maureen's sadness illustrates the strong attachment to place, and the life that has been experienced and achieved within the context of home (Chapman & Peace, 2008; Findlay & McLaughlin, 2005; S. M. Peace, et al., 2005).

One of the ways that older people can delay the often difficult process of having to leave their home is through access to domestic support. Nina describes the home help service she receives, and how the service has been cut back by the DHB. She tops up the service by paying for an extra hour, and finds the whole process of doing this "agonising", showing that she feels she has no choice but to pay the extra.

Nina: Well, the health services, when we first got help, we had two hours every week, this was through the Invercargill hospital and then they got very short of money, and so they cut everybody back to an hour, so now there's too much here for someone to do in an hour, so then you pay. I pay \$54 and five cents a month, would that be a month, or every fortnight? What would that be, I can't work it out (...) I think it might be a fortnight, yes. I never bothered to think about it, it's too agonising. I just write the cheque out.

For many older people ageing at home, domestic support is not a luxury, it is a necessity. Doing several hours of housework a week can be exhausting, making

their living space a representation of physically challenging chores, instead of autonomy, independence and pleasure (Tanner, 2010). Nina's approach to the issue of home help illustrates the strategy of working out the requirements to age at home and deploying available resources accordingly (Baltes & Baltes, 1990; MacDonald & Cho, 2011; J. Wiles, 2005; J. Wiles, et al., 2009). Without domestic support older people often find themselves unable to meet their own standards of cleanliness and tidiness that they have previously been able to meet unaided (Tanner, 2010).

The home increasingly becomes a haven through the ageing process. It represents a place of safety and familiarity. Nina describes an upcoming change in her life, in that she is no longer going to make her annual winter holiday trip to Australia. For a number of residents in the Wakatipu this is one way that they access 'health services' in the holistic sense, by avoiding the severely cold winter months.

Nina:(...)so we would go back to Australia in the Winter for perhaps a couple of months, which we've done through all the years, 30 years, but this trip I'd say is my swan song, it's too nice at home.

Essentially Nina is redefining her place of ageing to no longer include the overseas environment, and renegotiating her ageing 'space', as a geographically reduced, but certainly no less pleasant environment (Wahl & Iwarsson, 2007; J. Wiles, et al., 2009). This has been an important part of her life for a long time, and although she rationalises the decision by simply saying that it is "too nice at home", there is an acceptance that the effort to plan the trip and travel there is starting to outweigh the enjoyment, due to the general experience of decline as she ages. Flying abroad becomes more difficult as one ages, due to the increased effort of resettling in a place, managing medications, the fear of becoming unwell overseas, and missing the embodied feeling of safety and familiarity of one's own home (Nair, 2005).

As well as negotiating time away from the house for leisure reasons, older people who are ageing at home, instead of an aged care facility, may need to be away for extended periods of time for medical treatment or respite care. Denise talks about being desperate to get back home from hospital.

Denise: Oh, it's lovely to be home dear, yeah. I mean they were wonderful in the hospital, although I'd break my neck to get out again, mm.

Even though Denise is very satisfied with her care, this extract illustrates how the home is closely aligned to the embodied self, a place of familiarity, safety and security in so many ways (Kearns & Andrews, 2005). This example does also however highlight that the home often cannot cater for serious illness, especially when there is no district nursing structure. Frail people living on their own have no choice but to stay in hospital during illness and recovery, even if it is just for monitoring purposes (S. M. Peace, et al., 2005).

Needing to spend time away from the home is not the only issue for older people. Ageing in the home can mean the loss of privacy and dignity. Deborah feels invaded when the support person visits her. She pulled a face when she talked, letting the interviewer know that it is not a welcome event.

Deborah: None, well, I don't know, we get visitation once a week, every Thursday.

Clearly Deborah is uncomfortable with unwanted visits and sees her home as a private haven, synonymous with her identity as an autonomous person who is capable of caring for herself and making good decisions (Milligan, 2009; Tanner, 2010).

Whilst ageing at home has a number of advantages, such as feeling safe, secure and familiar, it is important to acknowledge the challenges associated with remaining at home into very old age and frailty. Ideally older people should feel

that they have options of where to age safely and happily, and should be supported to make the appropriate choice (Ministry of Social Policy, 2001; J. Wiles, 2011).

Moving through spaces and to places

As people age, mobility increasingly becomes an issue in many ways, from difficulty walking and negotiating hazards such as stairs and busy roads, through to driving and accessing public transport. Although there is public transport available in the Wakatipu, and intercity buses service Invercargill and Dunedin, the logistics of these services are not always ideal. For example, the intercity bus for Dunedin leaves at 7am from the centre of Queenstown and does not reach Dunedin until lunchtime, with several stops on the way. Consequently, attending hospital appointments would require an overnight stay in a motel, or staying with friends or family. Several individuals in this study were still driving, but the participants' responses indicated that it is around this time of life that they started to negotiate their way through changes to driving behaviour.

Many older people, even those who continue to drive locally, are unable to drive the five hour round trip, and so the prospect of having to travel to the hospital is a source of frustration and anxiety. Deborah and Molly raise the issue of the lack of a direct transport service to Southland hospital.

Deborah: Well I would think, I don't know if I'm right, we used to have (coughs) you know specialists coming up, having a clinic, now to my knowledge I don't know, but you know there'd be different ones come up from Kew, I think different ones come from Dunedin and go to the medical centre, but I would think (pauses) and [sic] extension of people, because I know some people have had to go to Invercargill, and it's a bit of a bloody carry on.

Deborah's response here is interesting, as she attempts to depersonalise the difficulty of accessing services in Invercargill, describing other people who have

had problems. In fact, she has experienced her own challenges, having to get the bus down by herself, only to discover that the specialist was not there. By moving the narrative to others she is retaining her identity as someone independent, who can still access services competently (Loe, 2011; Tanner, 2010).

Molly similarly reminds the interviewer that there is a whole community of people that are disadvantaged by this lack of service provision: it is not just her individual concern. Here she describes the possibility of the new dedicated bus service that will transport non-urgent patients to Southland hospital.

Molly: Yes, I saw that in the paper too and that'll be absolutely wonderful, but I, I think they're just looking for drivers at the moment, and that was in the paper. I think that'll be absolutely wonderful, cos that's always been my worry as, as, as hundreds of others, lots of people, but er, so that, it's been a couple of weeks so it might be getting nearer.

Molly's interest in this service was heightened at the time of the interview, because her daughter was overseas, and her usual access to family support for hospital transport was not available. She discussed the issue several times through the interview, illustrating how access difficulties can preoccupy and cause anxiety amongst older people, reminding them of the increasing dependence and isolation (Dobbs & Strain, 2008).

Bus services are often scheduled without taking the needs of older people into consideration, especially with regards to waiting times. For Maureen this is a reason not to use the local service.

Maureen: I must admit I've been going, we've been going to try it out, but you know it's not as convenient for older people, because when you get to where you're going, you've usually got to change a bus to get to the next piece and erm, other than that, if you wanted to go to the store, the erm New World or

something I think you have to, knowing how long it takes to do the shopping you probably have to wait quite a while.

Maureen recognises that the bus service is not designed for people like her, and that using the service would be risky and inconvenient, being away from the safety and security of home longer than she would like. Poorly designed public transport systems are often a source of frustration, and can a barrier to community access for older people (Wahl & Iwarsson, 2007; J. Wiles, et al., 2009). It is unlikely that Maureen is going to utilise a service that she does not identify as considering her needs, or feel safe using, especially as research shows older people who can drive prefer to continue, rather than utilise public transport (A. Smith, 2010).

Moving between spaces and places for older people in New Zealand is heavily dependent on private transport. Several of the participants talked about their driving behaviours, the recent changes that have occurred for them, and the attachment they have to being able to continue to drive.

James relates how he has stopped doing the round trip from Queenstown to Dunedin in a day. Although still a very active and healthy eighty year old man, he is aware of his the gradual decline in his functioning, which requires him to adapt his driving behaviour accordingly. James has started the embodied monitoring process that's helps him decide on safe driving practice. He also reassures the interviewer that he will be driving for a while yet, making comparisons with other elderly people in the community. Interestingly James remarks that losing the ability to drive is what he dreads most.

James: O right, yeah. If we have to go to Dunedin for any reason, we go overnight now. Gone are the days when we would leave early in the morning and arrive back at seven at night. It's just not worth it, it gets too dangerous.

James: I've just passed the medical that you have to have when you're eighty, yeah so I'm good for another two years

Interviewer: 'cause that's quite important that isn't it?

James: It is actually yes, that's the thing that I dread most getting older, losing the capacity to drive so when I read that some bloke of ninety eight and one hundred are still driving (laughs) that gives me encouragement.

Driving is one form of mobility that keeps older adults connected to services, and generally to their community, and is a key component to ageing in place in rural areas (Dobbs & Strain, 2008). James recognises this, and like many older people, illustrates that driving represents many things, such as independence, self-agency, ageing well, the ability to age in his own home, and the capacity to support spouses who do not drive (Findlay & McLaughlin, 2005; Tanner, 2010). Like many older people, James must make small changes to adapt to his declining function, whilst optimising his ability to move to and through places (Wahl & Iwarsson, 2007).

Whilst some people, like James, are able to continue driving into very old age, many have to go through the often slow and unpleasant process of giving up driving. The decision can especially difficult when it is not entirely of one's own volition, as was the case with Nina.

Nina: Peter drives now. Unfortunately I (laughs), I've got arthritis in my hands and my knees, and I've got a doctor umm, we always had a marvellous doctor that we went to but he retired, and so we've got a new doctor, and, I think it was a couple of years ago I went to renew my licence, and to my horror I see his face change (laughing) and he said, well I'm responsible to the transport department and he said that, I don't know that I'd be happy for you to have your licence, so I got really mad then I thought, Oh dear, I've got a fight on my hands here, so I said to him, erm, well you can surely give me, if you won't give me a full

licence, you could give me a part licence, because of where we live, and erm we need transport, so he said you're twisting my arm. I said, indeed I am (laughs). I was desperate by this stage, so, he weakened, yes; he said he would give me the part licence...

Nina knows how important it is to be able to independently mobile for getting around the community, and to places further afield, so she fights to hold on to her licence. However, after all the work to secure the licence, Nina then goes through a renegotiation with her husband, and makes the decision to give up driving. This decision is made with considerable, and on-going regret, even though in practical terms having her husband drive is working quite well at the moment.

Nina(...)but then I came home and I told Peter about it and then he said, well, you know, as you get older (laughs) you don't react to things quickly, so after he talked to me for a while I thought, oh, I won't bother, I've got a perfectly good driver here(...)so I might as well go along with him, and he'll take me everywhere I want to go, which he does, but oh no never, I would never advise anyone to give up their licence until they really have to. Your whole life changes, when you've got transport, you're just out into the car, you go, wherever you want to go.

Even though Nina has her husband to drive her places, she recognises the irreversible loss of independence and freedom, which demonstrates that driving is about much more than access to services. Nina illustrates how the decision to give up driving is more distressing if it is influenced by the views and actions of others (Tanner, 2010), and that no longer driving represents another reminder that she declining and ageing, and losing the skills that make up her identity as an active and independent woman (Dobbs & Strain, 2008). Evidence suggest that older people engage in a complex dance with driving, re-evaluating, reducing and adapting, before ceasing (Findlay & McLaughlin, 2005).

The consequences of being unable to move through and to places easily are outlined in the next extract. Nina describes the uncertainty of access to specialists for her husband's eye condition.

Nina...but no, we've found that we don't have to go down there now, cos Peter has got an eye problem and for a while the specialist came up here, which was fine, and then they decided that they had to go down there, but now the whole thing has reversed again the specialist is coming up, that's absolutely...

Interviewer: Quite unsettling though?

Nina: oh, well, it is! Because you get the date, and it's usually a month or so ahead, and you can't help thinking, so it is, but no things seem to be getting sorted out very slowly. We still wait anxiously to see what Invercargill hospital people are going to do.

Nina feels at the mercy of the decisions made by people in Invercargill, who are not local to the Wakatipu, and who may not consider the issue of having to drive a five hour round trip for a specialist appointment. Nina's anxiety is also intertwined with her increased reliance on Peter remaining well and able to drive, as she no longer drives herself. This reliance and co-dependency intensifies the shared embodied experience with a spouse, as Nina's own life would change irrevocably if Peter's sight deteriorated and he could no longer drive (Connidis, 2001).

Moving to and through spaces that are not within walking distance for older people living in the Wakatipu is a necessity for accessing core health services. The bus services are inadequate for their needs and like many older people the ability to drive becomes increasingly difficult as their senses and reactions deteriorate.

Despite efforts by local councils to assist older people with accessibility, they can still feel that essential amenities are difficult to reach. Deborah describes how she feels about being out in the community, and even though she has equipment, in the form of her stick, and resources, such as her mobility card, she could still be left stranded and unable to do her errands if the disabled parks are occupied.

Deborah: I've got a walking stick, and er I'm very wary of, you know, where I go, well erm I go to the Warehouse and they've got mobility parking there, right outside, and New World's that's the same and I always have to think twice.

This example shows the precarious relationship with place that older people can have, especially with limited services, such as only one or two mobility car parks at a location. They may be unable to engage in activity and experience feelings of exclusion and disempowerment when undertaking daily activities that are required for ageing in place (Carman & Fox, 2009).

Lack of footpaths in rural areas is a common issue that can prevent access to local amenities. Denise highlights the lack of pavements and the proliferation of bike tracks, with recent opening of the Wakatipu Trails. The absent footpaths prevent her from walking to the doctor's, which is only a couple of hundred metres from her house.

Denise: this is one thing Arrowtown's sadly lacking in yeah(...) they spent millions doing bike tracks but then nothing (points outside), no footpaths.

Denise recognises that resources are being allocated to the leisure activities of young fit citizens, at the expense of necessary services for older people to engage safely with their environment. Denise and Deborah's comments about inadequate footpaths and mobility parks highlight how the inability to move easily to and through places can easily lead to older people sensing that their needs are being ignored (Carman & Fox, 2009; Wahl & Iwarsson, 2007).

Ageing in communities: Invisibility

Being unable to move about and reach places easily is one of the factors involved in older people feeling and experiencing invisibility (Tanner, 2010). As outlined above, older people age in the context of their wider community, in the types of amenities and resources they require, and the changing way they interact with the environment. Often they are made to feel invisible when they feel that the community is not designed for them, decisions are made without their input, or essential services are unavailable or hard to access.

The awkward location of essential services can sometimes make access difficult or dangerous. Raewyn highlights the challenges of the location of the podiatrist, a service that is often needed by older people, when cutting their own toenails becomes too difficult. If not accessing the building by car, the only option is to cross a busy state highway, with no pedestrian crossing facility.

Raewyn: Well, I mean, I'm fortunate, until quite recently I've been able to cut my toenails. Well now the guy who usually do.., does them he's right up at the Terrace do you know and erm, he, to cross that road up there. I hate I, and you know I go there with heart in mouth and I said, oh if only we could have somebody here who could do, you know, look at your toes.

Raewyn is also indignant about the poor location for the audiologist, which is also a service frequented by older people. Raewyn defends her cohort and her sense of self-worth as a member of the community, whose needs should be considered.

Raewyn: well, here, as you, I have to go to the audiologist, not every, you know, perhaps once a year, and now of course, he's, they've moved up to just along there, you know by the park and of course there's no lift there and no, er there's a handrail upstairs but nine times out of ten you see elderly people going in there. It's not the right place for them.....yes, no lift. It's ridiculous, ridiculous of

people of our age I mean I fortunately can get up the stairs but I'm not, I'm alright coming down but I'm glad they've got that handrail cos it's quite steep, yes and most of the people, I say most, a lot of the people are elderly.

Raewyn's protests highlight how barriers to engagement with and control over our environment can impact negatively on self-esteem (S. M. Peace, et al., 2005). Even though she is still interacting with her neighbourhood, Raewyn feels that aspects of her lived 'out of home' space are designed in an exclusionary way. This can lead to increased feelings of frustration and isolation, and decreased well-being (Carman & Fox, 2009; Scharf & Bartlam, 2008; Tanner, 2010).

Another aspect of invisibility is a sense that the community does not contain services or entertainment that would be of interest to older people. Raewyn describes how she no longer ventures far from her neighbourhood. Journeying into Queenstown does not hold much appeal, because she feels that there is nothing there for her, invoking a feeling of civic invisibility.

Raewyn: yes, you get in the car and off you go but I'm, I've got used to not having a car, so that doesn't interest me, now I, I mean I go to Queenstown sometimes on the bus, it's free, not because it's free, but because it's just down the road and sometimes I go on the bus, but I go into Queenstown and I think, oh, what do I want here? Is, all the fashions are not my age group, and erm if I go in with a friend we might have a bit of lunch down there and off we come back again.

Raewyn does not feel a positive connection to the environment in Queenstown, and experiences bodily self-consciousness when she is confronted with the shops full of clothes designed for young women. This dissonance is enough to discourage her from visiting, other than occasionally, as is often the case with older people (Finlay, 2006; Tanner, 2010).

Spending less time in the community means a decreased ability to discuss issues of concern. Nina describes how isolated one can feel when you are older, as there are not necessarily the forums to be heard on issues that affect older people.

Nina: I thought I'd just be one, one voice crying in the wilderness and I found I'm the only one and no-one else volunteered!

It should not be assumed older people will raise their voice about accessing health services and ageing in place, as they often feel excluded from their communities (Scharf & Bartlam, 2008). In fact, invisibility and exclusion are often synonymous with older people ageing in their communities (Tanner, 2010).

Invisibility: Aged care facilities

Absence of the specific services required to age in place also reinforces the invisibility of older people in the Wakatipu area. Derek and James acknowledge that there are gaps in aged care, and a lack of consideration of how older people in the area can age in place, with a lack of facilities for when you are no longer able to look after yourself at home, but are not ready for the rest home. James uses the third person to express his concern, saying "I know a lot of older people" and "it must be awful for people whose old folk have got dementia", in an effort to provide reassurance the interviewer that this is not relevant to him.

Derek: no, there's nothing in between. You want a proper home that you are sort of monitored a wee bit and everything but er, er, definitely. There's a place in Cromwell, I can't think of it and that's a very nice place, that's in between the two.

James: I know a lot of older people would like to stay here in a nice good retirement. I think what we really need is a good retirement village like they've got over in Wanaka. They've got a lovely one, the Aspiring, whatever it's called.

As Derek and James highlight, having access to staged retirement and rest home care can enable older people to age in place with continuity and peace of mind (Eales, Keefe, & Keating, 2008; Nair, 2005). In essence these types of facilities erase the marked difference between ageing at home and ageing in a rest home.

There are no secure aged care facilities in the Wakatipu that cater for people in the moderate to severe stages of dementia (Foley, et al., 2011; Lynch & Boulay, 1999). Therefore people suffering from dementia are rendered invisible in the area, by having to be moved away to access appropriate care. James identifies the 'unspoken' issue of people with moderate dementia having to leave the area and be placed in residential homes, often far away from their families.

James: It must be awful for people's whose old folk have got dementia, having to travel to wherever they go, I don't know, Invercargill or Dunedin.

He was the only participant to raise this issue, despite it being discussed at length in health service reports about the area (Foley, et al., 2011; Lynch & Boulay, 1999). As with previous extracts, James utilises the strategy of using the third person to describe old people, a common strategy older people use to distance themselves from the experiences of decline (Higgs & Rees Jones, 2009). He identifies the place that people with dementia continue to occupy within their families, but that the possibility of ageing in place does not apply to them due to community and service provision invisibility (Means, 2007). Treatment of dementia patients in the Wakatipu is representative of their social exclusion, and ignores their place within the family, regardless of significant loss of function (Higgs & Rees Jones, 2009). Dementia is regularly portrayed as the destruction of one's competency, agency, and identity, and it is therefore

unsurprising that James distances himself, and that the other participants failed to mention it all (Baars, 2010).

Often the aged care facilities in the community that are available make assumptions about the space that people need to age in, as illustrated by Derek:

Derek: They've got a home out there attached to the hospital, but, oh no, I wouldn't like it, I couldn't, I couldn't live there, but erm, suffer from claustrophobia, the rooms are so small, and everything...

This is often a problem with the design of rest homes assuming that older people need very little space, which indicates a lack of attention to the importance of space for identity and quality of life, (Adams, 2009; Nair, 2005; S. M. Peace, et al., 2005), as well as exclusion of older people from contributing to the design of their own places in which to age.

Invisibility manifests itself in many different ways for older people ageing in the community. Whether it is a dearth of facilities, unattractive facilities, poorly designed environments, lack of appropriate forums, or a culture focused on younger people, they all serve to undermine the value and relevance of older people, and the significant contribution they make to their communities (Eales, et al., 2008).

Ageing in communities: Health services

The way that people interact with health services changes as they get older. Most obviously they usually need to see doctors more often, and as the list of ailments grows, they are unlikely to want to have to repeat their story to numerous health professionals. One of the themes that arose during most of the interviews was how participants had enjoyed long-standing relationships with their doctors in the past, and that these doctors were dedicated and easily available. For the most part, this is no longer the case, due to many doctors

working part time, the demise of home visits, limited weekend clinics, and higher staff turnover. James describes the difficulty of accessing the family doctor, who he and his wife have a strong trust in, especially on the weekend.

James: Yeah, yeah, that is a bit of a problem here actually, your favourite doctor, your chosen doctor is not always there when sometimes you might need it. And if Mary suddenly gets really crook which she does very rarely, she's had pneumonia twice. Each occasion it's happened over the weekend, that's something you can't help and she's had to go to the medical centre, you know the emergency department, which is open, so that's been a bit of a problem.

James knows that it is important to maintain a meaningful relationship with his doctor, which is also highlighted in the literature on health service access for older people (Higgs & Rees Jones, 2009). However, as James illustrates, the world of health is changing, where important connections for older people are being eroded (McKinley & Marceau, 2002).

Not only is it important to maintain a relationship with one's doctor in old age, feeling unable to access a doctor can be a terrifying experience for older people, as outlined here by Maureen.

Maureen: yeah, well, you know those things didn't, the biggest thing that really hit me was when I got the flu one time, oh I felt as if I was dying, on Saturday, and it was 1 o'clock(...)I suppose it would be the second or third day of the flu, and I thought I was passing out. In desperation I rang the doctor's rooms, thinking there's nobody there on a Saturday, I did it, I don't now, just to calm myself or something, and erm, tut, ha, the doctor answered the phone! Now that's something!(...)and he er answered the phone and he said look, I'm awfully sorry, but I just can't, we can't do anything for the flu and he just told me to take some Nurofen or something like that, and I didn't have it in the house anyway, I took something else equally, you know, and so that was that.

Interviewer: At least that was comforting, to speak to a doctor?

Maureen: Well, even to know that he was there.

Maureen: Mum suddenly collapsed and died because she had the flu(...) she died that night, erm, just after we'd been visiting, so, you know...

Maureen states that she calls the doctor, "just to calm myself" and to "know he was there", illustrating the deeper meaning that accessing a doctor has other than dealing with the immediate health problem. That day, feeling very frightened, Maureen used ringing the doctor to anchor herself in the world, make sure that she was visible, and to assuage her anxiety at the possibility of dying alone as her mother had done. The ability to access the doctor by telephone can enable older people to feel grounded and to feel more in control of their situation, despite there being a lack of adequate face to face medical services available (Daly & Grant, 2008).

Older people remember when the experience of health services was more personal, with better staffing levels and priority given to care and compassion. Deborah compares the quality of care she received during a recent stay in hospital with how things were when she was younger.

Deborah: They were, ahem, alright. I just, see I'm old (bangs the table) fashioned, and I just think, people, the nurses haven't got time, which I think (pause) is not very nice, erm, when I was training, we had time, to not sit down and talk to people, but you know, you see somebody who'd been crying or something you know, what's happened, can we help you, and there was that little bit extra that, to me it's not there now. I know they're busy, I know all the hospitals seem to be busy, perhaps I shouldn't be saying this but I just feel time sometimes with somebody who's sick (pauses).

Deborah highlights how people's place in the world is often defined by the interactions that they have, and that her experience in hospital was of being ignored and feeling abandoned, (Kane, 2000), which is exacerbated by the loss of professional status and visibility experienced in retirement (Blaikie, 2005).

High staff turnover means that older people have to repeat their story and constantly build new relationships with health professionals, as outlined here by Nina:

Nina: oh, yes, they've also changed, er, the people as well you no sooner get used to one person then he disappears into the blue and you've got someone else.

Nina invokes the image of a situation of constantly starting relationships, having to repeat the story, so one's 'place' in the health professional's sphere is precarious and often temporary (McKinley & Marceau, 2002), despite the increased need for continuity and trust as the body ages and begins to fail.

The importance of the relationship with health care providers, in particular the GP, increases as people age (Greene & Adelman, 1996). Each visit to the doctor is a bodily reminder of ageing and decline, but the relationship may also serve as a mode of reassurance, remaining visible in the community, and a long-standing relationship with a person who understands the minutiae of our life and history, and place in the community (Lazarus & Lazarus, 2006; Loe, 2011).

Ageing in unequal places: Lack of resources

Another aspect of ageing in place and its interaction with health services is the cost of accessing GP services. Although financial hardship is not a common experience amongst these participants, the considerable difficulty of ageing in the context of limited financial resources deserves attention. In addition, ageing may be more difficult for those who lack resources in a community where such lack is less likely to be recognised. Denise was the only participant that related

experience of financial hardship. Due to limited income she is forced to rely on the goodwill of the doctor from time to time, in terms of accessing health services.

Denise: Yes, it can get very expensive. Yes we had an add up and I can't remember what it was. It was far too much for a, for a year, that and the chemist between them. I know, it was gonna be a struggle that month especially.

Interviewer: But that hasn't stopped, it's not to the point it would prevent you from accessing them, you're able to do that?

Denise: No, no, because sometimes they say "Oh don't worry about it", you know, when I've been about 3 days beforehand.

Whilst Denise seems satisfied with this arrangement, it leaves her vulnerable to the whim of the doctor's decision to waive the fee (Scharf, 2009), and makes her place in the patient doctor relationship less empowered.

Another perspective of inequality is the availability of core services in rural areas, compared to areas of larger population densities. Ageing in rural areas often means limited or no access to basic health services, as outlined here by Molly when she broke her arm.

Molly: I did see a physiotherapist before I left the hospital, but there isn't one at the hospital, so I've got to have, if I want some I've got to get some private ones, because it's not on ACC, because I didn't fall or anything, it just happened, so I'll get that, but she did suggest I waited a couple of weeks to let it settle down.

At the time of this research the position of hospital physiotherapist had been vacant for several months. Despite rural health service availability being identified as key to ageing in place, and a goal in the New Zealand government's positive ageing strategy, older people in rural areas continue to be denied access to important amenities (Chapman & Peace, 2008; Ministry of Social Policy, 2001).

Ageing in lonely places: Vulnerability and fear

Although the literature on ageing in place often highlights the advantages of remaining in the community for sustaining social networks and remaining part of the wider community, this is not the experience of all older people. For some, ageing in place is a lonely experience. Despite considerable efforts by the participants to be seen as coping, proactive, vital and positive, analysis of their talk demonstrated that ageing in place can be lonely and frightening.

Raewyn and Deborah both provided narratives around their feelings of anxiety and vulnerability at night. Both women are widowed, and the embodied experience of ageing alone is exacerbated by the quietness and solitude of the night.

Raewyn: because you lie there hour after hour thinking about all sorts of sappy things and one thing goes to another doesn't it? And, you know they don't worry me, but at night time it seems to expand.

Deborah: I, I don't go out at night. I haven't gone out at night since Douglas died. It's alright in the summer time, but I always have to be home by about half past eight or or something like that, but going out at night, no way, it's just freaky really isn't it?(...) it's just about coming back to an empty house at night, yes. I think that's what it is.

From the perspective of ageing in place at home, it raises the issue that whilst it is held up as the ideal, it can still be a lonely and frightening space to occupy, especially for older people living at home alone (J. Wiles, 2005; J. Wiles, et al., 2009), and should not be thoughtlessly reified as the best option for ageing in place (Katz, 2005).

It is not only the home that can invoke fear and vulnerability. Denise's fear emerges when she is away from her home, on the long journey to the hospital in

Dunedin, which requires travel through one of the most remote areas of New Zealand. Out of all the participants she was the most vocal about fear of dying, and this may have been because she has experienced two heart attacks, as well as recent protracted stays in hospital.

Denise: Course you're scared. I mean the people are wonderful, those St. John's people are wonderful but it's still, you're still scared. Any, anything like that yeah you must be very scared because most of them, a lot of the accidents and things that happen are people on holiday, so their family are millions of miles away.

Even though she trusts the St. John's paramedics to be professional, Denise still feels lonely and vulnerable on the journey, being very conscious that she is a long way from her family and home if anything serious happened. Denise's place where she feels safe and in control does not incorporate the vast, open landscape of Otago that she has to surrender to in order to access essential services. Each time she has to leave is a reminder of the threat to her being able to continue to age in place (A. E. Joseph & Cloutier-Fisher, 2005).

Changes in life circumstances, such as the death of a spouse, can make the home a lonely place to age in. Feelings of loneliness can precipitate change, such as feeling the need to move out of one's home and into an aged care facility.

Maureen comments how she has observed this phenomenon in the community.

Maureen: Oh, it's important to stay independent I think that's, anybody that you hear talking about going to the home or anything, Oh no they don't want to go into the home, and unfortunately women seem to need to do that when husband dies, which I think's a bit sad, but um, it gets lonely you see.

Here Maureen illustrates the entwined nature of place, where the home is no longer an attractive place to age, because there is no company, and the place within the spousal relationship has gone (Chapman & Peace, 2008). Entering

the rest home represents the non-negotiable sacrifice of independence and autonomy, as well as the failure to continue ageing successfully (Findlay & McLaughlin, 2005).

Another place that can invoke fear and vulnerability is the hospital. As older people decline they are more likely to undergo frightening medical procedures. In this final example, Maureen describes her experience of radiation therapy. She feels very isolated and vulnerable when she is placed in the machine.

Maureen: I can't explain it to you, except what happened to me, because when I had the treatment, it was basically, erm, the mach, the mach, the machine was just like what they would do for any cancer I think, and, and they, they put you in a room that has a door, that has a wall was 6 feet deep and they have a wee hole that they look through and they shut everybody off, except the poor patient.

Whilst it is clearly not only older people that feel vulnerable when they undergo these procedures, the older one gets, the more likely it is that you accumulate frightening experiences around ill health, and how these experiences will influence feelings around accessing services, especially as the likelihood of recovery decreases with age (Bludau, 2010; Daatland, 2007; Higgs & Rees Jones, 2009).

The above analysis shows that lonely and frightening places occur through the environment for older people, and are interlinked with physical frailty, awareness of mortality, and loneliness and isolation. These experiences work to undermine the confidence of older people to continue ageing in place (Gilleard & Higgs, 2000; J. Hendricks, 2010; Lazarus & Lazarus, 2006; Scharf, 2009).

Ageing in social relationships

Older people do not age alone; they age in relationships with others, with spouses, family members, friends and acquaintances. One of the important expectations regarding social relationships is in terms of reciprocity. Physical and cognitive limitations, financial constraints, and other changes associated with ageing, such as retirement from the world of work, mean the rules of reciprocity have to be renegotiated.

The number of relationships decline as people age, and some people feel able to only ask for help from family. Molly struggled with accepting assistance from outside of her family, even when this meant waiting in her home in pain until the morning.

Interviewer: ...tell me about what happened, because you said, well, the second time you sort of woke up in the middle of the night, but you had to wait, well you felt you had to wait until the morning?

Molly: Well, yes, cos I thought rather than get somebody else to take me there or do, if it had been my daughter I wouldn't have minded, you know I would have got her, but to get somebody else, so I thought I'd just basically got myself organised, packed a bag (laughs) then waited and then went up first thing in the morning.

Molly avoids any type of non-kin relationship, where she would have to ask for help, with nothing to give in return. Clearly this avoidance results in smaller numbers of reciprocal relationships, and a greater reliance on family (Fiori, Consedine, & Merz, 2011), and in Molly's case it is making her ability to age in place more precarious.

Ageing forces people to renegotiate social relationships. Molly actually engages in renegotiation during the course of the interview. Firstly she starts to rank the

kinds of help you can and can't ask for, with a lift to Invercargill being out of the question. In the second extract she begins to realise that she may be avoiding receiving help from willing members of the community.

Molly: Oh, I think so, it always, that always takes time I think to get to know people and find out, so I think that that wouldn't be a problem, but it's always there, you think about it, you know like asking someone to take to you to, to Invercargill, say, that's a different matter.

Molly: I try not to like everything else, but I feel quite sure, I'm slowly in the 11 years I have built up, erm, friendships with different organisations, and I feel I could...if I needed I would just have to say (claps hands) I feel quite sure that they would help me, but, I, I, you don't like doing that, which is stupid I suppose they'd be cross, they'd be cross to think that I thought that way too, but I feel I know people, erm, a bit well, a bit more now that I could do that.

Through this discussion, Molly realises that she does have social relationships that she could call on, and this insight encourages her to consider accepting help, especially when her family are not available. The reframing of the rules of reciprocity is fundamental to being able to continue ageing in place, and informal reciprocity and size of social network are factors that affects access to health services (P. Bernard et al., 2007; Tanner, 2010; Wenger & Keating, 2008).

Even family relationships require careful balancing to ensure reciprocity. Raewyn wants to show that she understands the reciprocal balance required within her own family. She doesn't call on her family too much, and emphasises that she does not abuse the support that her family provides.

Raewyn: I know that they're there, but on the other hand they've got their lives to lead and I appreciate that.

Raewyn takes comfort from her family just being nearby, whilst at the same time emphasising that she is not a burden (Tanner, 2010). Raewyn recognises the psychological support her family provide by just being there just in case, which is an increasingly common pattern of reciprocity amongst families (Izuhara, 2010).

In the places that older people age, relationships and the rules of reciprocity change. For example, in the nursing home Denise feels that reciprocal relationships all but disappear.

Denise: Well I've been in there to have a look and, oh no, unless you lose your mind I don't see how you could fit in, how you could talk, I mean how you could live, nobody to talk to (laughs) except the nurse you know and they haven't got time to be sitting around talking. I don't know... er, if it got to that stage I hope, I hope I could manage as long as possible at home here, yeah and have perhaps just the last little while there or whatever, but I since, sincerely hope I don't have to spend years I'd, because I've seen people in there for years you know.

Denise suggests here that relationships are a vital part of living: we only exist if we are in meaningful relationships with the people around us (Tanner, 2010). For Denise, they disappear in the rest home, so in her view you might as well not exist. The home is the place to die, not to live, and is where agency and reciprocal relationships cease to exist (Findlay & McLaughlin, 2005; Milligan, 2009). Even the marketing literature and discourses about quality of care are often aimed at the carers or family, not the cared for (Gilleard & Higgs, 2000).

Ageing in social relationships sometimes means that the relationships take precedence over ageing in geographical place. The need to be close to family increases as older people become more reliant on them for transport, company and care, as illustrated here by Molly.

Interviewer: Is this the place that you want to be for ever? Do you see yourself being in the Queenstown area?

Molly: Oh yes, oh, in the Queenstown area? oh yes, I think Oh yes, but it will depend on, I think it's made me realise erm, but fortunately it is going to change with my daughter's situation, they're going to have to go back and forwards, my grandson's going to be here and I'll feel a lot better but if they, if my daughter decided to go away then, that's why I came down here, that's why I came to New Zealand to be with them or nearby, so er that, but I'm quite happy in Queenstown.

Molly's situation highlights how people are sometimes ageing in places because of the family, either because the younger family members moved there, or because they raised family there. Although Molly says she is happy living where she is, she also makes it clear that the only reason she came to New Zealand is to be with family. For Molly her connection to place is related to her 'place' in the family. For some, this connection is much stronger than to geographical place (Wenger & Keating, 2008). Molly's situation highlights the uncertainty experienced around ageing in the family place, as her daughter and son-in-law work for lengthy periods overseas. As work commitments increasingly entail people travelling globally, the family support network becomes fragmented and less reliable (Lowenstein & Katz, 2010; Phillipson, 2007). Molly's increased dependence and expectations that they will be there for her also illustrate how the dynamics and experience of one's place in the family shifts through the lifecourse (Phillipson, 2007).

Social relationships also become less easy to control and maintain in old age. In this final example Nina talks about her relationship with her domestic support worker. She is very complimentary about the quality of her work, but then talks about her anxiety when she heads overseas.

Nina: Absolutely everything is shining, and I say, it's a shame to have to go into the kitchen and it looks so beautiful, erm, but then when we were away, she was going overseas for a while, and so I thought, well, probably I won't have her back, but no, it all worked out, she's back, she's back here, so all's well.

Nina worries about losing this relationship and having to get used to another person. Staff turnover is a common problem in homecare, and this means that older people may have to get used to the presence of strangers in order to continue ageing at home (Foley, et al., 2011).

Ageing in many places

Whilst the analysis thus far has been presented as several distinct places of ageing, in reality older people are ageing simultaneously in many places. This final extract illustrates well the effect of ageing in the body, which is no longer private and intimate place; within the home, which is no longer about choosing who comes and goes; and within social relationships, which become less about friendships and more about service provision. Although the majority of the participants' talk in the interviews was focused on maintaining autonomy and agency, there were several examples of the experience of unavoidable loss of privacy and dignity. For example, Denise outlines her interaction with aged care services. She has designed a specific role for her support worker, rejecting the more conventional option of being physically showered, and instead requiring her to be an observer and potential contact with the outside world if something goes awry.

Denise: We've got aged care comes in and helps with the housework, that's, and erm 3 times a week she comes to help with the showering, although I, she usually just sits round while I have a shower, or does something while I have a shower.

Denise rejects the more intrusive act of being physically showered and negotiates to maintain her personal space and independence. Whilst domestic

support enables people to age in their home for longer periods, the provision of care at home has significant impact on identity, privacy, and security (Robinson, 2007; Sims-Gould & Martin-Mathews, 2008; J. Wiles, 2005). The requirement to have relative strangers enter the most private and personal spaces in one's home, such as the bedroom and bathroom, is a reminder of the changing relationship that people have with their home as they age (Milligan, 2009). Older people desire familiarity, consistency and continuity in their relationships, but in reality they may need to adjust to new people entering their private space on a regular basis (Milligan, 2009; Tanner, 2010).

Maintaining the positive ageing ideal

Much of the positive ageing literature emphasises the need to be in control of ones ageing, which implies that uncertainty needs to be minimised, but as is illustrated in the previous results section, the participants are ageing in many places, and these ageing processes often mean that older people are more reliant on the behaviour of others, less in control of what their bodies are going to do, and less able, or less inclined to feel able to effect change (Higgs & Rees Jones, 2009; Mroczek, Spiro, Griffin, & Newport, 2006).

A variety of terms are used to describe the overall concept of ageing well: positive, successful, productive, robust, resilient, healthy (Bartlett & Peel, 2005). Each of these terms has a slightly different focus, ranging from economic productivity to maximising health, and engagement in activity. In fact, there is little consensus on what ageing well means, and the participants each have a unique view on what it takes to stay well, in light of their own physical health challenges. This superordinate theme contains several sub-themes and the participants were keen to show the positive faces of aging: the robust elder, who

knows how to compensate and adapt one's life to access the services required and to continue to age in place (Albert & Freedman, 2010).

One of the consistent messages from these participants was about doing everything to keep themselves competent and well. Participants wished to avoid being a burden on services, wanted to choose where to age, and wanted to engage with life to the best of their ability, demonstrating how older people want to retain their agency, even in the face of decline and increasing dependency (Blaikie, 2005). It is a relatively recent 20th century concept to examine human agency in relation to how we experience and talk about ageing (Gilleard & Higgs, 2000), and yet it is evident throughout the participants' responses, suggesting that they have absorbed this phenomenon. One of the key psychological strategies to ageing in place, and feeling able to do so is to celebrate gains and minimising losses (Freund & Baltes, 2007), and there are many examples of the participants doing both in the following subthemes and associated extracts.

Ageing as a competent actor

The participants presented themselves as people who make good choices, and who are competent at running their own lives. The following quotations from Deborah, Denise and Raewyn all aim to portray a similar image: that of a strong, independent minded woman, who still holds her place as the matriarch in the family, capable of making her own life decisions, especially about ageing in place. These participants mention that family members want to start making decisions for them, and this is interpreted as representing loss, decline and incapacity. As such, the participants resist this encroachment on their self-agency (Tanner, 2010). Some of the language is quite forceful, such as Denise telling her children to "shut up" when they make suggestions about moving out of home, showing that it sometimes requires a quite directive approach to let the family know that they have overstepped the bounds of responsibility. Deborah

describes the way that the options were written down in big letters, implying that her family's treatment of her is quite demeaning.

Deborah: I was in (coughs), yes I was, erm this was January last year, and this is when it all came to a head, Mother, Mother, this is the way the kids talk to me, like that erm, I think it's time that you move, and that, but that, I'd already made my decision, so it was a family meeting when I got home, and my eldest son, right mother, would you please have a look at this, and he'd typed something out in big (bangs the table) letters, and said right you have four choices, you live here, you live where you are now, you come to the PSS cottages, you go to Invercargill, or you stay where you are. Right, you make the decision, I said I've already made it, and that's why I came here, but it was the way it was all printed out (pauses)...I told them I'd made my decision. I made it myself. And Abbeyfield was one of them, and that was the last place I wanted to go.

Denise: Yeah, you have to make that decision. Yes well I told the boys that I don't, that I will make a decision when the time comes. In the meantime I er, shut up!!(...) well naturally they've said you've got to think about this Mum, so I've thought about it just you don't you bother! I'm thinking about it.

Raewyn describes the experience making her own choices about where to live as slightly more collaborative, in that everyone was happy, but she is still keen to point out that it was important to her to make the decision herself to come permanently to New Zealand, and not merely following the suggestion of her daughter.

Raewyn: because I really wanted to, oh you know to suddenly say o you're coming to New Zealand, you're coming Mum is different from erm.... making that decision in my own head, yes but they were right to sort of let me come, well not let me come here and we're very happy all of us.

Much of the talk signifies considerable effort made by the participants to retain control, which is a key factor in continuing to participate as an agent in one's social world (Higgs & Rees Jones, 2009). Relinquishing power of attorney becomes an increasingly likely reality as one ages, and in this context, it is important for these three participants to communicate clearly their capability to make their own choices, to remind their families that they are still very much able to make rational decisions.

There were several examples of the participants demonstrating through their answers that they made good choices, and one of those core choices was choosing to live out their lives in the Wakatipu. For example, Derek justifies his move from his remote hilltop property, to be much closer to town. It is important for him to convince the researcher that he still has a great view, and that he has not given up too much of what he loves in the move. *Derek: yes, well that was the only problem. I was in a lovely area with a lovely view, although I've got a lovely view now.*

For Derek, ageing in place is about retaining visual access to the landscape, and the maintenance of open space in his relational world, a factor that is often forgotten in the design of older people's housing (Carman & Fox, 2009).

Utilising favourable comparison was one of the specific techniques used to demonstrate that living in the Wakatipu is a good choice. Participants articulated that they would not be better off elsewhere, and in fact they could well be worse off. Denise for example, reminds the researcher that it is not all about flash services, it's as much as about cherished relationships.

Denise: No, I think it's, no I think it's erm easier, the people in Arrowtown, like I could just, well everybody who goes down here (points to the doctors) cos, why wouldn't you, why would you go over there to Queenstown? So the doctors get to know the families sort of, they know where you live and if they're

younger people they'll know the families. It makes it all sort of more like Lumsden, just a yeah very close community.

Denise: yeah, I tell you, that's pretty good pretty blummin good, you won't get that in any great big city you know it's just everybody knows everybody else. That's all there is about it.

Denise is lauding the close knit community she lives in, and strongly believes that this she would not experience these feelings of closeness in a big city. This strategy of comparison demonstrates that the speaker is in control of decisions, and that the decisions they make are rational (J. Hendricks, 2010).

As will be demonstrated in the subsequent subthemes, making good choices and begin able to demonstrate one's competence plays a central role in in maintaining the positive ageing ideal (Butcher, 2012).

Ageing with the resources I need

Research shows that access to economic and community resources increases the ability to age in place (MacDonald & Cho, 2011) and that older adults actively engage in building knowledge in what can sometimes be a confusing landscape (Tanner, 2010).

As demonstrated by the following extracts, most of the participants have access to sufficient resources to pay for private health insurance and to travel overseas to a warmer climate in the winter.

Molly: I think the only thing that we did when we came here, went there was get private insurance and that was, that's the only time I thought about it, so I didn't think any more about it and I've still got it cos I got it when I came here but I keep tossing up whether I should because it's getting quite expensive and I keep thinking well should I or shouldn't I and then I think, no I'll get rid of it and then something else happens and then I think oh maybe I should keep it.

Much of the gerontological literature focuses on older adults in poverty (Curtis, 2004; MacDonald & Cho, 2011; Scharf, 2009), however, even those with considerable resources experience challenges to ageing in place and accessing health services (Hall-Gueldner, 2000).

James highlights a pattern of activity of that is reasonably common in the Wakatipu: retired people spending the winter months in the sun, usually Queensland.

James: I mean, we go away in April over to Australia and she is basically away then until the end of September... she [my wife] hates the cold. She was born in Northern Queensland and she hates the blummin cold, but the local GPs are really good. They give her 3 months' supply and then I'll take, or I'll send some over to her from here, really good yeah.

Providing sufficient resources are available, this strategy can help people to age in place, as they avoid the risk of becoming very unwell due to the harsh Winter (Katz, 2005).

The following quotes are examples of how the participants showed that they know what's available to them, how it keeps them mobile and independent. The card that Derek talks about is a parking concession Queenstown Lakes District Council provides to anyone aged 75 so they can park for free in the pay and display parking areas.

Derek: Yes I've got an over 75 free park anywhere and if I can't find a free park I can find a disabled cos I've got a disabled card as well because I can't walk very far, so provided I don't park on bus stops or broken yellow lines I can park as long as I like anywhere, it's very good.

As well as focusing on the resources needed for the present, participants also identified the need to know what was available for future ageing in place. Derek

recognises that he may need daily oxygen in the future. He does not see this as a barrier to ageing in place, as he is aware that he can access equipment that can be used in the home to deliver oxygen.

Derek: No, no, no, one day, in years to come I will be dependent on Oxygen, even at home, but, they can, there is a thing that actually you can have, I don't know how it works, but it provides oxygen for you.

These two extracts sum up Derek's on-going engagement and negotiation with age-related change, and illustrates how older people seek out knowledge and resources to enable them to continue ageing in place at home (Ryan & La Guardia, 2000; Tanner, 2010).

Older people have to be active in finding out information and accessing useful resources and services (Tanner, 2010). The participants demonstrate the importance of available community resources to enable access and facilitate ageing in place (Eales, et al., 2008), as well as the availability of considerable personal resources in the case of those participants who live overseas for a number of months each winter (Katz, 2005).

Ageing without 'giving in'

Older people are encouraged to do as much as they can for themselves, within the positive ageing ideology. What is often ignored is the effort required to slow one's decline and to resist supports associated with ageing. Denise gives two examples of how she is working hard to reverse aspects of her decline, even though she knows that it is inevitable (Freund & Baltes, 2007). She shuns 'unnecessary' support equipment for walking, and is very unforgiving about the "ghastly" meals on wheels.

Denise: No, if it was, when I was really sick and just out of hospital I went in a wheelchair but now, insist on walking, yeah, no I just use the trolley. I got a wee pusher out the back there yeah, there since I got it. I told her I didn't want it.

Denise's efforts to shun the walking aids challenges the clichéd unidirectional decline of older adults (Loe, 2011). She is maintaining the positive ageing ideal by showing she is motivated to stay active and mobile (Resnick, 2011), pushing back on the provision of equipment.

Denise: Yep, and I know for a fact that the day's gonna come when I can hardly, when I won't be able to look after myself. I was on meals on wheels for a long time when I come out of hospital. I stopped those cos (whispers) they're ghastly, (normal speech again) and I'm a good cook so I cook my own meals.

Denise wants the interviewer to know that she still likes to cook, and that being a good cook is part of her positive ageing identity (Loe, 2011). She implies that meals on wheels is for people who don't care about taste and quality of food any more. A lack of desire to maintain standards of taste is synonymous with decline (Tanner, 2010).

Older people often do not see themselves as old (Higgs & Rees Jones, 2009), and several of the participants endorsed the use of support services for older people, whilst showing how they themselves resist the need for these services. Maureen describes how she has managed so far to avoid getting domestic support.

Maureen: I don't mind, I feel that I do a wee bit of gardening, and I do, I just vacuumed right out here this morning, but at my age usually, some of them have had help, I haven't called for it yet, erm, that's important, if you, if you, if you feel, if a person's feeling that they can't cope with the cleaning, they really need to get somebody.

Maureen believes that she is doing better than would be expected of someone of her age, perhaps by her peers, or the community in general. She has absorbed the positive ageing ideal of being optimally independent, and implies it is not advisable to just give in and get extra support, such as for housework, unless you

absolutely need it, and are not coping. Receipt of such services can be viewed as a sign of lack of coping (Tanner, 2010). Maureen's talk is a good example of the dissonance between not giving in and accepting decline.

We are now living in a youth oriented culture, nowhere more so than the self-proclaimed adventure playground of the Wakatipu (Destination Queenstown, 2013). It seems there is little meaningful dialogue about alternative identities to those other than the one that is in a continuous battle with the ageing process, fighting to retain autonomy and resist frailty (Becker, 1994; Gilleard & Higgs, 2000).

Staying visible

Older people can often be at once highly visible, possibly for all the wrong reasons, such as a fall in the street, and invisible if they are increasingly isolated through loss of functioning. During the interviews many of the participants described positive ways that they keep themselves visible, as well, as emphasising the importance of making the effort to stay connected to place and people. A strong social network is a central tenet of positive ageing. Raewyn describes how she was very proactive in joining clubs to make friends when she arrived to live in New Zealand in her eighties.

Raewyn: When I first came here I didn't know a soul apart from the family and I thought, well, you've got to get into something, so I joined a few clubs and I had friends there, which has been good, travel club, music club.

Raewyn implies that no-one was going to approach her for social opportunities. Older people become less visible when they are no longer working, and ageing in their own home, so it is necessary to be proactive and create visibility and status (Tanner, 2010; Wenger & Keating, 2008). Raewyn's experience of emigrating in late life also highlights the additional challenges that older people face in an increasingly global environment (J. Hendricks, 2010).

As well as maintaining visibility in a social sense it is also important to raise one's profile with health providers to ensure fast and efficient care when it is required. Deborah describes going to see her doctor, not because she is unwell but to develop trust and rapport.

Deborah: About three times, just to get established, you know, with him and the last time I went he has written me a prescription, because that's the way he writes them out have one 3 monthly, so I've got one now until the beginning of October, so, but if I want to ring him, I can talk to him.

Deborah is demonstrating that the need to establish and maintain visibility with her doctor is so important she is prepared to pay for three relationship building visits. Developing and maintaining visibility with health practitioners is one way that older people can increase their sense of control over the ageing process, in line with the positive ageing paradigm (Haug & Ory, 1987). Older people are also aware of the changes in the nature of doctoring, and how much more tenuous the relationship has become due to reduced tenure and flexible working practices (McKinley & Marceau, 2002). Decreased access to GP services is a threat to maintaining wellbeing in old age (J. Wiles, 2011), and explains the considerable efforts made by older people to maintain this key relationship. This strategy is additionally important if one is ageing in place at home, where social isolation and lack of meaning supports may compromise the ability to access services (Wenger & Keating, 2008; J. Wiles, 2011).

Ageing without becoming a burden

In recent decades the depiction of older people has tended to shift from one of dependency and frailty to vibrancy and independence (Higgs & Rees Jones, 2009). Several of the participants demonstrated that they had absorbed this changing paradigm, and referred to the ways that they minimise being a burden on the health system, friends and family. There are consistent references in the media and academic literature to the ageing population, and the burden that this creates on this

health system. Through this message older people may feel that utilising health services it is at significant cost, but little benefit to society. James illustrates how older people are keen to dispel this myth by emphasising their lack of need for services due to robust health.

James: The only problem I've had was a couple or 3 years ago I had a hernia, which was diagnosed as such in November and I had the operation late January up in Christchurch, so that's the only time I've accessed health services really in the last 10 years and it worked out pretty well, and that was done under the health insurance done privately.

James typifies the idea of successful ageing, a popular concept of an individual in good health, and being very little burden on the health system (Holstein & Minkler, 2007), challenging the stereotype of the often ill, high service-user (Victor, 2010). James seems to fit the notion that if you have a positive self-image of ageing, you are more likely to look after yourself (Levy, 2009).

As well as looking after one's health, working hard to not be too reliant on others is also a neo-liberal ideal. Molly has moved to New Zealand to be close to her family, but wants to make it clear that she will not be a burden to them, and would never try to impinge on their freedom.

Molly: Well my daughter I know, I feel quite sure my daughter erm well would be there I feel quite sure and my grandson and my granddaughter I feel quite sure so that's all I can think about that so I've got that support I feel quite sure. That's why it was good I could come here and they could go and do what they could do you know, and er you know, I'd never, I'd never do anything to stop them or anything silly erm, they have their lives to lead but er I know they're there and always will be so there we are.

Molly does not feel that she can negotiate with her family, or ask them for unequivocal support and presence in Queenstown. These feelings of not

wanting to be a burden are borne out of her family's experience of having to work overseas, as is often the case in an increasingly global world of work (J. Hendricks, 2010). Social and economic changes of this nature are beginning to have an effect on older people, who may have more security in the sense of reaching old age and greater life expectancy, but a decrease in the feeling of surety about who will be there to support and care for them (Phillipson, 2010).

Whilst resilience in ageing is seen as a positive attribute (Allen, Haley, Harris, Fowler, & Pruthi, 2011), critics caution against a lack of balance in policy approaches that ignore the inevitable decline in health for the majority of older people (Higgs & Rees Jones, 2009; J. Wiles, 2011). It may be that older people find that maintaining a resilient, non-burdensome identity becomes increasingly difficult as their support network becomes more tenuous (Bartlett & Peel, 2005).

Ageing without complaining

Linked closely to the identity of resilience and not being a burden, is the minimisation of problems associated with getting older. Whilst not complaining in general may be related to the cohort that the participants belong to, with the notion that life has become considerably easier over time, some of the interviewees accepted quite unsatisfactory treatment without complaint. Deborah relates the time that she had to go to Southland hospital for a specialist appointment, only to find that they were not there, and it was a wasted journey.

Deborah: Oh god, I had to erm go down to Kew. I've got to think what I went down there for now (laughs). That's terrible! I had to go down and see a specialist, and I went on the bus, had to get down there, and the specialist wasn't there and I so I had to come home.

Interviewer: And nobody rang you to notify you?

Deborah: No, when I got down there he wasn't there, so I stayed with my daughter that night in Invercargill, and came back on the bus, which was, that was quite nice.

Further on in the interview Deborah concedes that the wasted journey was “a bit annoying”, but still within the context of coping with the situation. Her quite passive reaction to this contrasts sharply with her indignation earlier in the interview when she describes the poor quality of care received in hospitals these days. As with many older people, Deborah does not want to assume the identity of a complainer (Alemán, 2001), shown to be making demands on an already overburdened system (Tanner, 2010). It is often more acceptable to complain on behalf of others, in the role of an advocate, than to complain about one's own experience and be seen as lacking resilience (Higgs & Rees Jones, 2009).

The acceptance of substandard levels of service can put older people at significant risk in terms of their health. Molly was suffering from a life-threatening illness, and had to travel four and half hours to Dunedin, instead of two and half hours to Invercargill, because the ambulance was going that way, not because she required the services at Dunedin hospital.

Molly: They go to Invercargill for some things and Dunedin for the others, it's a fact I had to go to Dunedin the night I went, because there was sending an ambulance to Dunedin, so it was a case of put two in the one ambulance, so it was er, and the care was alright there and I had to go, I had to have an operation, then I had to go to Invercargill and they put me on the emergency list and I went within a month, so I've got no complaints.

If older adults like Molly are not feeling able to complain when their health is put at risk, then it is unlikely that services will be improved. Rural areas are often ignored with regards to health service access and provision (Daly & Grant, 2008), contradicting the government's aims for equality in rural ageing (Ministry of Social Policy, 2001).

Older people often advise against talking about their problems, for fear of being seen as a complainer, unable to cope. Raewyn illustrates the identity of an older person with stoic coping skills.

Raewyn: O well, no dar, yes you don't want, if you've got a bit of an ache and pain you don't want to think o here comes somebody I can tell about my aches and pains. I've known people like that as we all have, mm.

Raewyn has clear beliefs about the need to refrain from expressing the inevitable decline into old age. Her talk illustrates how older people do not want to be seen as too frail to participate in other aspects of their busy lives or too slow to accomplish whatever it is they are expected to do (Hillyer, 1998). She is actively ignoring the embodied experience of ageing, instead conforming to the notion of the resilient older person, who is able to continue living well, despite pain and discomfort (Fernandez-Ballesteros, 2008; Tanner, 2010).

This section highlights how older people regularly use strategies such as accepting adverse situations, and minimising their negative reactions (Findlay & McLaughlin, 2005). It is important to ensure that these sense-making strategies do not give rise to the assumption that services are necessarily adequate or satisfactory.

Ageing with a strong network

Most older people appear to prefer the option of remaining in their own home, with the primary support from family and friends (Victor, 2010), and the general belief is that older people will continue to age well if they have a strong network of support. The participants in this study outlined the breadth of these networks, including family, friends, health professionals, and advocates. The analysis also uncovered the complex process of how older people actively develop, manage and balance these relationships to support ageing in place and maintain the positive ageing ideal.

The close physical presence of family provides comfort and security, and a feeling of being cared for. For Denise, knowing her family are there is core to being able to age in her home.

Interviewer: OK. That's a theme that's come up with a lot of people that in order to enjoy life and feel safe, it's having that family that you know, if you need to go somewhere.

Denise: Oh, most important, most important. Knowing they're there, they're as far away as the phone, that's it, that's just all it is. Yeah, always wanting to help.

Denise is happy to acknowledge her need of the family, and this counteracts the literature emphasising the individual, encouraging self-reliance and self-responsibility (Gilleard & Higgs, 2000). Even if the family are not in a formal caring role, the role of the informal care to support ageing in place must be acknowledged (J. Wiles, 2005). Absence of family support is often the root cause of loneliness and isolation for older people ageing in rural areas (Scharf & Bartlam, 2008).

Both friends and family are seen as a vital part of the support fabric for positive ageing in place in a rural community, and several of the participants described how friendships complemented and supplemented family support networks. Denise has several of her children living close by, but also highlights the importance of her network of friends and neighbours.

Denise: And and good friends otherwise I don't think I could, well I don't think I could manage on my own, there's a lot of things I can't do(...) Invercargill, I've got friends down there that I would have stayed with them if I had to go there (to the hospital)...and then there's Clive who moved down, he's a big help he does all the rubbish and he's always there if you need him just say I want to go to the doctor tomorrow, well, he's here.

Denise illustrates that for her friendships are integral to her being able to maintain the positive ideal of ageing in place. This non-kin informal support network is even less visible than family (De Vries, 2010). Much of the literature talks about the importance of having strong social networks, but often with the emphasis on the benefits of social contact, as opposed to essential help with everyday living and health service access (Fernandez-Ballesteros, 2008).

Older people often need to renegotiate the rules of reciprocity, especially within the realm of friendships and support. The importance of reciprocity was demonstrated in the earlier analysis of the ways people age in social relationships, and is also reflected here in the maintenance of strong support networks. Raewyn outlines how she enables herself to accept offers of transport from her friends through a reciprocal arrangement of buying them the occasional lunch.

Raewyn: If I did want to go anywhere, I've got some wonderful ladies who would take me there, you know, locally, and in return, you know when I first came, I said I'm not going to give you so much for petrol, but I said now and again I'll take you all out to lunch, so I do that about every three months, yes, to say thank you. Of course they won't have it you know, they won't take any notice. It's a way of saying thank you to them, that's all.

Raewyn balances out the relationship, and minimises her identity as dependent through pecuniary means. As with many older people, there is considerable effort made to present herself in a certain way, investing in future interactions and exchanges, and ensuring that support given is balanced with a reciprocal action of giving (Breheny & Stephen, 2009; Gilleard & Higgs, 2000).

Developing and maintaining a relationship with a primary care health professional is fundamental to keeping well as living independently in a rural area. For some older people without family, the doctor can take on a family-like role of caring and negotiating change, when functioning declines. Derek talks

about how his team of doctors worked to persuade him to move from a remote location.

Derek: I moved erm October last year and er they wanted me, the medical centre wanted me to be closer to town because I got snowed up where I was and they couldn't get me, I have medical problems, so I think they're very happy now that I'm in town.

Derek accepts the paternal role of the medical professionals, demonstrating how it is sometimes necessary and beneficial to compromise positive ageing ideal of autonomy. His previous home was beginning to work against him ageing well, but Derek required encouragement from his medical support network to make the move from his long-term home. Autonomy is encouraged in the positive ageing ideal, but collaborative decision making between can often result a more beneficial outcome (Loe, 2011; Milligan, 2009).

As well as a network of friends, family and professionals older people often require the additional supports of advocates to enable access to the community and services. Denise describes how important having an advocate was, when an expensive health procedure was required.

Denise: She is just one fantastic woman you know, she does, if you've got a problem, you just pick it up, Jane'll sort it, she's wonderful(...) I mean she gets things done and she isn't, doesn't have to hardly open her mouth even, but she gets things done...like I had to have a scan, because they thought that might be kidney (points to her foot) so we had to have a scan for that, which was put down as urgent, of course you, it was going to cost \$215, and Jane said no it's not, I thought how are you gonna get away with that? And no, I got away with it because Jane said she's not paying, it's too expensive with all the other stuff that was going on cos you've got to pay for petrol to go to Invercargill and erm...

Developing and accepting support from a wide variety of sources is essential for maintaining the positive ageing ideal of remaining at home and optimally independent (P. Bernard, et al., 2007; Collins, 1991). There is little doubt from this analysis that older people are sophisticated negotiators of every aspect of their lives, from making good choices through to managing relationships, in order to maintain their identity as ageing positively (Loe, 2011; Tanner, 2010).

It is worth noting that, whilst the importance of maintaining a strong network was recognised, there was also acknowledgement that not everyone has this type of network available. For example, Maureen outlines the dilemma for her friends having to access cancer treatment in Dunedin, with no family to help with transport.

Maureen: Well, I feel sorry for those that can't have any family perhaps that they can call on, cos there was another friend of ours here, and er, her husband needed cancer treatment, and erm, they had to go all that way and you know they weren't used to being out of the district here, they lived here for all their lives I think and that came really hard, and she had to drive that's another thing, you see.

Through her friends' experience Maureen recognises the challenges that people without support networks face, ageing in an isolated area, and having to travel long distance to access health care. Health professionals often fail to investigate the extent of a patient's support network, and assume that 'someone' will be able to help (J. Wiles, 2005), possibly due to older people's reluctance to complain or highlight difficulty, as outlined earlier in the analysis.

Another challenge of maintaining a strong network is that support may be present for an older person, but may not be consistently available. Molly relates having to go further afield to access family support for transiting to Invercargill, when her local supports are away.

Molly: cos there was some talk that I might have to go and see somebody because they weren't sure what was wrong, so I was organising for my granddaughter who is in Auckland , and she was going to come down and take me if I had to go to Invercargill, which I didn't want to do, but you have to, have to, but at least I warned her yeah well if she had to get off from work or anything, so because I was, had been thinking about it, and what am I going to do? If I had to go, because I would have probably had to go down by my own steam, because I'd only be going down to see, you know for diagnostic purposes, so....

Molly clearly feels anxious about having to renegotiate her family support requirements. In current times, there is much less certainty around the roles and responsibilities of family members in terms of caring for ageing, dependent relations (Gilleard & Higgs, 2000; Phillipson, 2010). Molly's experience, and Maureen's observations of her friends, highlight the challenges associated with maintaining a strong support network, and reflect the kind of difficulties often faced in achieving the positive ageing ideal.

Maintaining the positive ageing ideal predominated much of the talk by the participants, and there are clearly benefits for older people who build and maintain resilience to the ageing process (Allen, et al., 2011). It is, however, important to acknowledge that no amount of effort will enable older people to reverse eventual and inevitable decline and death, and that perhaps there should be more societal discourse about the acknowledgement of the less positive aspects of ageing (Bludau, 2010).

Case study: Abbeyfield retirement home

Part of the worldwide Abbeyfield registered charity, Abbeyfield Wakatipu is a purpose built residential facility for older people, aged over 55, who are able to live independently (Abbeyfield New Zealand, 2013). The organisation's mission statement is to provide affordable housing and companionship for older people. There is an onsite cook and housekeeper, modern spacious shared kitchen, lounge and dining facilities, and each resident has a large private room and ensuite, with separate external entrance and small garden area. The rooms are big enough to fit some of their own furniture and memorabilia. Several of the participants talked about Abbeyfield, and an interesting range of relationships and strategies associated with this place emerged. Interactions ranged from visiting for a cup of tea to living there permanently. In this first example, Abbeyfield provide a base for social contact for two of the participants.

Deborah: I visit Abbeyfield every Tuesday and have a cup of tea.

Derek: I still go to Abbeyfield once a week to have a dinner.

Unlike the nursing home, which was outlined earlier in the analysis as a negative place of dying, dependence, lack of space and meaningful relationships, for Deborah and Derek Abbeyfield is deemed an attractive place to visit. The facility fits with the positive ageing ideal of independence, space, and worthwhile social interaction (Ministry of Social Policy, 2001), and also demonstrates how older people actively seek out ways to remain visible and social in the community (Tanner, 2010; J. Wiles, et al., 2009). Purpose built to accommodate the needs of older people, with wide entrances, no steps, and grab rails, facilities like Abbeyfield enable older people remain able to participate in social environments without anxiety or feelings of exclusion (Eales, et al., 2008; Granberry, 2009).

Providing there is a vacancy, it is also possible to utilise Abbeyfield for a temporary stay. In Derek's case he spent several months at Abbeyfield, following a long bout of illness and a period in hospital. This enabled him to recover in a supportive environment, with cooked meals and easy to access social interaction.

Derek: oh, yes, yes, no, it's been good, I didn't move straight here, I, even though the house was here, I'd bought it and everything, I had been very sick last winter, and I went to Abbeyfield, which is a retirement place for elderly people, and I had several months in Abbeyfield(...). It's a lovely place, but I do like to be, have my own house I like to do my own thing and everything and though it's very nice and there's no stairs and, flat, comfortable and all your meals, all your meals are cooked for you and everything so it's great actually, it's, if I had to leave here permanently, and I hope I won't for many many years, I wouldn't mind going to Abbeyfield (...) and one of these days possibly I may not be able to get up 3 sets, 2 sets of stairs, which probably, it fitted every bill when I moved here, except that I didn't really want stairs but I had it anyway, so I think I'm going to be alright for quite a few years yet, but if I do have to leave, well Abbeyfield is waiting.

For Derek, Abbeyfield figures strongly in his desire to continue ageing at home for the foreseeable future. Its flexible policy around residency means that he can stay temporarily, whilst keeping his home, and returning when he feels strong enough. Often older people feel pressured into giving up their home, as there is a lack of flexible options open to them when they become unwell (Tanner, 2010). Derek's experience illustrates that whilst the overall direction of ageing is one of decline, within that process there are peaks and troughs of functioning that occur. With the availability of flexible respite accommodation options, older people can continue to age in their homes if they wish (Mandy, 2009), although it is worth noting that this does require significant individual financial resources (Keating, 2008).

It is possible for the initial stay in facilities such as Abbeyfield to be temporary, but for the experience to be so positive, that the older person begins to evaluate the proposition of remaining permanently. Raewyn initially moved into Abbeyfield, when her local supports were going to be unavailable for a period of time, and she had a negative experience in her own neighbourhood. She is now contemplating whether to stay longer.

Raewyn: I've still got my house, I'm not quite ready to give up my complete independence, butwe've got our own room. I haven't got much in mine because I don't know whether I'm staying or not, but you never know.

Like Derek, Raewyn is in a sufficiently well-resourced position to keep her residential options open and is essentially ageing in two places, her home and Abbeyfield. Being able to exercise choice of place to age is an important aspect of agency for older people, and can help to make the decision to move permanently into a retirement home less distressing (Andrews, 2005).

Older people who do make the decision to move into residential homes permanently are keen to retain aspects of their past lives and to demonstrate the ways they maintain agency in their new environment. Molly has lived at Abbeyfield for several years, following a change in her family circumstances.

Molly: No, I was with the family, but then erm they were going overseas because he was going to work there only temporary (...) I just saw an ad for Abbeyfield(...)so I came in on a temporary measure and I think I'm permanent...well, it's basically independent living for over, I think the age is 60, or 55 now, and er you have a very good size room, as you've seen, and an ensuite, and our meals provided and we are independent to come and go, but we do have to look after ourselves, that's import...there are a few things that can come in and help you, but basically it's independent.

Molly's situation is indicative of many older people, who are no longer able to live with extended family due to the need to source work further afield (Granberry, 2009). Molly compensates for initial lack of choice about moving by emphasising her continued independence in Abbeyfield, letting the interviewer know that this is not a rest home, and that she is still managing well, and able to live well with minimal support. This highlights the efforts of older people working hard at not giving in to the ageing process, and continuing to maintain the positive ageing ideal of independent living (Tanner, 2010), renegotiating their space and place when change is required (J. Wiles, et al., 2009). Molly had made her room very homely, and there was room for her own furniture and artefacts. With a well thought out spacious design, older people like Molly are able to turn a residential unit into a home and to achieve an attachment to place through the retention of the familiar items (Easthope, 2009; Milligan, 2009).

Whilst retirement homes like Abbeyfield enable older people who live there to retain an identity of independence and ability (Kearns & Andrews, 2005; J. Wiles, 2005), it is not a universal solution. Derek highlights that if you are very frail and dependent you will not meet the criteria for entry.

Derek: Abbeyfield is very good, but that's at the other end of the scale, you've gotta be able to look after yourself. If you can't look after yourself you can't get in there.

Derek provides a salient reminder that maintaining the positive ageing ideal of living independently is not an option for many older people who are in an advanced state of decline. His observations illustrate the limitations of the positive ageing philosophy, because despite efforts to age well, most older people will experience significant decline, loss of function, and dependence (Higgs & Rees Jones, 2009; Pond, et al., 2010).

For some older people the idea of any form of communal living is an anathema. For example, as outlined above, Deborah enjoys visiting Abbeyfield for a weekly social visit, and can see some of its advantages as residential option, but she would not consider the option of moving there permanently.

Deborah: you've got your own room with your furniture and everything, but living with people, and (pauses), your meals are all provided there, and you all eat together and, no, that was the last place I wanted to be, you know, and I love being here... one old girl said to me when I first moved here, she lives sort of in the centre of the complex, Deborah you must feel out of it here, where you're living. I didn't know what to say, I said I'm not, you know this is my place, and I'm not in amongst.

Whilst Deborah has previously emphasised the need to be visible through social contacts and interaction with health service providers, she baulks at communal living. Unlike the other participants she does not consider Abbeyfield such a positive place to age, due to reduced privacy and space. Deborah's differing feelings about Abbeyfield as a place to age is a reminder that older people's ageing experiences are as variable and unpredictable as their preceding life courses (Andrews, Evans, & Wiles, 2012; Higgs & Rees Jones, 2009).

Although it is not a universally available or desired permanent residential option, Abbeyfield does fulfil a variety of roles for people ageing in the Wakatipu basin. It provides choice, flexibility, and the opportunity to retain the identity of home, visibility, and continued independence within a safe, secure and social environment. The nuanced ways in which the participants utilised the facilities represents the diversity of needs and experiences of older people as they age in place (Andrews, et al., 2012; Higgs & Rees Jones, 2009). In many ways Abbeyfield epitomises the international cohousing model, helping older people from diverse backgrounds to age safely in a mutually beneficial environment of support, companionship and ergonomically designed housing (Granberry, 2009).

Reflecting the earlier analysis of older people ageing in many places, Abbeyfield is another place in which some of the participants are ageing, in quite different ways. This reflects the idiosyncratic nature of ageing and highlights how older people require a range of options for accommodation, social contact, and support (J. Wiles, 2011). The ways in which the participants utilise Abbeyfield also illustrates aspects of maintaining the positive ageing ideal through keeping visible, opting for a more independent accommodation solution, and making competent choices about how to utilise the facility.

Chapter 5: Discussion

The main finding of this study was that older people age in many places, including but not limited to the physical home space. These ageing processes occur simultaneously and create a complex holistic environment of ageing. The participants were engaged in a variety of activities associated with ageing in places, such as adjusting to, and accepting changes in their bodies, which in turn caused them to navigate their environments in different ways. The study also showed that, despite efforts to articulate high levels of autonomy, older people are not ageing independently, but are reliant on a myriad of relationships, including spouses, friends, medical professionals, paid carers, and advocates. These relationships, and the ways in which people age in different places, are not static. They are perpetually in flux, being reconsidered, renegotiated and realigned to take account of the changes brought about by ageing.

Through the participants' talk about accessing health services, it emerged that they were working hard to maintain the positive ageing ideal of independence, stoicism, and social and community engagement. Despite these efforts, it was not possible to entirely compensate for inevitable decline, increasing frailty, and loss of function. The participants' talk illustrated that they experienced aspects of the dependence and decline as well as active engagement and independence in complex and idiosyncratic ways, across all the places that they inhabited.

The analysis highlighted the equivocal nature of ageing in places, the contradictions, the negotiations, and the sense-making that older people are engaged in. The study also captured the embodied nature of experience for older people, and how this pervades every aspect of how the participants understood and interacted with their worlds.

The rich data elicited from this study also reflected other qualitative work in the field, which has highlighted how ambiguous, multi-layered and dependent on

relationships, resources and wellness ageing in place can be (Butcher, 2012; Keeling, 2001; Tanner, 2010; J. Wiles, 2005; J. Wiles, et al., 2009). This research also highlighted the complex interaction between two powerful stereotypes of older people: the frail, declining, needy old person versus the vibrant, healthy, successfully ageing person, and reflects recent New Zealand research in this regard (J. L. Wiles & Jayasinha, 2013). This notion of a less polarised view of older age has been developed within the theory of 'selective optimisation with compensation', where the two stereotypes are intertwined each in a unique way for individuals experiencing age related decline, in a state of flux, as functional losses begin to outweigh maintenance, resilience and successful ageing (Baltes & Baltes, 1990; Bartlett & Peel, 2005).

More recently research has specifically identified 'option recognition', the process by which older people adjust and make choices based on their level of functioning, and available supports and resources to optimise and individualise the experience of ageing in place (S. Peace, Holland, & Kellaher, 2011), reflecting the optimising work done by the participants in this research. The participants' considerable efforts to optimise their worlds, and to maintain the positive ageing ideal, demonstrates also that older people have absorbed the 21st century ideological shift away from paternalism to the neo-liberal mantra of self-responsibility for determining how to age well in place in good health. This phenomena is reflected in several UK based studies (Gilleard & Higgs, 2000; Tanner, 2010), and whilst resilience and autonomy are key factors to ageing well (Allen, et al., 2011), if older people do not feel able to present the less positive aspects of ageing, there is a risk of need, frailty and vulnerability being overlooked (Higgs & Rees Jones, 2009).

IPA provides a lens to view how the participants actively achieve ageing in place in an embodied way, as opposed to observing what ageing 'is', and how it affects quality of life and ageing in place. Although there is still a dearth of literature on the embodied experience of ageing, Laz (2003) describes ageing as something we 'do', with the body either preventing or enabling older people to live well. Laz (2003)

theorises that if one views the body as being responsible for living well, this drives the ideology of positive ageing, ‘ageing gracefully’ and looking after oneself, which reflects the findings of this study, and the focus of older people’s maintenance of the positive ageing ideal.

Much of the international ageing in place literature focuses on ageing in place in the home, with some reference to neighbourhoods and communities (Cutchin, 2003; Rojo Perez, Fernandez-Mayoralas Fernandez, Pozo Rivera, & Manuel Rojo Abuin, 2001). This literature provides considerable focus on making practical recommendations for the improvement of the quality of life for older people ageing at home and in the community (Addae-Dapaah & Wong, 2001; Clarke & Nieuwenhuijsen, 2009; Johansson, Josephsson, & Lilja, 2009; Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009). There is no doubt that research that identifies potential improvements to older people’s quality life is beneficial, but the lack of focus on interrelationships, and the lived, embodied experience may omit many of the nuances and fluidity of ageing in places, and therefore not be as useful as it could be in identifying and prompting change (Andrews, et al., 2012). One key aspect identified in this study, was the centrality of the relationship with a doctor, and how participants used this relationship to strengthen the ability to age in place, despite the changing nature of doctoring in recent times. The importance of the GP relationship and the issues associated with how this relationship changes as people age is an important issue: relationships such as these play a vital part in older people’s ability to age in place.

The fundamental reason for differences between this study and the international literature is the choice of IPA as the analytical approach. IPA explores the talk and experiences of the participants on multi-layered levels via the hermeneutic circle. The analysis therefore does not just simply reflect what is being said, and identify practical but potentially overly simplistic or narrow solutions to the challenges of ageing in place. It allows for the detailed interpretation of older people’s embodied

sense-making of accessing services and ageing in places. As a result, the research captures the complex, interrelated and idiosyncratic nature of their experiences, identifies new concepts such as the role of the GP, and reminds the reader the experts on ageing are older people themselves.

Limitations

One of the limitations of this study was that most of the participants were financially comfortable and were not representative of the range of income levels for older people in New Zealand. This is indicative of the fact that it is very difficult to remain in the Wakatipu basin in older age without significant resources, due to the high cost of living and a lack of affordable housing. Notably, the findings of the study highlighted that lack of poverty does not eradicate the considerable challenges and barriers to ageing well.

The participants also represented a narrow ethnicity band, being exclusively New Zealand European. This demographic is not representative of the ethnic diversity of the population of the area, nor does it reflect the presence of Māori and Pasifika peoples in the Wakatipu. It does however represent the over 75 cohort in the area, which is a reminder that Māori have different patterns of morbidity and mortality (Statistics New Zealand, 2009), and that socio-economically disadvantaged groups are likely to be excluded from ageing in the Wakatipu basin, due to lack of resources.

The research clearly focuses on a specific geographical area, and the unique challenges associated with ageing in place and accessing health services in the area. This limitation was intentional, aiming to focus on the particular needs of the community, in response to the often highly general recommendations for ageing well in New Zealand, and worldwide.

Implications and recommendations

There are several implications that emerge from this research. Firstly, the emergent theme of ageing in many places suggests that the well-established concept of ageing in place can be viewed through a different lens to encompass a broader focus. Policy-making may be better served by research that takes account of the multiple places that people age, and how this influences late life activities, choices, decisions and experiences.

Secondly, there needs to be an awareness that older people have absorbed the positive ageing mantra, and their efforts to portray themselves as ‘doing well’ may mask the challenges they face, and their unmet needs in the communities within which they are ageing. As older people go to considerable effort not to be seen as being a burden, a complainer, or demanding, it may be erroneously assumed that they are ageing very successfully, and that current service and amenity levels are satisfactory. Maintaining the positive ageing ideal actually serves to render older people invisible in terms of the challenges of ageing in place.

Thirdly, there are also implications around the acknowledgement of embodied experience, and how older people are the best communicators of how they interact with their world. It follows that younger people, who are not experiencing the world in a declining and ageing body, cannot anticipate or appreciate the ageing process and the challenges associated with trying to live well into old age.

Finally, there are implications around the reality of older people’s heavy reliance on support networks to enable them to continue to live in remote locations. There may be implications for ageing well in place in rural and remote areas as families become smaller, more disparate, and women increasingly participate in the paid workforce, resulting in fewer children to act as intergenerational carers.

The implications of this social change for people ageing in rural areas like the Wakatipu, is that they may not be able to continue to age in place when they are frail, and no longer independently mobile.

These research implications highlight a number of potentially useful areas for future research. For example it may be worthwhile to explore the experiences of the 'young old' in the Wakatipu, to see how their experiences reflect or differ from their older cohort. There are increasing numbers of people choosing to retire in the area, but without easy access to family, a source of support that featured prominently in this study. It would be interesting to see if this group are compensating for the lack of family, and reconstructing the fabric of social supports (McCracken & Phillips, 2004; van Tilburg, 1998).

It may also be useful to explore further the different places that people age. Whilst this study identified several areas where older people age, there are likely to be additional places, such as the media (Fealy, McNamara, Treacy, & Lyons, 2012; Hodgetts, Chamberlain, & Bassett, 2003; Kirkman, 2006; Rozanova, 2010), the legal world (Doron & Werner, 2008) , and the technology environment (Blaschke, Freddolino, & Mullen, 2009; Brittain, Corner, Robinson, & Bond, 2010; Selwyn, Gorard, Furlong, & Madden, 2003). All of these places can serve to either empower or disempower older people, so further analysis could explore the experiences of older adults in these spheres, with a view to identifying effective interactions, and rationales for change.

Whilst broader theoretical work can present fresh conceptual thinking around the process of ageing in place (Andrews, et al., 2012; S. Peace, et al., 2011; Janine Wiles, 2005), and regionally focused research may reveal useful data on issues such as inequalities in health service access and housing (Addae-Dapaah & Wong, 2001; Curtis, 2004; Walker, 1994), it is also important to continue to research the idiosyncrasies of ageing in specific places in different geographical areas. Studies of this type may elicit specific recommendations for improving

the experience of ageing in place for a particular area (Alun E. Joseph & Chalmers, 1995; Keeling, 2001; Lynch & Boulay, 1999; Vandeskog, et al., 2012).

In general terms, IPA is a very useful tool for future research with older people. It provides a forum within which researchers can explore participants' sense-making activities, and how this links with the forming of late-life identities (Butcher, 2012; Tan, Ward, & Ziaian, 2010). These findings can then be utilised to inform policy making, enabling older people to be more involved actors in their own and others' futures (Jon Hendricks, 2004; Ray, 2007).

Conclusion

The findings from this research highlight the need to depend upon older people for planning and decisions about ageing well in their communities. Through their embodied experiences of ageing, they are the experts in what it means to age in the world. Older people go to considerable lengths to portray themselves as ageing positively, and to avoid being identified as complaining, needy, or burdensome, and this often results in exclusion and invisibility. It is therefore vital that they are actively recruited and included to provide input on environmental design, service provision, and the development of policy in their communities, not as lobbyists, but as respected insiders.

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APPENDIX A

Accessing health services in the Wakatipu basin: Experiences of older adults

INFORMATION SHEET

Who am I?

Hello, my name is Rachel Rose and I am a Massey University student, based in Queenstown, working towards a Master's Degree in Psychology. I am writing my thesis on the experiences of older adults accessing health services in the Wakatipu basin.

Why am I contacting you?

I am contacting you to invite you to take part in research about your experiences of accessing health services in the Wakatipu basin. I will be interviewing people aged over 75.

The research will provide an opportunity for the voices of older adults in the community to be heard, and to highlight personal experiences of accessing services in the area.

Who will be involved in the research?

To participate in the research you need to be aged 75 or over. You also need to be currently living in the Wakatipu, or to have only recently, within the last 12 months, moved from the area. I am contacting people I know in the community who I think may be interested in taking part, and am also utilising my voluntary sector links to see if people know anyone who may be interested, who I can then contact.

As the research process will involve an interview, it is not possible for individuals whose speech is severely compromised to take part. The questions I will be asking will involve thinking quite deeply about one's experiences and recalling specific events, and therefore it would not be possible to work with people who have a diagnosis of dementia.

I am hoping to interview 6-10 people to understand the range of experiences older adults have when accessing health services. Recruitment will proceed on a 'first-in' basis, and once I have recruited the sufficient number of participants

the public information about the study will be removed, as no more than 10 participants can participate in the study.

How can you help?

If you would like to be interviewed, you will meet with me, Rachel Rose, for an informal interview. The interview can be at your home, or at any other place that you choose and should take approximately an hour. With your permission the interview will be recorded. You are welcome to have support people with you during the interview. At the end of the interview you will be given a \$20 voucher as a thank you for your help with the study. If you wish to take part you can contact me in person or on any of the following:

Home phone (evenings only): 03 441 1281

Mobile (call or text): 027 279 6862

Email: Rachel.cityfan@gmail.com

What will happen to the information you provide?

The interviews will be transcribed and analysed by me, Rachel Rose. All the information you provide will be kept in a secure place.

The data will be analysed and used to produce my thesis, r. You will not be identified in the thesis, or any research publications that arise from the thesis material. You will be offered your transcripts for editing and will be given a copy of these. Once the thesis is completed the transcripts and analysis data will be securely stored by my supervisor. At the end of the project I will provide you with a summary of the research findings in paper or electronic format, whichever you prefer.

Your rights as a participant:

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question;
- Ask for the recorder to be turned off at any time during the interview;
- Withdraw from the study by the end of November 2012;
- Ask any questions about the study at any time during participation;
- Provide information on the understanding that your name will not be used unless you give permission to the researcher;
- Be given access to a summary of the project findings when it is concluded.

Contact details:

Please do not hesitate to me by telephone on 027 279 6862 or 03 441 1281 (evenings) or email Rachel.cityfan@gmail.com, or my supervisor Mary Breheny if you have any questions or concerns about the study.

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Phone: 06 356 9099 ext. 2069

Email: m.r.breheny@massey.ac.nz

Thank you for taking the time to read this information sheet. I will contact you to see if you would like to participate in the study.

Yours faithfully

Rachel Rose

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 12/30. If you have any concerns about the conduct of the research, please contact Dr. Nathan Matthews, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 350 5799 x 8729, email humanethicsouthb@massey.ac.nz.

APPENDIX B

Accessing health services in the Wakatipu basin: Experiences of older adults

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:-----

Full name printed:-----

APPENDIX C

Accessing health services in the Wakatipu basin: Experiences of older adults

Interview Schedule

1. Tell me about how you came to live in this community?

Prompt: Why did you choose to live in the area? What things are easy and convenient? What things are harder to access?
2. Tell me about what health services you, or someone close to you, have used in the last 12 months or so?

Prompt: Can you tell me about any other times you have used health services? Can you tell me about what health services you, or someone close to you, have used in the last 5 years or so?
3. What positive experiences have you had when accessing services?

Prompt: for example transport, finances, availability of service, waiting times, options provided?

4. What challenges/difficulties have you encountered when accessing services?

Prompt: When you encounter these challenges how do you feel?

5. What ways do you try and overcome difficulties in accessing services?

Prompt: family/friends to transport, staying in major centres

6. What services would you like to see available?

7. How do you think your experiences of accessing health services differed when you were younger?

8. Is there anything else that you think is important for me to know that helps me understand your experience better?