MEDIA, ADVERTISING AND OTHER INFLUENCES ON DECISIONS TO ENTER AGED RESIDENTIAL CARE

Robyn Elizabeth Henderson

March 2016

Youth is full of pleasance, age is full of care

William Shakespeare (Malone, 1821)

Table of Contents

List of Figures

Attestation of Authorship

I certify that the work in this thesis is my own work and that to the best of my knowledge and belief, it contains no materials previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Robyn Henderson

07 March 2016

Date:

Acknowledgements

The journey within doctoral study is never taken single-handedly. It involves the scaling of considerable heights best achieved with strong support and guidance for the route chosen. In my situation I have been guided generously on this journey by three remarkable academics - Associate Professor Valerie Wright St-Clair, Dr Tony MacCulloch and Professor Marion Jones. These individuals have ensured academic challenge for my pathway and generously provided pastoral care when I thought I could not possibly go on. I applaud their commitment and the gift of their time and resounding support.

I would like to acknowledge my twin daughters for their continued support. They have been unrelentingly in their encouragement and their belief in my ability to undertake this research. Brigitte and Ursula have added so much to the depth of my understanding of humanity through their care of me, and their ability to walk alongside me through this journey. I also acknowledge my parents; and specifically my mother for her ability to instill in me a strong sense of social justice regarding the rights of individuals to equitable treatment and support despite their life stage, social status or other social markers.

The older adults who participated in this research kindly shared their life journeys and gave voice to their anxieties and their challenges as they transitioned into residential aged care. These voices deserve to be heard; they can no longer be quiet or silent. Society must ensure that the compelling rights of older individuals in their life trajectory is valid and must be respected. I thank all participants in this research for their honesty and the telling of their stories.

Abstract

There are continued concerns, politically and socially, regarding the future growth in over 65 year olds; described as an unavoidable "demographic silver tsunami". New Zealand has a high utilization rate of aged residential care beds, compared to most other OECD countries, with some 34,000 individuals living in 600 residential facilities across the country. In tandem, with this high rate of institutional aged care, social concerns have been expressed regarding both the quality and increasing commercialization of aged care nationally. This critical discourse analysis draws on an eclectic range of critical theorists to examine the sources of power within contemporary discursive frameworks that influence older adults to enter aged residential care in New Zealand. Older adults aged between 65 years and 92 years currently residing in aged residential care were recruited into focus groups to illuminate the key influences that had supported their entry into aged residential care. In tandem with the focus group sessions a six month scan of media and advertising of residential aged care in the local area was undertaken with a view to examining the relevance of media advertising as an influencing factor in decision to enter aged residential care. Findings were that older adults are influenced into residential aged care through a complex array of discursive frameworks such as the political narrative of ageing and the social narrative of ageing, with its manifest assertion of the appropriateness of residential aged care as an accommodation solution for older adults. Finally, the analysis reviewed the critical relationships of older adults, including the values and beliefs of family and their ability to exert power and control over older adults' lives and their decisions. The findings of this study provide a description of the decision processes and experiences of transitions to residential aged care from the perspective of those older adults directly affected. This study has identified the complexity and multiplicity of discursive forces that directly and indirectly influence such decisions made, often at vulnerable times, in older adult's lives. These findings contribute to an enhanced understanding of the current construction of ageing in contemporary New Zealand; and strongly argue a need for review of existing models of accommodation for older adults within New Zealand society into the future.

1. CHAPTER ONE

Age has no reality except in the physical world. The essence of a human being is resistant to the passage of time. Our inner lives are eternal, which is to say that our spirits remain as youthful and vigorous as when we were in full bloom.

(Gabrielle Garcia Marquez, 1981)

1.1. Introduction

This chapter introduces the background to this study and provides an overview to the structure of this thesis. This study is undertaken within a framework of a professional doctorate which supports learning and knowledge growth whilst allowing the individual student to remain immersed in the real world practice experience of their professional role - in my case; this is the profession of nursing. The overall aim of this research is to explore the complexity and lived impact of various critical discursive influences on older adults' decision to enter aged care living arrangements. An overt intent of this thesis is, in some modest way, to 'give voice' to the needs and concerns of this largely silenced group.

Overall, the global population is aging and, in the next 15 years, New Zealand will join a number of other countries to be classified as 'super-aged', where one in five people are aged over 65 years old. A recent United States report has indicated that in the next few years, for the first time in history, people aged 65 years and over will outnumber children under age 5 years (National Institute on Aging, 2007). In contrast to previous historical epochs, humans now live longer and have become subject to estimates of longevity; such as the suggestion that an individual born in 2014 may live 2.5 years longer than an individual born in 2013 (Penrose, 2014).

In some jurisdictions such as the United Kingdom and Wales, policy makers have initiated new services and support to reform and enhance the structures and policies which manifestly impact the lives and living conditions of older adults choosing to live in residential aged care or assisted living complexes. Initiatives underway in these countries acknowledge that age and frailty have much more requirement that simply the provision of safety and having physical care needs met. These policy makers promote the notions that older adults also require respect, compassion,

self-determination, choice and control over their lives (Faulkner & Davies, 2006; Netton, Darton, Baumker, & Callaghan, 2011; Older People's Commission for Wales, 2014). Many of these internationally radicalized policy changes have been motivated by a recognition that ageism in the face of significant growth in older adults is unacceptable currently and into the future (Nolan, Davies, Brown, Keady, & Nolan, 2003).

In this highly globalized world, New Zealand is engulfed by mass communication, technology and consumerism, and this is reflected in the changing social identity of older adults (Gawande, 2010). In contrast to the quote from Gabrielle Garcia Marquez (1981), at the commencement of this chapter, referring to agelessness, the contemporary societal shift in New Zealand, as in other jurisdictions, reflects a quite different response to the much publicized growing numbers of older adults within society. The concomitant political, economic and social discourses of power and influence, related to this specific group, have evolved different meanings for ageing than those evidenced in previous generations. As recently stated by the former Minister for Health, Tony Ryall:

Twenty years ago hardly anyone had heard of the names Ryman, Metlifecare and Summerset. Yet today these retirement village operators and aged care providers are worth a collective $6 billion on the New Zealand share market, and are caring for thousands of New Zealanders. (Ryall, 2014b)

Associated with this changing demographic, the concepts of choice and participation in lifestyle decisions have gained momentum in the rhetoric of health and welfare and it is this very notion of *choice* regarding ongoing living arrangements for older adults, and the influences on this choice, which is at the very heart of this thesis.

This study is based on interviews with 25 residents of three aged residential care facilities within a mid-size city in New Zealand. The stories of these older individuals exposed the influence of families and advisors on their decision to enter residential aged care. The stories also brought into sharp focus the subtle, often invisible influence of societal discourse prior to entry into aged residential care. The emergent themes from these older adult stories provide a rich tapestry for enhanced understanding of the drivers for re-location of living accommodation for older New Zealanders.

Media advertising is a powerful pillar within the societal substrate supporting older adult's decisions to enter aged residential care. The perceived influence of media as a manipulator of the public mind through legitimating the uptake of residential aged care for older adults is scrutinized in this study and illuminates the powerful rhetoric of commercial interests of the "for profit" businesses in the commodification of older adults. For the purpose of this thesis, the term *commodification* is taken to mean those processes of "taking a good or service that has been produced and used but not bought or sold and turning it into an item that is exchanged for money" (Estes, Wallace, Linkins, & Binney, 2001, p. 49). Within this paradigm care for a parent, emanating from a loving family perspective, far from being an altruistic transaction is ontologically reclassified to that of a marketized commodity. This reclassification translates the familial labour of caring into a saleable item whereby marketing semiosis positions elder's age specific accommodation and support needs into marketable goods and services (Fealy, McNamara, Treacy, & Lyons, 2012).

My own history and experience of older people is one where I have always had a strong interest in the expressed wisdom of older adults drawn from a life well lived. This, together with a natural curiosity for understanding the challenges the older individual has faced, the support being provided from family, and the place the individual has held within society, has captured and held my attention both professionally and personally for considerable years. My curiosity relating to aged residential care decision making has emerged from the roles I have held both in the private and public sector health arena across New Zealand. Particularly, when managing large numbers of private aged care facilities across New Zealand for two of the largest aged residential care providers, I was constantly surprised at the number of relatively independent older adults who were living in these residential care facilities; some appeared well adapted to this life whilst others struggled to adapt and to cope with a sense of loss of their former life. With these individuals I noted the multiple pressures, tensions and discourses that had catalyzed their entry into residential aged care. I have also noted the experience of social isolation many of these older adults experienced coupled strongly with a sense of powerlessness. In addition to people's social isolation within the environment of residential aged care I also noted the loss of personhood within a framework of high levels of routinized living. This scheduling of life was associated with concomitant loss of independence a situation which is echoed in a recent

literature review undertaken by the Centre for Work + Life in South Australia where a key theme relating to perceived quality of care by older adults was independence and individuality (O'Keefe, 2014). Examples of this facility led routine for older adults include set times for rising and retiring, meal times and attending to personal hygiene needs (showering, toileting and bathing or being bathed). The highly structured environment of the residential aged care facilities I was managing required a strong balance of fiscal sustainability with care delivery and translated into managing staffing costs vs delivery of patient centered care. This tension often resulted in a sense of powerlessness not only of older residents but also of those regulated and non-regulated staff caring for older adults. Many staff complained of low nurse to patient ratio's and the "burden" of trying to deliver patient centered care in the face of fiscal demands for profit by owners. Lower staff numbers also translated into difficulties for registered nurses to attend to older adult residents who were unwell or required additional resources. On many occasions there would only be one registered nurse on site for up to one hundred older adults of varying need. Thus, the often advertised promise of good quality care seems contradictory to the reality of care delivered to older adults once in situ in residential aged care.

At a personal level, my own mother was admitted into aged residential care in the latter stages of her life for a period of time. Following an episode of illness, which necessitated enhanced care, the family was advised by her medical team and the social work service that she needed to enter aged residential care in Christchurch. The decision to enter residential aged care was made via a combination of family members (my sisters, brothers and I) and the advice of the experts. Although the decision was definitely inclusive of Mum's wishes, she conceded only very reluctantly to enter aged residential care. Emotionally charged decisions occur most often as a result of a family or illness crisis for older adults and as a result lead at times to negative consequences. Not too long into her new living arrangement we noticed that Mum's former independent spirit had been dampened by the good intentions of all. A former nurse and vigorously involved in local body politics, my mother was strongly driven throughout her life by social justice and the need to ensure effective community care. Her spirit and drive which had been so effective working for the good of others for so many of her years waned in the new living arrangements we had so carefully intended to benefit her. During her short time within the

confines of this new living arrangement she withered emotionally and physically to a point where the family took the decision to manage her care at home.

On her return home she flourished again within her familiar surroundings, enjoying her ability to drink cups of tea at will and to engage with family members as and when they could visit. My younger sister agreed to manage her care personally and moved in with my mother; an effort supported as much as possible by my sisters and myself from our lives in other cities. In due course my mother suffered several minor strokes at home and eventually fell victim to a major stroke which ended her full and vital life. In the end, my mother lived her life out in her familiar surroundings and very much felt the "captain of her own ship", as she so often advised us as she neared her final days. This was a precious and sometimes precarious situation but every member of the family contributed to ensure it worked well with the focus on my mother's empowerment, dignity and integrity. It is important to note at the outset that this study has been influenced by my subjective judgments and I contribute this research as a scholar curious to understand the structuring and shaping of older adult's decision to enter aged residential care.

Old age may, on the one hand, be seen as a time of entitlement following extended years working or contributing in other ways to society. Indeed it can be anticipated as a time for leisure, contemplation and the joy of involvement with generations following in the form of grandchildren or simply the young. Yet all of these somewhat idealized visions of older age are scant reward for the ubiquitous devalued status of older adults within contemporary New Zealand society. The efforts of contemporary business and government to isolate older adults in homogenous institutions and communities affirm a belief that these individuals have little to contribute to the rest of society. That older adults, like many marginalized groups, cooperate with this segregation corroborates the power associated with the stigma of ageing.

The current configuration of retirement villages/aged residential care combinations, present a conundrum in modern life. These campuses, occupied entirely by the older adults, often take the form of small suburbs, and are typically segregated from the wider community in the area by high fences or walls. What is virtually absent is connection to the wider society, to the young and to high levels of meaningful participation in the wider context of a generationally integrated society (Wiersema & Dupius, 2010). Within these walled communities, often coexisting on the

6

same campus, are scaled down housing for independent and semi-independent older adults alongside aged residential care facilities. This seamless trajectory promises an uninterrupted slide from one perceived level of ageing to another; that is, from independent to semi-independent to supervision and monitoring (rest home), through to dependent and cared for (hospital/dementia unit) and finally to death.

Over the past 20 years, in a situation similar to that experienced in Australia, New Zealand appears to accept that although coexisting within the same campus the independent village living and residential aged care facilities are attached to different discourses (Petersen & Warburton, 2012). Many older adults find that they can no longer maintain their current home situation with gardens and maintenance becoming more and more difficult. Some older adults will therefore choose willingly to "downgrade" or "downsize" their existing home or living arrangements whilst ensuring maintenance of a high level of independent living. In so doing numbers of older people take up the highly advertised and commercialized retirement village living arrangements. These living arrangements are ideal for meeting the needs of individuals who have capacity to purchase (or lease) smaller dwelling units or town house style units. Older adults within these communities generally have some negative perceptions include fear of risk to privacy and independence, inequitable and confusing financial arrangements but also positive perceptions include a strong sense of security, opportunities to socialize and to take up a change of lifestyle Residents also generally have positive perceptions of their communities (Kendig, Crisp, Gong, Conway, & Squires, 2014).

Residential care facilities, although often discussed in the text of advertising materials for residential *village* living, paradoxically do not provide images of frail older adults or debilitated or bed bound individuals requiring high levels of care in their advertising image portrayals. In fact, quite the opposite occurs to support the advertising rhetoric. Images are drawn from the discourse of independent living older adults whilst the text alludes to a discursive trajectory of "care" and "nursing care". These images act interdiscursively to edit and link together the image and the meaning by colonizing messaging from one cohort to another. In so doing these images draw from a wider cultural understanding of older age whilst attempting to mean the same "field of action" or reality to the reader of the image (Wodak & Meyer, 2009b, p. 90).

The well documented fear of admission to residential aged care felt by older adults is not bound up within the discourse of independent living within a retirement village; it is, however, keenly associated with entry (admission) into residential aged care (Biedenham & Normoyle, 1991; Cheek, Ballantyne, Byers, & Quan, 2006; Ellis, 2010; Nolan & Dellasega, 2000; Reed, Cook, Sullivan, & Burridge, 2003b).

As a nurse, oftentimes I have witnessed the courage of older adults to rail against allowing disease or disability to define their life or who they are as an individual. It is my experience that in the face of a weakened body, the spirit of the older adult is alive within the ageing body; and it is this spirit that older adults draw upon, coupled with their lived experience, to push through pain, discomfort and, at times, the limits of disability associated with age. It is the essence of this individual control and agency that I seek to understand. Specifically, I am interested in how influential, persuasive discursive frameworks mediate older lives causing decisions to be taken regarding relocation of individual accommodation at times of high levels of vulnerability for this group in contemporary New Zealand society.

1.2. Definitions

Language and text have critical importance for human understanding individually and socially. Whilst the meaning of words is important in and of itself, the social context also impacts the subsequent meaning and interpretation of words within social phenomena (Fairclough, 1992 a). Several key terms/concepts that are used through this thesis warrant detailed definition. These include 'institutional retirement living arrangements', 'residential aged care', 'retirement village', 'discourse' and 'critical discourse analysis'.

Institutional retirement living arrangements: This term is used to refer to rest home and hospital/continuing care services provided to older adults. It does not refer, in this thesis, to psychogeriatric services, dementia services or retirement village living for older adults.

Residential Aged Care: The Grant Thornton Report (2010) defined residential aged care as follows:

Aged residential care facilities are licensed in four categories:

– *Rest home, intended for residents with the lowest level of dependency in residential care*

– *Continuing care hospital, intended for residents who require 24-hour nursing supervision*

– *Specialist dementia services, intended to minimize risks associated with the confused states of residents with dementia Aged Residential Care Service Review*

– *Psychogeriatric, intended for residents with an organic illness at the extreme end of dementia and defined by clinicians as those with features of BPSD (behavioral and psychological symptoms of dementia). (Grant Thornton Report, 2010, p. 133)*

For the purposes of this research, the first two categories of the above definition (rest home level care and continuing care hospital) are the domains of interest. Specialist dementia services and psychogeriatric services have not been considered as part of this research.

Within this thesis terms "aged care" and "residential aged care", "nursing home", "rest home", "long-term care", "care home" and "aged care facility" are taken to mean the same entity; that is, entry of an older adult into a residential aged care facility for the management of activities of daily living and the provision of health care, oversight and monitoring. The title "nursing home" historically provided a clear guide to the purpose of these facilities. The shift in title for these facilities is one that has grown out of the transformation of the industry since the 1990s, whereby the focus is on accommodation and the need for nursing care is subsumed to the notion of "services"; despite the complexity and acuity of these individuals having requirements for extensive nursing care. The author's preference is for the industry standard term "residential aged care" and this is the term used throughout this study.

Retirement Village: The Retirement Villages Act (2003) Section 6 states:

1. *Retirement village means the part of any property, building, or other premises that contains 2 or more residential units that provide, or are intended to provide, residential accommodation together with services or facilities, or both, predominantly for persons in their retirement, or persons in their retirement and their spouses or partners, or both, and for which the residents pay, or agree to pay, a capital sum as consideration and regardless of whether—*

    a. *a resident's right of occupation of any residential unit is provided by way of freehold or leasehold title, cross lease title, unit title, lease, license to occupy, residential tenancy, or other form of assurance, for life or any other term; or*

b. *the form of the consideration for that right is a lump sum payment or deduction, or a contribution or a payment in kind of any form, a periodic payment or deduction, or any combination of such payments or deductions, whether made before, during, or after occupancy; or*

c. *the consideration is actually paid or agreed to be paid by a particular resident or particular residents or on behalf of that resident or those residents, or by another person for the benefit of that resident or those residents; or*

d. *the resident makes an additional payment or periodical payment (for example, a service fee) for any services or facilities or access to such services or facilities; or*

e. *the services or facilities, or both, are provided by the owner of the property, building, or other premises, or by any other person under an arrangement with the operator of the village.*

2. *A retirement village includes any common areas and facilities to which residents of the retirement village have access under their occupation right agreements.*

3. *Despite subsections (1) and (2), if 1 or more of the residential units referred to in subsection (1) are located in a rest home or hospital care institution, the only parts of that rest home or hospital care institution that comprise, or are included in, the retirement village are-*

   a. *the residential unit or units themselves; and*

   b. *the common areas and facilities within the rest home or hospital care institution (if any) to which the resident or residents of the unit or units have access only by reason of their occupation right agreement.*

Older adults: Specific words used to describe the particular group of individuals in this thesis include "elderly", "seniors", "aged", "old age", "older people", "older adults" and "old". These terms have synonymous meaning within this research and are descriptors attributed to individuals over the age of 65 years in New Zealand who require some form of care and assistance. Preference is given to the term "older adult" as this adequately describes the cohort in question but does not perceivably provide a negative or ageist "label".

Discourse: Within this thesis *discourse* is defined as a set of common assumptions which, although may be normalized and taken for granted so as to become invisible, provide the basis for conscious knowledge, values and actions (Fairclough, 1993).

Discursive frameworks: Discourses create *discursive frameworks* which order reality in certain ways. Discursive frameworks both enable and constrain the production of knowledge in so far as they allow for certain ways of thinking about reality while excluding others. In this way they

determine who can speak, when, and with what authority, and also who cannot speak to the purported reality (Cheek, 2000).

Critical discourse analysis (CDA): For the purpose of this study, and the writing of this thesis, the following definition of CDA is used:

CDA sees discourse - language use in speech and writing as a form of "social practice". Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institutions(s) and social structure(s) which frame it. The discursive event is shaped by them, but also shapes them. That is, discourse is socially constitutive as well as socially conditioned - it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the status quo, and in the sense that it contributes to transforming it. Since discourse is so socially consequential, it gives rise to important issues of power. Discursive practices may have major ideological effects - that is, they help to produce and reproduce unequal power relations between (for instance) social classes, women and men, and ethnic/cultural majorities and minorities through the way they represent things and position people. (Fairclough & Wodak, 1997, p. 258)

This definition provides a useful and clear articulation of the purpose of critical discourse analysis in locating the construction of the social practice of residential aged care which powerfully and seductively influences older adults' uptake of this accommodation option in contemporary society.

1.3. The Voice of Older People

All western societies have economic, political and social structures, policies and practices which encroach on individual life choices and decisions. In terms of aged care in New Zealand, government supported superannuation, access to subsidized aged residential care and lower cost medical care or carer support to remain at home, all impact on the lives of older adults. Issues over the poor public opinion of and continued sustainability of residential aged care into the future, have seen multiple government documents developed analysing and modelling potential future demand and cost for these services (Bryant, Teasdale, Tobias, & McHugh, 2004; Buckle & Creedy, 2014; Sonerson, Bryant, Tobias, Cheung, & Mchugh, 2005; Stephenson & Scobie, 2002b).

It could be argued that at an individual level, any one person has little capacity to influence those powerful governmental discursive structures or strategies in relation to older adulthood needs. In a New Zealand study on the relationship of older adults to their social and physical

spaces Wiles, Allen, Palmer, Hayman, Keeling and Kerse (2009) suggested that it is of "critical importance to listen to the views of older people themselves" rather than subscribe to the simplistic view that older adults have and/or need shrinking social and living spaces (p. 670). Such a person-focused paradigm shift would also suggest a much more focused recognition of the unique individual older adult and the development of a discrete approach to the ongoing living arrangements and needs of older adults themselves.

In addition to the governmental discourses in play, Nolan et al (2006) suggest that the "curative model of care" emanating from the evolved specialization of medicine has acted to marginalise older adults into an "incurable" domain within society (p. 6). Such a discourse would support the somewhat dated suggestion of Felstein in 1969 cited by Nolan et al (2006) which suggested that there was a view held by acute medicine and surgical specialisms who perceived at that time "no value in spending time, money, energy and bed space on redundant senior members of society" (p. 6). This same discourse is still noted in the contemporary Australian medical system as noted by Wilcocks (2015) where she suggests "Some doctors seem to view old patients as a different species of human unrelated in any way to their younger selves" (p. 7).

 It seems as though the rich complexity within the voice of the older individual can, at times, be lost and unheard in the face of more pressing economic considerations at a societal level.

Internationally there is acknowledgement that whilst residential care homes do not enjoy a good reputation or have high regard from the general public there continues to be a strong demand for growth in size as the population of frail older adults intensifies (Nolan, Davies, & Brown, 2006). This study seeks to build on a call to action from New Zealand society by two key politicians in 2010; namely Winnie Laban and Sue Kedgley, who, alongside Greypower[1], undertook an investigation into the quality of care provided to older New Zealanders residing in residential aged care (Kedgely & Laban, 2010; McAllen & Steward, 2014). This investigation acknowledged the vast numbers of New Zealanders who are currently residing in these facilities

---

[1] **Grey Power** is a New Zealand advocacy organization promoting the welfare and well-being of all those citizens in the 50 plus age group.

and the "promise" of good quality care which influenced these older adults decision pathway into residential aged care initially. Ongoing concerns over compromised quality of care of older adults have continued since the publication of the Laban and Kedgley report; and, in the year 2013, the Health and Disability Commissioner received 111 complaints about residential care homes while 318 complaints were dealt with by the Health and Disability Advocacy Service (Wilson, 2014). Supporting the ongoing need to urgently address future policy relating to the nature and quality of care, Connelly, Broad, Boyd, Kerse and Gott (2014) suggested that residential aged care mortality is high and that in New Zealand most people do not leave this setting once they have transitioned into a *care* situation. These authors also noted the "de facto hospice" requirements for end of life care for older adults requires additional training and staff resourcing to ensure good quality of care (p. 114). In her study of the Australian situation for older adults Hitchcock (2015) notes that "in Australia people currently live an average of three years once placed in residential aged care" (p.54).

As previously mentioned, the international findings of lower than acceptable standards of care in residential aged care has catalyzed the initiation of significant action in other jurisdictions namely the United Kingdom and Wales. In their work on relationship-centred care Nolan et al (2003) note that the notion of person-centred care has become "lionized" in its support of individualized care. In so doing it has missed the wider value of a more eclectic team based approach to care with inter-dependence of all parties tasked with achieving the goals of the individual older adult. In such a model an appropriate balance is sought between independence, inter-dependence and dependence (Nolan et al., 2003). The evolution of a SENSES framework by this group of researchers proposes that all parties involved in the care of older adults (and including older adults themselves) should provide relationships that embrace and promote a sense of security, belonging, continuity, purpose, achievement and significance (Nolan et al, 2003, p 49).

An investigative inquiry undertaken by the New Zealand Equal Opportunities Commissioner in 2011-2012 was driven from two key concerns, namely: (1) the value society places on the aged residential care workforce and the pay disparity experienced by those individuals (mostly women) within that workforce, and (2) the nexus between the value society places on that workforce and on the respect and dignity of older New Zealanders (Human Rights Commission,

2012). Together, the Laban and Kedgley Report (2010), the Human Rights Report (2012), and a further investigation from the Auditor General regarding poor quality of care in contemporary residential aged care (Office of the Auditor General, 2009), heightened my awareness of the conditions experienced by many older adults in "care" in residential aged care facilities in New Zealand. These reports, and my own experiences of aged residential care working inside national providers, have heightened my deep emotional concern for the wellbeing and free choice of older adults. The outcome of these reports, at a very personal level, contributes to a profoundly felt need to make visible the powerful impact of discourses on the lives and decisions of older adults. Through research into the discursive frameworks that support entry into aged residential care for older New Zealanders, I seek to answer the research question, "What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?"

1.4. Background to the Study

According to the American actor, Robert Redford, becoming older is a "fact of life" (Cora & Luther, 2014, p. 983). In my experience and understanding, for those members of society who achieve older age it is, as it should be, a time of celebration for a life well lived, a time for reflective wisdom on the things achieved and the things yet to achieve, and a time for visibly role modeling the gift of life and its capacity for richness to those coming along behind. The rite of passage into older age, whilst ambiguous and contradictory, is intensely personal. It is influenced by the institutional fabric of society: home, previous working life, health, family and even religious beliefs. Older age can also be characterized by discourses related to appropriate expectations of age, societal values and media representations, which have the ability to influence the behaviour of people within society.

Over recent years the profile of an ageing demographic has translated into a situation where policy makers, commercial businesses, and health professionals have become more closely focused on older members of society; particularly in the development and provision of services such as aged care accommodation. While it would seem that the majority of older adults will not reside in aged residential care at any given time, the "nursing home represents one of the most pervasive sources of anxiety marking later life" (Biedenham & Bastlin, 1991, p. 107). Indeed

nursing home care is reported as a negative prospect for the future by older adults, their families and the general community, including policy makers and academics (Nolan & Dellasega, 2000).

Supporting the notion of anxiety related to entry into aged residential care, Bytheway (2011) talked in his book, *Unmasking Age*, of his early interest in ageing and his familiarity with the idea of "old people's homes ... as places where old people were 'dumped'" (p. 5). A similar position is echoed in an Australian article regarding older adults housing where Kaufman (2005) stated many of us "dread getting old and being 'warehoused' into a retirement village" (p. 76). This perception is echoed by McAuley et al. (1997) who reported, in their study on personal search and selection of nursing homes by families, that stereotypical beliefs regarding nursing homes are that they are "warehouses for the hopeless and dying" (p. 245). Ultimately the life choices exercised by older adults emanate from societal structures and institutions such as economic policy and expert/medical systems, which are beyond the control of most individuals (McDonald, 1997).

A growing macro-economic perception, within contemporary society, is the notion of the increasing economic burden of older adults. This view proposes that this anticipated or presumed *burden* must be offset by other working aged community members' contributions, since "labour related income at an older age is insufficient to meet material needs" (World Bank, 2010, p. 6). Clearly this argument is based in economic and political rationalism as high income countries, such as New Zealand, struggle to manage the demand for enhanced consumption of goods and services (World Bank, 2010). The futuristic assumptions underpinning this macro-economic discourse is replete with looming time and age related metaphors that then look to sharpen the focus on management strategies to mitigate potential economic risk of an ageing population (Barry, Brescoll, Brownell, & Schlesinger, 2009).

Although this current study relates to *residential aged care* and not to *residential village living* there can be little doubt that entering a residential aged care facility is perceived with trepidation by older adults and is a major life event (Cheek et al., 2006; Nolan & Dellasega, 2000). In the face of strong attachment to their existing homes and neighborhoods, transition to new accommodation facilities within residential aged care has been described as being so

emphatically anxiety producing that it exceeds even more traumatic occurrences such as experienced with the death of a loved one (Nolan & Dellasega, 2000; Wiles et al., 2009).

Within the stratification of society, age is a clear and typically uncompromising division which may at times exceed other categorical separations, such as class and financial status (Livingston, 2005). In contemporary society, people's lives are played out in the context of social groups and organisations which may be designated as "institutions". In turn, these institutions are shaped by powerful discourses which guide the form and structure for individual action. Critical theorist Michel Foucault, in his voluminous work, analysed the notion of social institutions for their exclusion, domination and internalization of societal norms and suggested that in the broadest sense, the body can be perceived as a *political field*:

Foucault looks at the institutions, both material (families, school, prisons etc) and discursive (the disciplines and other formalized knowledges in the human and social sciences; the penal discourse of the law and so on) that shape the body, the situated, embodied structure of subjectivity. (Braidotti, 1991, pp. 77-78)

In what Foucault (1977) suggested is the "domination of individuals, based on the sanctioned politico-medicalisation of society", the body is both an object of, and target for, power and manipulation which is subsequently enacted through powerful discursive frameworks (p. 155). Drawing on Foucault's work, it seems that the contemporary and vigorous evolution of institutionalised care of older individuals has effectively separated aged people from the wider population; thus controlling them in a form of what Foucault terms governmentality. This concept of governmentality links power with domination which is achieved through guided coercion and influence over individuals by powerful forces such as government, experts (e.g. medicine), family and commercial interest groups (Lemke, 2000).

In achieving acceptability of aged residential care, as a normative transition for older adults, government achieves economic rationalism and commercial interests achieve economic exploitation of older adults. It may also be argued that society discharges its duty to older adults by ensuring their "safety" within secure campuses, away from, and outside the view of, the general public. In effect, these powerful forces shift some of the economic and social "burden" of aged and non-productive adults who require care provision to the private sector, to self-management by older adults themselves within retirement villages or to the families of older

individuals. This contemporary technique of subjection is achieved through management and institutionalisation of the older body; embracing Foucault's argument that "the body is a bio-political reality" (Foucault, 1994a, p. 137). Through an asymmetrical relationship of power, older adults often have only limited ability to oppose the powerful forces of government, experts (medicine), or family who also are subjected to these powerful and seductively persuasive, discursive frameworks.

In terms of a life well lived, and ensuring an aged person's integrity and dignity, the decisions and choices made by older adults regarding their later life accommodation makes visible the discourses of ageism, marginalisation and power. This is at the very heart of this research and is what I seek to make visible and to understand more fully.

1.5. The Contemporary Context of Aged Residential Care in New Zealand

New Zealand's utilisation rate of aged residential care beds is recognised as high compared to most other OECD countries (Grant Thornton Report, 2010). The question as to why this rate is so high in a first world country provides a justifiable basis for beginning to investigate the discursive strategies that support and enhance this approach to accommodating or housing New Zealand's older adults. This research seeks to examine the influence of contemporary discourses on older adults that, I claim, manipulates them to enter into institutional care within New Zealand. The study utilizes critical theory to expose the multiple potentials for ageism, social dominance, potential marginalization, stigmatization, exclusion and other power relations, as enacted with our older citizens, to regulate and normalize the institutionalization of aged care.

Within this context there is a powerful economic element that should be noted. In New Zealand the health budget expenditure accounts for approximately 20 percent of all government spending at approximately $15 billion dollars annually (Ryall, 2014b) and this amount currently represents approximately 6.9 percent of national GDP (Blakely et al., 2014; Williams, 2011). Long term care, as a subset of health spending, is funded directly from general taxation and accounts for almost 20 percent of all public healthcare expenditure within New Zealand (New Zealand Treasury, 2012a). Older adults deemed to require this level of care are required to

undergo income and asset testing to determine the level of subsidy from "Vote Health"[2] spend (New Zealand Treasury, 2009). Around a third of all aged residential care residents are not eligible for government subsidy and are, therefore, required to pay privately for their care out of personal income that goes directly to aged care providers (OECD, 2005).

Widespread and pervasive national predictions indicate that increased demands, emanating from an ageing population within New Zealand, will place unavoidable future fiscal pressure on national health spend percentages of GDP by 2051 (Grant Thornton Report, 2010; New Zealand Treasury, 2005, 2012a; Rea, 2009). Indeed, this same concern regarding "apocalyptic" population ageing is echoed across many international countries (Beard et al., 2012; OECD, 2011) including Australia (Biggs, 2014; Borowski & Hugo, 1997) the United Kingdom (Bytheway, 2011; Gilleard & Higgs, 2010b), in Finland (Bockerman, Johannsson, & Saarnie, 2011) and the United States (National Centre for Chronic Disease Prevention and Health Promotion, 2013). Population ageing is thus perceived to be one of the most critical risks to worldwide prosperity, economically, socially and politically, in the years ahead (Beard et al., 2012).

This apparently disturbing notion of a rapidly growing and increasingly needy cohort of aged people is pervasive and underpins the view that the future care of New Zealand's older adults is being contaminated by budget constraint rather than by evidenced individual need (Ashton, 2000). In apparent contrast, a growing groundswell of people believes that remaining in their own home is optimal for healthy ageing. This notion is also stated in the Health of Older People Strategy (Davey & Glasgow, 2006; Dyson, 2002; Petersen & Warburton, 2012) and in the guidelines for Specialist Health Services for Older People (Ministry of Health, 2004). However, having a choice of living location in older age, whilst encouraged nationally, remains restricted due to the somewhat limited government funding for support and care services to enable frail older adults to potentially remain at home (Dalziel, 2001b; Schofield, Davey, Keeling, & Parsons, 2006; Wiles et al., 2009; Wiles, Leibing, Guberman, Reeve, & Allen, 2011). In recognition of the looming potential ageing demographic "crisis" and the associated fiscal risk,

---

[2] **Vote Health** is the term used to describe the government's national health budget spending across New Zealand

the New Zealand government, more recently, has increased spending on home support for older people in keeping with its policy of ageing in place (New Zealand Treasury, 2012a; Office for Senior Citizens, 2013).

Current government familiarity with the perceived impending welfare state "problem", i.e. demographic pressure on welfare from an ageing population, and its inherent economic implications, is imbued with power and the need for governmental techniques for management (Foucault, 1994a). In his work on the marginalisation of minorities, Van Dijk suggested that political discourse accomplishes political aims and goals such as the distribution of social resources. This, in turn, is underpinned in multiple subtle and indirect forms of enactment, reproduction, and domination of defined subgroups (van Dijk, 1993a). Applying van Dijk's argument to the current narrative of ageing and aged care and the societal definition of this cohort as problematic, contemporary discursive frameworks have potential to marginalize and exclude older adults from the main body of society; normalizing residential aged care in its multifarious forms.

Within and beyond political discourse and its supporting narrative of ageing, other key discourses potentially influence institutional aged care entry by older adults. Discourses such as the medicalisation of ageing; the commodification of ageing (particularly the commodification of aged care as a "quality" lifestyle) and the influence of the existing societally normative and pervasive discourses on family members of aged individuals act persuasively in tandem with changing family dynamics (Biedenham & Bastlin, 1991; Hugman, 1994, 2001).

Fairclough (1993) is one of many authors to articulate the commonly drawn conclusion that modern or contemporary culture can be characterized as a "consumer" culture. Within such a cultural milieu there is potential for society to commodify life itself, making this a tradable asset importing value relative to any life stage and, in this instance, ageing (Kermode & Brown, 1996). In her early work on the impact of ageing within society, Estes (1979) was prophetic in the suggestion that the government management of older adults is compatible with the organisation of a country's economy. She suggested that goods and services would develop "to be consumed by the *silver* industries" (p.2) likely to develop in support of the predicted demographic growth in older adults internationally.

In recent years, bio-scientific developments have been evolving rapidly in an attempt to better understand and explain the ageing processes and "age related" diseases (Foddy, 2012; McCallum, 1997; Moreira & Palladino, 2009). In recognition of the power of medicine to claim jurisdiction over disease and act as an expert in relation to ageing, Estes and Binney (1989) coined the phrase the " biomedicalization" of ageing to explain the "paradigmatic perspective that focuses on individual organic pathology, physiology, etiologies (*sic)* and biomedical interventions in aging" (p. 587). The advancement of the dominant discourse of medicine and the medicalisation of life developed momentum from the mid-20th century, at which time a more formalized institutional establishment of medicine occurred with its ensuing capacity to exert authority and practice over disease states.

Meanwhile, the more contemporary notion of biomedicalization relates to the "increasingly complex, multi-sited, multidirectional processes of medicalisation extended and reconstituted through new social forms of highly technoscientific biomedicine" (Clarke, Shim, Mamo, Fosket, & Fishman, 2003, p. 161). Clark et al (2003), suggested that the core overlapping components of this biomedical discourse are made up of five fundamental processes, namely: "major political economic shifts; a new focus on health and risk and surveillance biomedicines; the techno-scientization (*sic)* of biomedicine and consumption of biomedical knowledges; and finally the transformations of bodies and identities" (p. 166); whereby medicine exerts control over bodies through practices and techniques such as naming disease states to enable intervention. It is appropriate here to draw a parallel between contemporary biomedicalisation and Haraway's (1991) concept of *cyborg*[3]; given the pace of biomedical developments in recent years and the advances in medicine, science and technology which fuse body and machine. These developments have established what Foucault (1973) argued was a regime of truth which established a code that individuals and society are motivated to accept, abide by, and participate in, as the new knowledge is established (Smirnova, 2012). In turn the societal normalisation of medical, scientific and/or technology intervention occurs as regulation of the body (Salter, Howe, McDaid, Blacklock, & Lenaghan, 2011). The consequence of

---

[3] A **cyborg** is a cybernetic organism consisting of a hybrid machine and organism

biotechnology and science advances have capacity to produce new individual identities (Smirnova, 2012) which are then regulated from the inside out as a type of "biomedical governance" with the potential to manipulate and control the body through medicalised practices and interventions and "desires for transformed bodies and selves" (Clarke et al., 2003, p. 181). Examples of these new technologies are the increasing use of plastic surgery, stents, hip and knee replacements, ophthalmology laser techniques and the like.

Whilst biomedical advances and controls seek what Kirkwood (2001) suggested is the impending desire to bring about "the end of age," the socially constitutive construction of older people as being in a state of biological decrement (Coupland, Coupland, & Giles, 1991) is based on a model which increasingly frames ageing as a state of physical, mental and emotional frailty and decline (Gilleard & Higgs, 2013). This discourse makes salient the power and control of predictive medical rescue where the clinical gaze of medicine is very focused on the inner physical world or bodily world of individuals (Hyden, 1997) and may be seen as an ideological system that serves as a mechanism of social control (Clarke, 1991).

Medicalising the normal processes of ageing brings with it the inherent capacity to recode natural human conditions as social or economic risks with calculative costs, as noted by Bytheway (2011) who stated "... bureaucracies ...use the date of birth to establish age and thereby the potential to control access to resources" (p. 181). In so doing, bureaucratic processes and their legitimated forms of statistical or demographic reporting create the opportunity for the complex phenomenon of human ageing to be transformed into a biological cost-benefit formula which is able to be manipulated in market terms (Nadesan, 2008; Walker, 2005). This notion is in keeping with Foucault's concept of "biopower" wherein political practices and economic considerations subjugate bodies and control populations within a paradox which evidences ageism and supports discrimination (Bytheway, 2011; Foucault, 1978b; Sinnerbrink, 2005).

As highlighted above, within contemporary society, power and domination are associated with elite knowledge generated in specific social domains such as medicine and biomedical science. Hence, these disciplines generate rules and routines and a medical "gaze" which act to visibly illuminate the physicality of ageing and then medicalise and control it (Foucault, 1973; van Dijk,

2001). There is a substantial body of evidence to suggest that the dominance of the medical model in western society influences social policy and funding priorities giving primacy to medical explanations or dogma relating to ageing and aged care (Koopman-Boyden & Waldegrave, 2009; Laws, 1996a; Whitfield, 2001; Zola, 1972). Increasingly human conditions and social relations are governed by medical discourse and medical definitions of reality.

The medicalisation of reality can be interpreted as underpinning the construction of our world through everyday reproduction of conceptual structures and beliefs that also influence and organise political thought and policies (Gamson, 1992). Such hegemony not only provides a means of constructing a political reality of humanity but also influences individuals' construction of their own reality. In so doing, this emergent political and individual construction is naturalized rather than challenged. This in turn controls the potential for questioning of such construction or for demystifying the underlying paradigm on which it is founded to expose the power, influence and even deception that may oppress or dominate vulnerable or naive individuals (Muralikrishnan, 2011).

The commercial management of the residential needs of older adults in New Zealand occurred as a direct result of political influence by successive governments over public health institutions within the 1990s. Government initiatives at that time, in New Zealand, required public health providers to extract themselves from the direct provision of residential aged care on the basis that this was no longer "core business" (Upton, 1991). This political influence and Vote Health strategy left open a market space for privatised provision of services for older adults and thus an opportunity for business to commercialize ageing and aged care. Devolution of health care services shifted the "burden" of aged residential care to the private sector successfully fragmenting this from main stream health services under the guise of efficiency. While nationally, the publicly funded cost of aged residential care is in excess of $800 million dollars each year, supporting some 33,000 beds nationally, significant profit is generated by private providers of aged residential care services most of which is sent offshore (Kedgely & Laban, 2010).

Despite the social power of medical discourse related to aged care, publicly concerns have continually been raised regarding the quality of care delivery for aged persons including

questions about the potential "warehousing" or institutionalizing this aged cohort of New Zealand society (Kedgely & Laban, 2010; Young, 2011). Residential aged care in New Zealand is an area where profit motive and commercial growth targets are seen to underpin concerns attributed to low staffing levels and poorly skilled staff. In their Report into Aged Care, Kedgley and Laban (2010) noted that aged residential care is an area which is in "desperate need of a revolution" (p. 5). They suggested that we (New Zealanders) should go beyond the current "institutionalized model of care" (p. 5) and require that the individual's needs take precedence over those of the institution providing care. Again, in relation to quality of care delivery to ageing persons, a report by the Auditor General, in 2009, reviewed the quality and safety in rest homes in New Zealand and found high levels of inefficiency amongst designated audit agencies in providing assurance of the quality of care provided in rest homes (Auditor General, 2009). This report acknowledged that older persons living in rest homes are some of the most vulnerable in society and noted that serious failure in the care to some residents of rest home residents had been identified.

Discerning the everyday discursive reproduction of individual agency and power influencing institutional aged care decisions may or may not be an easy task for ageing individuals. To make visible the underlying discursive frameworks that pervade societal thinking in relation to residential aged care this research was conducted in two phases. Initially, I undertook an exploration of current discursive practices in relation to the discourses related to aged care that are evident in selected, publically available texts and media. Following this, focus group interviews captured the voices of older adults (currently resident in aged residential care) in relation to what social and cultural factors influenced them to enter into residential aged care. Discourses related to individual agency, medicalisation of ageing; commodification of ageing, and quality of care were examined within all research data in order to critically evaluate power relations, regulation and marginalisation of older adults in New Zealand.

In contrast to the fear and promoted "burden" of ageing, a growing groundswell of people believe that remaining in their own home is optimal for healthy ageing. This notion of remaining in one's own home is also stated in the Health of Older People Strategy (Dyson, 2002; Petersen & Warburton, 2012) and in the guidelines for Specialist Health Services for Older People (Ministry of Health, 2004). However, currently having a real choice of living location is

unsatisfactory for many ageing people due to the limited government funding for support and care services to enable frail older adults to potentially remain at home.

1.6. Structure of the Thesis

The following outlines indicate respective chapter sequencing and content focus.

Chapter Two sets out to develop, for the reader, the relevant literature informing this research. Initially, adopting a genealogical approach, this chapter steps through the historicity of ageing within the context of the past hundred years; focusing on the dominant discourses of various evolutionary political cycles in the history of New Zealand. It also explores the notion of the "birth of a problem" following the political reforms commenced by the Labour government in the late 1980s and implemented by a National government in the early 1990s. This period marked a time which was instrumental in privatizing aged residential care away from public provision. The ensuing commercial management of aged care accommodation has grown significantly since that time which is a key aspect discussed in this chapter.

Chapter Three begins with an overview of the presuppositions underpinning this research. It describes the methodological rationale and foundations for this research across the multiple CDA scholars. Here CDA is discussed more fully to illuminate the discursive framework of ageing and aged care within contemporary New Zealand. It includes arguments that support the use of CDA to expose dominant discourses.

Chapter Four describes the methods and phases of the research and the broad details of data collection and the details of the analytic processes for both phases of the research, along with the ethical considerations.

Chapter Five begins the findings segments of this research; commencing with an exploration of the findings from both media materials and focus groups political discourse and the relationship to the "burden" of ageing within contemporary society. The images provided in the three findings chapters were captured during the time-bound scan of print media and provide instantiations of discursive frameworks and their articulation of the ideological positioning of older adults. In some instances visual images used in this study provide layers of influence for older adults

through the representation of the perceived *older person's* world, representation and appeal to the inner emotional world of the older adult, and/or enacting the social world of elders. For this reason some of the visual images have been used on more than one occasion and have been provided with a different figure number.

Chapter Six frames the findings from the media and focus groups illuminating the relationships to the discursive dominance of commodification of ageing within contemporary New Zealand society.

Chapter Seven provides details of the discursive influences experienced or visible (from the media and advertising) in relation to family; and the impact that family have on the choices and decisions of older adults in relation to aged residential care. Analysis of the perceptions of individuals within focus groups are exposed and describe the opaque discontinuities that family have on choices made by older adults in relation to their living arrangements.

Chapter Eight presents discussion of the endemic societal problematising of ageing and acceptance of a trajectory toward entry to residential aged care by older adults where salient points are drawn from the data analysis. Prevalent discourses are discussed and integrated into relevant literature to make visible those previously elusive discursive frameworks that impact older adults and support their decisions to enter residential aged care. Also discussed is the Foucauldian notion of *resistance* to power and the impact of this on subsequent decisions and quality for the lives of older persons.

Finally, this chapter brings together important conclusions and new insights that emerge from this research. It acknowledges the limitations of this research with the concluding remarks directing the meaning of the findings for future older adults, their relatives, for medicine and for government policy makers. The research question guiding this study is answered and whilst solutions are not provided, the findings and recommendations support further exploration of the prevalent discourse of ageing. Recommendations are made regarding the continued utilisation of the omnipresent aged residential care facilities as an appropriate solution for families or older adults who could, and perhaps should, be supported more fully to remain in their homes. The ethical, epistemological and political implications are covered in this final chapter.

An integral component of any research is the review of extant knowledge in the domain of interest to enable positioning of this research within the wider context of epistemological knowledge. Having now outlined the structure of this research and thesis it is appropriate to review the relevant literature in relation to the evolution of ageing and aged residential care in New Zealand, which is presented in the following chapter.

2. CHAPTER TWO

Do not go gentle into that good night,
Old age should burn and rave at close of day;
Rage, rage against the dying of the light.

Dylan Thomas (Thomas, 1952)

2.1. Introduction

This literature review traces the evolution of residential aged care in New Zealand in order to make visible the meaning this creates within the contemporary lives of older adults. There are multiple discourses and discourse frameworks that serve to influence older adults and their choices and decisions regarding accommodation alternatives as they age. The chapter aims to establish the themes that constitute and underpin these discursive frameworks; including the political, biomedical, and commercial discourses, as well as the changed role of older people within modern families, that impact and influence their lives. Chapter 2 begins with an overview of the search processes used to source an initial broad spectrum of relevant literature. It then takes the reader through the process used to obtain more fine grained literature relevant to the research question. From this point, the first element of literature develops an historical overview of the early political structures and the positioning of legislation impacting ageing in New Zealand. Next, the provision of income maintenance for older persons through benefits with the development of Universal Superannuation is discussed. I then turn to look at the central themes of the post war baby boom and the state provision of uniformity of coverage for care of the older adult.

With the advent of the 1990s, increasing political recognition occurred in relation to the modern phenomenon of an "apocalyptic" demographic trend evidencing increasing numbers of older adults. In tandem with this awareness, economic and fiscal reform led to the a move away from the provision of aged care as "core business" of public health care providers and a new era was heralded in which privatised institutional care for older adults. The social construction of ageing and aged care, under a private provider umbrella, has continued to grow. Currently the situation has evolved to a point where the normalization of segregation of older adults' institutional living arrangements can be found for the provision of aged care and in other forms such as the "gated" aged living arrangements found in retirement village campuses. Alongside this growing

institutionalization of older adults, a national and international surge in the development and formalization of medicine has evolved from the middle of the 20th century. This has resulted in an increasing biomedicalisation of ageing including enhanced "rescue" and intervention for older adults (Maturo, 2012). Gawande (2014) suggested that advanced medical technologies can "rescue" an individual patient's specific conditions (e.g. stent a coronary artery in an older cancer patient) almost without recognition of the incurable nature of ageing. He argued that knowing when to stop using the technologies of contemporary medicine is virtually the antithesis of the medical practitioners' ethos; which is to provide curative measures. "In the past few decades, medical science has rendered obsolete centuries of experience, tradition and language about our mortality and created a new difficulty for mankind: how to die" (Gawande, 2010, p. 158).

The literature and themes developed in this chapter aim to situate the research question against a background of political, economic, cultural and social narrative, and construction of older adults.

2.2. Searching the Literature

The literature search process for this study has been both comprehensive and lengthy. Initially it started with a formal search using relevant search engines available from Auckland University of Technology (AUT) library, local medical and nursing library searches and targeted searches with assistance from both local and national librarians to review legislation, Government speeches (New Zealand Government) and the national library archives for historical documents. From the initial search flowed more targeted searching for relevant literature related to my topic of study and, specifically, to the narrower searches emanating from key articles or aspects of knowledge that required further understanding on this journey. The following discussion describes this journey.

There is abundant published literature related to the commercial management of older adults (e.g. retirement village residency, financial management, tourism), as well as a plethora of clinical, epidemiological and sociological studies or themes examined for the effective management of older adults. Evident in the very wide spectrum of research related to older adults are investigations into strategies, such as the determinants for successful rehabilitation, depression management, active ageing, healthy lifestyles and medical interventions for issues such as delirium, hearing loss, vision loss/correction, joint health and, more recently, the maintenance of

agelessness through cosmetic surgery. A large body of information is present in the literature on the specific and targeted technologies for anti-ageing in the forms of medical tourism for cosmetic surgery, dental work and prosthetics (Connell, 2006), and the search for the fountain of youth and perfect ageing have escalated considerably (Weintraub, 2010) as evidenced in the literature on older adulthood..

In searching for relevant literature, to inform and guide this study, I utilised multiple search engines including CINAHL, EBSCO (including MEDLINE), SCOPUS, Pro Quest Central, Joanna Briggs and Google Scholar. The EBSCO search contained articles from 11,000 journals, magazines and newspapers over a wide variety of subjects and includes MEDLINE as a subset. Google Scholar indexes journal articles, theses/dissertations, books, patents and other scholarly publications across all disciplines. SCOPUS sources current information from 18,500 peer-reviewed, scholarly journals, plus patents and conference papers covering all disciplines. Pro-Quest Central contains the full text for over 13,000 journals, magazines and newspapers across a wide range of disciplines. The Joanna Briggs database is supported by the Joanna Briggs Institute and contains systematic reviews of healthcare practice from peer reviewed journals. Also used was AUT Library Search' which provided a full search of all AUT library resources including databases, catalogue, e-journals and holdings of theses and research within a 'scholarly commons'.

Key words and phrases used in all searches for influences on older adults living arrangements and which were used either alone or in Boolean combinations, included the following: "older adults", "old age", "rest home", "nursing home", "aged residential care", "older people", "nursing home placement", "family", "care-giving", "frailty", "parent-adult child relationships", "relocation of older adults", "elders", "ageing in place", "demography related to age", "permanent care", "assessment for residential care", "older persons living arrangements", "decision making in living arrangements for older adults", "transitions for older adults", "transitions for elders". These word and phrase combination searches generated research articles, reports, newspaper articles and books covering an array of sub-thematic approaches to the construction of older adults and the subsequent construction and influences related to the aged living arrangements for older adults. Results from all searches generated older adult population comparisons among multiple countries (Canada, United States, Europe, United Kingdom, South Africa and Zambia); bio-medical determinants of age, for example rectal cancer survivorship, obesity in age, dementia, the need

for breast screening for older women, and nutritional management; and multiple studies on the impact of ageing on policy, benefits and health services into the future.

Using the multiple search engines listed above to search for relevant literature with the key words "critical discourse analysis", "discourse analysis", "aged care", "residential aged care", "elders", "nursing home", "decisions", "decision context", "contextual decision models", "marketisation", "commodification", "influences", "older adults", "relocation", "competence", "family", "loneliness", "sense of belonging" and "residential aged care in New Zealand" generated only a very small number of results. Very little information in the academic literature located relates to discursive influences on the decision of older adults to enter residential care. Of the published literature available, specific, New Zealand publications in relation to critical discourses or influences impacting aged residential care entry or aged residential care decision making by older adults is largely absent.

When the key words were changed to "critical discourse analysis and aged residential care decisions" in New Zealand, only one study from 1999 was located. Using the AUT library search engine with a combination of the terms "older people, New Zealand, decision making" generated one research paper from 2009. A combination of "marketisation, discourse and New Zealand" generated one research study relating to retirement villages. Meanwhile the combination of terms "ageism in New Zealand" generated 1484 "hits" including themes of elder abuse and neglect, leisure activities for older adults, burnout in medicine and intergenerational relations between older adults and youth.

Using Google Scholar as a search engine and the key words "commodification of ageing", generated 17,900 "hits" mostly not relevant to this study. Meanwhile an AUT library search using the same terms generated 10,976 research articles including studies on the enhanced bio-medicalised anti-ageing literature; for example, viagra as a new medical technology for older men, female cosmetic surgeries (i.e. "nip and tuck" interventions) (Haboush, Warren, & Benuto, 2012; Johnson, 2011). Also noted in this literature were research works related to retirement village living; ageing demography; pensions and economic considerations of ageing; productive/active ageing; gay "queer" ageing and the feminization of ageing.

Considering the notion of older adulthood to the specifics of the New Zealand situation; using Google Scholar as a search engine and the key words "Public Policy and aged care in New

Zealand" generated 32 "hits" with historical policy development articles and other non-related research. An AUT library search using the same terms generated 13,103 results including historical policy developments, studies on the law and ageism in New Zealand, pensions and the fiscal drag of older adults on the economy, and bio-medicalisation considerations, such as falls management and the costs of falls to the health budget.

One significant strategy used in all ongoing search activities related to the research question has involved locating key articles and following citations of these in other literature. I have also used references found in key research papers to follow up on further important scholarly publications in order to guide my knowledge, understanding and inquiry throughout this study.

2.3. A History of Ageing in New Zealand

The wider literature search to inform and give context to this study generated significant information on the contemporary power and influence of bio-medical determinants in older adults. In combination with the growing domains of information technology and marketing, bio-medical determinants have evolved considerably since the 1980s, both internationally and nationally. Also noted throughout the background information search process is that the dominant discourse of modern New Zealand society (and western society internationally) has become one of free trade, competition and a reduced role for government in the provision of social services (Simpson & Cheney, 2007). From this political 'turn', targeted marketing and the commercial management of older adults is seen to have embraced the potential 'for profit' opportunity within the growing "silver tsunami" (Miles, 2013). However, the powerful superiority of the functions of bio-technology, marketing and information technology have not always been present within New Zealand society but have evolved over the past 50 or so years. The published literature, which gives context to this study, involves a chronological re-examination of historical events occurring in New Zealand as an essential beginning point to understand the historicity in relation to ageing and aged care. Specifically, it illuminates junctures and discontinuities which have given rise to dominant discourses that support contemporary narratives of ageing and the influences these exert on aged residential care choices and decisions by older New Zealanders. This approach is congruent with a critical theory paradigmatic model and recognizes the histographical (archaeologies) studies undertaken by Foucault (1972, 1973).

It is suggested that in New Zealand older adults are willingly entering into residential aged care facilities to receive potentially compromised care within a space that is caught between the rival discourses of medicine, communal care and day to day living (Kedgely & Laban, 2010; Stafford, 2003; Young, 2011). Some groups have argued that New Zealand should be urgently increasing the number of aged care beds for older adults (Grant Thornton Report, 2010). Meanwhile others are encouraging the New Zealand government to actively promote the responsibility of individuals to age well and reduce disease burden, as well as the predicted impending explosion of health costs (Morgan & Simmons, 2009).

The historical constitution of ageing and aged care are invested with past relations of power which have established ageing and aged care constructs as economic and ideological objects within society. Foucault (1972) suggested that power is infused into these dimensions of life through techniques of knowledge and procedures of power invested within the historical structures and functions that evolved throughout time. Each epoch of New Zealand's history has constructed these notions of ageing and aged care differently and locally; and in order to understand how they are manifest and what power techniques underpin them it is appropriate to examine how they have evolved in New Zealand.

The terms "old, older and elderly" are significant in themselves in that clarity and visibility of meaning for these terms from different epochs, as well as the social construction and represented "truth" and "power" infused within them, is directly linked to specific historical times which build to enlighten modern understanding. Power has a significant role to play in what is stated or what is silenced or unspoken within a given society. Each culture or discipline within society (such as aged care) has its own regime of truth brought about by constraints or acceptance of dominant discourses that produce compliance or disagreement in what Foucault termed the 'political economy of truth' (Foucault, 1994a). Foucault (1994a) stated this clearly when he suggested "Each society has a regime of truth, its 'general politics' of truth - that is, the types of discourse it accepts and makes function as true" (p. 131).

Old age, particularly since the seventeenth century (depending on specific location globally), has been variously defined as the accepted juncture at which there is the ability to receive some form of pension or supportive benefit; and this has widely become the accepted dogma of public economic policy internationally (Smith, 1984; Walker, 2005). New Zealand has followed this

dogma and established an accepted age for eligibility to universal superannuation as 65 years whilst having no legal requirement for this convention for the general population (Ministry of Business Innovation and Employment, 2014). Challenging the rationality of an economic discourse relating to age, the stability of age 65 years for retirement is currently questionable within the wider global environment. This is brought into sharp focus when reviewing the arbitrary specific age as a critical date for access to full benefit or Social Security retirement pensions in other countries. Age 65 years is being supplanted by age 66 and eventually age 67 in some jurisdictions. For example, France increased its pension eligibility from 60 years to 62 years in 2010, with full pension access now 67 years for those born after 1955. The Australian government has developed an incremental scale for age access to pensions with 70 years becoming the age of access by 2035 (Siegal, 2014). Whilst age 65 will undoubtedly remain a useful heuristic for retirement, this iconic birthday may become less relevant to the organization of older adults' actual behaviour, than to a notional stage for public policy development and implementation (Ekerdt, 2010).

Focusing on the chronological construction of age raises the questions *who are* or *who were* the older adults historically in New Zealand? In the emergent country of New Zealand, in the 1800s, immigration was the predominant factor impacting the number of the aged persons in the population. From records documented in 1896, and almost certainly prior to this, foreign born individuals made up a significant proportion of older New Zealanders (Cheyne, O'Brien, & Belgrave, 2008). Such a high level of older immigrants was largely an outcome of the colonial drive for expansionary population growth which resulted, in 1911, of some 96.7 percent of non-Māori aged 65 years and above evidenced as being born overseas. This trend did not reverse until the 1936-45 intercensal period when New Zealand born older adults became the majority of the aged population (Heenan, 1993).

As early as the 1861 census there was a perception that the number of poor older adults was growing; yet, New Zealand did not have large numbers of older adults in its earliest times. In the early settlement times, and as late as 1881, only 1.3 percent of the census population was aged over 65 years. However the numbers of people aged 65 plus reached 2.1 percent of the population in 1891 and 3.8 percent by the 1901 census and demographic projections indicated that the proportions of these older adults would keep on rising (Preston, 2008).

Within the new democracy of New Zealand there was no nation-wide plan for prepaid or privately paid medical or hospital care services in the early years of its colonialist history. The more affluent members of society who could afford to pay were expected to meet the economic burden of their own health care needs; those who could not afford care were required to rely on the benevolence of others (The Royal Commission on Social Policy, 1988). Indeed, voluntary groups, such as friendly societies, levied their members for the purpose of covering costs of such care and it was only through individual arrangements with doctors and hospitals that members could access medical and hospital treatment free or partially free (McLean, 1966). In seems that in the main, however, people made their own arrangements and met their own costs for medical and hospital treatment as and when the need arose. Doctors engaged in individual practice recovered their fees directly from their patients and public hospitals charged patients at rates varying with the type of institution and the ability of the patient to pay (Allan, 1996). For the completely destitute and the aged, private doctors often provided compassionate care in the form of a measure of free treatment, whilst hospital boards administered relief under the Hospitals and Charitable Institutions Act and semi-formal charities provided some small amount of assistance (Thompson, 1998). However, such free treatment and relief were not obtained as of right and often people seeking relief had to undergo full investigation of their financial and other circumstances so that inability to pay could be formally established. Many of the poorer people, especially the old, were too proud to disclose their poverty or accept charity and so went without adequate medical care in the early development of New Zealand society (McLean, 1966).

Whilst in the developing New Zealand there was some, albeit variable, provision for health care assistance, the lack of a formal public pension system did not impact all of New Zealand society. Some individuals received Imperial or New Zealand war pensions for military service and some former public servants obtained government pensions on retirement; meanwhile the really destitute older adults could receive informal charitable aid (Preston, 2008, Thomson, 1998). Formal philanthropic charities were few and far between at this time and older adults - defined as those persons over 65 years without means - were strikingly absent from these charitable organizations' priorities (Thomson, 1998). In essence, 19th century New Zealand relied on a form of colonial Poor Law where welfare for older adults , the indigent and deserted women or children of poverty were cared for through donations mostly via churches or private charities (The Royal Commission on Social Policy, 1988).

It was at this time in the late 1890s, in Christchurch, Nurse Sibylla Maude is documented as fulfilling her love of caring for impoverished poor and older adults who were typically sick and at home, by establishing New Zealand's first District Nursing service. As Allan (1996) suggested, at this time in New Zealand's history, the clustering of small, Spartan cottages in thickly populated areas were the homes of the working classes and the poor who had high levels of "superstitious ignorance" of disease as labeled by others. The establishment of the Nurse Maude District Nursing Association focused care and support to Christchurch society as encapsulated in their objective "*to provide the care, nursing and general welfare of poor, aged and sick persons in and about the city of Christchurch*" (Allan, p. 70). This situation highlights the former provision of nursing care for older adults and impoverished within an egalitarian and humanistic model driven by discursive frameworks constructing the older adults somewhat differently to the current epoch. Minimal medicalisation of aged care occurred within the early years of New Zealand's history and was mostly focused on the care and management of the "insane" which included many alcoholics. As noted in the Royal Commission Report on Social Policy (1988) wider public health "was subject to supervision of a department of the state that remained minute and incapable of enforcing policy until the 20th century, with responsibility not only for the sick but also for the aged and the indigent" (p. 12). At this time in the evolution of New Zealand society, commodification of older adults was unlikely given that economic and cultural drivers were focused on broad sustainability goals within the emerging country.

2.4. Early Legislation Impacting Ageing in New Zealand

As previously mentioned, for the emergent country of New Zealand, in the 1800s expansive immigration was the predominant factor impacting the number of the aged persons in the population. Gauld (2010) noted that by the 1880s, the New Zealand government had become increasingly involved in the design and implementation of the health and welfare system. In 1885 the central government set up a colony-wide system of Charitable Aid Boards (similar to Hospital Boards) so that charitable aid and benevolent support could be distributed to the local poor. Relief was represented as an unattractive option to prevent "pauperisation of the wider community" and able bodied individuals did not have access to any form of relief. In contrast the indigent aged, who were mostly "derelict old men", were able to access care in old people's homes and hospitals (The Royal Commission on Social Policy, 1988, p. 17).

As a key piece of legislation, impacting the early New Zealand history of aged people, the Hospital and Charitable Institutions Act (1885 and 1909) set the pattern for the hospital system and has largely remained a cornerstone for health up to the present time. The Hospital and Charitable Institutions Act effectively divided New Zealand into 28 hospital districts, each controlled by a Board whose members were appointed annually by the local authorities of the district. The hospitals were to be financed by patients' fees, and, it was hoped, by voluntary contributions from charitable individuals, the balance being supplied by local rates with a Government subsidy (McLean, 1966). A new Act was passed in 1909 under which Hospital Board members were to be elected by their local body electors in their district, and to hold office for a three year term. All the separate institutions, which could not operate without assistance from the local ratepayers, were taken over by the hospital boards, and the number of hospital districts was increased to 36 under this revision of the original Act (Victoria University, 2008).

Given that New Zealand was seen as a land of opportunity, the colonial government expectation was that immigrants would provide for themselves and their family members as enshrined in the Destitute Persons Ordinance of 1846 and the subsequent Destitute Persons Act in 1877 (and revisions). It appeared that, politically, New Zealand aspired to be a neoliberal state without poverty and not, therefore, in need of public income support for the aged (Preston, 2008). However, this aspiration did not necessarily represent the reality facing many people, particularly those impacted by the Depression of the 1880s and 1890s. Compounding this situation was the reality that many older adult males were single and had no relatives to support them. Thus the majority of those aged 65 years and above had to find their own sources of support.

The view that the new colony of New Zealand could avoid the "social distress", similar to that being experienced in other older countries including the United States, became a theme of public debate at the end of the 19th century. Prime Minister Richard Seddon, an enthusiastic sponsor of liberal reforms in the 1890s, introduced the world's first legislatively mandated pension for older adults through his 1898 Old-Age Pensions Act (Ministry for Culture and Heritage, 2014). Seddon reportedly felt strongly about the ongoing welfare of miners from the West Coast in light of their contribution to the development of New Zealand economy and this supported his drive to ensure the State took some responsibility for older adults unable to support themselves (The Royal Commission on Social Policy, 1988). New Zealand's Old-Age Pension Act reflected the nation's legislative and electoral arrangements of that time, which allowed bold policy-making by

politicians who knew the pain of poverty. Seddon is quoted as stating that his Old Age Pension Act would "... act as a measure which will redound to the credit of our colony and the Empire and which will be copied by the whole of the English speaking world" (Richards, 1993, p. 51).

The introduction of the 1898 pension was vigorously debated in light of the perceived growth in numbers of relatively poor older adults. It consisted of a maximum amount of £18 a year for a single person and twice this amount for a couple (Preston, 2008). Receipt of the pension, however, was subject to vigorous means testing which required an income review and review of any assets. Additionally it required demonstration of other desirable characteristics to substantiate appropriateness such as evidence of good character (unavailable to criminals, drunkards and those who had abandoned their wives and families; Asians were excluded) and the ability to attend a public court session (Preston, 2008). These requirements, and the fact that only around a third of the over 65 years of age population were able to qualify, fueled the debate on pensions and catalyzed widespread discussion around alternatives such as compulsory social insurance, tax concessions for private provisions and universal pension access (Preston, 2008). While this legislation drew the New Zealand government into a welfare relationship with a proportion of those aged 65 and over, it also made provision for real poverty in the older adult population to be avoided within a budget envelope which was manageable for the government (Saville-Smith, 1993). Thus, with the enactment of this legislation, ageing had now attained a status of a public issue rather than merely a private trouble.

In 1989, the introduction of "tax-funded, non-contributory old age pensions for those aged 65 years in New Zealand" was seen as a bold decision internationally and this legislative leadership earned New Zealand a place in the history of the evolution of state based welfare (Thomson, 1998, p. 146). In a democracy, like that of New Zealand's early colonist history, the functions of the State were, naturally, numerous and varied. Although the initial trends of legislation may have been termed 'progressive' or even socialistic, the institutions controlled by the Government were conducted mainly on the lines of those prevailing in the "mother country" - England.

This alignment to the Westminster system of law was something of a reaction to the new country's colonization; where, although most of the Westminster legal system was simply transferred directly into legislation in New Zealand, the Poor Laws from England which dated back the sixteenth century were not incorporated into the new country's legal system (Preston, 2008).

In something of a colonial variant, New Zealand had introduced, in 1846, a law relating to destitute persons; namely the Destitute Persons Ordinance Act enacted by the non-elected Crown Colony government. This legislation differed from the English Poor Act (1601) in that rather than having local parishes assume responsibility for destitute people, including the aged, the responsibility for care of the destitute was to be assumed by the family of the individual. This Act and subsequent laws were amended at various stages with 1877, 1883, 1894, 1908, and 1910 revisions. This Act also remained in force in New Zealand until it was repealed by the Domestic Proceedings Act 1968 (Thomson, 1998).

While structurally, as well as from census to census, the number of people aged 65 or older had increased from 1900, at times this trend reversed due to fluctuations in fertility which appeared to reduce the peaks in older persons (Heenan, 1998). To stave off the potential for the government to subsidize aged people, further legislation was enacted in 1910 when the National Provident Fund was set up to encourage workers to save for their old age. Meanwhile the Finance Act of 1915 encouraged individuals to contribute to private superannuation through tax concessions. In 1916 concessions were extended to superannuation fund earnings and interestingly, in 1921, employer contributions qualified for tax rebates (Preston, 2008). Whilst still contentious and vigorously debated, the original Old Age Pension Act remained in place for four decades and by 1936 pension levels had increased from the original level by 28 percent for the 5 percent of the population who were eligible (Heenan, 1998).

2.5. Superannuation

The thirties in New Zealand history were most memorable for being the years of the Great Depression which spanned the late 1920s until 1935. The Great Depression, which resulted from the stock market crash in the United States, had a worldwide impact and was characterized for thousands of New Zealanders by enormous stress, hunger and despair (Dorothy, 2001). However, the Depression years also were critical for the architecture and subsequent evolution of welfare state (Cheyne et al., 2008). The election of the first Labour Government was a turning point in New Zealand's history in terms of the development of social policy. Under the leadership of Michael Joseph Savage this government initiated a shift away from the previous reliance on benevolence or charity for provision of health, housing and pensions to one of universal provision

in the enactment of the Social Security Act 1938 which came into effect in 1939 (Cheyne et al., 2008; Oliver, 1988).

The preemptive policy intent for this new Act was provision of a fully state funded, integrated and universally accessible National Health Service, which expanded various benefits and pensions such as those covering sickness, disability and invalidity (Gauld, 2009). This policy and subsequent legislation, however, was strongly opposed by the medical profession. The medical profession, with their unique capacity to influence both the health sector and government policy, vigorously opposed political initiatives for freely accessible health care for all. With this powerful medical opposition the vigor of the legislation was compromised and in 1941, resulted in the evolution of a "dual" system of public and private provision of health care in New Zealand subsidized through a series of arrangements known as the General Medical Services (GMS) benefits (Gauld, 2009; Parliamentary Library Research Paper, 2009). At the same time there was achievement of a move to formalize the New Zealand medical profession with the establishment of the British Medical Association of New Zealand in 1887. This organization was to go on to become a powerful lobby group and voice in New Zealand health policy and legislation (Gauld, 2009).

The main feature of the 1938 welfare scheme was the provision of universal eligibility to an enhanced, non-taxed but means tested pension called the Age Benefit (Saville-Smith, 1998). However, there was also downward pressure in terms of age of entitlement which saw the age of entitlement lowered from 65 years of age to 60 years of age and the pension was boosted to 30 shillings a week or £78 a year (Preston, 2008). Pension rates had also risen by some 71 percent in a very short time span of four years; thus shifting older New Zealanders from a somewhat marginal situation experienced throughout the austere and stark Depression of the early 1930s to a very favourable economic position by contemporary standards at the end of the 1930s.

At age 65 years those not entitled to the Age Benefit received a small universal superannuation payment of £10 a year, effective from 1940, along with the promise that this payment would gradually be increased to match the Age Benefit. However, it was not until 1960 that this point was actually reached. At its inception the new pension scheme was expensive, with more costs signaled through the universal superannuation promise. A new Social Security tax of 5 percent of earnings (one shilling in the pound) was introduced to cover the increased costs of pensions,

other social security payments and health services at this time. In practice, however, the taxation levy was insufficient, and much of the social security cost increases had to be funded from general revenues. Social policy underpinned by a strong welfare philosophy had come to stay. Alongside this, the cost of welfare began absorbing an ever growing share of the national tax dollar (The Royal Commission on Social Policy, 1988).

2.6. Age, Pensions and the Post-War Baby Boom

The 1938 Act placed eligible aged beneficiaries in a favourable economic situation. Even as late as 1947 the Age Benefit for a couple was equal to about 72 percent of the average ordinary time wage after tax, although notably this was subject to an income and asset test. Whilst this was an expensive social policy for the government to fund, there was little debate about the need for ongoing support for older people. Saville-Smith (1998) suggested this support was essential and related directly to the "relatively low dependency ratio" (i.e. the ratio of adults in the workforce to adults and children outside the workforce (p. 86). This dependency ratio is suggested as having been due to the relatively short life expectancy of those over 65 years at that time.

Changes in attitudes in the 1950s were indicative of broader shifts in New Zealand society. Various welfare reforms and economic improvements occurred in New Zealand and these, coupled with the impact of global youth culture and social upheaval, created new opportunities and challenges for New Zealand. The expectations and frustrations that resulted were to be influential beyond the fifties. In the 1950s New Zealand had one of the highest standards of living in the world, according to Mitchell (2002).

The nuclear family unit was the most important aspect of society post the Second World War. This unit was the vortex of New Zealand society. In classical terms the family unit resembled *pater familias* on a small scale where male dominated families included parents, children and the extended family of which older adults were firmly fixed as a generational extension of the nuclear unit. According to this societal context, this was a period which was underpinned by public policy on employment, education and housing as well as welfare benefits (Cook, 2009).

There are marked differences between current existing age cohorts within New Zealand society and those of antecedent epochs (Jorgensen, 2006b). Jorgensen pointed out that there are four critical generational cohorts each of approximately 20 year periods within New Zealand society at

this time. These are the "silent generation" born pre-World War 2; the "baby boomers" – born 1945 to 1964; "Generation X" born between 1965 and 1981 and finally "Generation Y" born 1982 to 1995". The impact of these generations is most apparent through their demands and requirements for health care and specifically for aged care. The "silent generation" cohort was driven by hard work, a sense of duty, sacrifice and the nuclear family. This cohort embodied respect for authority and conceded much power to the medical model of health; willingly accepting that the doctor would know best. It is this group that is currently the recipient of care in aged residential care facilities and retirement villages.

The number of people in New Zealand over the age of 65 years has more than doubled since 1951 to reach almost half a million or 12.3 percent of the population in 2006. The 2006 census also noted that there were 531 people in New Zealand over 100 on census night and around 75 percent of these centenarians were female (Statistics New Zealand, 2007). In the 2013 census, the number of people aged 65 years and over shows continued increase; there were 607,032 people in this age group making up 14.3 percent of the population – an increase of this population group from the 2006 census of 12.3 percent (Statistics New Zealand, 2014). These data, showing the growing number of older people, has fueled political debate about the financial impact of the predicted explosion of older citizens on the New Zealand economy by 2030 (Creedy & Ball, 2013). In turn, this has enhanced increasing political dialogue regarding the prospect for personal accountability and responsibility for support and care for older adults over time (Dyson, 2004; Grant Thornton Report, 2010; Ministry of Health, 2004, 2006). The Grant Thornton Report (2010) suggested specifically that "the ageing of the New Zealand population presents well known challenges to the Crown, providers of services to older adults and, ultimately to society as a whole" (p.5).

The key finding within the publication of the Grant Thornton Report on Aged Care, was largely a requirement for further investment and support to aged care providers across New Zealand. This finding occurred within a landscape of national and international political and economic anxiety related to the growing expectations for Vote Health spend on age related care. In response Health Minister the Honorable Tony Ryall, quoted a report from *Science* magazine arguing that the rising life expectancy and improved health has translated into the population ageing more slowly thus reducing the potential "burden" of an ageing population (Ryall, 2010). Minister Ryall concluded in his speech to the New Zealand Aged Care Association that "The old are not so old anymore"

(Ryall, 2010, p. 1). One could deduce from Minister Ryall's comment here that the notion of the population ageing more slowly supports a discourse of economic rationalism which is attractive to politicians as a key strategy for managing the predicted explosion in older adults requiring care into the future. Such a strategy would underpin societal encouragement programmes for self-management and personal responsibility for health outcomes. The polar opposite of this, of course, is that those who contract naturally occurring disease states; for example cancer, diabetes and some cases of heart disease due to their genetic endowment, may be blamed or marginalized within the wider society of New Zealand without reasonable cause.

2.7. A Political History of Aged Care

Changes in the delivery of care to older adults have evolved over the past 100 years in New Zealand. Institutional support for aged people requiring care in early New Zealand rested either with families or charitable organizations as discussed above. Between 1908 and 1948, if older adults resident in care homes became acutely unwell and charitable organisations could no longer cope, larger public hospitals assumed major responsibility (Jefferys, 1991). During the 1950s religious and welfare organizations invested their funds in building considerable numbers of aged residential care institutions for older people taking some of the pressure off the public system (Koopman-Boyden, 1993). This situation continued largely unchanged In New Zealand prior to the 1970s (Jorgensen, 2006).

The State's political discourse related to ageing in the 1970s was one heavily aligned to the medicalisation of age within a discursive framework which stratified ageing people as primarily embodied in a decremental disease state. Over the course of the 19th and 20th century's, advances in the biological and medical sciences had led to an increased dependence on medicine for matters concerning ageing and maximizing life span through new technologies, and minimized traditional beliefs about the life-death course (Conrad, 1998). Medical terminology and intervention relating to age grew considerably over the 18th to 20th century's and specifically the growth in nomenclature identifying diseases and death related to age in the second half of the 20th century (McCallum, 1997). Medical discourse as the dominant social and authoritative paradigm had a significant impact on the institutionalization of older adults in care homes through the social construction of ageing as frail, diseased or a state of decline; and subsequently resulted in a "relatively large proportion of older New Zealanders being systematically excluded from social

42

and economic life by institutionalizing them in rest homes" (Koopman-Boyden & Waldegrave, 2009, p. 76). Indeed, whilst early care homes were motivated and developed by secular organizations and charities, aged care now became a problem of the state and older adults' choices now needed to be made within the constraints of the State.

In 1970 around 6.2 percent of the aged population was in rest home care but, as noted in the Grant Thornton Report (2010), this proportion had decreased to 5.9 percent between 1996 and 2006. However, even at this lower level it "remained higher than most other OECD countries" (Grant Thornton Report, 2010, p. 86). Interestingly, within the written submissions to the Royal Commission on Social Policy in 1988, 18 percent of the submissions from the general public contained comments about "unfair treatment of the elderly with many being pleas for increased financial assistance" (The Royal Commission on Social Policy, 1988, p. 357). This time in New Zealand's history was a period of socio-economic development in which the free market and the welfare state evidenced an uneasy co-existence (Ng & McCreanor, 1999). While at policy level connections between housing, social policy and ageing were slow to evolve in the latter part of the 20th century, the post war housing boom and "quarter acre" culture of New Zealand supported many older adults to own their own homes in suburbia into retirement. Living on New Zealand superannuation without any additional income, however, was living on the edge of poverty and in the face of increasing costs of living, physical limitations and widowhood/widower-hood, many older adults turned to supported accommodation of residential care facilities (Kendig & Gardner, 1997). As suggested by Hayman et al. (2012) housing conditions influence both the physical condition of older adults and their psychological wellbeing, and inadequate housing raises the possibility of poor health, disease and injury. According to Hugman (1994) similar claims have been made by older people in Europe who live in compromised housing and accommodation due to their relatively poor financial situation. In the face of this situation, however, most older adults would prefer to remain in their own homes with the ability of social services or care to be delivered in their own home (Cheek et al., 2006; Kendig & Gardner, 1997). Thus the discourse of ageing as a public or social issue, to be managed expediently, occurred not at the hands of the disadvantaged group themselves but essentially from the hands of those sections of society on which these people were likely to rely on for care; that is, the dominant rather than an oppositional discourse (Gibson, 1998).

Within aged residential care historically (and in their contemporary forms) significant elements of living arrangements mirror institutionalised living such as separation from the wider community (in stylized buildings or gated communities), limitations for individual agency, concentration of all critical elements of one's life in one place and control by staff regarding the use of time and space by residents (Hugman, 1999; Petriwskyj, Gibson, & Webby, 2014; Reed, Cook, Sullivan, & Burridge, 2003a). Aged residential care facilities within the New Zealand context have formerly been known as "nursing homes", "old people's homes" and "rest homes" with common criteria of sharing one's life with individuals whom one might normally not have chosen to live with. Cheek et al. (2006) found, in their study of older adults transitioning into residential aged care facilities from retirement village living, that residential aged care is viewed very negatively by older adults and their families with the prospect of this suggested as being "one of the most pervasive sources of anxiety marking later life" (Biedenham & Normoyle, 1991, p. 107).

Significant health reform occurred in New Zealand in the 1990s following on from the period of monetarist economic developments initiated in the 1980s. In the period from 1984, a more fiscally responsive economy was being developed where successive governments sought to "balance the books" of the state in order to ensure that citizens lived within their means and thus reduce state expenditure (Barnett & Jacobs, 2000). The Lange led Labour government of the late 1980s began the major restructuring of the health sector and this was subsequently picked up by the National government in 1990. In what has become known as the Green and White Paper (Upton, 1991c), proposals to introduce competition into the health sector and increased privatisation were made. There was little health sector consultation associated with the presentation of this document due to government at that time perceiving the health community to have significant vested interests. Subsequently government, through the Green and White paper, made it clear that both health institutions and health professionals (including doctors) "were part of the overall resistance to change" in the sector (Upton, 1991c, p. 10).

Central to the health reforms of this time was the need to manage expenditure. A National Advisory Committee on Core Health Services was established to rank health services and advise the Minister on which "*core* health services would be retained" and which would no longer be offered (Parliamentary Library Research Paper, 2009, p. 10). Surreptitiously, in the early 1990s, public Health Boards extracted themselves from the provision of aged residential care seeing this as non-core business (Upton, 1991c). This provided an opening for the enhanced development of

private aged residential care as the government sought to drive efficiency into the health sector (Barnett & Jacobs, 2000; Gibbs, Fraser, & Scott, 1988). Thus government policy, which had formerly evidenced a significant commitment to the welfare of older adults, now required that they became more self-sufficient. As noted by Ng and McCreanor (1999), this political shift echoed what Foucault would have argued was a discursive battle for ideological control as the State, private providers, welfare providers, secular providers and public health care providers, as well as citizens, "contested the issues in the media, in Parliament and in everyday discourse" (p. 474).

In 2001 the Minister for Senior Citizens, the Right Honorable Lianne Dalziel, created a Positive Ageing Strategy for New Zealand with a goal of ensuring New Zealand society is a place where individuals can age positively. This document established a set of principles as a framework for integrating policies and programmes across the government sector. Following this, in 2002, the then Associate Minister of Health, Ruth Dyson posited a new approach to the delivery of health services for older people and initiated the Health of Older People Strategy (Dyson, 2002). This document provided a "blueprint" for the care and management of older citizens through until 2010. However, whilst legislation is informed by values held by politicians, parties and the communities of the day, multiple governments have subsequently tinkered with legislation around health of the older adult without boldly managing effective change over recent years (Gauld, 2009).

2.8. Contemporary Aged Care Provision

Currently the State supports the majority of aged residential care at around 64 percent of the total utilization through a funding envelope of $985 million dollars of $15 billion dollar Vote Health expenditure deployed by government annually (Ryall & Goohew, 2014). While projections about future costs of health, and in particular aged related direct costs, is challenging, there is optimism that health care inflation will keep pace with CPI inflation (Von Lanthen, 2004). In 2004 the average 90 year old male in New Zealand utilized approximately $16,000 worth of care compared to the average 30 year old male who received around $900 worth of care (Bryant et al., 2004). Ten years on, these figures are likely to have changed significantly with the evolution of enhanced technologies for age rescue, including increased polypharmacy prescribed for older adults (BPAC New Zealand, 2012). However, despite the significant investment by the state in residential aged care, substantial uncertainty surrounds the issue of the relationship between aged residential costs and quality of care (Kedgley & Laban, 2010; Hicks, Rantz, Petroski & Mukamel, 2004).

2.9. Access to Residential Aged Care in New Zealand

Currently in New Zealand, eligibility for publicly funded residential aged care requires the individual person to have a needs assessment to determine his or her current health status, their requirements and the level of care to meet identified needs. Completion of this needs assessment may determine that the person is able to receive services in the community or in a supported living environment, and that residential care is not required to meet their current health or safety needs. A referral for assessment is made to the Needs Assessment Coordination Service (NASC) from a general practitioner, a family member or the individual older adult themselves. The process of assessment involves gathering information using the structured assessment tool InterRai to establish:

- *whether or not the person has a condition that can be reversed;*

- *whether or not the person can be safely supported in the community; OR*

- *if the person needs long-term residential care indefinitely, what level of care is required – in a rest home or a continuing-care hospital*

- *(Ministry of Health, 2011b).*

NASC services then advise the older adult and family about eligibility for government funded services and whether the individual older adult will qualify for these services. Any help obtained from natural supports (e.g. family members living with the individual) will be taken into account when needs are being considered. Some individuals are not eligible for District Health Board (government) funded services as this is asset tested with the current threshold for support set at NZD$218,423 or below. If an individual has assets valued above the threshold of NZD$218,423 they are not eligible for District Health Board funded services and must meet the cost of these services personally (Ministry of Health, 2011b). Those in high-level care and who would otherwise pay privately (because their assets are higher than the threshold) are entitled to receive a *top-up* subsidy for costs that exceed an amount known as the *maximum contribution* (Broad et al., 2014).

2.10. Contemporary Residential Aged Care in New Zealand

As a subset of ageing, "aged residential care" (not including retirement villages) in the contemporary privatised commercial environment is a practice of modern marketed lifestyle and consumer services to older adults by *for profit* organizations. Market *segmentation* of the residential aged care sector is a relatively new phenomena evolving over the past 25 years in New Zealand. The historical concept of "aged care" formerly had a discursive meaning that was generally subsumed into a range of institutional forms including charitable, private or public 'nursing homes', 'rest homes', 'old people's home', 'hospitals' and other forms of services for the care of older adults (Hugman, 1999). More recent market segmentation of the various services for older adults in contemporary society such as aged residential care, retirement village living, private home based care *products* have colonized the discourse of 'aged care' in terms of the language of business, efficiency, and consumer acceptability (Fairclough, 1992 a; Simpson & Cheney, 2007). This commercialisation and packaging of aged residential care, constructs and identifies consumers of residential aged care on a market based model as suggested by Simpson and Cheney (2007), who stated "Gone are the 'patients' and 'inmates' of hospitals and rest homes (nursing homes), to be replaced with 'independent and active clients" (p. 192). Commercialized and marketed residential aged care is dominated by a vocabulary of care services such as health benefit(s), enriched lifestyle and safety and security in a subtle but distinctive discursive framework (Gilleard & Higgs, 2000; Walker, 2005). This marketized discourse of contemporary aged care includes options which exploit consumerism for older adults and is predicated on the assumptions of an aged stereotype. When the marketized discourse is colonized with medical discourse the suggestion is that increasing age will require care of a specialist nature that can be provided in semi-institutional or institutional organizations (Hugman, 1999). Such a "lifestyle" choice is seductively persuasive when legitimized by the functionalist gerontological paradigm in which the cohort of perceived homogenous older people become mere pawns in what is assumed to be the inevitable biological and social deterioration processes associated with increasing age (Walker, 2005).

Currently many private developers and investors perceive high level profitability through the narrative of contemporary residential aged care. In a recent business opinion piece regarding a

new player in the aged residential care market, Hunter (2014b) noted that "In the last five years Ryman shares have risen about 300 percent, Metlife about 80 percent, while Summerset which listed in 2011, has gained about 90 percent in the last three years" (p. D11). By supplanting the traditional forms of "care" with cost effective "service" models delivered precisely and in prescriptive time to old age consumers, high levels of profitability are achieved for these private providers. Hunter went on to state that, "Despite the demanding nature of the work, aged care staff tend to be paid a low hourly rate" (Hunter, 2014b, p. D11). Low hourly rates are seen to be shoring up the profitability of private providers of aged residential care and impacting on the quality of care delivered to older adults within such facilities "...who deserve to have sufficient care to meet their needs" Vicky Mee, President of the New Zealand Federation of Business and Professional Women (BPF NZ) quoted in Greypower Magazine (2014, p. 21). Baars (2005) suggested that whilst a service based model of care may be suitable for older consumers of short term *pit stop* or respite maintenance and repair care, this model is not appropriate for long term care or residential aged care. According to the Grant Thornton Report (2010) around two thirds of aged residential care facilities are owned by for profit organizations within New Zealand. This is a contrast to Australia where not for profit organizations remain the largest provider of care to older adults (Kendig & Gardner, 1997).

Many of the aged residential care facilities are now owned by multinational companies. In her report on substandard quality in residential aged care, Wilson (2009) reported that at that time 58 aged care homes were owned by Oceania Care Group (Macquarie Bank, Australia); 45 care homes were owned by BUPA (UK); 22 homes owned by Radius Residential Care (Kuwait Finance House); 21 owned by Ryman Healthcare (Garland Management, Canada and Ngai Tahu Holdings); 17 homes owned by Metlifecare (JP Morgan Nominees, FKP & Macquarie Investment Holdings – Australia); 16 facilities were owned by Ultimate Care Group (Investors from China); and 12 for Somerset Group. In contrast, Presbyterian Support, the Selwyn Foundation and Christian Healthcare Trust owned 49 residential aged care facilities amongst them at that time.

Advertising and marketing of their "product" by the "for profit" aged care providers evidences high level specialist consumer strategies which target older adults and their families through discourses of consumerism and marketed lifestyles for the aged coupled. Specifically these discourses contain emancipatory promises of modern "home" like ageing to attract aged people to purchase residential aged care beds (McHugh, 2003). As noted by Kedgley and Laban (2010),

the Grant Thornton Report (2010) stated that the "average operating cost per resident per day is $78.70 and yet the government subsidy is $109 per resident per day" thus generating significant income in the "for profit" sector of aged residential care (p. 44). This revenue demand has driven down the costs of staffing, food and put in place "additional charges" above the subsidy for "superior" accommodation to residents; for example, rooms with ensuites or view of a garden.

Questions have been raised by politicians and the public as to the level of care currently provided in aged residential care facilities. It is suggested that older people are resident in long term residential aged care because of their co-morbidities, dependency and vulnerability (Cheek et al., 2006; Smith, Kerse, & Parsons, 2005). However, quality of care is largely dependent on untrained care assistants of whom fewer than 25 percent of these workers have vocational qualifications. Caring for older adults is understood to be a relatively low skilled, low paid and low status vocation (Badkar, Callister, & Didham, 2009). Disturbingly the number of caregivers and Registered Nurses is so low in aged residential care, residents are not being mobilized regularly so lose their mobility, are not being toileted regularly so lose their ability to remain continent and increase the risk of infection, and are being left in front of television all day and rushed to complete meals (Kedgley & Laban, 2010). In one submission to Kedgley and Laban's investigation, it was noted that "human beings [are being] "warehoused" often in wretched misery because they have in effect been dumped in these warehoused boxes – where they sit depressed and lonely in a void of solitary meaninglessness … [it's] people farming for a profit" (p. 43). Aged Concern in their submission to Kedgley and Laban's report stated that rest home proprietors had a duty to ensure that the pursuit of profit did not force managers of aged care facilities to deprive residents of material essentials since to do so would amount to elder abuse.

The "goodness of fit" between older adults needs and the resources and requirements imposed by their environment are critical to optimal care outcomes (Hays, 2002; Young, 2011). Meanwhile it is worthy to recall Winston Churchill's wise word in his research into Housing Standards where he stated that "we give shape to our buildings and they in turn shape us" (Howden-Chapman, 2004, p. 64). Providing aged care beds for those in need is one thing, using them appropriately is quite another. In 2009, there were some 392 complaints to the New Zealand Health and Disability Commissioner regarding the quality of aged care, including the case of a patient who had her mouth taped by staff (Office of the Health and Disability Commissioner, 2009); another aged care resident who had not received a shower for a year; and a case where an 88 year old man lost 8

kg in weight in just 10 days whilst in residential aged care. These situations were subsequently discussed by the Acting Health and Disability Commissioner (2010) who stated that "issues essentially fall into the following categories: lack of appropriate knowledge and experience in specialist areas … communication, wound care, falls and fractures, nutrition and fluid management, medication, end-of-life care and a lack of coordination of care" (p 35).

The experience of residential aged care can often be a battleground of opposing ideologies between the provider establishment and those older adults who live in residential aged care (Hugman, 1999). Conflicting ideals about what constitutes "home" is contrary to the organizational requirements for staffing such as the economic use of kitchen, laundry or activities personnel (Gibson, 1998; Hugman, 1994; Willcocks, Pearce, & Kellaher, 1987). Thus the institutionalization of older adults is very much regimented and organised along "best for business" requirements rather than the requirements of the individual aged person. Noting the continued problem of alienation of older adults living in residential aged care, and the aspiration of many owners to integrate their facilities into communities, Willcocks, Pearce and Kellaher (1987) found that effective links remain elusive and that these facilities remain "in" the community but are not "of" the community (p. 2).

In the contemporary research literature on aged care, as interpreted through a critical theory CDA lens, it is notable that much of the work to date has addressed concerns with the social construction of ageing from its potential to exclude individuals from the mainstream of western society on the basis of poverty, the determinants (and management) of illness, disability, social acceptability (consumerism) and fear (Andrews, 1999; Baars, 1991, ; Lui, Warburton, Winterton, & Bartlett, 2012; Tulle-Winton, 1999). These works have problematized the dominant cultural and social construction of ageing and aged care within a socio-political framework based on discourses of power. The pervasive societal view of the homogeneity of older adults (Hugman, 1999) and the technology of aged residential care discourses reduce older adults to their chronological years and categorize these individuals as frail, helpless, incapable, dependent, an economic drain on society - a 'burden' (Borowski, Encel, & Ozanne, 1997). Political and economic narratives flowing from these discursive constructions of older adults subsequently manifest in governance policies for this demographic; thereby creating further power/knowledge relationships which prevail in our wider society related to management and the marginalization of older adults (Borowski et al., 1997; Lumme-Sandt, 2011; Wilinska & Cedersund, 2010).

Supporting a discourse relating to homogeneity of older adults is sensationalist media published demographic information using terms such as the "grey tsunami" or "silver tsunami" to echo fear about the impending societal wave of dependency predicted for this cohort into the future (Bartels & Naslund, 2013; Minkler, 1989; Schumpeter, 2010). This discourse illustrates the assumption of the growing numbers of older adults living to advanced age who may require assistance as a societal burden (Borowski et al., 1997), variously suggesting rationing of services as New Zealand attempts to cope economically with an increased older cohort (Katz, 1992; Kedgely & Laban, 2010; Koopman-Boyden & Waldegrave, 2009; Upton, 1991c).

In relation to the research question within this study, examining the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand, only one specific New Zealand study was located that is directly relevant to the CDA aspect of this research question and older adults. Ng and McCreanor (1999) studied patterns of discourse about 'elderly people' [sic] in New Zealand using submissions made to the Royal Commission on Social Policy in 1986. From their discourse analysis three key discourse patterns emerged from submittants to this Commission in relation to older adults namely, "society's obligation to senior citizens, anti-ageism, and old age as a positive resource" (Ng & McCreanor, 1999, p. 477). Recognition of individuals' previous contribution to New Zealand's economy was captured in the rhetoric of many submissions received by the Commission. The researchers found anticipation of credit for contributions made by older adults embedded in words such as "should" and "must" in relation to expectations for a fair and just society in terms of housing, health and financial support for older people (Ng & McCreanor, 1999, p. 485).

Multiple and complex factors related to the influences for older adults entry into residential aged care emerged from a more recent New Zealand study by Jorgensen (2006a). Using a longitudinal, mixed methods approach, as a sub study of a larger New Zealand research project called Older People Entering Residential Accommodation (OPERA), Jorgensen's study was based on in-depth interviews with a sub-sample of 131 people from the Assessment of Services Promoting Independence and Recovery in Elders (ASPIRE) study (Parsons et al., 2012). Jorgensen's findings indicated that family, medicine, high dependence scores on an activities of daily living instrument, distant family members and being at home for long periods alone were some aspects which were likely to enhance transition into residential aged care (Jorgensen, 2006a). Building further on the earlier 2006 research, Jorgensen, Arksey, Parsons, Senior and Thomas (2009)

conducted a longitudinal study looking at determinants of why older adults choose to enter residential aged care rather than remaining at home, and attempted to understand who makes the decision to enter residential aged care. The study invited wide participation from older adults, caregivers and health professionals to have input into the causal influences and satisfaction with the decision for permanent residence in aged residential care. Striking findings from this study showed that "70 percent of older adults regretted the decision to relocate into residential aged care" and that in the view of older adults, doctors were more likely to make the decision for entry of an older adult into residential aged care; while in contrast family members believed that they had taken this decision (Jorgensen et al., 2009, p. 200).

Taking a specific view of frailty, as an influential predictor for entry into residential aged care, Heppenstall, Keeling, Hanger and Wilkinson (2014) adopted a qualitative approach to enhance the quantitative model from their previous studies which had been able to predict only 40 percent of residential care admission (Heppenstall, Hanger, & Wilkinson, 2009; Heppenstall, Wilkinson, Hanger, Keeling, & Pearson, 2011). Acknowledging the complexity of residential care decision making these researchers found that older adult resignation regarding the *inevitability* (of admission to residential aged care), *loneliness, carer stress or burden* and *physical health* contributed to the decision to enter aged residential care (Heppenstall et al., 2014, p. 12). The psychological implications of moving from independent to dependent care was the subject of a further study located in Australia in which Cheek et al. (2006) looked at the transition of older adults from aged care "retirement village" life into residential aged care (rest home or hospital level care). Of particular importance, emerging from this study was the finding that influential factors contributing to a move from retirement villages into residential aged care included previous health related crises; the creation of doubt in the older person's mind at being able to cope within the current living environment; altered (enhanced) care needs; a desire to retain independence (perceived loss of independence in aged residential care); navigating the system; availability of a place and the desirability of the residential aged care facility. This notion of "created doubt", emanated from both family and doctors (Cheek et al., 2006, p. 12).

2.11.   The Geography of 'Home'

The social construct of ageing is associated with the physical self and the "emplaced" self (Laws, 1996b). To a large extent, our identities are also embodied in our "place" in the world be it our

home, neighborhood, community or nation (McHugh, 2000, 2003a; Wodak & Meyer, 2009b). Tulle-Winton (1999) problematizes the organisation of services for older adults by describing how this contributes to the construction of the discourse of ageism in terms of helplessness, frailty and ageing-as-deterioration, leading to the requirement for residential aged care. The concept of home is important because of its central role in everyday life, coupled with its rich social, cultural and historical significance. Home in this sense is not just as a concrete word but as an abstract signifier of a very broad set of associations and meanings (Manzo, 2003; Moore, 2000). The notion of 'home' may be conceptualized as having three core dimensions: the physical relating to objects, spaces and boundaries; the social, which involves other people, relationships and interactions; and the metaphysical, which relates to the meaning and significance attributed by individuals to their home (Willcocks et al., 1987). Unsurprisingly the psychological implications of the perceived loss by an elder of the social aspects of "home" include their valued memories, disruption of social networks and personal coping within a new environment (Dwyer, 2005; Jungers, 2010). Transition from *home* for an older adult is a critical and meaningful lived experience given this space is acknowledged as "fundamental to our sense of being" (van Manen, 1997, p. 102).

Noting the paradox in the use of the term *home* in relation to aged residential care, Hugman (1999) suggested that literal comparison between a building designed to house a large number of older adults in a society where *homes* are normatively for nuclear families is a strategy used by institutions to cover over the fact that the people within these institutions are "*different*" (p. 198). Most current residential aged care architecture is designed and built around staffing needs to accomplish responsibilities and tasks rather than optimizing residents quality of life and enhancing privacy (Miller, Booth, & Mor, 2008); and aims to create a surrogate family setting or home with an artificial grouping of people with whom one might not have chosen to live, which must be deemed absurd (Hugman, 1999; Willcocks et al., 1987).

There is a high potential for marginalization of older people within a "residential care" environment where, as mentioned earlier, they are caught between two worlds i.e., their former "home and living" and the new organization and culture where the older adult may not be fully part of either. Such a disjuncture is in keeping with Park's (1950) concept of marginality where individuals are "caught between two social groups" and experience high levels of unease and distress (Park, 1950, p. 370).

The association between the political and social construction of the older adult body and power is clearly seen through the engagement of politicians and policy makers in processes to enhance the privatisation of services. This is visibly demonstrated by the significant growth in aged care facilities over the past 30 years in New Zealand (Ryall, 2014a). This agenda for cost shifting from Government to older private citizens and their families has seen an increasing emphasis on individual responsibility for personal health management and care for older adults (Miller et al., 2008; Simpson & Cheney, 2007).

Long term residential care facilities are recognized as being institutional places of residence where a large number of older adults (together) lead an enclosed, formally administered way of life (Jorgensen et al., 2009; Wiersema & Dupius, 2010). In such settings the notion of complete surrender is suggestive of Foucault's (1977) notion of *docile bodies* where control and power over older adults is achieved through actions of discipline and control of behaviours and compliance with regimes. Foucault asserted that discipline and regimes that fix individuals in time and space is a technology of power which in the situation of older adults translates into aged individuals being managed as objects by staff essentially silencing the individual self and creating marginalization and domination (Foucault, 1977; Hugman, 1999).

The voice of frail older people is a very quiet one; to the extent that this vulnerable group is often not heard at all (Bowers et al., 2009). In terms of long-term residential aged care policy, as well as in service delivery, the voices of older people with high support needs are so quiet that they are practically silent or indistinguishable from the people who speak on their behalf; for example, professionals, relatives, policy makers and politicians (Bowers et al., 2009). It seems reasonable from this assertion to assume that if an older adult has no voice then there is little hope of exerting personal agency or control over support or their life.

There is a significant gap in the contemporary literature regarding the discursive influences on older adults entering aged residential care in New Zealand. Whilst the initial OPERA study undertaken by Jorgenson (2007) and the extension of this research in 2009 (Jorgensen et al., 2009), sought the views and experiences of older people, caregivers and health professionals to identify a number of key factors for residential care entry, this research did not examine the wider societal discourses at play in persuading older adults to take up this life choice. A valuable insight into patterns of discourse relating to older adults in New Zealand undertaken by Ng and

McCreanor (1999) some 25 years ago identified three key discursive patterns namely old age as a positive resource, the paradox of the anti-ageism/ageism dichotomy and a firm expectation of the discharge of societal obligations to older adults. Since this current research commenced, the issues of an ageing population in New Zealand society have become even more prominent and have attracted strategies of urgency economically and politically. Two key politically driven strategies for older adults gaining momentum nationally are the promotion of active ageing (Office for Senior Citizens, 2015) and the newer notion of advance care planning (Ministry of Health, 2011a).

It is anticipated that in undertaking a contemporary CDA of the influences on older adults entry into residential aged care it will be possible to make visible those language and semiotic discourse structures occurring within modern society emanating from government policy makers, from experts such as health professionals and from the powerful advertising media to answer the research question of this study: "What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?".

2.12.   Summary

This literature review has adopted a broad approach to examine the evolution of residential aged care within New Zealand. Starting from a historical perspective through to current times it has examined the political, social and bio-physiological structures underpinning the evolution of residential aged care. In doing so it has problematised the dominant cultural and social construction of ageing behind the contemporary discourse of residential aged care and linking this to current discursive frameworks.

Three key themes have emerged from this literature review. Embedded in each theme are a range of discourses that shape, define, construct and influence older adults and their choices regarding institutional living in later life. These three themes are as follows:

Theme 1. The Birth of a Problem and the Historical Dimension

Aged care in New Zealand and the political changes over the past 100 plus years have significantly influenced the discursive framework related to current residential aged care. Residential aged care is governed and rationalized by the New Zealand government, private

provider (commercial business) organizations, relatives and caregivers through power relations and moral and ethical choices. Frail older adults are also governed by others in residential aged care where their bodies are given over to "care" in a framework of surveillance and power rendering them silent, docile and powerless. Political changes and the evolution of contemporary New Zealand society have created the modernized ideological construction of residential aged care which has become normalized and expected as an outcome for older adults. Making this visible will challenge this discursive framework and the powerful underpinning hegemony and, in doing so, illuminate the potential for change.

Theme 2. Epidemiology and Medical Dimensions

Sophisticated metrics and political discursive frameworks have impacted on the dependencies, choices and rights of older individuals to ongoing care, particularly as they age. Medicalization of ageing and the underpinning ideology and pedagogy of medicine have significantly influenced the societal discourses and "truth" related to health, ageing and aged care (Cheek & Porter, 1997). In their study on why older people in New Zealand enter residential aged care rather than remaining at home and who makes that decision Jorgensen et al. (2009) found that in the opinion of older adults, doctors most frequently made the decision for their entry into residential aged care.

Theme 3. Commercial Interest Dimensions

The political discourse related to health policy and divestment of non-core health activity opened a space for commercialization of aged care. This commercialization and profit motive have shaped contemporary New Zealand aged residential care, silencing dissident voices through powerful networks of influence and ideological control of the various interested parties (the government and private providers) (Ng & McCreanor, 1999). Just as social phenomena are linguistic and text based, they may also be semiotic, providing visual representation and images to make messaging more salient. In a world that embraces neoliberal economics in the form of commercial free trade and competition, in tandem with a reduced role for government providing social services, residential aged care is one social domain being increasingly colonized by advertising media (Simpson & Cheney, 2007). Fairclough (1989) suggested that within media and advertising discourse there is hidden power and it is the capacity of capitalist society and other power brokers to exercise such power through systematic media and advertising activities which position individual identity and agency within society (Fairclough, 1989, 1992/1992, 1992 a). The

power of media and advertising as an influential and persuasive force within society has redrawn the boundaries for contemporary aged care (Simpson & Cheney, 2007). However, within this proliferation of marketing of aged residential care services there remains ambiguity as to who such marketing is aimed at – who is the customer? Is this the older adult or the family of the older adult? On the one hand, older adults are constructed in media advertising as actively participating in decisions about their future living arrangements. On the other hand older adults are also constructed as passive and requiring assistance in determining their needs into the future (Fairclough, 1992 a). It would appear that there is an asymmetry of power which acts to silence the voice of older adults through a discursive framework which naturalizes the congregation, segregation and potential marginalization of older adults within the confines of residential aged care in contemporary New Zealand society.

These three dimensions have come together to support the question this research addresses namely:

"What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?"

In order to undertake this research it has been critical that the plan of action or research strategy developed sits within a specific paradigmatic framework that is congruent with the epistemic assumptions, values and practices of that framework. Assimilating these assumptions, values and practices into the research process informs the research approach and, in turn, guides the methodology used to provide the outcome. This study thus closely examines those critical discourses and power relations that inform peoples' decisions to move into aged care within New Zealand at this time.

3. CHAPTER THREE - METHODOLOGY

Men (sic) make their own history, but not of their own free will: not under circumstances they themselves have chosen but under given and inherited circumstances with which they are directly confronted.

Marx, 1973 (Wisman, 2013)

3.1. Introduction

The purpose of this chapter is to describe the research methodology and how it has shaped this study. The goal is to explicitly articulate the philosophical underpinnings that have guided the design of this research; and to position concern for the voice of older adults in order to answer the research question concerning the discursive influences on older adults in their decisions to enter institutional retirement living arrangements. The chapter concludes with explanation of the reflexive perspective which situates my position within the context of this research study.

The focus of this study is to illuminate, or bring into view, the many ways in which language and other forms of semiotic communications convey power and status in contemporary social interactions that influence older adults' decisions to enter institutional retirement living arrangements. My driving purpose for this research is to make visible how older adults are being deprived of real choice in their decisions regarding their own living arrangements in later life. Thus, this research has an emancipatory and empowerment intent, with the view that from exposure and visibility of these discourse processes there is the possibility to challenge the status quo and reinvigorate dialogue regarding older adults' accommodation needs.

The study itself provides an examination of the apparent neutrality and objectivity of information emanating from public sources such as government agencies, government documents and political speeches; from authoritative bodies (e.g. medicine); from powerful organisations (those with vested interest, i.e. commercial entities); from family, and from media and advertising. All of these agents produce and structure a viable account of the world for older adults. In the unfolding of this study I set out to examine the many and varied complex relational forces that influence older adults into institutional retirement living arrangements in New Zealand. I also seek to expose the sources of social power and persuasion that normalize residential care for older adults.

This study seeks to illuminate those powerful influential societal factors on older adults by drawing on critical theory and CDA to uncover the "taken for granted" sets of social relations that imbue the contemporary script "normalizing" aged residential care in New Zealand. This study seeks to examine those societal forces that may act to powerfully influence older adults, such as the socially pervasive power of politics, as well as the potential for the commodification of aged care living arrangements effected through omnipresent media advertising related to residential aged care (Fairclough, 1989; van Dijk, 1989b, 1995d). By closely examining the role and impact of "elite" forms of power in the manufacture and reproduction of opinion, values, attitudes and other strategies of influence, which form part of the prevailing societal and market forces, it is anticipated that the authentic voice of older adults will be discerned. From this I anticipate an awakening may occur regarding other alternatives for the possibilities of older adult living arrangements in New Zealand.

3.2. Methodology

Philosophical Framework

Any methodological framework chosen for this study must ensure a robust epistemological foundation from which to interpret and explain those areas of social life, such as aged residential care, that are shaped by, and that produce and cause, social actions by older adults. Such a framework also needs to be sufficiently capable of analyzing those functioning bodies of knowledge and power vectors inherent in social relations; moving then to challenge reductionism, dogmatism, marginalization and social injustice, before finally exerting capability in developing an agenda for social change (Chouliaraki & Fairclough, 1999; Foucault, 1973; van Dijk, 1989b).

Critical Theory

This research is largely grounded in a 'critical theory' view of the world and seeks to identify the different discourses that create and sustain relatively powerless states in the very people at the core of this thesis – older adults. It is my belief that these discourses potentially manipulate older adults into living arrangements that suit dominant groups such as government, family, medical practitioners and commercial (for profit) residential aged care providers. Critical theory philosophy is grounded in Marxist thinking that locates power in the hands of dominant groups within society (Comor, 2015; Fracchia, 1995; Jeannot, 1994; Pranger, 1968). This in turn leaves some members

of society open to "hierarchic exploitation" (Pranger, 1968, p. 196), marginalization, oppression and disadvantage, whilst the dominant groups ensure their interests are served through maintenance of the status quo.

At the very core of critical theory is the study of injustice, inequality, marginalization, power and dominance by elite groups (or agents) over others, occurring within, and as a result of, social relationships, social practices and social interactions (Fairclough, 1995/2010; van Dijk, 1989b). Fundamental to this theoretical stance is the examination of social life and its relationship to activities, practices and networks of power such as the economic, the political, and the cultural activities occurring within society that produce shared beliefs, values and actions. Whilst critical theory acknowledges and supports an eclectic approach to enhance understanding of wider social and cultural processes, and to capture time related shifting configurations of discourse types and processes, it also acknowledges the influence and abstraction of theorists such as Foucault in relation to critical theory (Fairclough, 1992 a).

Throughout this study the ideas of Foucault are frequently drawn upon and, at times, drift to the foreground; largely due to his radical thinking which enables the research question to be considered from different perspectives. However a particular difficulty with drawing on Foucault's work, alongside a largely 'critical theory' driven analysis, is the different ways in which Foucault interpreted the use of power. For Foucault, power is not automatically the oppressive, disempowering force that Marxism describes. Rather, Foucault sees power as a circulating force that can be used and brought together by different people in particular situations (Foucault, 1994c). In this sense, I would argue that unless older adults and wider society are aware of the means by which they are being manipulated by particular interest groups (such as family or government policy) they are deprived of the opportunity to challenge or use the power talked of by Foucault. Where my thinking sits more comfortably with Foucault is from the perspective that where there is power, there is also always capacity for resistance and this thesis brings into sharper focus the means by which such resistance might be enacted through making visible the various discourses at play.

There are aspects of my approach in this study that include both 'structuralist' and 'post structuralist' origins. I draw on Ferdinand de Saussure's (Basel Al-Sheikh & Ibrahim, 2014) work regarding the role of language and signs particularly as this applies to advertising media as a

specialized form of semiosis which has evolved in relation to the needs of commodity producers to convey meaning and to influence consumers (Comor, 2015; McDonald, 2012). I also draw on Kress' post-structuralist social semiotics and multimodality approach to meaning making within the life world, which includes hearing, sight and seeing, language, touch, feeling, and taste (Kress, 2010b; Kress & van Leeuwen, 1996). This latter work of Kress has particular relevance for the print media advertising in this research which contains imagery and context relevant to older adults.

Critical theory is located in the midst of social "struggles" and has an emancipatory agenda to use knowledge produced from its examination and involvement in these struggles to understand and make visible key components and to provide alternative views (Chouliaraki & Fairclough, 1999). It is based on understanding and working inside the socially shared knowledges and beliefs that subordinate some individuals or groups agency whilst simultaneously enhancing the dominance of others (Chouliaraki & Fairclough, 1999). In relation to this study, the social construction of aged residential care, with its ideological underpinning, is firmly embedded in age related stereotyping (Reyna, Goodwin, & Ferrari, 2007), commercialization (Simpson & Cheney, 2007) and medicalization (Gray & Dakin, 2011). As such, participation by individual older adults in decision making, regarding ongoing accommodation needs, may not necessarily reflect equality in power relationships or the ability to influence decision making, recognizing personal agency (Jorgensen et al., 2009). A critical discourse analytic approach is, therefore, capable of drawing out societal values of justice, humanitarianism, opposition to prejudice and marginalization of older adults.

Much of the work of critical theory is carried out within the interstitial boundaries of politics, societal practices, relationships and activities at large; and, as such, given its emancipatory agenda, the critical focus is positioned within the "struggles that occur in these social practices" (Chouliaraki & Fairclough, 1999, p. 31). As an aspect of social action, aged residential care may be seen as a "practice" within society in that it has become permanently embedded and "normalized" as a contemporary approach for the living arrangements of older adults. In contemporary New Zealand society, aged residential care is taken for granted as that trajectory which might be expected to occur in older age (Grant Thornton Report, 2010; OECD, 2005; Sonerson et al., 2005). Taking a critical theory approach requires that relational inquiry occurs into the networks of practice that surround aged residential care, with a focus on structures of social control and the underpinning structural relations embedded within societal activities of

groups, classes or other social entities, and between individuals as social participants (van Dijk, 1989b).

Critical theory posits that it is possible to apply deterministic relational approaches to power and control by elite groups such as the widely promulgated belief that economics is the source of power within contemporary capitalist societies. However, it is important not to close out the examination of the relational dialectic between economics and other system elements of actions occurring from politics, and the more general contributions of the media, and the embedded societal beliefs regarding ageing and aged care. The widespread recognition of population ageing as a shared global phenomenon with heightened concerns socio-economically contrasts the specific challenge for the older individuals themselves in the reality of their day to day lives and their local communities of interest. Indeed while structures and institutional practices may be seen to be the more stable long term conditions of social life, which may transform only slowly, at the individual level, life "events" reflect the immediate happenings of everyday living for older adults. Acknowledging older adults lived reality and listening to their voice regarding their own personal experience and meaning of age is essential for clarity of interpretation in the intergenerational space and by the wider society at large (Wright St Clair, Grant, & Smythe, 2014). Omnipresent to this personalised "story" of the experience of ageing, however, are the elite or dominant and powerful institutions and groups who mediate the societal cognitions related to ageing and expectations for the trajectory into aged residential care.

The importance of institutionally embedded practices in critical theory is due to the intractable structural underpinning role they play in the coherence of expression, enactment and reproduction of opinions, values, social representations and prejudices (Chouliaraki & Fairclough, 1999; Foucault, 1980). However, a focus on what Chouliaraki and Fairclough term "conjunctures" is an important key to unpack those aspects of aged related practices which cut across and bring together different institutions and new meaning to aspects of life (p. 22). This conjunctural aspect of practices is relevant particularly in the consideration of aged residential care where it is possible to trace a conjuncture occurring politically in 1992 in New Zealand with the declaration of the National Government that aged residential care was no longer "core public health business" (Upton, 1991c). This political declaration opened the possibility for the subsequent privatization and commodification of aged persons' accommodation.

3.3. Critical Theory in a Globalized World

Across our earliest historical times, social relations, social structures and activity relied heavily on the physical presence of individuals within communities to share information from which values, opinions and beliefs emanated and were localized (Fairclough, 1995/2010). In more recent times the rapid evolutionary modernization of societies, supported by technology advances, have progressively "stretched" social relations in terms of the requirement for individual physical presence to maintain relationships. This new technology has affected significant global shrinkage for families, friends and connectedness to others geographically distant from older adults. People are now able to communicate and participate in relationships from great distances via social media and the spread of global news is instantaneous on modern communication devices (Barford, 2013).

Within a modern "global" world, technologies (media, the internet, enhanced global relations and travel) have far reaching power which impact considerations such as the notion of the impending cataclysmic demography of aged individuals requiring *care* (Friedman, Steinwachs, Rathouz, Burton, & Mukamel, 2005). Rapid information sharing and thus global ideological positions are occurring in relation to phenomenon such as the ageing demography internationally. More recently, this has been seen as a mutual problem across both poor and developed countries who may otherwise have little else in common (McDaniel & Zimmer, 2013).

The striking global scale of the ageing narrative has significant impact on political power agents within countries and, in turn, the circularity of knowledge and information sharing perpetuates high visibility of this perceived "problem" on the global stage (National Centre for Chronic Disease Prevention and Health Promotion, 2013; OECD, 2014; WHO, 2011). In turn, global communication and mediated information from the global stage infiltrates local contexts and acts to construct the notion of the social burden of age and aged care (Borowski & Hugo, 1997; Coupland & Ylanne-McEwan, 1993; Petersen & Warburton, 2012; Powell & Biggs, 2000). Encapsulated in mediated messaging regarding this anticipated demographic trend are terms such as "the grey tsunami" or the "silver tsunami" which not only *name the phenomenon* of contemporary modern ageing within society but also cast *powerful stereotypical shadows* of a pending aged tidal wave over the older adult community (Horvath, 2013; Perry, 2009). These stereotypical labels pervasively organize public knowledge and potently act to create, and then

perpetuate, the reproduction of socio-political anxiety; at the same time exacerbating societal beliefs and attitudes such as ageism by political and social elites (Bartels & Naslund, 2013; Coupland & Coupland, 1993; Minkler, 1989; Schumpeter, 2010; van Dijk, 1995b).

3.4. Critical Theory and Political Technologies of Power

Within critical theory the concept of 'technology', in its broadest sense, refers to "any apparatus applied to materials within a practice to achieve particular social (economic, political or cultural) effects" (Fairclough, 1995/2010, p. 23). Clear examples of political apparatus are visible within the enactment of laws to control older adulthood. Legal and economic changes to government commitments for older adults in the form of access to pensions have occurred in New Zealand twice in the past 30 years. Initially an instantaneous reduction in the age of eligibility was enacted by the National government under Robert Muldoon in 1977 and a progressive increase in entitlement age was enacted again by a National government under Prime Minister Jim Bolger in 1992 (Hurnard, 2005). A further political change in commitment to welfare for older citizens occurred more surreptitiously with the removal of aged care services from core public health provision in 1992 (Upton, 1991c). Yet another legislative change followed closely with the initiation of income and asset testing requirements for older adults in long term care in the form of the Social Security Long Term Residential Care Amendment Bill in 1993 which significantly changed older New Zealanders financial contributions to their own aged care.

The elimination of aged care away from the mainstream of public services was largely based on neoliberal economics and the introduction of privatization and deregulation across the public sector, including the health sector, with broad social discourses of competition and managerialism emanating from within a wider framework of economic reform (State Services Commission, 1998). This trend in government policy, for redefining the role of the State in the welfare of older adults, was based on fiscal principles and subsequently saw many religious and welfare organizations withdraw from aged residential care provision; thus opening up the opportunity for private commercialization of aged care accommodation (Simpson & Cheney, 2007).

From a critical standpoint, all of these political technologies have colonized ageing and aged care in contemporary New Zealand society within a dominant discourse of economic risk, political hegemony, social marginalization and as a culturally identifiable "problem" or "burden". Adopting

this new commercialization of aged residential care, the growth of the private *for profit* commercial providers is evidence of the marketization of older adults within New Zealand. In achieving this commercialization of living arrangements for older adults, the currency of provision is made visible through advertising and media discourses which pervasively penetrate society. I claim these discourses overtly or covertly influence older adult's decision making with regard to their accommodation trajectory. Commercial discourses weave lifestyle, care, rest and tranquility within a discursive framework to construct residential aged care as a safe, caring environment for older adults.

3.5. Power and Mental Models

Individuals carry with them their evolved knowledge of situations, events, actions, objects and people and also sets of evaluative beliefs to enhance understanding and to situate information in relation to what is already known textually, contextually and epistemically. These existing knowledges or mental models[4] have a central role to play in construing, integrating or rejecting new or changed information as it occurs in everyday life via social phenomena (van Dijk, 1982). Different or new knowledge or ideologies are evaluated against prior personal experiences or previously held mental models and may be rejected or accepted as normalized socially shared information or ways of viewing reality. New knowledge has higher level acceptability if models are consistent with the knowledge and "the ideologically based attitudes and interests of group members and the information is perceived to be determined or originated from a credible or expert source" (van Dijk, 1995b, p. 33).

The concept of mental models or social cognition is an important one for enhancing a broad understanding of human information processing as well as understanding the process of

---

4 **Mental models** relate to the beliefs, ideas, images and verbal descriptions that we consciously or unconsciously form from our experiences and which (when formed) guide our thoughts and actions within narrow channels. These representations of perceived reality explain cause and effect, and lead us to expect certain results, give meaning to events, and predispose us to behave in certain ways. Although mental models provide internal stability in a world of continuous change, they also blind us to facts and ideas that challenge or defy our deeply held beliefs. They are, by their very nature, subjective, fuzzy and incomplete. Everyone has different models (that differ in detail from everyone else's) of the same concept or subject no matter how common or simple.

discourse production (van Dijk, 1995c). The theory of mental models assumes representations in episodic memory of "situations, acts or events, spoken or thought about, observed or participated in "thus creating the individual actor's experience (van Dijk, 1997, p. 1). Mental models have been shown to be an important factor in the comprehension of shared information, ideologies, opinions and values of groups within specific contexts and cultures (Gigerenzer, Hoffrage, & Kleinbfilting, 1991; van Dijk, 1990b). As mentioned above, the goals and personal position of speakers set the context for information uptake and impact interpretation within individual mental models, which are subsequently referenced against already known information, then co-referenced until a coherent (albeit subjective) model is achieved (van Dijk, 1995c). The manner in which speakers, writers or events are expressed acts to signal prominence, relevance or importance of the "perspective, point of view and/or ideological stance of the speaker or the text", as well as to establish agency, accountability, responsibility and causality (van Dijk, 1997, p. 211).

The concept of mental models draws heavily from socio-cognitive and social psychology theories and developments in artificial intelligence. Mental models are naturally evolving cognitive processing conceptualizations of the world which enable predictive explanatory power for individual understanding and interacting with the environment and with others (Norman, 1983). Mental models represent the interface between episodic, personal knowledge on the one hand and socially shared beliefs of groups on the other; thus these models are constantly being updated from fragmentary information received from the social world via social interaction and semiotics by social actors (van Dijk, 1997).

A model or representation of a particular phenomenon is imbued within the consciousness of the individual with opinion, values and subjective understanding. One of the many methods to influence the structure of a mental model is to manipulate what information is important within the semiosis by displaying it more (or less) prominently, in headlines within news reports (text or televised) or with photographs or other visual representations (van Dijk, 1995d). In more recent times, economic and cultural conditions, supported by technological advances (television, internet, social media), have served to foster a cultural "turn" in relation to consumerism with advertisers delivering discursive messaging via radio, television, magazines, the internet, via the letter box and on hoardings in local streets, shopping centers and sports arenas (Fairclough, 1989). Van Dijk argued for the constitutive role of social power through media, advertising and other public representations. He suggested that social power, as manifest in influential streams of

66

public communications, provides a powerful means of influence and control of people's attitudes and ideologies through general socio-cultural knowledge about issues (van Dijk, 1995b). Thus, it can be argued, the creation, reproduction and sustainability of patterns of influence or control are achieved through exposing individuals' mental models to systems of persuasion occurring via text, talk or other semiotic practices and processes such as occurs via media, imagery, gesture, games, music, news, television and the worldwide web (Chouliaraki & Fairclough, 1999).

Mental models, provide the "missing link" between texts, and more commonly available knowledge or "socially shared information", in that such models allow the individual to build representations in general and abstract forms which then provide a constant reference point for the individual in relation to people, places, events and time (van Dijk, 1995c, p. 396). Individuals create and build their mental models in relation to events that they read or speak about or engage in, using knowledge and information to process the content of discourses and the relevant meaning they may have. Simultaneously individuals also update the context model of the situation in which they participate or when reading a newspaper, electronic media or watching television.

Using instantiations of general social knowledge, beliefs, values, attitudes and ideologies, politicians, experts, media and advertising strategically act to create and construct phenomena that powerfully influence people through framing issues within versions of reality which resonate with particular groups of society. Tailoring information strategically to influence people's mental models in relation to aged residential care powerfully manipulates those models to normalize ways of thinking in relation to the construction of this as an appropriate solution for older age. Mental models are applied within political and social discourses in relation to everyday issues such as access to scarce resources. Access to social welfare is one such issue relevant to older adults and which finds prominence as a key political platform on which politicians mediate opinion with pervasive discussions in the public arena articulating real or perceived fear regarding the anticipated growth in numbers of dependent older adults (Ryall & Goohew, 2014).

Manipulation is achieved by elites such as politicians, authoritative institutions (residential aged care owners e.g. foreign banks, public shareholders, medicine) or other powerful groups by influencing the social construction of aged residential care and, therefore, the shared understanding and beliefs in relation to social structures and the appropriateness of aged residential care as a solution for older adults accommodation needs. In doing so, these discourse

structures and beliefs are normalized so that they become the putative *way things are* symbolically or materially for groups of people, such as older adults (van Dijk, 1995b).

3.6. The Power of Semiotics

Multimodal[5] semiotic (sign) systems including non-verbal communication help us to understand the world as well as to understand one another (van Leeuwen & Kress, 2011). The fundamental need for human understanding has been significantly enhanced in modern life through access to, and use of, modern technologies including the internet and other social media which now permit almost instantaneous global communications to occur. Semiotic communications in contemporary social life mediate our knowledge through multimodal genres and act to variously construct our world in particular ways within society; for example, our family, our sexuality, our work and ageing and aged care. This mediation of knowledge occurs through genres such as text, telephone, email, the web, advertising and the mass media, as well as political, organizational and interpersonal messaging (van Dijk, 2004). In this study I have chosen to use print media advertising for their ability to show language and imagery representations relevant to older adults which may influence meaning making in relation to residential aged care. Meaning making from representations arise from the social, cultural and psychological context of the sign maker (older adult) bringing together the form (image) and the meaning from the representation (Kress & van Leeuwen, 1996).

Social power is embedded within, and behind, semiosis and particularly within globalised media communication which acts to systematically and cumulatively magnify power through the attribution of causality, agency and the particular ways in which it positions the reader (Fairclough, 1989; van Dijk, 1995d; van Leeuwen & Kress, 2011). This occurs by virtue of media semiosis' ability to reach entire populations and expose them to relatively homogeneous information outputs relying on cultural connotation and experience to make meaning of messages (Fairclough, 1989).

---

[5] **Multimodality** designates a phenomenon rather than a theory or method. It acknowledges different communication modalities such as language, text, images, non-verbal communications e.g. music, architecture, art, advertising and media etc.

Semiotics are produced and emanate from the socio-cultural world as well as from the psychological mental models of the individual sign maker, and variously represent their ideological position. In his discussion on the manipulative power of the media, Fairclough suggested that the professional beliefs and assumptions of media workers are critical for keeping the power of media discourse hidden from the mass of the population (Fairclough, 1989, p. 46). Kress and van Leeuwen also noted that given the consumption of semiotic entities *everywhere* in contemporary life, the study of semiotics should be included as an important part of critical theoretical disciplines:

The plain fact of the matter is that neither power nor its use have disappeared. It has only become more difficult to locate and to trace. (Kress & van Leeuwen, 1996, p. 14)

Whilst the global "turn" in communication (semiotics) requires that the cultural specificities of semiotics can be widely understood, these communications also flow rapidly and broadly and thus, impact localized production and interpretation within local social structures. Rather than being neutral, social power, that is the power to persuade, to manipulate and to influence the social construction of reality and social practices, is embedded across the spectrum of multimodal semiotics and translates into local or national narratives. Such narratives are produced from the multiples of semiotic discourses transforming how people think, act, their self-talk and their conversations in contemporary social interaction (Fairclough, 1989). Narratives may also draw on multiple communicative sources to illustrate or narrate noteworthy events or experiences supplementing moral or commercial paradigms, probing the contours and meaning of events or opportunities to establish truth and accuracy. Narratives also instantiate identities and positions; for example, what people have seen in an advertisement and the text that is included in that advertisement assume meaning alongside a story people have heard verbally in relation to the particular issue in question, such as for example particular aged care events, issues or acceptability (Ochs, 2011).

Asymmetrical relationships occur within language and semiotic communications in elite text and talk and in advertising discourse. In his voluminous work on the ideological basis for discrimination, Teun van Dijk, (1990a, 1993a, 1994, 1995a, 1995b, 2006) has clearly evidenced fundamental elements of the substrate of identity, actions, goals, values, norms, interests and group relations of ideological group(s) from which flow positive self-representation and negative other representation. These polarised actions and behaviours are used to legitimate the access

to, and control of, scarce resources to enhance the interests of "in groups" or social elites (van Dijk, 2011a, p. 403). Such an argument may be made in relation to older adults and their perceived non-productive drain on society with its effect of marginalization of older adults within society.

Semiosis and communication in language, text or sign is not only about content but also about context and thus provides the vehicle through which agents may re-contextualize content. In his discussion on consumerism and advertising discourse in contemporary society, Fairclough (1992 a) pointed out that the very nature of advertising discourse is that which is oriented toward the achievement of specific goals. Strategically positioning messages and information, acts to powerfully influence societal thinking in relation to specific issues, beliefs and appropriate actions. Advertising discourse portrays an ideological representation of the relationship between the producer of the product being advertised and the audience. These representations serve at once to achieve broad appeal but also to "personalize messaging to the potential consumer of products" evoking *frames* or references to desirable social states e.g. lifestyles (Fairclough, 1989, p. 169). These frames or mental models tie together social subjects in specific relationships, activities, situations, locations and so on, in powerful ways to show how one should or could live in modernity. This has particular relevance to aged residential care advertising which utilizes imagery of settings, people and text to evoke potential lifestyle opportunities for older adults.

The function of specific text may also act to "anchor" images providing more specific meaning within currents of socio-political context; particularly those contexts relating to time and space. The visual composition, design and placement of images have the ability to assign different meaning as a function of their placement in advertising materials. Placing visuals left to right creates a "dynamic contrast between a *given* and a *new"* source of information (van Leeuwen & Kress, 2011, p. 115). If two elements are contrasted in some way and placed left to right the one on the left is assumed to be the taken for granted whilst the image on the right will be assumed as the new contrasting information. Meanwhile if there is a vertical polarization the top element is perceived as the ideal or the "promise" of the product (e.g. idealized lifestyle, success or alluring proposition) whilst the lower section picture or image is seen to be the real or factual representation of the product (van Leeuwen & Kress, 2011).

Finally critical discourses must be understood from their cultural and historical context (Fairclough, 1992 a). Drawing from the wellspring of critical theory I seek to illuminate the various interests being served and the locus of power regarding the influences upon older adults' decision to enter aged residential care. Critical theory is my overarching guide as I use CDA as a tool to interpret my examination of these influences and to answer the research question: "What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?". Using a critical approach to analyze the very existence of social institutions and roles of individuals within the context of the social world unpacks the influence of language, text, talk, images and symbols in power relations. The intent of a critical theory approach is to advance understanding through the development of multi-disciplinary theories underpinning the strategies and structures of discourse production and the ways that discourses are related to communicative, social, political and cultural situations (van Dijk, 2011b).

In order to form social constructions of reality, people use a variety of discourses including those derived from interpersonal relationships and the information flowing from them. Public discourses such as those emanating from government, media and other semiotic sources (images, television, text, advertising etc) determine the beliefs held by older people (and society) regarding ageing and the appropriateness of solutions regarding aged care accommodation. Before moving to the more pertinent discussion of CDA, it is timely to now turn to an explanation of discourse in contemporary society.

3.7. Defining Discourse

The concept of discourse is a complex one which assumes that language use (and other semiotic communications) are part of contemporary social practices connected in a concentric or dialectic manner to the context in which they are created but which also act to constitute social understandings (Jiwani & Richardson, 2011). Discourse analysis is the product of a broad church of theoretical approaches. In more recent times the evolution of discourse studies has seen a broadening of its theoretical base from pure forms that focused on linguistics specifically to include social sciences and humanities; all with a goal of understanding complex societal issues (van Dijk, 1993a). As a fundamental component of the social order construed and reproduced by discourse, power, power abuse and domination are enacted through access to, and control over, public discourse by social groups or organizations. Through multifaceted discursive processes,

"controlling the minds, knowledges, attitudes, ideologies, norms, values and intentions of language users and indirectly the actions based on these representations discourse may be an important condition of social inequality" (van Dijk, 2011c, p. 4). However, the power within or behind discourse is not manifest in unilateral inequality only; rather, it may have divergent effects as a crucial tool of resistance within the political order of society (van Dijk, 2011c).

Local manifestations of specific practices and relational engagements bring together particular practices or habitualised ways of existing within a community or society based on knowledges, values, norms and cultural beliefs occurring within shared societal, institutional or community groups. Rabinow (2010) proposed that utilizing Foucault's philosophy is useful in understanding the forces of power which suggests that power is invested, colonized, utilized and transformed in the everyday practices of individuals manipulating, conditioning and ordering them. Foucault examined the field of power stating:

Let us not ask why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of those continuous uninterrupted processes which subject our bodies, govern our gestures, dictate our behaviours etc ... we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc. (Foucault, 1980, p. 97)

Taking Foucault's view, one might expect that continued exposure to the ever increasing visibility of aged residential care in television reports, advertising and other media communications, have served to shape older adults' beliefs regarding long term care facilities; often striking fear into their hearts and causing significant anxiety (Biedenham & Bastlin, 1991; Cheek et al., 2006). Such beliefs become the dominant ideology of the societal sub group members or community and are thus "normalized" within existing values, behaviors and actions of group members (Fairclough, 1995/2010). Meanwhile, and in contrast, my experience suggests that wider societal ideological positions and subsequent beliefs and values may see aged residential care as the normative trajectory for older individuals. This study seeks to identify and make visible those discursive frameworks that colonize the function and normalization of residential aged care in contemporary New Zealand society.

For Foucault, discourse reflects ways of thinking and speaking about specific realities. For example, when he wrote the *Birth of the Clinic* (1973), Foucault described clinical medicine arising from a clinical 'turn' which was the result of the evolution of knowledge in pathological anatomy in

the 19th century. This new medical knowledge transformed, legitimated and gave authority to medicine through a somewhat tangled (and often opaque) matrix of social, political, economic and institutional practices or discourses. Early medical discourses and those emanating from medicine and science in more recent times have gained prominence and legitimization over others in achieving "truth" status related to health in contemporary society (Cheek, 2004). Thus, in this example, medical discourse has the power to "close out" or gain greater standing over other discourses and to shape dominant "taken for granted understandings of what is appropriate and authoritative practice" in health (Cheek, 2004, p. 1143). Foucault also noted:

That in every society the production of discourse is at once controlled, selected, organised and redistributed according to a certain number of procedures, whose role is to avert its powers and its dangers and to cope with chance events, to evade its ponderous, awesome materiality. (Foucault, 1971, p. 16)

Discourses provide the scaffolds for discursive frameworks and, in turn, these frameworks establish and order our reality in certain ways. In essence discursive frameworks provide the capacity to both enable and, at the same time, constrain the production of knowledge by acting to include some knowledge whilst excluding others; and by determining who can speak, when and with what authority (Cheek, 2004). Finally, discourse is a complex multilayered phenomenon which assimilates the three key dimensions of natural language namely, "form or expression - sounds, visuals, words, phrases, meaning and action" (van Dijk, 2011c, p. 4) within global and local structures and meaning. Deconstructing the discursive framework of residential aged care within the local context related to this study; thus has particular relevance to this thesis as it attempts to illuminate influences on older adults that are assumed to underpin contemporary residential aged care decisions.

3.8. Critical Discourse Analysis

Critical Discourse Analysis (CDA) emanates from both social and political paradigms linking multifarious theories and methodological assumptions to the study of the common culture within a given society, its shared symbols, meanings, and the language into which actors have been socialized, politicized and conditioned (Cumming & Moore, 1984). As there is no singular theoretical background from which CDA emerges (Fairclough, 1989; Powers, 2007; Schiffrin, 1997; van Dijk, 2011b, 2012; Wodak, 2009b), contemporary CDA has evolved many and quite varied interests and directions for research activities. Current examples of the breadth of use of

CDA include political, media and racism discourse (van Dijk, 1989a; Wodak, 2009b); new capitalism and globalization (Fairclough, 2002; Fairclough, Graham, Lemke, & Wodak, 2004); education (Henderson, 2004; Janks, 1997; Luke, 1997a; Patterson, 1997) and linguistics (Pennycook, 1994; Schiffrin, 1997; Wodak, 2005).

Supported by a critical theoretical approach, CDA is clear regarding its intent to explore social phenomena but also to *change* them. It explicitly positions itself alongside dominated and oppressed groups to challenge the oppressors of these people (Fairclough, Mulderrig, & Wodak, 2011). Indeed the distinctiveness of CDA is that it endeavors to locate discourse within a particular view of society which is that pertaining to a critical lens, focused on dominance, social power and inequality as it is enacted, reproduced and resisted in social and political milieu (Hammersley, 1997; van Dijk, 2001).

As mentioned above, CDA can be used eclectically since it is derived from multiple theoretical orientations across a number of disciplines including sociology, anthropology, social psychology, cognitive psychology, applied linguistics, cultural studies, literary studies and pragmatics (van Dijk, 2011b; Wodak & Meyer, 2009a). This somewhat broad landscape of disciplines and theories is not a "unitary or homogeneous" entity but, as suggested by Fairclough et al.:

CDA does not begin with a fixed theoretical and methodological stance. Instead, the CDA research process begins with a research topic. Methodology is the process which, informed through theory, this topic is further refined so as to construct the objects of research… (Fairclough et al., 2011)

In his early work, social CDA theorist, Teun van Dijk, suggested that CDA is specifically the study of dominance as it emerges within text, talk, verbal interaction or communication (including signs and symbols) (van Dijk, 1993 b). Indeed, according to van Dijk, this notion of dominance may involve different modes of discursive power relations including those modes of social action which imply "more or less direct or overt support, enactment, representation, legitimation, denial, mitigation or concealment of dominance, among others" (van Dijk, 1993 b, p. 250). Van Dijk perceived that one of the key principles of CDA is to take a "top down" approach to studying dominance as and where it occurs as opposed to taking a "bottom up" review of resistant forces to power and domination. This former approach requires an acknowledgment that the paradox of resistance, compliance and acceptance of power and domination are all possibilities rather than a unilateral imposition of domination by an elite group "over" others (van Dijk, 1993 b). The CDA

approach, at its core, deconstructs the foundations of domination and marginalization by questioning the opacity of relationships and social processes occurring through the use of language and meaning within given contexts of society and social processes at large (Hodges, Kuper, & Reeves, 2008; Huckin, 1997; Kress & van Leeuwen, 1996; Wodak & Meyer, 2009a).

The various modern roots of CDA stem from the traditions of the Frankfurt school and critical social theory and critical linguistics (Powers, 2007; Wodak, 2007), and includes the work of Barthes, Chomsky, Foucault, Bourdieu, Habermas and Gramsci (Barletta Manjarrés, 2011 ; Huckin, Andrus, & Clary-Lemon, 2012). However, the various schools of thought within the CDA paradigm differ in their theoretical underpinnings, as evidenced in the work of Fairclough who draws heavily on Foucault. In contrast, van Dijk's work draws from the work of Chomsky and others (van Dijk, 2011b; Wodak, 2009b). Wodak (2009) suggested that the most substantive difference between discourse analysis and CDA lies in "the constitutive, problem-oriented, interdisciplinary approach of the latter" with a specific focus on studying complex social phenomena that require a multidisciplinary and multi-methodical approach" (p. 2).

As mentioned earlier, CDA is characterized by a number of key principles, including a focus on problem solving which, in contemporary society, necessitates a multidisciplinary approach due to the complexity of the problems being examined (Wodak & Meyer, 2009a). It is also suggested that CDA is uncompromising in its pursuit of unmasking the opacity of power relations through "systematic and retroductable investigation of semiotic data (written, spoken or visual)" (Wodak, 2007, p. 7). Unlike other (and perhaps more positivist) paradigms in discourse analysis and pure or applied linguistics, CDA focuses not only on texts, but also on semiotic communications which include spoken and written language as well as visual images and symbols as objects of inquiry (Kress & van Leeuwen, 1996; Wodak, 2007).

To achieve the "critical social standpoint" any account of older adulthood and residential aged care discourse necessitates a description of the duality of the social processes and structures which give rise to the production of a text (symbol or communication), and to the social structures and processes within which individuals or groups, as social actors, create meanings in their interaction with texts (semiotics) (Fairclough & Kress, 1993). Supporting this view, Hammersley (1997) suggested that in its "simplest" form the notion of "critical" added to the phrase "discourse analysis" clearly implies the absolute "abandonment of any restraint on the analysis of texts and

contexts being studied" (p. 238). Consequently, by tangentially examining and questioning the "taken for granted" use of language, symbols and meaning within ageing and residential aged care choice, it is possible to examine the relationships between discourse and social action, between text and context and between language and power in contemporary age care and ageing in New Zealand (Fairclough, 1989; Luke, 2002).

In my exploration of the influencing factors on older New Zealanders entering residential aged care, CDA provides an approach with capacity to bring together social, psychological and linguistic theories incorporating both macro (social structure) and micro (language/media) level analysis. Morgan (2010) suggested that CDA provides more that than a methodology – it provides a philosophical way of "being" in the social world which challenges taken for granted assumptions and views about the world in pursuit of an insightful critical understanding.

The evolution of "critical" discourse analysis has also evoked significant scholarly criticism as articulated by Pennycook (2001) who suggested that CDA is linked strongly to neo-Marxist ideological perspectives in which power is located in the material reductionism of class and economic production within society. Pennycook suggested "many CDA researchers are unable to separate their own ideological and political position in their claim to knowledge and truth", and he noted the circularity of this since knowledge and truth are also political (1994, p.125). One solution to this circularity problem, according to Mannjarres (2011), is to ensure that each researcher is self-reflexive and problematizes the knowledge that is generated from any critical discourse research.

3.9. Definitional Complexity Issues with CDA

There are multiple and diverse definitions of CDA each extolling the complex nature of the foci under review and reflective of each definition's epistemological underpinning or foundational source such as critical linguistic theory, socio-cognitive theory or critical social theory (Cheek, 2004).

Within this plurality of theories each takes a slightly different approach or lens through which to view social life and social practices. Socio-linguistic discourse analysis unpacks use of language to expose socially constituted relationships between language and the influence and significance of this in the production of social relations of power (Fairclough, 1989).

Lupton (1992) provided an elegantly simple definition of CDA drawing from social theory which is a useful starting point for the establishment of a clarity regarding the exactitude of CDA. This author stated that CDA is:

A group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures. (Lupton, 1992, p. 145)

Of significance here is Lupton's concern with locating cognition within language and language use on the one hand and, on the other hand, situating or coupling this within a wider social practice landscape. Supporting this approach, Fairclough (1985) saw "language as social practice" (p. 16). Fairclough suggested that language is socially determined and thus is a social act in itself; that is, part of the social processes and practices and not merely a reflection of social phenomena (Fairclough, 1989). In clearly articulating this approach, Fairclough has been critical of the narrow positivist conceptions of sociolinguistics, conversation analysis and pragmatics. He noted that these "positivist" approaches are "strong on '*what*' questions, such as "what are the facts of variation", but weak on '*why*' and '*how*' questions e.g. "why are the facts as they are" and "how - in terms of the development of social relationships of power - was the sociolinguistic order brought into being and then how is it sustained?"; and "how might it be changed to the advantage of those who are dominated by it"? (Fairclough, 1989, p. 6). A more generally accepted or popular definition amongst CDA researchers (Wodak, 2007) is that which accepts language as social practice and asserts the belief that the "context of language use" is fundamental for research using CDA.

CDA is entirely appropriate for evaluating current social discourses and attempting to explain or challenge older adults' thinking and views of aspects of ageing and residential aged care choices. With this in mind, Fairclough and Wodak (1997) provide an expansive and more sociological definition has guided me in this research (noted in Definitions section of Chapter 1):

CDA sees discourse- language use in speech and writing as a form of "social practice".

Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institutions(s) and social structure(s) which frame it. The discursive event is shaped by them, but also shapes them. That is, discourse is socially constitutive as well as socially conditioned - it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the status quo, and in the sense that it contributes to transforming it. Since discourse is so socially consequential, it gives rise to important issues of power. Discursive practices may have major ideological effects - that is, they

help to produce and reproduce unequal power relations between (for instance) social classes, women and men, and ethnic/cultural majorities and minorities through the way they represent things and position people. (Fairclough & Wodak, 1997, p. 258)

Drawing on the above "social" theory definition, from Fairclough and Wodak, this research study argues that CDA is pertinent to the examination of concerns regarding aged care and aged care choice of living arrangements. The rationale for this is the belief that CDA has the potential to lay bare the ideological dimension of such phenomena as age related health beliefs (Coupland, 2013), the authority of doctor-patient relationship (Salmon & Hall, 2003), power within parent-child relationships and the dissemination of age specific information in the mass media - a dimension often neglected but remarkably influential (Kozakowska-Molek, 2013).

Through the examination of the social context which exerts influences on older people and subsequently underpins some individuals' movement from independent living into residential aged care, I have chosen to utilize a methodology, research design and analysis appropriate to this multi-modal research question regarding the influences on older adults which cause them to take up residential aged care accommodation. Importantly, I require a theoretical and methodological framework which is capable of galvanizing together multiple analytic strands for examination in relation to aged care influences and decision making including historical government policy, social structures, socio-cognitive mental models, language, symbols and meaning context within New Zealand society. Such an analysis will make visible how semiotics (media, advertising, government policy etc) and social context construct ageing and aged residential care for older adults.

The analysis will be informed by different critical voices in order to explore power inequalities and areas of social injustice related to aged individuals interviewed/accessed in this study. Adopting a multi-theorist approach can thus incorporate political, social and other critically informed points of view to assist this research. The intent of the analysis to honour scholarly research principles calls it to acknowledge the subjectivity and reflexivity of myself as the researcher with an emancipatory intent for this study.

This study draws from key contemporary theorists such as Teun van Dijk's socio-political approach, Michel Foucault's postmodern political approach and Norman Fairclough's socio-linguistic approach. In bringing all three theorists together, into this study, it is possible to explore critical discourses related to aged care as well as the dialectical relationships between these

discourses and other elements or critical decision moments in the lives of older New Zealanders with regard to their ongoing living arrangements and independence (Fairclough, 2010). Utilizing an eclectic theoretical approach to this study permits an integration of CDA frameworks to address the issues of marginalization, institutionalization, and inequality for ageing people. The emancipatory agenda of this research calls it to give voice to its participants. Its critical social theory agenda also calls it to critically analyze the messages conveyed through print media advertising and to expose the ideological underpinning of such discourses and to address the research question "What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?".

3.10. Reflexivity

The field of qualitative research clearly supports researchers' need to acknowledge their subjective biases and political intent that render impossible the ability of the individual researcher to remain neutral, completely objective or emotionally impartial. As suggested by Malterud (2001), "A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (p. 358). Acknowledging the above, my own involvement in a professional doctorate programme of study supports my desire to link my research with real world issues in order to bring about transformative change. The significance and importance of such a desire is evident in the literature comment about knowledge production in which Rolfe and Davies (2009) talk to the importance of knowledge production via *Mode 2* which is that knowledge produced by professionals "in the context of the situation to which it will ultimately be applied rather than in the context of a laboratory or the academic research study" (p. 1268).

In preparation for this research study I have undertaken a comprehensive presuppositions examination with supervisory support and, in so doing, clarified my personal ideological values, attitudes and beliefs in relation to ageing and aged residential care and the disjuncture and/or alignment of these with the prevailing and dominant "taken for granted" societal ideologies within New Zealand.

As a registered nurse, having worked in both the public health system and private aged care businesses, I have been guided by my subjective judgments regarding the considerations and decisions required to undertake this research. The orientation I have taken in this thesis reflects my interest and deeply held beliefs regarding older age and the care of older people within our community. Nursing as a profession provides many experiences and challenges. It enables and facilitates a privileged relationship with patients that peel away many of the layers unable to be penetrated by other professions. At once it is an intensely personal but also therapeutic space that the nurse and patient enter. It is this space into which I have stepped many times to discover the fears, courage and experiences of older adulthood.

Three key nursing leaders have influenced the spirit of inquiry that underpins this research. At a very personal level the work of Sybilla Maude in Christchurch with desolate and desperate older adults has been, and continues to be, a key driver for my own practice. Against significant opposition Nurse Maude challenged the dominant discourse of the late 1800s establishing a district nursing service to take care to older individuals in their own homes (Allan, 1996). In the midst of community poverty, child labor and often finding herself in harrowing situations, she provided good quality nursing care to older adults with nowhere to go other than live with a family member. Sybilla Maude had found an expression for her strong desire to bring comfort and support to the old and the sick in Christchurch (New Zealand) where, "There was nowhere for the old and infirm to go to be nursed free of cost. They had to stay in their own homes which most of them preferred and receive what care they could ..." (Somers Cocks, 1987, p. 38). Sybilla Maude was an innovative and courageous nurse who shone the light on aged care provision in early New Zealand. She transformed nursing care services at that time to directly benefit and enhance the lives of older adults, providing leadership into new models of care that still prevail today.

Patricia Benner's theory and research on nursing development of competencies *From Novice to Expert* has been a constant guide for my own practice and in my work as a mentor and nurse leader for other nurses. Benner introduced the notion that practice should inform theory and, in doing so, challenged the belief that an "expert" nurse is the person who holds the most prestigious title. Instead she suggested that a truly expert nurse is the individual who provides the most patient centered and appropriate care for the individual (Altman, 2007). Benner's theory is important in the care of older adults where caring is grounded in relational understanding, unity and connection between the nurse and the individual. Such a view challenges the orthodoxy of a

purely scientific "being" which sees everything in the world as a resource to be used or explained in reductionist terms of bio-molecular truths.

The third key nursing influence for my practice is Florence Nightingale. As a statistician, demographer and epidemiologist, Florence Nightingale is more than a mere historical figure guiding my professional nursing practice. Contained within her writing is a quote I reflect on often:

It may seem a strange principle to enunciate as the very first requirement in a hospital is that it should do the sick no harm. (Nightingale, 1859, p. iii)

Replacing the term *hospital* within this quote to reflect *all care*, I find this reference keeps me grounded in the patient's need and endorses safe and quality care delivery. I hold strong views regarding the integrity, respect and need to honour older adults for their contribution to New Zealand society. I have witnessed poor quality aged residential care due to insufficient funding in the face of financial profit imperatives for public shareholders or international owners (banks, insurance companies etc). I have observed the struggles of small aged residential care facilities and their demise as large corporates have taken them over in order to grow their portfolio of residential aged care facilities. I have also witnessed registered nurses struggle ethically, emotionally and physically to deliver on the "promise" of good quality care to older adults within aged residential care when they are the sole health practitioner with a significant number of frail, needy older adults for whom they could not possibly provide adequate care.

In conjunction with the above, I also have a natural curiosity to examine the reasons why rational, thinking and independent older adults appear to willingly submit to institutional living arrangements at a time when the overwhelming evidence indicates that they may prefer to remain in their own home. Given the literature supporting the meaning and value ascribed to older adults' community of interest, their home and their belongings it seems incredibly odd to me that older people appear willing to enter institutional living accommodation. It is this which I seek to more fully understand through this study.

Situating myself as the researcher in the midst of this research process and establishing personally held values and beliefs reflexively is important to establish limitations of subjectivity and prevent finding only what I set out to look for in this study. This approach supports the notion that scholarship cannot be "value free" and accounts for acknowledgement and inclusion of these ideological biases by ensuring they are visible for all.

3.11. Conclusion

Situating the research question of this study within a critical framework to enhance fundamental understanding regarding the influences on older adults influencing their entry into institutional retirement living arrangements in New Zealand, has been the goal of this chapter. Contemporary residential aged care in New Zealand is framed by policy makers and the financial imperatives of investment organisations and developers. It has also been integrated as an expedient contemporary solution for 'supervision' and 'monitoring' of older adults from within contemporary New Zealand medical discourse. Given the complexity underpinning the dominant paradigm regarding the creation and sustainability of residential aged care living, which acts to isolate, marginalize and homogenize older adults, critical theory and CDA provide a problem oriented approach through which to undertake a semiotic analysis of contemporary influences. This methodological choice respects the centrality of the visual and textual construction of aged residential care within social life through mass media, media advertising and various political and other institutional documents. CDA acknowledges the constitutive, dialectic relationship between the construction and shaping of social and institutional norms, values and beliefs, and the discursive objects of such shaping, such as the identities and relationships between people and groups (Fairclough et al., 2011). Using CDA it is possible to make visible the contemporary rhetoric of aged care advertising within the media, politics and emanating from organizations, and to contrast this with the voice of older adults themselves who have experienced transition into such institutions of care. To illuminate the research design more fully and the relevance and appropriateness of the specific methods (focus groups and media scanning) used, I now turn to the methods section which articulates these choices made more fully in the journey to uncover the discursive influences on older adults to enter residential aged care.

4. CHAPTER FOUR – RESEARCH METHOD

At last I will devote myself sincerely and without reservation to the general demolition of my opinions.

René Descartes, 1596-1650 (Wilson, 2003)

4.1. Introduction

This chapter describes the methods used in this study and how they are informed by the chosen research methodology. As discussed in the previous chapter, CDA provides a well-established framework for examining the ways in which language and media construct ageing and aged care within contemporary social meaning in New Zealand. Discursive construction then potentiates an influential impact on individual decisions to enter aged care living arrangements for older people (Cheek, 2004). Using a CDA philosophical approach is acknowledged as an effective process to uncover and make visible those power relations embedded within social life. Using a critical discourse approach also provides an appropriate framework to gain insights into how people actively produce and make meaning and order of their worldview, and are subsequently prepared to take life choices or decisions as a result of these social influences (Fairclough, 1992 a).

In this chapter I explain the choice and development of the research design, the framework for data analysis which emerges from the CDA and the critical paradigm, and then overview the processes used for analysis of this data. My purpose, in keeping with the CDA approach, is to identify and expose those dialectic relationships between contemporary discourses of ageing and the uptake of aged residential care. Included in this exposé is an examination of individual agency heard within the voices of participant older adults. This will, then, also elucidate understanding of those influences underpinning individual older adult's decision making processes preceding their entry into residential aged care. Reviewing the accessible media related to aged residential care and simultaneously talking with older adults and listening to their voice and hearing their words is anticipated to align to those social discourses within which embedded power, domination and manipulation biases assert themselves. These processes are presented in this chapter to make visible my journey to answer this study's research question which is, "What are the critical

discourses influencing older adults entering institutional retirement living arrangements in New Zealand?" (as illustrated in Figure 1 below).
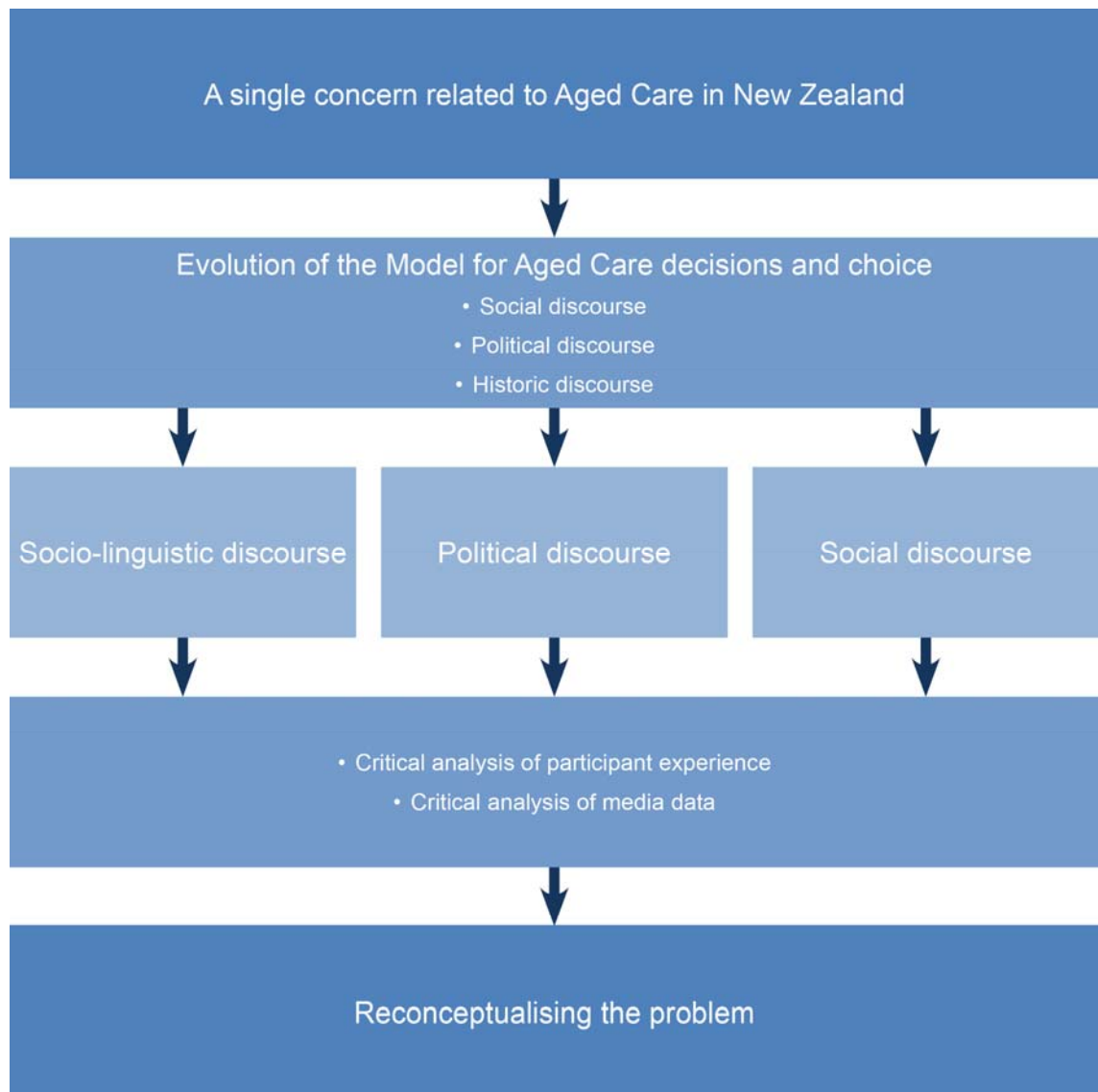
Figure 1. Overview of the line of inquiry into discursive influences on decisions of older people to enter aged care

4.2. Research Overview

This research study was undertaken in Nelson, New Zealand and consisted of three core phases: 1) a media scan of relevant advertisements related to aged residential care; 2) opportunity to give voice to older adults already residing in aged residential care through their stories via focus group interviews, and 3) exploration and analysis of the data generated from media sources in phases 1 and 2.

Each of these three phases contained multiple steps in order to enhance the breadth of data captured and the granularity of the analysis, with a final goal of heightened understanding in

relation to the research question. An overview of the three phases is contained in Figure 2 below which highlights the objective of the various data to be collected and the method used to source these data. This summary of the various phases of the data which capture the analysis framework shows the objective of the data sourcing strategy and the various methodological and action modalities of this within the context of the overall research design.

PHASE ONE

OBJECTIVE	METHOD
To gather popular (accessible) magazine media and local daily media to review discourses related to ageing adults	*Data Collection:* Literature review, capture of popular magazine media and daily print media and advertising materials available to older adults
	Data Analysis: Content scanning and thematic discourse analysis

PHASE TWO

OBJECTIVE	METHOD
To develop a framework for and undertake focus groups with older adults to discuss discourses influencing their decision to enter aged residential care	*Data Collection:* Literature review, framework development for focus groups and conducting focus group sessions
	Data Analysis: Content scanning and thematic discourse analysis from groups work

PHASE THREE

OBJECTIVE	METHOD
To develop a discursive framework through which to use CDA to analyse the thematic content of both the media data and the focus group data collection	A computer data-base program was selected and used to enable storage and retrieval of identified content themes

Figure 2. Overview of research process

This CDA methodological approach is informed by the philosophical work of Fairclough, Foucault and Van Dijk. These scholars channel and guide this research as it seeks to uncover the discursive frameworks underpinning, and thus influencing, older adults, decisions to enter into residential aged care. The three critical discourse perspectives draw from socio-linguistic, political and socio-cognitive discourse analysis paradigms, and provide an eclectic philosophical platform to inform this research. Taking this somewhat mosaic approach was anticipated to realize exposure of the social determinants of residential aged care discourse within current language and semiotics in use. Similarly this approach intends to bring into light the influence of political discourse related to aged residential care and to make visible the construction of aged residential care through social forces in contemporary New Zealand society relating to older adults.

Using Fairclough's (1992 a) three dimensional model of discourse processes and practice, Figure 3 below illustrates the three various components of traditional discourse analysis; namely linguistic (text) analysis (examination of the formal properties of the text in play), the activities of people as they attempt to make sense of their lived experiences within their world (social practice), and finally how individuals relate these semiotic factors to social structures that contain and define their world view (discursive practice):

TEXT

DISCURSIVE PRACTICE
(production, distribution, consumption)

SOCIAL PRACTICE
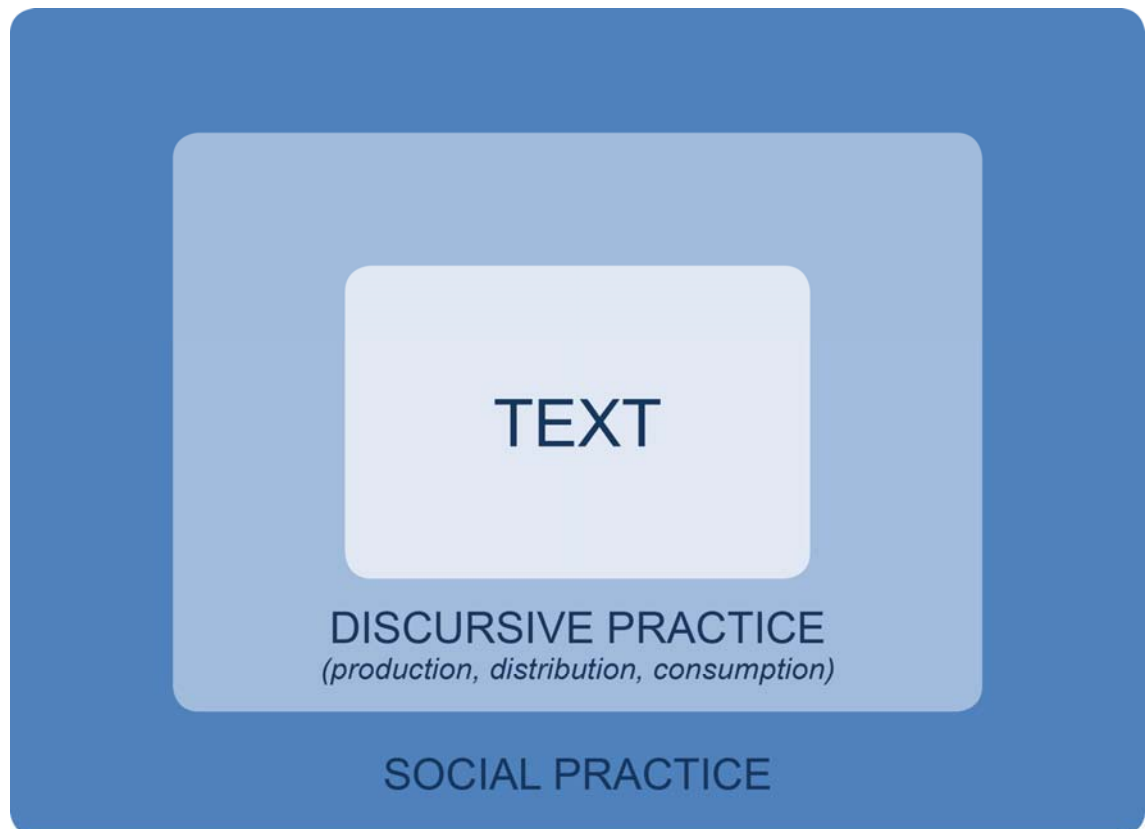
Figure 3. Fairclough's (1992a) Three-dimensional model of discourse

The two phases of data gathering (phase 1 and phase 2) were undertaken in tandem to ensure that the media exposure captured was that which may perceivably have had a potential to influence and impact those individuals who had recently entered into aged residential care.

4.3. Phase 1. Print Media

Ethics Approval and Ethical Considerations

Ethics approval was not specifically required for media scanning within this study as all data were publicly available. Ethical considerations for media related to the requirement for all copyright images to be approved. To gain copyright permission I approached the owner of these copyright materials and was provided with written permission to use their images. Copyright approval

included the use of Fairclough's model in Figure 3; approval was provided to use this model within this thesis as a single use only.

Print Media Inclusion Criteria

Print media used in this research was to be obtained from three key local sources namely locally available print mass media, popular magazines and print advertising. These materials needed to be readily available in the Nelson region and to contain images and specific items such as health and wellness information, local interest articles related to aged care and residential aged care advertising targeted at potential aged care consumers. Local daily newspapers and weekly community newspapers, as well as age acceptable current magazines expected to be read by over 65 year olds, were to be reviewed for content and advertising related to aged residential care. Examples of these mass media materials are the Nelson Mail, the Nelson Weekly and the Nelson Leader, New Zealand Women's Weekly and the Automobile Association magazine (Directions). General age relevant advertising and advertising materials available through a variety of sources such as aged care societies (Returned Servicemen's Association - RSA, Aged Concern, Grey Power, inpatient wards and rehabilitation providers and general practitioners) were also sought.

The rationale for choosing the above mass media sources is the observation that these media provide local and national health and wellness information relevant to older adults, including significant advertorial information related to aged residential care facilities. For example, the New Zealand Women's Weekly contains advertising related to personal alarms for older adults living alone to enable them to summon assistance if they fall or have an illness event. The Automobile Association magazine which is read by many older adult males contains advertorial information related to aged care. These print media provide local and global information for older adults. In his work on the role of the mass media, van Dijk (1995) identified that contemporary politics, policies, exploitation and marginalization are ideologies which require production and reproduction through public text and talk, and that this is arguably the prevailing role of modern media.

Print Media Exclusion Criteria

Local mass media excluded general social event reporting and sporting activities not related to older age or age related residential care. Also excluded were mainstream advertising (e.g. white ware, furniture and supermarket advertising), local news (unrelated to aged residential care) and other more general background community (sporting, local Council activities/politics, and features such as gardening or local interest stories unrelated to age) or world related news reporting or articles.

Gaining semiotic evidence of discursive frameworks within media advertising acknowledges and respects the importance of visual imagery and text communications in the social construction of our lives (Fairclough et al., 2011; Kress & van Leeuwen, 1996; van Leeuwen & Kress, 2011). The objective of the first phase of this research was to identify and gather advertising text and images related directly to aged residential care and contained within popular press magazines and mass media. The use of media such as magazines and newspapers continue to be widely read by older adults (Vasquez, 2013) and this exerts not only a powerful influence on individuals but also on the cultural, social, political and economic structures within society (Fairclough et al., 2011; van Dijk, 1995d).

Particular magazines believed to be of high readership for the over 65 year old age group such as the Directions magazine from New Zealand Automobile Association; the New Zealand Women's Weekly; Mudcakes and Roses - a local Nelson City Council magazine and an array of daily and weekly print media - the Nelson Mail, the Nelson Weekly and the Nelson Leader, were included as sources for advertising materials related to aged residential care. Images and text appearing in these media were included in the sampling if they met the criteria of relevance in answering the research question and were pre-analyzed to identify and situate content related to residential aged care either in the images portrayed and/or the text content.

Print Media Data Gathering

The period of collection for these materials was for a period from October 2011 through until April 2012. Individual subscription to Directions Magazine, New Zealand Women's Weekly and Mudcakes and Roses magazine were obtained by the researcher to ensure continuity of access to these sources during the print sampling period. This six month scan generated a large volume

of material for review of embedded discourses and power relationships related to ageing individuals. My daily subscription for the local newspaper was reviewed for relevant information and where this appeared it was cut out and stored in a box. All local newspapers are delivered to all Nelson residents and these were scanned and relevant material clipped out and stored in a box for future analysis. Subscriptions to the New Zealand Women's Weekly and to New Zealand Automobile Association magazine *Directions* were established and these magazines were scanned, relevant material cut out and was stored in a box. Advertising materials were sought from multiple sources e.g. Aged Concern and stored in a box.

Print Media Data Analysis

Data generated from the media, advertising and magazine scan were visually examined, then read multiple times to enable categories to be coded for discourse content. Images contained in the print media were noted for content such as family (present/absent) in images; gender; ethnicity, activities portrayed; vista e.g. trees and gardens; building offering resort style accommodation and colour such as sunlight and light and dark features of the images. Also noted was body language e.g. a daughter with an arm around her mother or body positioning implying rest and recreation.

The language of the print media was reviewed multiple times for reference to care; deteriorating health; nursing/medicine; safety; resort style living; exercise; active living; loneliness; death of a spouse; inability to cope with home maintenance; retirement and local colloquialisms. The presence or absence of slogans or strap lines to attract the reader and any political or government hooks or attractions which may entice an older adult to visit the facility were noted.

Similarly, this data were grouped according to theoretical themes and entered in to FileMaker Pro and subsequently into Excel for analysis. From these themes key discourses became apparent including the 'burden of ageing' found in political discourse, the powerful influence and control of family in persuading older adults to enter residential aged care; and finally the discourse of commodification of older adults.

4.4. Phase 2. Focus Group Interviews

The objective of the second phase of this research was to listen to the voices of older adults who had already entered into residential aged care and to establish the breadth of influential factors underpinning or behind their individual decision regarding ongoing accommodation. The choice to use focus group interviews was a deliberate decision underpinned by my belief that older adults, in a natural and permissive group environment, could elaborate on their perceptions, points of view, values and beliefs, as well as their shared experiences in the decision making regarding entry into aged related residential care facilities. In such an environment I anticipated that the depth of conversation occurring in a focus group could lead to a more naturally occurring, open sharing and enjoyable experience for older adults regarding the influential discourses experienced by the individuals within these groups (Krueger & Casey, 2009).

Ethics Approval and Ethical Considerations

This study design required multiple methods for data gathering in order to achieve its goals. A significant start point for this study was the recognition that my data gathering method involved human participants in focus group sessions and thus rigorous ethics approvals needed to be obtained. Ethics approval was sought from Health and Disability Health Committees - Upper South B Ethics Committee under the 2006 Guidelines and prior to the revision of Ethics Guidelines which occurred in July 2012. This revision did not fundamentally change the existing ethical standards and principles set out in these *Ethics Guidelines* which require health researchers to safeguard the rights and interests of participants in research and reflect the principles of the Treaty of Waitangi.

Considerations for my research ethics approval also needed to demonstrate respect for people and their right to self-determination (to agree to participate or to decline to participate) and the requirement for the protection of people agreeing to participate who have impaired or diminished autonomy. Aged individuals are recognized to have high levels of vulnerability at times and thus participants needed to be afforded security against any potential harm.

The notion of natural justice is an important one for ethical consideration and this required that I did not discriminate in the selection and recruitment of participants by including or excluding them on the grounds of ethnicity, disability or religious or spiritual beliefs. However the inclusion criteria

for the study (discussed more fully on p. 94) required that these people were older adults (over 65 years), did not have dementia and were recently resident in an aged care facility (less than 6 months).

In anticipation of the requirement for ethics approval, and in light of my role within the Nelson Marlborough District Health Board (DHB), I approached the DHB Iwi Health Board to establish their requirements for Ethics Approval in October 2011. The Government is committed to fulfilling the special relationship between Iwi and the Crown under the Treaty of Waitangi (Minister of Health and Associate Minister of Health, 2002). As a crown entity the DHB is the contract holder with Age Related Residential Care facilities for provision of services to older adults, thus a necessity for endorsement by the Iwi Health Board which is a key Board of the DHB, was a critical requirement. This approach was supported by the Director of Maori Health within the DHB. The formal approval from the Iwi Health Board meeting in November 2011 endorsing the research proposal and requesting that if a cohort of Māori were identified through the research process they be recruited as a case study, and that regular updates are provided in terms of the study findings and outcomes, is attached in Appendix A.

As a member of the DHB Executive, I was also required to declare this research on the Conflict Of Interest Schedule within all Board papers to ensure the integrity and transparency of the research process involving DHB contracted Aged Care Facilities.

Approval for the research was also sought from the Upper South B Ethics Committee. This was approved in June 2012 (Approval URB/12/EXP/034) see copy of this approval as Appendix B. A final formal ethics approval was sought from AUT Ethics Committee and this was granted in July 2012 (12/151), see Appendix C.

Throughout this process it was also acknowledged that a "Locality Agreement" would be provided to all residential aged care providers involved in this research. This agreement provided a brief overview of the study, as well as providing contact details of the researcher, to ensure appropriate local study arrangements and follow up capability were in place. This locality agreement is provided as Appendix D.

Anonymity and Confidentiality

Confidentiality has been maintained by the researcher at all times with aged care facilities being identified by a unique letter code (Facility A, Facility B and Facility C) and all participants allocated alphanumeric coding. Participant details and interview details have been maintained by the researcher in a locked cabinet and on password protected computers during the research study.

Participants Right to Decline to Take Part

All participants had the right to withdraw from the research at any point, clearly explained verbally on the initial meeting and prior to participating in the focus group meeting itself. Information related to this right to withdraw at any time without penalty was also contained in all documentation provided to potential participants and subsequent participants. The information sheet provided to participants is provided as Appendix E, as well as to Facility Managers to enable follow up should withdrawal be something any participant wished to enact after the focus groups had been undertaken.

Informed Consent

Informed consent was gained from each individual participant once they had received a full explanation of the study, their right to withdraw without penalty at any time and contact details for the researcher, so they could effect this withdrawal at any time in the future. Informed consent documentation is attached as Appendix F. Informed consent must always include comprehensive information sharing about the proposed research in a manner that is appropriate for receivers of this information and must also provide information about the likely outcomes of the research (Allmark et al., 2009).

Focus Groups Inclusion Criteria

Potential participants within this research needed to meet several key criteria in order to be included. It was important that any participant was able (physically and cognitively) to join in group discussions and was fluent in speaking English. The study sought males and females aged over 65 years to be resident in the Nelson region for at least one year prior to entry into aged care. It was assumed that this minimum timeframe would allow for exposure to mass media and advertising related to aged care.

It was also planned that male and female participants were placed in matched groups i.e. male only groups and female only groups. The rationale for this was the belief that there may perceivably be differing discursive frameworks for each gender e.g. females may feel more vulnerable living alone in a residential house and seek aged residential care for safety reasons. In contrast males may be living alone and have insufficient support to manage activities of daily living. It was also my belief that the "matching" process would eliminate any confounding of potential gendered discourses and increase potential for self-disclosure of views and perceptions of potential influences in their decision making processes (Krueger, 1994). Krueger (1997a) recommended homogeneity of participants in focus groups since this enhances sharing of information when one response heard by another encourages additional comments beyond their own original response. For this reason, gender specific group discussions were conducted with male only focus groups and female only focus groups.

Each potential participant needed to have been resident in an aged care facility between 2 weeks and 6 months. Up to 2 weeks it was assumed that a normal "settling in" period of transition may be in progress thus impacting ability to focus in a group discussion fully. Beyond six months it was assumed that there may be potential erosion of discursive drivers for entry into aged care. All ethnic groups were potentially included but not specifically targeted. Potential participants were resident in aged care facilities owned by individual providers and or corporate providers.

Focus Group Exclusion Criteria

The exclusion criteria for potential participants were diagnoses of dementia or cognitive impairment as identified by the Clinical Manager within the Facility. Diagnosis of dementia was believed to significantly impact the ability of an individual to participate fully within this research.

Sampling Strategy and Recruiting Participants to the Study

In keeping with the research question, "What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?" the purposive sample of older adults was anticipated to include those individuals who had recently moved into residential aged care. The goal of the focus group sessions was to inform the study as to the nature and impact of discourses that older adults had been exposed to that influenced their decision to enter aged care. To recruit the focus group participants, following identification of all locally available

aged care facilities, I spoke with three Nelson Facility Managers explaining the research and checking for interest, numbers of older adults who had entered their specific facility in the previous six months and their (Facility Manager) appetite for supporting this study. All three Facility Manager's willingly agreed to support the research and allow me access to their residents to explain the research study and seek participant interest. Facility Managers and Clinical Managers discussed this research with their residents and asked for those who were interested to participate in an initial meeting with the researcher.

All focus groups were established by arranging an initial meeting of the potential participant group to explain the research, discuss the need for informed consent, confidentiality of materials and tapes (including storage), withdrawal (at any stage) and feedback on completion of the study.

Approach to Data Gathering

Aged care facilities were identified through use of websites (Ministry of Health, Aged Concern), the Nelson telephone book and local professional networks. Access to older adults resident in aged care facilities within Nelson was achieved by the researcher contacting Facility Managers to seek interest in supporting this research within their facility. Initial approaches met with universal support to undertake discussions with current residents in rest home level care to gauge their interest to meet the researcher and participate in an initial meeting for a comprehensive overview of the study, its aims, informed consent, withdrawal and feedback mechanisms. This purposive sampling of older adults was appropriate to ensure focus group participants were informed of the purpose of the study (Sandelowski, 2000).

Focus Groups

Focus groups were chosen, as in my view, CDA directs research to the field of practice at the meso level[6] and the study of discourses at the micro level. Focus groups are a means of capitalizing on the communication between research participants in group interviews in order for them to explore and clarify their views in ways which may be less accessible in a one to one

---

[6]**Meso** level analysis indicates a population size that falls between the micro- and macro-levels, such as a specific community or an organization.

interview (Gee, 2014a). The discussion generated from focus groups can create a "snowballing of ideas" effect where one person's comments trigger another to comment. Such groups generate discussion which is more conversational in style and therefore offers the opportunity to generate discussion which is more diverse, meaningful and animated than that obtained from individual interviews (Patton, 2002).

This research planned to attract three groups of women and three groups of men in gender matched groupings. Focus groups do not discriminate against people who cannot read or write, a factor that was potentially relevant for the age group in this study. Furthermore, focus group interactions can encourage participation from people who may otherwise be reluctant to be interviewed or those who feel they have little to say (Kitzinger, 1995).

The goal of the focus groups was to provide the participants' perspectives on the key factors that had influenced their decision to enter residential aged care. A Locality Agreement was signed by the Facility Manager prior to the research focus group activity. This Locality Agreement provided an outline of the study; information related to the researcher's background and details; detailed information on the suitability of the researcher; suitability of the local research environment; and specific considerations in relation to the vulnerability of the cohort and mitigation of these factors (such as embarrassment) by providing contacts for local Health and Disability Consumer Advocates and ensuring Facility Manager and clinical manager oversight of participants to ensure no ill harm occurred. Also contained in this Agreement were the researcher's contact numbers and email address see Appendix D.

Information sheets were provided to all participants inviting them to participate in this research and providing contact numbers and an email address for the researcher (Appendix E). Appended to these information sheets was an overview of the study, what the study involved, the time commitment of potential participants, potential discomforts for participants participating in the focus group sessions, withdrawal from the study, confidentiality, outcomes of the study and mitigation strategies for participant vulnerability or discomfort (Appendix G). There was a moderate risk of participant discomfort and this did not eventuate. These information sheets were provided at the initial meeting with potential participants and contained an overview of the study. Aged individuals, who were potential participants, were invited to ask any questions in relation to the research ahead of participation.

Participants were all asked to sign an informed consent form prior to participating in the focus group sessions. Consent to participate was entirely voluntary, no incentive was provided and no duress exerted by the researcher. Assurance was also provided to all participants that withdrawal from the research process could occur at any time without any penalty either by the researcher or anyone within the Facility.

The focus group sessions each lasted approximately one hour with one session lasting 90 minutes. The focus group checklist (Appendix H) was used to prepare the room for the group session and to manage the catering requirements for the participants. Introductory questions and probing questions were designed ahead of these group sessions and provided a framework for information gathering in a logical sequence ((Krueger, 1994). All focus group sessions were supported by a note taker and all were digitally audio taped for later transcription. All notes were subsequently retained and cross referenced to the taped recording of the sessions.

During the focus group sessions participants were encouraged to ask questions or clarify any concerns or issues arising from the discussion. All focus group sessions were conducted during daytime ensuring time for older adults to manage their requirements for daily living and to meet meal times. All participants participated only once in any focus group session.

Focus groups were chosen as CDA directs research to the field of practice at the meso level and the study of discourses at the micro level. Focus groups are a means of capitalizing on the communication between research participants in group interviews in order for them to explore and clarify their views in ways which may be less accessible in a one to one interview.

Overview of Focus Groups Residential Setting

Three residential aged care facilities agreed to participate in this study. Two of these facilities have retirement village provision on their campus, as well as rest home and hospital level care capacity. For the purpose of description in this study each of these facilities is allocated an alphabetic title - Facility A, Facility B and Facility C.

Facility A

Facility A is an older style aged care facility owned by one of the major national chains. This facility has 37 hospital beds and 14 rest home level beds. The facility itself is located in urban

Nelson and has a local school next door with playing fields able to be viewed from the lounge area so older adults can watch children playing sport and engaging in other activity. It is accessed up a long tree lined drive way and has ample gardens and outdoor areas in the form of courtyards for individual residents to find a quiet place to read or reflect. It has large lounge facilities with capacity to take a significant number of residents involved in activities or recreation. Individual rooms and shared rooms are available for older adults depending on their needs and level of care requirements. Generally, the atmosphere in this facility is that of a homely nature with no bustle or clinically sterile environment apparent.

Facility B

Facility B is also an older style facility owned by a major national chain. This facility is located in a small suburban village with access to Nelson library facilities, large supermarkets, hairdressers, doctors, cafe's and Aged Concern. The building is older style and not particularly attractive externally but the inside of the facility is warm, inviting and homely. Gracious lounges and long corridors with rooms running off these are the living arrangements. It currently has a mix of rest home, hospital and dementia care. The mix of these groups of care was noted as disruptive by some of the participants in the study since those older adults with dementia had been crying out during the night and keeping awake some of the participants. Access to local parks makes up for the lack of local grounds in this facility. The beds available in this facility are 43 hospital level care and 40 rest home care with 10 independent living units on the campus.

Facility C

This facility is relatively new and is a very contemporary multi-story design. It is owned by private consortia of business people. It has a large reception area which may seem a little sterile to the uninitiated although the atmosphere was unhurried and homely. This facility provides rest home, hospital and village services. Multiple lounge spaces are available for residents to engage in activities together or to withdraw and have quiet spaces for reading or time to reflect. Located on the north side of Nelson, this facility is a distance from major shopping areas although a local dairy is nearby. Garden spaces were not obvious and local parks are a reasonable distance to walk to for older adults. Currently this aged care facility has 82 (48 Hospital level and 34 Rest Home) beds, 34 Studio/Apartments and 5 independent village units.

Participant Profile

Twenty five older adults participated in the study. All of these individuals were 65 years of age or over, the oldest being 92 years. Initially 27 participants agreed to participate, one subsequently withdrew prior to the focus group session and one was eliminated as he had dementia. The final number being 25 active participants in the form of 8 males and 17 females as can be seen in Table 1 below.

GENDER	FACILITY A	FACILITY B	FACILITY C
Female	3	5	9
Male	4	4	0
Total	7	9	9

Table 1. Participant gender and facility

Two of the participants were individuals who had transferred to Nelson as a direct result of the earthquakes in Christchurch. Both of these participants were women who had come from facilities that had been wrecked in the earthquakes. One participant had his wife in the same facility; however, she did not participate in the research.

Focus Group Data Analysis

Data arising from the audio recordings from the focus groups were transcribed verbatim into transcripts to ensure accuracy of content and to eliminate any potential bias. The data were saved in a Word format on Windows 8 and later transferred in to FileMaker Pro where it was thematically analysed for discursive content. Problems encountered with Filemaker-Pro led to a decision to transfer collected data to an Excel spreadsheet for analysis.

The aim of the analysis was to establish common discursive themes occurring throughout the focus groups and to group these theoretically using the framework developed below in Figure 4 (p. 102). This Figure was designed to assist in the clarification and understanding of the potential themes that may arise from the data collection emanating from particular theoretical approaches. In particular, it picks up on the notion of the powerful influences of family, friends, groups, societal expectations and societal ageism in keeping with Fairclough's dialectical social model of discourse in contemporary society (Fairclough, 1992 a; Fairclough et al., 2011). It utilizes the work of Michel Foucault in relation to the role of experts, such as medicine with its language of remediation for failing bodies. It also acknowledges the powerful language and use of

demography and statistics alongside the notion of framing individuals within identificational groupings. This framing acts to construct representational networks to invest and sustain relations of normalization and domination in relation to ageing and thus the appropriate and proper user of residential aged care (Boje, Oswick, & Ford, 2004; Fornet Betancourt, Becker, Gomes Meuller, & Gauthier, 1987; Foucault, 1973; Gros, Ewald, Fontana, & Davidson, 2010; Rabinow, 2010). This model acknowledges the manifest power of politics to produce societal order within economic ideologies; utilizing policy strategies such as the privatization of aged residential care to enhance the commercialisation and commodification of ageing and to abjectly enhance the contemporary lifestyle promulgated by developers of these new age institutions using contemporary strategic media and advertising technologies (Fairclough, 1992 a; van Dijk, 1995b, 2011a). Finally, all of these discursive frameworks come together in the moment of decision for the older adult by effectively constructing their decision as the *normalized* approach to accommodation choice appropriate at an older age. The arrows in Figure 4 below are intended to show the continuum of influence of older adults from the multitude of discursive frameworks each with its own significant impact on the ultimate decision to enter residential aged care.
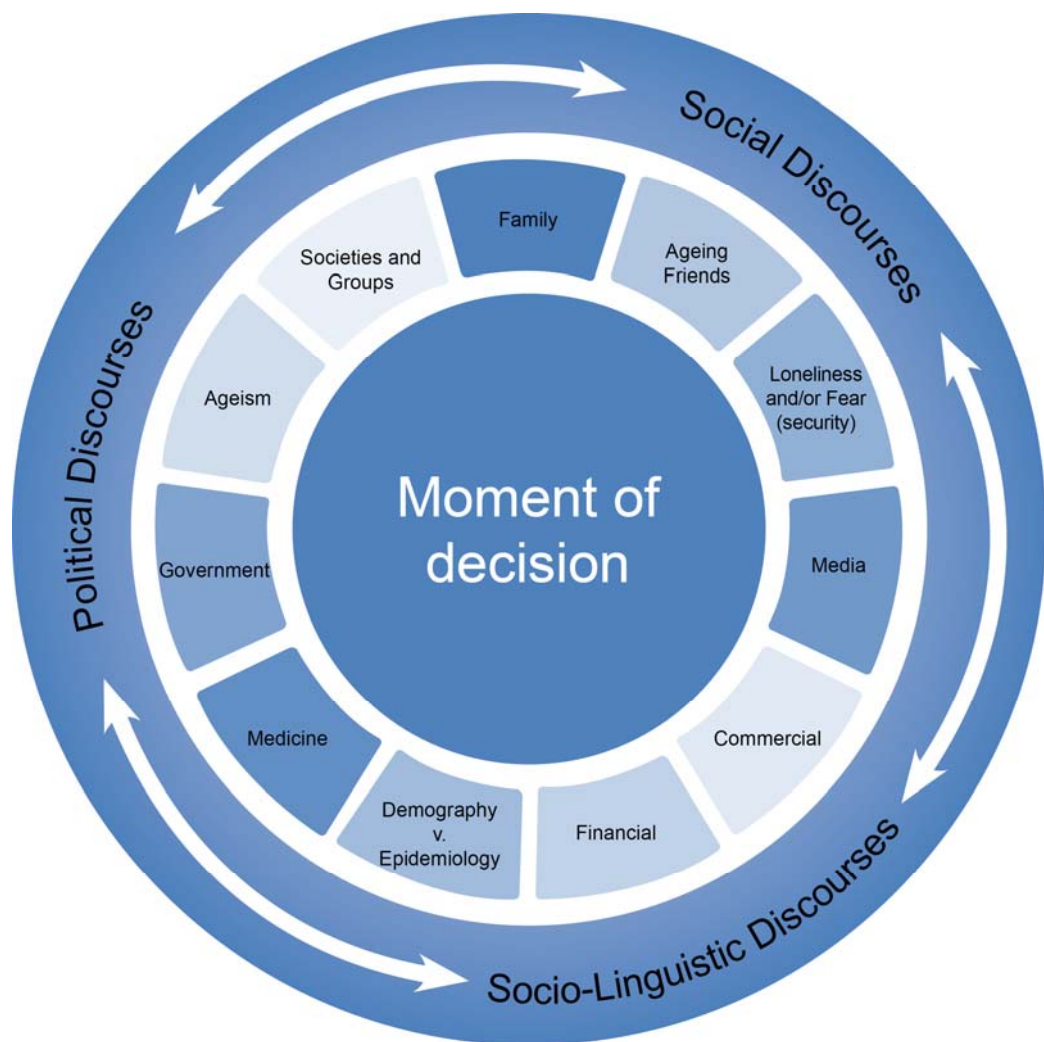
Figure 4. Model of discursive frameworks influencing decisions to enter residential aged care

Discursive Themes Identified Throughout this Research

Discursive themes were identified and developed throughout this research. These various themes are identified in Table 2 below.

Interpretive Thematic Findings
Active and passive discursive pressure surrounding residential aged care
Discourses of experts
Conflicted positioning of older adults evidenced from focus group interviews
Portrayal of 'free-choice' for consumers of residential aged care
Other portrayals of helpless, 'needing care' elders
Idealized synthetic personalization within media advertising
Normalization of institutional living evident in media advertising
Positioning between different worlds of existence i.e. home and institution
47% of over 65's access residential care facility
Institutional living counter to preferred home living
Decisions to enter residential aged care are made at point of vulnerability Multiple factors precipitate decisions including previous experience of known others in residential aged care facilities
Power and authority of medical discourse
Influence of statistics and economic modeling
Government policy to head off 'grey tsunami'
Aged demographic and fear of economic ruin
Seductive commodified resort type lifestyle offerings
Growth of individualism and 'self-focus' within NZ society
Proliferation of 'designer' style retirement landscapes
Promotion of glamorized lifestyles
Power and influence of family members
Older adults silenced through power exerted by family
Compliance and passive acceptance of the inevitability of residential aged care is common
Problematizing effect of social policy
Invisibility of older adults in New Zealand society
Care of older adult parents defined as problem
Normalization of residential aged care for white European elders
Older age variously defined
Marketing technology reinforces social expectations
Dominant discourses silence opposing views
Initial resistance gives way to surrender by older adults to family pressure
Multiple discourses at work and intersect across the over 65 year old cohort
Media influence mostly indirect
Market for 'residential living' appears to be rising

Table 2. Identified discourse themes

4.5. Phase 3. Analysis

The objective of the third and final phase involved explicitly establishing a discursive framework for analysis of the data in order to understand the social, political and ideological context of age related decision making and the factors that influence the ultimate decision to enter aged care by older adults. Significant data were generated from both streams of review. The media scan generated a significant amount of advertising materials related to residential aged care; local interest stories related to residential aged care; health and wellbeing information for older persons and advertising. The focus groups similarly generated significant data for analysis.

Issues of Rigor and Trustworthiness

Undertaking CDA requires significant" systematicity and careful thought" in order to optimize conceptual and analytical premises and to bring focus to the broad potential of a research study for its contribution and application of findings in the field of health sciences (Chouliaraki & Fairclough, 2010, p. 1213). Used as a means for critical enquiry, CDA theory and methodology are relationally linked to one another, privileging social relations over individual or organization actions and preventing dislocation of the theory from the methodology (Chouliaraki & Fairclough, 2010). Fairclough (2005) suggested that a CDA focus embodies four general dimensions namely the emergence (of discourse in social relations), hegemony, recontextualizsation, and operationalization of discourses. In this instance the concern that informed the commencement of this CDA related to the emergent social, political and medicalized view of residential aged care as a 'normalized' or inevitable trajectory for older adults. Thus adopting a CDA approach provided a vehicle for making visible any potential hegemony in language and semiotic use of media advertising and in the lived social world experiences of focus group participants. Throughout this thesis I have provided documentation of decision-making processes which have been used to inform the evolution of the CDA method as I have applied it.

The analytical framework incorporated interpretive forms of theoretical thematic analysis concerning the discursive construction of ageing and aged residential care utilizing Gee's discourse analysis toolkit (Gee, 2014a). Whilst Gee (2014) is emphatic that there is no "grand agreed upon body of content for discourse analysis" his toolkit provides a range of tools or questions to assist and support a comprehensive interrogation of the data and thus illumination of discourses (p. x). Of the twenty seven tools Gee identifies, only three of these were utilised to

provide guidance for thematic analysis of the data. The notion of utilizing only those tools appropriate for the data at hand is fully supported in Gee's overview and guidance for use of his toolkit (Gee, 2014a, p. x).

Using the tool of "situated meaning" (Gee, 2014a, p. 200) it was possible to identify in the data from both focus groups and media what the situated meanings of words, phrases were thematically. In essence this related to the meanings expressed by older adults in the focus groups such as the term "rest home", family, care, frailty, coping with illness and the like. For media advertising use of the term care, safety and security in the context of residential aged care provided valuable themes for analysis from the data in this study.

A second tool from Gee's portfolio utilised to support thematic analysis was the "social languages tool" (Gee, 2014a, p. 200). This tool asks how phrases and the structure of language or texts and symbols are used to signal or enact a given social language. An example of this is the phrase from the Kensington Court media advertising "W*e are more than just a rest home and hospital" (Kensington Court, 2012b)* Figure 29. This type of phrase relies on a distinct social language in relation to rest homes and hospitals from which I was able to build the theme associated with this. An example from the focus groups regarding social language relates to the phrase used by one participant "he would have me *under the ground* by now if he could" (p160). This phrase relies on social language relating to death and the burden of an older adult to family and again added insight to the thematic analysis regarding the influence of family in the decision to enter residential aged care.

Another of Gee's tools utilised in this thematic analysis was the "figured world's" tool (Gee, 2014a, p. 201). This tool suggests that individuals use words and phrases to assume mental representations or models of meaning. Within these meanings are values, representations and ways of acting or behaving within the social world. One example of such a phrase is that contained within Figure 20 where the media advertisement states "It's all about lifestyle". This notion of lifestyle for older adults was repeated across many of the advertising materials in this study and generated an illuminating theme for examination. Another example from the Focus groups participants was that that contained within the statement "if you go into care now". This again provided interesting thematic analysis in terms of the meaning of *care* to older adults and adult children.

Within this analytical framework, emergent themes were found to link to identified contemporary representations of older adults in the media and advertising with a further link made to themes emerging from focus group data related to those who had decided to access aged residential care. This latter data was anticipated to provide thematic information regarding potential for hegemony in the lived reality and outcomes emanating from the individuals currently living within aged residential care. This framework is congruent with the CDA methodology underpinning this study (Wetherell, Taylor, & Yates, 2001) and is visually represented in Figure 4 (p.102).

In keeping with the design of this study, unpacking the complex mix of persuasive discursive influences have been triangulated within a framework of socio-linguistic discourse, political discourse and social discourse in order to reconceptualise the patterns of dialectical relationships and to expose (operationalize) the sources of power behind and within these influential practices and technologies. Data were entered from these three streams of analysis into thematic categories in order to visualize the emergent themes and to understand the discursive construction of aged residential care. This understanding related to how those older adults, who access residential aged care, are represented in the news media, popular magazines and advertising; and how older adults themselves experience discursive influences through the construction of ageing and thus aged residential care as an option for accommodation in contemporary New Zealand society. Data analysis was undertaken initially utilizing an electronic database software tool. This required that all data were transcribed (focus group interviews) and media texts reviewed for appropriate content.

This multi-phase approach offered a multi-layered approach to address the aims of the study in keeping with the socio-linguistic, political and social discourses underpinning the influences on older adults' decision to enter aged residential care. This process is fully congruent with a CDA approach.

4.6. Conclusion

This chapter has provided the design strategy and decisions taken to conduct the research and answer the research question. In undertaking this research, this exploratory framework respects Fairclough's assertion that time, space and context has undercut traditional ways of caring for older adults in terms of the contemporary commercialized institutionalization models. The media texts and images obtained in this research study support the current rhetoric commodifying old age with simulated personalized messages regarding lifestyle choices; despite the overwhelming evidence that most older people would prefer to remain in their own home. The role and power of family and the opaque political discourse in modern society have also been illuminated. It is to these findings, flowing from this method that this thesis now turns.

5. CHAPTER FIVE – THE BURDEN OF AGEING: A POLITICAL DISCOURSE OF EXPEDIENCY

"For your own good" is a persuasive argument that will eventually make man agree to his own destruction.

Janet Frame, (Frame, 1961)

5.1. Introduction

This chapter is the first of three interpretive discourse analyses from the focus groups and review of the media advertising in this study. It specifically makes visible the discursive frameworks underpinning the political positioning of older adults in relation to privatized institutional living arrangement and discusses the key themes emerging from the data: political discourses of ageing and aged care, the "burden" of ageing and the expediency of the construction of age and, subsequently, the accommodation solutions for older adults. Next, establishing themes derived from the data that exemplify these concepts was initiated. Examples of such themes include the homogeneity proposition for aged adults within contemporary society, the political discourse of active ageing and the emergence of "experts" as advisors and touchstones for political discourses relative to ageing. Concluding this chapter is a discussion on the role of media in constructing older adults, as has emerged from this data.

5.2. Politics, Discourses, Media and Expediency

Language and images support the creation, definition and categorization of phenomena allowing cultures to mutually understand their shared knowledge and reality. When compared to previous generations, the constitution of modern 21st century reality is significantly shaped and molded through discourses of talk, text and (multi) media representation which in turn is inspired variously by political, commercial and financial interests (Fairclough, 1989). Indeed, whilst the use of words operates to shape our thinking in a stealth like manner (Coupland et al., 1991), the imaginative provocation and vigor of images can be argued to have a much more powerful impact on how we view our world (Carrigan & Szmigin, 1998; Fairclough & Wodak, 1997; Gee, 2014a; MacDonald, 2003; Machin, 2013). The compelling nature of images is evidenced in the picture (Figure 5)

below of an older woman with her mouth taped in Auckland's Belhaven aged care facility which shocked the country, raising into public awareness the notions of scandalous abuse in aged care (Johnston, 2008).

Figure 5. Woman gagged at Belhaven Rest Home, Auckland 2008

As discussed in previous chapters, CDA provides a valid framework to review the tangled network of power infused through communication from multimodal semiotic resources within the context of daily living (Chouliaraki & Fairclough, 1999; Gee, 2014a; Kress & van Leeuwen, 1996). Contemporary society experiences discourses through multiple sources such as newspapers, television, movies, advertising and magazines, all of which may be communicated through different genres to achieve differing kinds of communicative tasks (Carrigan & Szmigin, 1998; Kress, 2010a). These "tasks" of semiotic resources serve to construct, as well as to *be constructed* by, political and social practices; and it is from these sources that ageing and aged care discourses evolve within New Zealand society.

Use of the term "expedient" in this chapter title requires explanation by stating clearly what is intended to thematize through use of that particular word. The intent here is to scrutinize discourses from a political perspective in relation to privatized institutional forms of accommodation for older adults. Along with this, is the requirement to establish if the political agenda for ageing accommodation is a convenient solution to declining government funded provisions for the over 65 year old aged group. Van Dijk (1993b) proposed that the relationship between elite discourses of government, media and the "everyday" discourses that take place in our homes and communities is indeed a mutual one. This, in effect, suggests van Dijk (1993b), ensures that "political definitions of events and issues may in turn influence public debate and opinion formation through the news media and in turn influence and legitimate policies and

legislation thereby closing the full circle of influence" (p. 50). This influence is achieved through the expansive access to media in newspapers, advertising, television and increasingly, our access to media sources such as the internet and social media sites such as Facebook and Twitter (Fetzer & Weizman, 2006; Schaffner, 1996).

The data from this study shows contemporary economic discourse emanating from government policy for older adults impacts older individuals decreased economic security. Some individuals in this study, with lower socio-economic status, indicated difficulty accessing comprehensive, affordable housing and care options, and these individuals faced increased vulnerability to exploitation through commodification of age related housing. Media advertising supports this notion as is evidenced in the following advertisement Figure 6 below, which shows the aged care provider making a commercial pitch for "affordability" to older adults wishing to relocate into residential aged care.

Figure 6. Stillwater Gardens (Stillwater Gardens, 2012b)

Within the political discourse of ageing and aged care there is a "naturalizing" of understanding within the social world through the political shaping and construction of societal activities as can be seen evidenced in the media advertisement above (Figure 6). The evocative image of planting tomatoes provides a natural, normalized behaviour for many older middle class New Zealanders and, when linked to aged residential care, the above advertisement suggests this is a natural and normalized approach to older age.

Naturalization of communication within political discourse captures people's vision, values and views, successfully obscuring the situation and influencing people to subscribe to the view that

the way things are is simply common sense. In turn, this captivating and pervasive normalization of political messaging is, as suggested by Muralikrishnan (2011), difficult to resist on the basis of its common sense value; which then makes it difficult for individuals to question the dominant ideology. Applying the notion of political discursive narrative to the domain of ageing and aged care, it is possible to suggest that this is not presented as an outcome that might be questioned or challenged, but is merely accepted as simply *the way things are* within contemporary New Zealand society.

That there is a symbiotic relationship between politics and the media is the source of a significant body of research which suggests that political information, political beliefs and political opinions are transmitted and subsequently shape the reception of ideological values in the wider community or receiver audience (Borowski et al., 1997; Fairclough, 1998; Fetzer & Weizman, 2006; Schaffner & Bassnett, 2010). Mainstream media advertising appears less than interested in its key role in the constitutive establishment of perceptions related to ageism within the wider community. The subsequent formulation of life positions or stereotypical beliefs, associated with ageing and aged care in the media, provides a vehicle to perpetuate marginalization of older citizens; depicting them as frail, helpless or other negative stereotypes (Carrigan & Szmigin, 1998; Coupland et al., 1991) as illustrated in the following media advertisement (Figure 7, p. 112).

Retirement Living and Care at its Best!

Above: Resident Joyce and her two daughters Lynley (left) and Heather (right).

After 65 years in the family home we are extremely happy with Mum's new beginning and beautiful journey at Ernest Rutherford Retirement Village.

Joyce's daughter Heather:
"Mums attitude has changed towards life, her health is so much better and she now has so many wonderful reasons to get up each day."

Joyce's daughter Lynley:
"This is a new life for Mum without Dad, so it's a huge relief for the family knowing during the night someone is always around should she need a little extra assistance."

Joyce:
"I feel like I'm on a cruise ship without the seasickness! Having the marvellous staff around for a bit of assistance with shopping trips and outings I now have a bounce in my step again."

Joyce, Serviced Apartment Resident

Brand New Apartments

Available now are beautiful brand new Independent and Serviced Apartments. Our Independent Apartments are affordably priced from just $259,000* and Serviced Apartments, where a little extra assistance is always close at hand priced from $159,000*. Be in quick as only a few remain! Ask me about our friendly terms.

*Ongoing service fees apply.

Ernest Rutherford
RETIREMENT VILLAGE
A Ryman Village

For more information please phone
Debbie Edwards on 03 538 0882
49 Covent Drive, Stoke

Fetzer and Weizman (2006) suggested that in contrast to "rights and obligations of a ratified co-participant in an ordinary face to face interaction, a media discourse audience is not in a position to take part in the negotiation of meanings in a direct manner" (p. 144). There is also a suggestion that the move to more conversational approaches of the mass media, in recent years, has translated into high levels of resonance of political messaging with wider audiences; and this media supported communication acts to mediate these messages and create a pseudo-democratization of political discourse in the day to day lives of receivers (Fairclough, 1992 a). This conversational approach and informality is clearly evidenced in the dialogue contained within Figure 7 above.

Media create new ways of being in the contemporary world and, as noted by Scannell (1998):

If language is world-disclosing, we must attend to the world and the worlds it discloses. A mediatised world is not hyper-reality or indicative of an "external reality" (external to who or what we might ask?). It is a historically specific, specifically historical way of being for those who live in the world. (p. 263)

This "being in the world", as Scannell suggested, is reflected in contemporary political discourse with an increased reliance on media as the medium through which to promulgate appropriate messaging to the wider society in order to enhance and support political action and ideological positioning. Advertising similarly picks up on politicized messaging galvanizing this interdiscursively together in marketing strategies with an understanding of consumers' thoughts, feelings and behaviors, and then fitting these to consumption demand; as can be seen in the media advertisement below (Figure 8), which provides older adults with access to changing road rule information and captures them in this situation with advertising for their product (Arnould, Price, & Zinkhan, 2004; Carrigan & Szmigin, 1998).
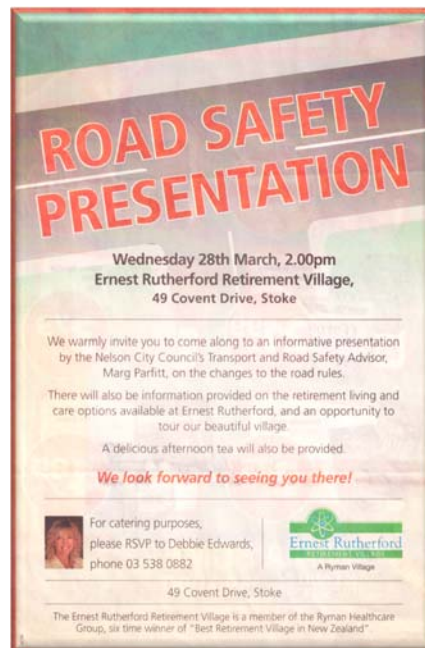
Figure 8. Ryman (Ryman, 2012b)

The political discourse of ageing and aged care results from particular actions and is in the service of particular interests. Evidence of this enacted, legitimated naturalization of residential aged care from conservative, right wing media advertising data, demonstrates that influence is possible by co-marketing core aspects of life targeted at older adults. In Figure 8, the advertisement shows co-marketing by a residential aged care provider of important life messaging – changes to the road rules. This duality of key political, legislative change to the road rules is used as a platform to engage older adults and their families in reviewing the offering of residential aged care to consumers who may not otherwise be accessed. This is clearly an example of what might, on the one hand, be perceived as a "service" to older adults or, on the other hand, it may be perceived as strategic consumer marketing of residential aged care.

The advertisement in Figure 9 below illustrates a "warm" and perceivably "caring" relationship between two European women - an older woman and a younger woman. In this way it is possible to suggest that there is a process of *normalizing* the relevance of these images to similar individuals who may identify with such a portrayal of older adulthood, including the promise of "the very best of care". It proposes "respite care" for families to ensure "your loved one" will be *minded* while family (presumably) are on "a break". The advertisement also suggests that the newer option of a "serviced apartment" is a realistic alternative to resthome care and that this can be subsidized (by Government) for respite care relief. It specifically talks of this being a "brand new"

apartment, leading one to assume that such an apartment is glistening with all bells and whistles; thus persuading the consumer of such service to enter into the "resort" type accommodation.

Figure 9. Ryman Health (Nelson Mail, September, 2011)

In an excerpt from an advertisement found in the New Zealand Automobile Association magazine *Directions* (Figure 10, p.115), Vision Senior Living use a testimonial from an older woman suggesting that older adults should "come in to care while you can enjoy it". Such a message is clearly signaling that older adulthood is a period where one may not, in due course, be able to enjoy life and that moving into a residential aged care facility is an appreciable outcome to take up whilst one can.

Figure 10. Vision Senior Living (Directions, 2011)

This advertisement also suggests a level of "fitness" associated with aged residential care; thus constructing ageing as a decremental process. It suggests aged residential care as inevitable and advises that older individuals must be proactive and embark on an aged residential care journey early to ensure they are able to "enjoy" this living arrangement. This statement privileges the

notion of "enjoyment" leaving unsaid the counter message that there is a potential for arrival in such facilities to occur at a time when one is less able to "enjoy" this arrangement presumably due to poor health or frailty. Notably there is also marketing pressure to act quickly which influences through the suggestion of acknowledging need now versus need that might occur after fitness level is lost. Whilst the epidemiological basis for increasing illness and disability is clearly evident for older people, in contrast, however, there is also evidence that there are many older adults who are disease and/or disability free (Borowski et al., 1997). The biomedical model of ageing is "sculptured perfectly for economic rationalism" where the images of death and disability cloak negative perceptions of older adults and illuminate the potential for increased cost burden for New Zealand going forward (Borowski et al., 1997, p. 60). As can be seen in the image of this advertisement, a potentially spritely, well presented older European woman is tending her garden in beautiful surroundings with quality housing behind her. This advertisement serves as a testimonial that life can be rich and rewarding in aged residential care, which the central character in the advertisement terms a "retirement home". Notable, she states in her testimonial that she believed it was "time" to enter a retirement home indicating that underpinning her decision to move into these living arrangements was a discourse of inevitability for older adults to progress into institutional living and that this time had now come for her.

This media advertisement also speaks to a collective understanding of "enjoyment" for older adults situating the contextual language to build an understanding of the notion of enjoyment within an aged care environment and providing key signals such as engaging "early" and ensuring a level of "fitness" in order to "enjoy" it. This media message implies that aged persons need to be able or capable to participate in the community of the aged care facility to attain "enjoyment" and that if poor health or decremental health status occurs this achievement of enjoyment may indeed be compromised.

The suggestion in the advertisement above (Figure 10 p.115) relating to compromised capacity or ability within the context of ageing is cleverly linked with an impending need for "care"; as is evident in another media advertisement (Figure 11) below, which suggests:

"Residents now have peace of mind knowing that total care is available under one umbrella"

Figure 11. Kensington Court (Kensington Court, 2012a)

This Kensington Court advertisement features three photos of European women in social situations; as a group perceptibly enjoying themselves either in some festive occasion, in the garden or, in the photo of a single woman, someone who appears to be happily gardening in the sunshine. All of these women look to be of middle class status presumably, and reasonably, fit or free of illness or frailty. This advertisement again evidences a continuation of the discourse of "care" as a requirement or inevitability associated with ageing. Gee (2011) proposed that it is important to understand the context of the message in written language and in particular the relationship of "reciprocity" where the use of language simultaneously *reflects reality* and then, in turn, *constructs* that reality in definite ways. This advertisement also contains the widely recognized idiom "*peace of mind"* to capture people's attention. Thus, if, as this discourse implies, there is a (somewhat constructed) worry about ability to access "care" required or associated with age and/or disability, seeking accommodation in such an institution will free an older individual of the worry of not having "care" available to them should they require it. Again, left unsaid, is an assumption of illness or decline associated with illness; although notably this advertisement does mention new hospital facilities which are purpose built, providing a contradiction to the visual imagery and casting a shadow over the portrayed vitality of the agents within the images.

5.3. The Political Discourse of Homogeneity

The creation and perpetuation of social stereotypes, and construction of the role of older adults within society, is influenced by public debate and public legitimation of the expectations for older individuals; as well as the degree to which society attributes social and moral meanings to ageing and aged care (Butler, 1969; Fealy et al., 2012; Iliffe & Manthorpe, 2012; Minkler, 1989). Positioning ageing or older adults as a homogeneous group, all descending slowly into decremental health status or dependency, "not only casts the dye in constructing older adult

characteristics but weights these characteristics with potential for social exclusion", including marginalization and socio-economic degradation (Wilinska & Cedersund, 2010, p. 335).

Assumptions on the cohort stability of the aged population (over 65 years) are based on the socially defined characteristics of chronological "age" as the determinant on which to base appropriate political decisions. Such an ideological stance supports the political discourse related to a contemporary apocalyptic demography with its associated impact on the economy and social services internationally (Coupland et al., 1991; Lassen & Moreira, 2014; McNeil & Hunter, 2014) and nationally (New Zealand Treasury, 2009; Statistics New Zealand, 2009a, 2009b; Treasury, 2012).

Coupland et al. (1991) suggested that there are multiple myths related to ageing which are based on stereotypical beliefs and which misrepresent normal ageing experiences and conditions in later life. An important factor in the imposition of arbitrary boundaries on older adults by society includes markers such as age bands, the retirement age which is the age of entitlement to universal superannuation (Carpinter, 2012) and access to lower cost services (e.g. heating, travel, local Council rates and so on) that are socially constructed by communities for particular purposes and ultimately subjectively interpreted by individuals (Coupland et al., 1991).

As an expedient for politics, the construction of a chronological age identity for older people supports policy decisions related to population predictions and the future or impending demand on health and social services (Bryant et al., 2004; Stephenson & Scobie, 2002a). Such predictions are frequently bound up in terminology such as critical fiscal "burden" and give rise to a constructed identity of dependency and images of ageing which do not specifically mirror the fundamental nature or quintessential experience of actual ageing (Ainsworth, 2007; Fealy et al., 2012; Patterson, Forbes, & Peace, 2009).

A common theme that emerged from the media advertising was imagery portraying middle class European women as potential candidates for entry into residential aged care (as can be seen in Figures 12-15 pp.118, 119, 120). As suggested by Bytheway (2011), the visual representations of older adults underpin the societal expectations of what might be expected at a particular age and, therefore, "direct the way we see age" (p. 86). Stereotyping of older adults validates the use of chronological age as a specific classification typology for a group of society; thus underpinning ageism and potentially strengthening distinctions between "optimal ageing, or the Third age, and

failed ageing, or the Fourth age" (Hurd-Clark, Bennett, & Liu, 2014, p. 27). In doing so, these images manifest the deeply held societal ideologies and stereotypes about ageing, gender and financial capacity of older middle class women but largely miss the diversity of this older population in terms of male representation or cultural mix (Hurd-Clark et al., 2014). Examples of European, middle class (perceivably) women's images in the media advertising from this study are collectively shown below in Figure 12. Below:

Figure 12. Metlifecare (Metlifecare, 2011)

Figure 13. Ryman (Nelson Mail, September 2011)

Figure 14. NZ Health Care (New Zealand Healthcare, 2012)

Figure 15. Ryman (Ryman, 2012c)

The social identity that is evoked from labels such as "old" or the discursive construction of age, is manifest as a declining ageing body whereby individuals become alienated, marginalized, congregated and managed into spaces like nursing and retirement facilities (Hugman, 1999). Such a discourse suggests, or assumes, that all older adults categorically age at the same rate in

a point to point correspondence with their chronological age and in some cases - age band (Bytheway, 2005b). In contrast to the notion of homogeneity of older adults, which may be the substrate for policy research, significant variability within and across the older adult (>65 year old) population is evident (Rowe & Kahn, 1987). When asking young people to imagine how their lives may subsequently turn out, Patterson et al. (2009) found that many of the young New Zealanders involved in their study drew upon images consistent with the "Positive Ageing Strategy" and indicated strong agentic orientation throughout their lives and into older age. Whilst public policy and political rhetoric continue to support the notion of homogeneity of the over 65s in New Zealand, focus group data evidenced the diversity of this cohort and the multitude of reasons they enter aged residential care:

Mrs E, a 66 year old woman with Type II diabetes indicated that whilst she seemed to manage this condition well she has restricted movement due to severe obesity. She talked about her severely dysfunctional family and specifically about one son who was demanding that she sign over her house to him as opposed to his five siblings. The constant bickering and demands for rights to property and being caught in the cross fire of this constant tension resulted in high stress for Mrs E and she subsequently decided, in agreement with her GP, to move into aged residential care.

This individual's drivers for entering into aged residential care emanated from a significantly dysfunctional family and disability status and a drive for a more peaceful life. In contrast, Mrs G a focus group participant in another residential aged care facility, evidenced somewhat different drivers for entering aged care, including an expectation that such a change in living arrangements was:

Something I never thought would happen.

At 89 years of age Mrs G's daughter had been diagnosed with cancer. Mrs G stated in the focus group interviews:

The one thing I could do for my daughter was to come into care so she did not have to worry about me.

Mrs G has led an active life to this point and continued visiting friends and family and enthusiastically engaging in local activities such as the local church fair and volunteer work. She willingly acknowledged her desire and need to remain as independent as possible. As a local member of Greypower she was aware of issues for older people and stated:

The thing you must not do is just sit here. I still go to the hairdresser even though it is a bit of an effort every week. (Mrs G)

This latter notion of maintaining her appearance indicated Mrs G's desire to retain a strong sense of personhood in ageing. Fundamental to this concept of personhood or selfhood is the notion of agency and the ability of individuals to exercise personal choice, to take decisions relative to their life; thus contributing significantly to the dignity and integrity of older adults' quality of life experience (Gilleard & Higgs, 2010a; Thompson, 1998). Arguably the older adult's outer physical appearance allows others to judge his or her age and this visual imagery of the physical appearance of older adults positions individuals as "outsiders" and supports judgment or categorization of them as senile, old fashioned or inferior (Bytheway, 2005b; Twigg, 2007). It also seems that physical appearance and self-presentation are key narratives individuals use to make sense of older adults' personal ageing experience and, as suggested by Featherstone and Hepworth, the perception of one's own body is mediated by judgments of others such as occurs in the ageist stereotyping of older adults (Featherstone & Hepworth, 2005).

Confirming this view, regarding personal agency and the older adult not relinquishing control over his or her body, Twigg suggested that maintaining hairstyling is an important signifier of competence and independence for older adults. Thus, hair and its management have a role in the ongoing constitution of age and age identity in the face of societal construction of older adults as "problematic" (Ainsworth & Hardy, 2004; Twigg, 2007). Whilst the visible diagnostic of ageing is in its identifiable characteristics, such as changes in body shape, muscle tone, skin texture and so on, not all people "look their age" and there is always a negotiation in the relativity of chronological time or age in years and age in appearance or age as subjectively experienced (Coupland, 2009).

Drawing from Foucault's work, it is possible to make the connection between the coupling of the aged or ageing body and the subsequent construction and problematisation of "old people" and then to link this to the societal marginalization and control of older people (Foucault, 1970). This tension of productive versus non-productive societal actors, such as the unemployed, the disabled and the older adults, can also be linked to the declining capability of countries to provide a welfare state and the political considerations inherent within this (Katz & Marshall, 2003).

Ordering of age into categorizations or age related "bands" both informs and anchors political decisions by articulating the life course or trajectory of ageing people (life expectancy) for the purposes of regulation by providing a "political voice" or rhetoric which captures and positions age outside of the autonomy or rights of individuals (Chouliaraki & Fairclough, 1999). In tandem with the creation of homogeneous groupings of older adults, political discourse couples power with knowledge (Lassen & Moreira, 2014) marginalizing aged individuals with a focus on morbidity, mortality and ensuing economic threat (Rowe & Kahn, 1987). Thus, the aggregation of disclosed chronological age is used widely to predict economic risk or pressure points, demand for support services, and enhanced health risk of older individuals (Coupland et al., 1991).

Census derived demographic data related to chronological age disclosures are represented in time interval tables ordering and sub-ordering age into various categorizations required for the passage of public policy involving financial considerations (taxes), social security (economic/benefit support) and more general functionalist controls (e.g. driving license limitations). This ordering and assigning of characteristics of age "bands" into discernible representations provides a platform for an almost perfect bureaucracy capable of enhancing capitalism based on its ability to produce calculability and predictability with regard to ageing (Lascoumes & Le Gales, 2007; Wilcock, 2007). In contrast, the effect of "normal" ageing has been found by researchers to be contradictory to the view of enhanced decrement; as noted by Hagberg et al. (1988) who found that older trained men had comparable hormonal and metabolic response rates to those of younger similarly trained men. In another cross sequential study, Schaie and Labouvie-Vief (1974) found that longitudinal comparisons of intellectual capability did not determine age related decrement but were mediated by rapidly changing cultural and technological changes when compared to younger cohorts.

Contemporary political discourse significantly impacts the social construction of target populations, such as the over 65 aged group, and has a powerful influence on policy agendas and the shaping of public policies related to older adults in New Zealand. Age, in relation to the total number of years lived, provides scope for differentiating adults and supports the contemporary classification of older adults into at least three numeric groups; namely those over 65 years - in toto; the ageless, agentic, participatory, consumerist old or Third age; and finally the old-old or Fourth age of dependent ageing beyond 85 years defined by decline and decrepitude (Coupland et al., 1991; Gilleard & Higgs, 2010b; Laslett, 1989). Some researchers have suggested that age

specific homogeneity or age specific identity has significantly changed since the late 20th century with the commodification and consumption of the post war consumer society leading to the third age emerging within contemporary western societies (Patterson et al., 2009). Ageing is clearly not only a biological progression but also socially determined within any given culture, and is impacted by the political, economic and social system in which the older adult finds themselves and the cultural beliefs and attitudes embedded within that culture (Gergen & Gergen, 2000; Patterson et al., 2009; Pierce & Timonen, 2010).

5.4. A Political Discourse of Healthy Ageing

Recent research indicates an evolving international and national policy discourse which seeks to promote the notion of healthy ageing as an enhanced means to politically manage ageing populations (Grant, 2008; O'Shea, 2006; Stephenson & Scobie, 2002b; Vincent, 2006). The emergence of an approach for enhanced lifestyles for older adults emanated from the World Health Organization, as early as the 1980s, and seeks to challenge the notion of ageing as a time of deterioration or decrement; focusing instead on the modifiable effects of lifestyle such as obesity, smoking and lack of exercise (Davey & Glasgow, 2006).

New Zealand produced its *Health of Older Person Strategy* in 2002; capturing the essence and spirit of enhanced or "positive" ageing and containing key objectives to support the achievement of full participation of older people in their health and wellbeing (Dyson, 2002). This *Health of Older Person Strategy* was one of a stable of reports related to "positive" ageing, including the *New Zealand Positive Ageing Strategy* (Dalziel, 2001a) and the report of the Prime Ministerial *Taskforce on Positive Ageing* (1997), all evolving from an increasing awareness of population ageing and the potential fiscal risk associated with this related to the ongoing role of the state and its accountability for older individuals (Davey & Glasgow, 2006).

With a policy goal of reducing dependence, and thus the potential drain on public funds or services (health and welfare), the political rhetoric regarding active ageing has emerged as a dominant discourse within the health and welfare sectors and all chief executive officers of Government agencies and organizations are required to adhere to and report on progress in the achievement of the *Positive Ageing Strategy Action Plan* (Ministry of Social Development, 2014). In a similar move, Australian social policy has a focus on promoting individual responsibility for

health in older age, encouraging smoking cessation and women to increase their calcium intake. This jurisdiction also promotes saving for old age rather than relying on state funding for welfare or tax funded social security (Borowski et al., 1997).

These key positive ageing documents and policies from the New Zealand government in the late 20th and early 21st centuries signaled a new emphasis on collective societal action to enhance older adults' lives, reduce dependency and value and promote self-reliance, independence and self-responsibility (Davey, 2002; Davey & Glasgow, 2006). The value proposition of "active ageing" is that for as long as possible, and *as much as possible*, individual older adults should, and must, maintain control over their own lives through increased activity and other healthful behaviours. As suggested by Locke (1996), however, most people are not motivated to actively exercise by the promise of a longer life or a better quality life. Rather, the majority of people will, in fact, ignore longer range goals; when for much of the 20th century ageing was deemed to be a time for relaxation, contemplation and passivity (Grant, 2008).

This political discourse and subsequent rhetoric related to active ageing has been picked up by private aged care providers in their marketing strategies aimed at linking product meaning (e.g. lifestyle choices and activities) to their brand for potential consumers of aged residential care (Arnould et al., 2004). The landscape of an ageing population is seen as a highly lucrative market, largely focused on increasing decrement rather than opportunity for active, agentic ageing. However, in recent times, useful marketing of enjoyable, collective activity is promoted and widely used in advertising by private residential care provider companies to socialize the values, norms and beliefs associated with consumers of residential aged care accommodation (Arnould et al., 2004).

Whilst dimensions of this "active ageing" policy discourse have been adopted commercially by providers of aged residential care, Grant (2008) suggested that significant numbers of the current older generations within New Zealand have no history of exercising merely for the sake of it alone. Thus, when portrayed in imagery of collective enjoyment for older adults in advertising, this will potentially resonate with elders who are alone, lonely or who wish to socialize within their own cohort (Grant, 2008).

As a policy based largely on segregation of older people, into a distinct cohort supported by assumptions of "older adults disengagement", active ageing has the potential to marginalize and

exclude those older individuals who have compromised health, disability, chronic conditions, who are financially compromised, emotionally compromised or socially excluded; since this socio-political discourse supports both a state of mental wellbeing and physical well-being (Hugman, 1999; Lassen & Moreira, 2014; Ranzijn, 2010; Scherger, Nazroo, & P., 2011; Wilcock, 2007). Once again, the assumed homogeneity of this over 65 year age group asserts a mainstream discourse with potential to demonstrate a "lack of fit" to large numbers of unique older people. Wilcock (2007) suggested that age is not chronological; indeed she stated, "I prefer to view people according to their felt age, to their action or doing age" (Wilcock, 2007, p. 16). It would appear that older individuals who may seek passivity or reflection past 65 years must now adopt a more capacity enhancing approach to their later lives, which includes such aspects as lifestyle planning and consumer engagement in sports and leisure activities, volunteer activity and active participation in community life in order to stave off poor health and dependency on the state (Boudiny, 2013). As noted by Giddens (1994), "Old age at sixty five years is a creation, pure and simple, of the welfare state" (p. 170), which negates individual difference and serves to obscure social differences and marginalize, even further, those who have (for whatever reason) limitations either physically or mentally.

In the media advertisement below (Figure 16, p. 127) for The Wood, an older male and female are seen in a pool, presumably having had or anticipating a swim. Both are European, both are visibly happy and smiling and appear at ease in their environment. Linkages in the text are to the accommodation available with reference to the hospital facility on campus in this facility. Yet, in contrast, both of the individuals in the picture look healthy and portray a level of fitness of sufficiency to be taking a swim.

In creating the political agenda for healthy ageing there is a clear recognition that whilst the source of such strategies may emanate from differing epistemological foundations, the direction of travel is confluent with the intended outcome for ageing individuals to accept responsibility for themselves and reduce functional decline; and thus fiscal and service burden of ageing on society (Davey & Glasgow, 2006; Stenner, McFarquhar, & Bowling, 2010). As already mentioned, this potential "burden", underpins political concerns related to the declining capability of countries, including New Zealand, to sustain welfare states internationally and nationally (Katz, 2000; Ranzijn, 2010). In her paper on active ageing Comfort (1979) stated:

The only thing that declines a little is speed of response; there is no change, normally, in intelligence and little in memory. Any blunting we do see in the absence of actual disease results not from age but from neglect, boredom and exasperation. (p. 92)

Positive aging in the leafy heart of Nelson

The Wood Retirement Village in central Nelson provides a happy, friendly, home-like environment with an emphasis on "positive aging".

All residents have access to the village's many facilities and recreational activities, and the choice of independent living in villas or serviced studios and apartments. Also available is a 34-bed rest home and 48-bed hospital wing; each unit has underfloor heating and the privacy of en-suite rooms, meaning there's a cosy option for everyone.

The hospital wing is delightful in presentation. It has three large

World Cup. A goldfish and budgie add to the homely feeling. Residents can indulge in a foot spa or manicure, or take a wheelchair walk with one of the friendly staff. There are always crafts, reading, games or baking activities during the day and happy hour on Thursdays. In summer there are barbecues in the courtyard extending out from the dining room with beautiful garden views.

There are vacant rooms at present, all with large en suites and well equipped with hoists, transfers aids and wheelchairs.

■ To view The Wood's high level

Figure 16. The Wood (The Leader, 2011)

From the above discussion, one might reasonably expect the nature of sustainable economic funding of ageing populations into the future now vigorously supports the notion of a healthy ageing discourse (Walker, 2009). The mediatization of this policy thrust has become increasingly embedded in everyday language and conversation through journalistic stylization (Chouliaraki & Fairclough, 1999). Evidencing this from the media data, within this research, an excerpt from Ryman Healthcare advertising espouses the value of healthy activities for older adults by stating:

Whether it be keeping fit with our Triple A exercise programme, taking a dip in our indoor heated pool or meeting a group for a bus trip - there's never a dull moment… (Ryman, 2012b).

Wide use of this notion of "activities" for older people feature in aged care media advertisers offerings demonstrating their uptake of this dominant political discourse from passive ageing to active ageing. Another example of this is found in the below media advertising from Wensley House (Figure 17) in Nelson which suggests aged individuals can gain:

...access to activities programme...
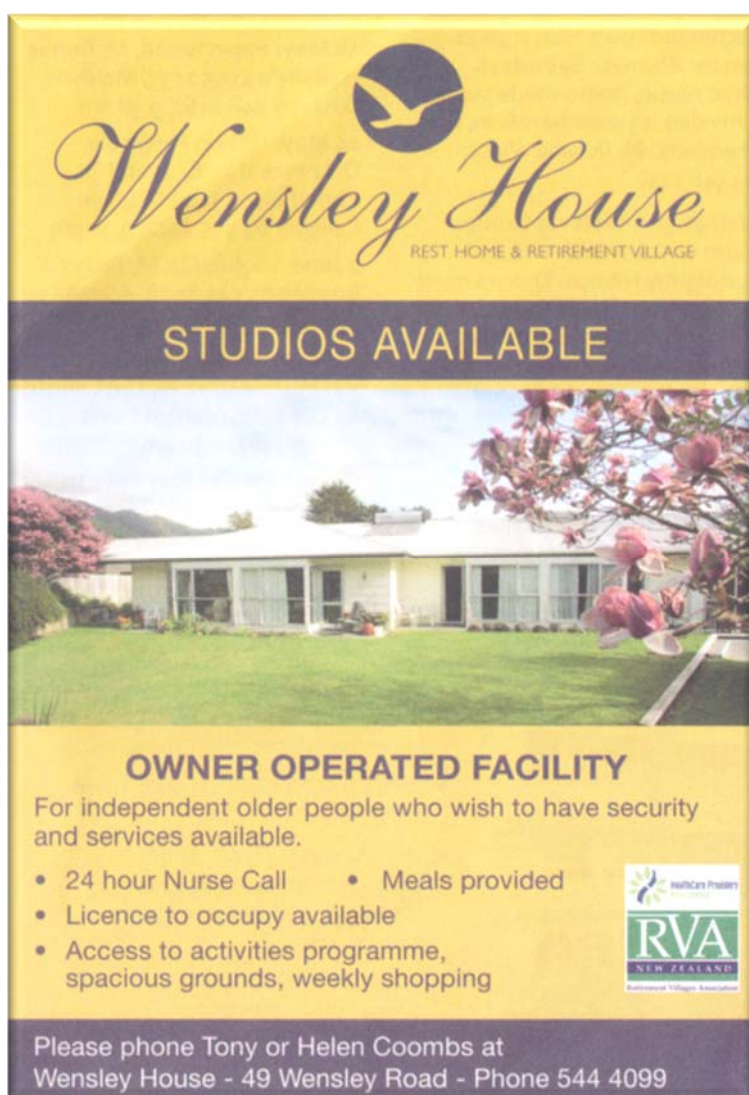
Figure 17. Wensley House (Mudcakes and Roses, 2012)

Yet another aged care provider, Oakwoods, suggests that:

Our residents have jolly good fun. Sometimes they'd get together for delicious morning teas, other times they'd meet up for drinks and dance around, (Oakwoods, 11 November 2011)

As can be seen from the images in the advertisement below (Figure 18, p. 129), gardens are portrayed as neutral, peaceful havens of tranquility; aligned with perceivably middle class European women enjoying a social discussion or interaction suggestive of a culturally constructed world of class, gender and age.

Figure 18. Oakwoods (November, 2011)

The text itself, in this advertisement (Figure 18), is representative of a fairy tale being told in child-like language to the reader, suggesting incompetence and dependence of older adults with potential to thwart the possibility of "competent" ageing of older adults (Coupland et al., 1991). Coupled with this almost baby-talk description of life in this facility are the colloquialisms "jolly good fun" and "a fine old time" intended presumably to resonate with older adults as reminiscent of previous times in their lives, perhaps their youth, when people did have such descriptors to indicate enjoyment and pleasurable activities. Such language and reference to drinking and dancing, however, may be seen to contradict or be at odds with the imagery provided of garden tranquility and older European women in an apparent day time conversation.

The expansion of an able-bodied and vigorous cohort of older adults leading active lifestyles provides a narrative that is dependent on internalization of ways of being "aged" that are grounded in what Foucault (1988) called "technologies of the self". Such technologies, suggested

Foucault, are the practices and beliefs that individuals apply to themselves, such as choices of lifestyles and the adoption of active living practices; thus constructing themselves as normative and ageless within a new narrative on successful ageing and thereby subjugating themselves to societal norms (Pylypa, 1998). This is clearly evidenced in Figure 19 below which makes mention of a new community center and portrays an older man under a caption enticingly suggesting that the older adult may write their own story within these surroundings.

Figure 19. Oakwoods (November, 2011)

Whilst it is possible to argue for the mutual benefit of "positive ageing", both to politicians and individual older adults, if older adults are to take up the potential life enhancing advantages of "active ageing" or "positive ageing" then the duality of this discourse, which advantages politics as well as individuals, needs to be promulgated widely and at early stages of life, as well as throughout older adulthood. Such an approach would ensure that those who have the most to gain from such a strategy are able to take this up and benefit their own lives through direct personal agency.

5.5. The Political Discourse of "Expert"

In the focus group discussions a theme that strongly emerged was the power of medicine to direct the ongoing living arrangements of older adults. Examples of this medicalized influence over older adults are as follows:

The last time I went to have an assessment by the doctor he said you need to think about going into care. (JB)

So I saw the geriatrician and he said yes we have assessed you and you need to go in to care. – (MS)

The decision was partly the DHB and partly family and by consensus this place was decided to be best. (JD)

The doctor said to my son, 'she will have to go in to care'. I said, 'no', but my son said 'well if they say you have to, then you have to go into care'. (ME)

Each of these examples highlights a medicalized ageing narrative of decline with its inherent power over older individual's lives and living arrangements. This narrative is embodied in medicine's highly colonized view of older age as being a time of frailty, failing bodies and subsequent decline. Such a narrative, within the contemporary medicalization of age, reinforces social prejudice regarding frailty, morbidity and mortality and the subsequent manipulation and control over older adults, their bodies, their life choices and, vicariously, at times, this is affected through families or supporters.

It appears that the dominant discourse of social regulation of the ageing body in contemporary western society emanates from the scientific knowledge underpinning medicine and results in conformity to discourses characterized in cultural norms and normality, as suggested in the concept of "biopower" put forward by Michel Foucault (1973, 1977). The force of biopower is its ability to draw on science and knowledge, such as medical knowledge, and to define clearly patterns of disease or dysfunction as alternative realities to normal function of the body; thus noting deviance from the norm. In turn, the science of medicine has been provided with an authority over the lives and bodies of individuals based on statistical information or research trials. Foucault (1972) also argued that power is dispersed throughout society, inherent in social relationships, entrenched in a network of practices, institutions and technologies and operates within the microcosm of everyday life.

The medical model (Engel, 1977), which consists of the set of procedures in which all medical doctors are trained, perceives the body as "fixable" and that individuals themselves have a cultural imperative to be "fixed" (Hurd-Clarke & Griffin, 2008). Biggs and Powell (2001) suggested dominant discourses in Western culture link physical deterioration with efforts to "control, supervise, and self-regulate the ageing body" (p. 3). This monitoring of, and intervention in, the perceived decline of the ageing body has resulted in the dominance of medicine and technology (Nolan et al., 2006). Foucault termed this dominance the "medical gaze", which has been cast into wider areas of social policy as evidenced in discourses, language and ways of seeing that persuasively shape societal understanding of ageing (Biggs & Powell, 2001).

Political debate on the future management of the population of ageing New Zealanders is supported by a medicalized view of ageing that suggests degeneration, infirmity and the subsequent "burden" of old age, and the likely impact of this burden on welfare requirements into the future (Bryant et al., 2004; Kedgely & Laban, 2010; Stephenson & Scobie, 2002b). Politicians are influential in their own right and, in turn, influenced via feedback from within their constituency by experts such as medicine, bureaucracies such as DHBs and Local Territorial Agencies (City Councils), and organizations such as private aged care providers. In democratic countries, such as New Zealand, politicians (and politics) determine public policy and in particular health and social welfare policy (Brunton, Jordan, & Fouche, 2008; Navarro et al., 2006). The mechanisms that determine health policy include ideologically driven fiscal considerations by the government regarding the sustainability of the welfare state, overall health spend, trade union strength, labour market policies and political tradition impacting health outcomes. In 2013/14, DHBs spent almost $1.6 billion on support services for older people – an increase of 40 percent compared to 2007/08 (Ministry of Health, 2013). Contemporary health policy considerations also take account of the potential threat to other sections of the population with enhanced numbers of older adults requiring welfare support or access to health services and the increasing costs of a medicalised notion of deterioration and decline (Biggs & Powell, 2001; Bryant et al., 2004).

As noted by Harrison and McDonald (2003) medicine operates effectively through a partnering arrangement with politics and is reliant on the ubiquitous legitimacy bestowed on it by the State, often as the funder of health activity across the national health space. The medical profession thus has significant legitimization and prestige through its scientific discourse, although the knowledge emanating from this discipline is not value free but represents specific conventions,

perspectives and motivations (Pylypa, 1998). Such legitimizing relationships serve to "manage" the resources for health care on behalf of the government of the day through public policy enacted by bureaucracies; for example, the Ministry of Health, the Health Quality and Safety Commission or PHARMAC.

Medicine, as a source of influence and legitimacy, is absent from all media advertising sourced for this study and is not referred to in any way in any of the advertising. Whilst initially this may seem a curious omission in the advertising material for aged residential care, review of the Medical Council of New Zealand Statement on Advertising (2010) is quite specific in its guidance to medical practitioners. This guidance indicates that it is necessary to ensure that medical advertising does not place undue pressure on people to use a service; must not unduly glamorize products and services and, finally, must not prey on the vulnerability of particular audiences. It may be that this statement is sufficient to ensure that medicine, as a discipline, is not engaged in visibly enhancing older adults' movement into aged care facilities but works through relationships at an individual level, as evidenced in the statements from the focus group participants at the commencement of this section.

Nursing services are mentioned in multiple media advertisements as can be seen in the examples below (Figure 20 and Figure 21, p. 134):

Figure 20. The Wood (The Leader, 2011

Figure 21. Kensington Court (Kensington Court, 2012b)

It is possible that professional nursing provided in aged residential care provides the legitimacy of expertise required to influence older adults that appropriate health care will be provided should this be required. Additionally, where necessary, these nursing health professionals will summon further expertise from medicine if required by an individual.

5.6. Media Support for Political Discourse

Media advertising, sourced for this study, portrays an archetypical model of aged individuals as variously healthy, white (European), female and middle class. This discourse constructs ageing within an aged care narrative as those individuals who reside in a specific place in a social hierarchy (middle class) and who variously fit other criteria or factors such as race (European), gender (female) and (potentially) economic status (middle class). This approach to marketing of aged residential care is driven to persuade consumers by aligning to their own held images of age appropriate activity (or desired states). Images and text rely on assumptions of the reader that "fill in" older adults' story, making inferences to their future state of what "might be" with the intention to create, transform and negotiate the frame of reference for the older adult (Gee, 2014a).

Images, in a similar manner to text, convey messages but go beyond this to create and reinforce social norms or "typical" ways of being for people. Thus, creation and portrayal of images and media create mental models that are based in the substrate of discursive narratives that frame older adults in a manner designed to capture their attention and influence and organize older aged consumers' values, thoughts and potential for residing in a residential care space, are effective mediums to enhance consumer uptake (Arnould et al., 2004; van Dijk, 1997). Gee (2011) argued that similar to text, images carry important and powerful messages relying on our "figured worlds" or stories and models of reality we carry and have been built up over our lifetime. When combined with graphic textual referencing or a mix of media images and text, these images exert powerful discursive frames of reference for individuals.

Politicians exercise significant power through their narrative and influence with the discursive construction and shaping of aged care as a "normal" life course for older citizens (Hugman, 1999). National rhetoric about the impending "grey tsunami" assert, problematize and marginalize older adults by popularizing concerns about the possible impact on national economics (Ministry of Health, 1999; Sonerson et al., 2005; Statistics New Zealand, 2002, 2009a, 2009b). This view,

that a political economy of ageing will represent a crisis fiscally in terms of welfare spending and reduced economic growth, has catalyzed what has been called a neo-liberal structural adjustment where older individuals have been perceived to be a burden or an *impending* burden on the national economy (Phillipson, 1991).

In contrast to the now common image of older age adults portrayed in media advertising of dependency, required protection and decrement, residing in aged residential care, most older adults continue to live in their own home, which is associated strongly with their identity and self-hood in undertaking their lives, decisions and routines of daily living (Hugman, 1999). Striking similarity to the emergence of workhouses to support the evolution of capitalism in the 1800s is clear in the emergent institutionalization of aged people as a pervasive discourse of modern society where the central value system of aged burden within society infuses and engulfs older adults and their families, the wider community and social services (Townsend, 1981).

5.7. Conclusion

The findings in this chapter indicate that in contemporary life people may experience difficultly discerning the fine line between recurring beliefs and ideologies of aged care and the construction and amplification of public concerns occurring in the language and media related to ageing and its impending societal burden. Over recent years the political construction of age has become imbued with the emotive and daunting reports of the (now) much anticipated burgeoning ageing of the population to inform reality, as discussed in Chapter 1 of this thesis. The discourses related to ageing in the New Zealand population and the subsequent use or uptake of aged residential care by older members of society is not important in terms of whether they are pure, in the sense of truth or lies or right or wrong, but rather whether they achieve importance in the minds and actions of the wider society.

Politically, the core of the looming fiscal crisis is a combination of inadequate revenues and projected healthcare spending, which are primarily driven by increasing health care costs due to technology advances and consumer demand *regardless of age*, not by population ageing (Binstock, George, Cutler, Hendricks, & Schulz, 2011). However, politically it is strategic to achieve cost burden relief through enhancement of consumer related ageing and to support of the rising "gray market" for consumer goods and services such as active retirement living. It is to this

we now turn to review the commodification of age and, in particular, the rise of age related residential care accommodation.

6. CHAPTER SIX – A SAFE PLACE TO BE: A SOCIAL DISCOURSE OF COMMODITY

It would be nice to travel if you knew where you were going and where you would live at the end or do we ever know, do we ever live where we live, we're always in other places, lost, like sheep.

Janet Frame, 1983 – The Day of the Sheep (Mercer, 1985)

6.1. Introduction

This chapter provides the second section of the findings from the focus groups and review of the media advertising in this study. It specifically sets out to make visible the discourse of commodification of older adults, in relation to their personal living arrangements, and highlights how the promise of safety is prominent in some of the advertisements. Its intent is to use the focus group and advertising data to expose the social construction of the older adult's identity within contemporary New Zealand society. Making visible this constructed identity enables an examination of the existence of, and implications from, embedded power relations, societal attitudes and social stereotyping within the specific context of older adults' ability to access resources, such as ongoing support, care and to meet their affiliation needs. I will look at themes derived from the data that exemplify these concepts such as the socially constructed discourse of commodity, ageism and the social identity of the older adult. I also intend to look at, the societal assumption of the inevitability of decrement for older adults and the horizontal differentiation and 'somatic turn' noted by Gilleard & Higgs (2013) of consumerism in third age older adults, as well as the commodification and choices for older adults living arrangements in contemporary New Zealand society. Concluding this chapter is comment on the role of advertising media in constructing older adults as a commodity, as has emerged from this data.

6.2. Social Discourse and Commodity

In Chapter 5 I reviewed the influence of political discourse on the life course of older adults in New Zealand and the impact of societal decisions taken within a the political narrative of ageing. Whilst political decisions in the early 1990s may have catalyzed the growth in the privatization of

the care and living arrangements of older adults, since that time, the "for profit" developers, supported by international banks and other foreign investors, have seen the potential financial gain from cohorting the aged into institutional living (Gilleard & Higgs, 2013; Hugman, 1999; Kedgely & Laban, 2010). Commodification is defined by Fairclough (1992 a) as "…the process whereby social domains and institutions, whose concern is not producing commodities in the narrower economic sense of goods for sale, come nevertheless to be organized and conceptualized in terms of commodity production, distribution and consumption" (p. 207).

Commodification of ageing may be seen as marginalizing through the processes of aggregating older people on the basis of a homogeneous view (of over 65 year olds) and alienating or problematizing age on the basis of deficit, disease, disability and decrement. This, then, is manifest in the embodiment and institutionalized responses to older adults' needs which segregate them on the basis of deficit and decline from the rest of the community. Such a view is supported across the landscape of ageing which, in turn, is supported by policy makers and professional practitioners, such as medicine and social work, within contemporary society (Bytheway, 2005b; Featherstone & Hepworth, 2005/2005; Patterson et al., 2009). Murray Hunter from the Independent Australia newspaper stated "Aged care has become *people farming* where a crop of people produce profits all year round for facility operators" (Hunter, 2014a, p. 6). The social construct of ageing and dependence within ageing, thus serve the "brave new world" of capitalism in relation to aged people by positioning older adults as a product for which services can be provided for commercial profit (Grant Thornton Report, 2010). The current uptake of the discourse of commercial commodity options for residential aged care in turn provides evidence that older individuals, their families and the wider society in New Zealand actively support the institutionalization of ageing people at one of the highest levels across the OECD (Kedgely & Laban, 2010).

Teun van Dijk captured the essence of discourse as social interaction by suggesting that it is a method of cognitively structuring and ordering our world (van Dijk, 2011d). In so structuring our world, discourse includes the social representations of speech, text and interaction, and also the process of producing and comprehending the discourse and accomplishing social acts. That social representations are constructed, acquired and modified through text and talk, is supported by Fairclough (1992 a) who suggested that "Discourse is a practice not just of representing the world, but of signifying the world, constituting and constructing the world in meaning" (p. 64). Thus

the underpinning content, structures and strategies constructing social representations of age and aged residential care are enacted through normalization which masks domination and control by political or social groups or organizations (van Dijk, 2011d).

Contained within residential aged care service offerings for older people are a range of provisions including housing, protection (safety), activities, housekeeping and the provision of support and "care" in the form of 24 hour nursing services or unregulated supervision. Marketers of aged residential care wrap all of this proposition up in persuasive language to link naturalized meanings related to ageing (including expectations or norms for ageing in New Zealand society) to product offerings as can be seen evidenced in the following media advertisement (Figure 22):

Figure 22. Ryman (Ryman, 2012c)

In this advertisement the two daughters attest to their mother's ability to access services should she require assistance. Meanwhile the mother "Joyce", herself, talks to the value of having staff around for assistance with shopping trips and outings. Heather (daughter) meanwhile talks to the very motivational aspect of this change of accommodation stating that her mother now has "so many wonderful reasons to get up each day". One can assume that this latter comment, by Joyce's daughter Heather, is naturalizing the ideological basis for power over Joyce (as older adult) to embark on a re-invigorated lifestyle within this new accommodation. What is assumed

here, or unsaid, is that perhaps Joyce suffered from loss, grief or depression – natural outcomes following the loss of her husband. In a case such as this, it is possible that concern by family members regarding their mother living alone at night, without anyone to take "care" or "protect" her, provides a strong rationale for their assurance that residential aged care and 24 hour monitoring is appropriate. One could also argue that if this were the case then the "burden" of an ageing sole parent would be relieved once in "care" of a residential aged care facility. It is interesting to look closely at the relationships portrayed in this advertisement which may be that of adult children assuming parental control over their mother to ensure their own "peace of mind". The institutionalization of their mother with the potential for care unable (or unwilling) to be provided by adult children removes the "burden" of care from the wider family and firmly places this in the hands of the private provider giving, presumably, an assurance of safety, protection and "management" of their mother's needs.

Messages contained in the texts of advertisements construct aged care through symbolic assertions that link signs and particular meanings together in relation to the person or persons, their life stage and emotional status including urgency to act or take up opportunities. Images and language or text then portray these meanings in a way that associates the desired state; for example, lifestyle with the target audience (Arnould et al., 2004). As can be seen in the following advertisement (Figure 23, p142.) persuasive messaging, tempered with a degree of urgency to come into residential care early, is portrayed as an imperative for happy healthy and active ageing. This advertisement also uses evocative language in terms of the "vibrant community", suggesting that the older adult may participate at perhaps a higher and more engaging level than they do currently. Similarly resident pursuit of the "things they love" manifests visually in older men playing pool, presumably since the other images contain chairs and a kitchen:

Figure 23. Metlifecare, Oakwoods (Oakwoods, 2012)

In the above advertisement (Figure 23) the two older European men pictured playing pool, presumably, suggests participation and activity in ageing. A key notion here is that of older adults taking personal accountability for their lifestyle in retirement and that this may be achieved by taking up the offer of a place within this residential care facility. This example indicates a discursive construction of aged identity through participation in a retirement landscape in which "lifestyle" rather than a service is "consumed" rather than "used". This image and the associated text (Figure 23) promotes an emphasis on leisure rather than dependency, with both males in the image presented presumably as fully functional older adults and not incapacitated in any way. Van Dijk (1997) suggested that the mental models evoked from such imagery taps in to socially shared schema or knowledge, attitudes and ideologies through the setting, place, circumstances, participants and actions portrayed. The smaller photos in Figure 23 do not specifically cohere with the text and contrast from it. Illustrative images of a homelike kitchen and lounge facilities conflate the relationship between independence and institutional living. Whilst this image may suggest domesticity, activity and independence, as noted by Hugman (1994) "life in residential aged care for older people continues to have similarities with prison or the poor-house" (p. 26).

In another example of advertising assumed to generate associative images or mental models from a marketing perspective is a media advertisement below that contains an image of someone

planting tomatoes (Figure 24). Gardening is widely acknowledged to be socially enjoyed by older adults and, in particular, many older New Zealanders have had the ability to plant and harvest vegetables such as tomatoes throughout their lives. Those older adults currently over 65 years may have experienced home growing of vegetables in particular during and post-World War II when perhaps many families grew vegetables to sustain themselves. Gardens in New Zealand have historically been a key source of household fruit and vegetables as well as providing a source of settlement and perceptions of "home" (Beattie, 2011). In the following advertisement from Stillwater Gardens (aged residential care provider), the link between safety, care and affordability are coupled with the visual image of planting tomatoes.

Figure 24. Stillwater Gardens (Stillwater Gardens, 2012a)

Whilst on the one hand, none of the single concepts contained in this advertisement of planting vegetables, safety, affordability and family values seems to stand out alone to link directly to aged residential care, the visual appears to intend to capture the attention of those older adults who have memories perhaps of enjoyment in gardening with this highly recognizable naturalistic image. Fairclough (1992 a) suggested that advertisers advantage their products or services through their visual imagery or "discourse technologies" making the connection between language, imagery and power by creating a world in which the potential consumer can inhabit or insert themselves into (p. 211). He also asserted that "coherence" of texts is critical to the signification and construct of social identities and social relationships and suggests that present-day commodity advertising mixes language and visual images where images are believed to have greater salience than text. Effectively advertisers utilize images as part of their marketing programme to ensure that images work to capture the attention of the consumer by publicly

presenting individuals or products and constructing identities or personalities for them. In so doing, advertisers of aged residential care create a point of commercial difference within the brand associated with their particular product or service. In this particular advertisement key words appear to relate to "safety" suggesting placement in this facility will ensure safety for the older adult; "affordability" signifies that as an older adult it is possible to afford to come to this facility; and finally "family values" which as a metaphor potentially signifies a promise of trust in the provider to take "care" and do no harm.

Once noticed by the reader (a potential consumer), the key text messages relating to safety and affordability followed by second level text messages of cost and family values (of the owner), act to capture the attention and influence the older individual. However, that said, the question remains how to link the relationships between planting tomatoes, safety, and affordability and family values? Using Gee's framework to analyze the above image and text it is possible to see the significance of the language and the visual image and to draw a parallel meaning between gardening or sowing tomatoes and safety (Gee, 2014a). It would seem that such an image may elucidate in an older adult yearnings from previous periods of life when independence and providing garden crops for family or friends were a normal part of life. Alternatively one may assume that sowing a new plant is (or can be) associated with transplanting oneself into a new environment and that from this one might grow and flourish.

Every gardener knows that if you tend to the soil well, dig it over and put compost on it and lovingly tend to your seedlings they will flourish and produce fruit. Here then is a possible link to concept of family values contained in the text of this advertisement; that is, we will care for you and nurture you and provide a safe place for you to grow surrounded by our environment which is instilled with "family" values. This advertisement thus potentially links key social values and traditions to influence the specific target audience of older adults within the wider community by capturing a highly recognizable activity and infusing it with key persuasive messages related to aged care.

6.3. Ageism and the Social Identity of the Aged Person

The dominant discourse of ageing traditionally constructs old age as a time of economic, social and physical decline (Biggs & Powell, 2001; Sneed & Krauss Whitbourne, 2005). Indeed the face

of ageing prevalent in contemporary western society may be seen as that of a set of discriminatory relations which set older adults apart and depicts them as a burden economically (Sonerson et al., 2005), as dependent and subjugated bodies (Hugman, 1999; Minichiello, Browne, & Kendig, 2000; Phillipson, 1991; Pylypa, 1998) and as a drain on societal health and welfare (Ryall, 2012; Stephenson & Scobie, 2002b).

Figure 25 (p. 146) of a media advertisement from Ryman Healthcare illustrates the increasing persuasion of older adults regarding the relative benefits of aged residential care. Specifically it frames aged residential care as resort style, congregated living, promising designer living spaces within manufactured and cultivated landscapes shaped to attract the niche market of the older adult. Picking up on Fairclough's work on commodification, these images purport to establish the organization (Ryman) as the provider of "best" care in a strategic discourse '*par excellence'* which notably, in the above advertisement, constructs older adults as requiring a "little extra assistance" (Fairclough, 1992 a, p. 210)*.* Utilizing the metaphor of *"peace of mind"* suggests older age is a worrisome time for older adults and/or their families and persuasively suggests that such moving into this type of accommodation can remove concerns related to home maintenance, laundry, transport and so on. This "luxury" lifestyle which emphasizes ultra-modern, high class interior design, bowling greens (as illustrated) and "stunning independent apartments" nevertheless congregates and segregates older adults on the basis of chronological age behind high walled areas controlling the lives of older people by staff of the organization (Hugman, 1999). The advertisement also utilizes persuasion in the form of the proposition that such offerings are "*proving to be immensely popular*". In turn, this statement normalizes the persuasion related to taking up aged residential care positioning it as "the ways things are" for many older adults and evoking in the simulation - the lifestyle within such a community.

Figure 25. Ryman (Ryman, 2011a)

Contemporary society utilizes discourse technologies (including advertising media) to provide "synthetic personalization" as a substitution for interpersonalised meaning based on the overall "strategic calculation of effect" which is to achieve the instrumental goals of the organization (Fairclough, 1992 a, p. 216). Again, it becomes easy for the older adult to vicariously insert themselves into this picture and to begin to inhabit the space offered by the advertiser (Ryman). It provides a notion of exclusivity and embodies a discursive construction of "appropriateness" powerfully persuading those older adults who have sufficient financial resources to make the choice to engage in such living arrangements.

This stereotyping or social narrative of older adulthood is clearly evident, nationally and internationally, in the literature on ageing (Borowski et al., 1997; Human Rights Commission, 2012; Kedgely & Laban, 2010; Lloyd-Sherlock, Barrientos, & Mase, 2012). Butler (1995) set about defining ageism as:

Ageism is defined as a process of systematic stereotyping and discrimination against people because they are old just as racism and sexism accomplish this for skin color and gender. Older people are categorized (sic) as senile, rigid in thought and manner, old fashioned in morality and skills. In medicine terms like "crock" and "vegetable" have been used. (p. 38)

Society uses chronological age as a marker throughout our lives. From early childhood chronological age sets the date of our enrolment in formal schooling (5 years), marks our years of schooling (e.g. Year 4 at school is approximately a 9 year old child) and is a key signifier through adolescence where rules and new obligations apply such as access to a driver's license (16 years) or participation in voting in national elections (18 years). Social norms based purely on age compete with other socially derived norms from key social institutions such as the family where privileges and duties are partly determined on age (Hendricks, 1995). Analogous processes are also found in occupational and public organizations where knowledge and experience is strongly linked to chronological age (Kanfer & Ackerman, 2004; Matthijs Bal, De Lange, Jansen, & ven Der Velde, 2008). In adulthood, questions are often asked socially related to chronological age and in medical or other "official" engagements; for example, pregnancy or other health related issues, in application for a passport or to engage in census data collection. Throughout adulthood we are also required to declare age through many other social rituals; for example, on-line in relation to clothing preferences or joining on-line sites, conversations with new acquaintances or joining clubs or other leisure activities (Nikander, 2009).

By positioning age as an immutable "social fact" individuals situate themselves along the spectrum of the life course and derive from this their normalized self-identity. Common expressions, such as "she is not acting her age", illustrate the importance of social expectation and age appropriate identity relative to the perceived age gradient and the social requirement for associated normative behaviour within a given society. Whilst the signification of adulthood is somewhat amorphous it has obvious social key markers such as young adult, middle aged adult or older adult. Reflecting on the social acceptance of age related markers Sneed (2005) provided a timely reminder of the work of Erikson (1963) in relation to the tasks of the human lifespan and achievement of happiness quoting Erikson's view that, "... the vital personality weathers (internal and external conflicts), re-emerging from each crisis with an inner unity, with an increase of good judgment, and an increased capacity 'to do well' Erikson (1963, p. 92).

Figure 26 (p. 148) highlights the portrayal of ageing well within a residential aged care environment with the "best of care". This narrative of ageing is embedded in stereotypes of older people which legitimizes social systems of status within society as illustrated in the happy, content nature portrayed in the women in the advertisement. It is possible to assume that this imagery portrays two European, middle class women, one of whom is presumably the resident of such a

care environment. As such, this image and text reflects the work of Cuddy, Norton and Fiske (2005) who found that the "pervasiveness of ageist stereotypes and widespread stereotypical beliefs in relation to older adults are resistant to change" (p. 279).

Figure 26. Ryman (Ryman, 2012d)

In contrast to the elegantly happy and contented picture of older age contained Figure 26 above, there is also a strong negative stereotype related to ageing (Sneed et al., (2005). This view suggests that the onerous task of the older adult is to adapt to changes in his or her body in the face of these negative stereotypes, which in turn presents complex intrapersonal challenges for sense of self and ensures that the underlying fear or dread of age and associated distaste for ageing within and across society remains (Sneed & Krauss Whitbourne, 2005). Self-identity of older people is strongly linked to their "home", to familiar objects as well as to community and family (Hugman, 1999). These aspects of life are key lynchpins in which self-hood is enacted. Entering aged residential care may present barriers or disruption to these signifiers of self as evidenced in the following focus group examples:

– *I miss all my neighbours - we had a really good group where I lived. (ME)*

– *Once they get you here though everyone kind of forgets you are alive. (ME)*

- *What gets me is that you go out and see something you like and think well I can't cook that when I get back anyway so there is no point. (PB)*

- *My motto now is - less is more which means exactly that - having the friendships that I had was the most valuable thing I had - I have to start over again here. (DC)*

Each of the examples, from the focus groups above, indicates a fracturing and fragmentation of former lives of older adults in their new lives in aged residential care. In the first two examples ME expresses the loss of neighborhood relationships which previously "gave her life". Inherent in these statements is a clear message of isolation from her former identity as an integral part of a local community. In the second example PB expresses her experience of limitation in going out and seeing food she would formerly have taken home to cook. This loss of her former independence to cook and eat as she chose previously resonates in the helplessness of her situation being unable to see the point of this previously enjoyed activity of cooking. Finally, in the third example, DC talks to her valuing of former friendships and the fact that she perceives she must start over to develop new ones. Each of the examples talks to new identities having to be created and the modification of individual life routines and enhanced dependency on others (e.g. staff of the facility). These examples evidence "management" of older bodies within the confines of certain types of spaces, such as residential aged care facilities, which congregate and segregate older adults based on chronological age and act to reinforce the social stereotyping of ageing in an "other than" or "less than" mainstream of adult life (Hugman, 1999).

6.4. The Parallel Commodification of Retained Youth for Older Adults

In contrast to, but in parallel with, the discourse of ageing as decrement there has also been a "somatic turn" in contemporary ageing relating specifically to the third age (Gilleard & Higgs, 2013). This new ageing modality is associated with enhancement of the ageing body and lifestyles through the new world order of anti-ageing consumerism which is related to new normative counter culture of able bodied, financially secure and educated aged individuals (Gilleard & Higgs, 2013; Hugman, 1999; Marshall & Rahman, 2014; Neugarten, 1974). This trend has seen a proliferation of services and products for older adults who seek physicality, good looks or eternal youth (Hurd-Clarke & Griffin, 2008). This oppositional discourse to decremental ageing constructs third age (over 65 years) identity and selfhood with a consumerist "lifestyle" which seeks to individualize older adults identity and push back the vestiges of the ageing body (Twigg

& Majima, 2014). Focus group interviews indicated that some older women continued to maintain a level of personal grooming to indicate control over their ageing processes:

– *I mean I still go to the hairdresser even though it is a bit of an effort and it is an effort because I have lost a lot of confidence. (NR)*

As a form of class and status distinction Katz (2013) drew on the work of Bourdieu (1984) who linked his notion of *habitus* with cultural capital and social structure to create "lifestyle" which he saw as a system of classified and classifying practices (Bourdieu, 1984, p. 171). In supporting this stance Katz (2013) suggested that the autonomy to select one's own lifestyle is in itself "part of an advantageous lifestyle but one that disguises its structural underpinnings and consumerist ethics", particularly in relation to the middle class (p. 4). Consequently Bourdieu's (1984) notion of lifestyle, when applied to ageing, reflects, generates and articulates distinctions between spaces of consumption, social habitus positions and individualized practices. This is particularly manifest in the consumption aspirations and achievements of post war 'baby boomer' generation as a distinctively different group from previous generations (Gilleard & Higgs, 2005).

This notion of "lifestyle" is picked up in the media advertising within this study as can be seen in the following advertisements (Figures 27, 28 and 29, pp.151, 152), which use the expression 'lifestyle' in a persuasive manner to attract potential consumers into a promise of an enlightened retirement:

Figure 27. Oakwoods (Oakwoods, 2012)

Figure 28. The Wood (The Wood, 2011)

In the first of these three advertisements (Figure 27, p.151) the text talks to "freedom" of the individual to pursue the things he or she really loves. Associated with this, the two males in the visual show a particular form of male (gendered) leisure activity which one might say is suggestive of modestly active pastime conducive to comradeship and relaxation. The second advertisement (Figure 28, p151) appears to contain mixed messaging in terms of 'lifestyle' in that they also feature text which talks to "hospital level" care. This is suggestive of a decremental inevitability or trajectory for older age but is coupled with alternatives for third age individuals who are independent enough to "walk to parks, shops and cafes". The third advertisement (Figure 29) portrays a vivid textual story regarding the beauty of the gardens and the homelike (cuppa with friends) environment on offer within this facility. It also talks to wonderful amenities for older adults supporting choice of a relaxed or busy lifestyle in a "safe" and welcoming community with extra assistance should this be required. This latter statement is suggestive of frailty and the need for oversight for older adults is embedded within the text.

There is a claim that the reconstitution of ageing related to the 'baby boomer' generation, in particular, is now prevalent amongst the people of the third age (i.e. the 'young old' –over 65 year olds) as distinct from the old-old or fourth age of man as suggested by Neugarten (1974). This shift toward reconstituting ageing in the late 20th century has supported the materialization of a

generational style directly attributable to the baby boomer generation who have variously been termed a "special" or pioneering generation (Biggs, Phillipson, Leach, & Money, 2007) or alternatively as a hedonistic, individualistic generation (Willetts, 2010). Supporting this latter suggestion, in their study of the concept of celebrity ageing, Marshall & Rahman (2014) found that in the contemporary consumerist culture of the third age 'baby boomers' this alternative discourse of ageing is experienced in terms of fitness, flexibility, function and being fashionable. Thus this new "somatic turn" suggested in contemporary ageing is supported by advertising imagery and the desire to sustain youth long into adulthood and in particular within the third age (Gilleard & Higgs, 2013, p. 28).

6.5. Commodification of Ageing and the "Target" Market

In the cultural shift toward consumerism for older adults, and the associated marketing of institutional living arrangements undertaken through advertising, a key question requires answering - who is the target market? In his discussion on the commodification of education in the United Kingdom, Fairclough (1992 a) talked to the importance of discerning who is the audience for advertising discourse and what is the product. Using Fairclough's example, within the educational environment, it is possible to propose the same question and ask what the commodity of ageing is and who is the target audience? The significant themes emerging from the media advertising in this study are those of "care", "safety", "lifestyle" and "resort" or "home" style living. Such expressions are in keeping with what Hugman (1999) essentially suggested is "the social structuring of age" in such a manner as to stigmatize, separate, isolate and marginalize older adults in communities based on chronological age providing perceived services to consumers of recipients of care in space and time controlled by others (p. 202).

The discourse associated with care of older people is an important one. Who will care? What is care and for whom will "care" be provided and at what cost? The following advertisements (Figures 30-33, pp.154-155) from the media collected for this study provide some examples of the concept of care, care providers and recipients of care and the spaces in which care will be provided to older adults.

Figure 30. Ryman (Ryman, 2012a)

Figure 31. The Wood (The Wood, 2012)

Figure 32. Metlifecare Oakwoods (Metlifecare Oakwoods, 2011)

Figure 33. Kensington Court (Kensington Court, 2012b)

Each of the above advertisements (Figures 30-33, pp. 154-155) use the term 'care' as a key expression within their material and this may, therefore, be seen as a signifier of the discourse of ageing. The implication of this signifier is clear; older adults with varying degrees of independence are commodities who require professional assistance and oversight in their daily lives. Whether commodifying older adults as recipients of care in rest home, hospital or independent living, each of the above media advertisements suggest assistance at any and all of the various stages along a trajectory of chronological decline. In Figure 30 (p. 154), Ryman suggested that if "either you **or your family"** are considering care "options" then they will be of assistance and link this to a talk about managing personal affairs with Enduring Power of Attorney. This link to the legislative requirements for settling older adult's affairs acts to *hook* older adults or their families to recognise ageing is a time for managing one's affairs and to exert control over this by putting their affairs in order. Part of putting affairs in order, associated with the messaging in this advertisement, may

also deemed to be reviewing the offerings associated with Ryman aged residential care. There is clearly a level of ambiguity regarding who the consumer or customer is in the above advertisements. Is it the older adult individually or as, suggested by Ryman in Figure 30 (p. 154), the family of the older adult who is the targeted consumer of these media advertisements? On the one hand this advertisement appears to construct the older adult as the active recipient of the persuasive messaging but on the other hand it eclectically talks to the family of older adults who may be concerned and require "care" for their relative in the future.

In contrast "lifestyle", as portrayed by The Wood in Figure 31 (p. 154), is a mix of *hospital care* with 24 hour oversight by nurses juxtaposed with warm, quality home living from which an older adult could potentially walk to town. Meanwhile in Figure 32 (p. 155) the advertiser (Metlifecare*)* commodifies the transitions an older person might require by suggesting that this is a "one stop shop" with everything an older person might require "at the doorstep" and "care" at the push of a button. In Figure 33 (p.155) the advertiser (Kensington Court) suggests that they are "more than just a rest home and hospital - **they care about people***"* which would seem to be something of an oxymoron or contradiction in terms of a statement made by an "aged **care**" provider

We turn now to the data from the focus group sessions regarding their awareness of media advertising related to aged care living. Data indicates a low level of awareness regarding residential aged care advertising.-

I didn't have a choice - they just brought me here out of the hospital because I couldn't go home and I have never been home again, and that's where I've been ever since. (JH)

I didn't have time to read any advertising; I was just told I was coming here. (ME)

My daughter rang some of them. My daughter knew I was interested in going to Kensington Court because I knew some people there who I used to visit there. But when I needed a bed they didn't have one. (PB)

A strong theme emerging from the focus groups is that media advertising did not impact older adults specifically in terms of choice of the residential aged care where they would personally prefer to reside long term. Rather, it was family members who appear to be largely influenced by the media advertisements and who often took the lead in the decision on ultimate institution for their parent/loved one; albeit at times with differing degrees of input from the individual older adult concerned. For those who expressed a particular preference in a specific aged care provider or

facility, when the time came to enter such a facility, availability of beds typically presented as an issue for entry.

In summary, the daily lives of older adults are cataclysmically changed by entering residential aged care at a time of considerable vulnerability. Focus group participants in this study indicated that they had somewhat limited choice regarding their ongoing accommodation needs and where they were consulted, this was often cursory rather than meaningful participation in the decision making process. Superficially, older adults appear positioned to have capability to choose their lifestyle and their future living arrangements but the powerful discourse of "appropriate ageing solutions" for monitoring and caring for older adults is pervasive as well as persuasive. Fairclough (1992 a) stated that "Under the influence of advertising as a prestigious model, the blending of information and persuasion is becoming naturalized" (p. 214). This assertion has a high degree of resonance in relation to the discourse of aged residential care living within New Zealand at this time.

Residential aged care, despite its best efforts at masking institutionalization through designer structures, independent apartments and leisure activities, continues to contain many of the factors that mark institutional living. Key aspects of life which would normally enact individual identity such as to privacy are contradicted; for example, by being perceived as "*being in a home"*, congregating with others of similar chronological age, dependence on others for meals, or other "normal" household or activities of daily living. These aspects of older adults lives, coupled with segregation, make a "powerful" statement that people in this environment are ***different*** (Hugman, 1999).

6.6. Conclusion

The source of the commodification of older adults into aged residential care facilities in New Zealand is a financial one - effectively pushing costs of care back to individuals who have convertible assets and are then capable of using these to provide institutional care for themselves. Specifically talking to the Australian situation, Gibson (1998) asserted that the cause underpinning the commercialisation of aged care living arrangements is directly related to financial incentives in the private for profit market and a lack of adequately enabled community

care services. However, families' play an important role in the lives of older people and it is this that is now examined; particularly the impact of family on older people's living arrangements.

7. CHAPTER SEVEN – THE CARING FAMILY: A SOCIO-LINGUISTIC DISCOURSE OF CONTROL

Other things may change us, but we start and end with the family.

Anthony Brandt (Pryor, 2009)

7.1. Introduction

The title of this chapter captures the three interconnected themes that develop from the media and focus group data; namely family discourse, control, and the intrinsic power of words and language in social practices. McGregor (2004) asserted the value of analyzing the written or spoken word in order to uncover how power, inequality and dominance are evident in family dialogue. Given the power exerted by the spoken or written word Luke (1997b) also provided a timely reminder of the need for CDA to uncover, describe, critique and analyze the ways that social life is portrayed in text in order to identify sources of dominance and power.

Language and text are elemental to social practices of life in the modern world. But while social interaction, social relations and practices are based on language and spoken and written texts these form only one part of critical discourse analysis. Sometimes overlooked is the factor of language and text *production* and the process that this production forms as part of the interaction of discourse within social practices. Another significant component of discourse processes as noted by Fairclough (1989) includes the interpretation and understood meaning of texts (written or spoken). To gain clarity of the impact of interpretation and understood meaning of texts from within which it is possible to gain understanding of power and influence at work.

Family discourse is of particular interest because families are often viewed as a microcosm of society as a whole. Such a microcosm provides the opportunity to gain understanding about what discourses are influential in communications within the family and the influence of family in decisions regarding entry into residential aged care.

Family discourse includes any written or spoken communication between family members. Each family unit has its own unique standards and methods of communication and also adopts its own

interpretation of wider social discourses. These factors contribute to the fascination of critical discursive structures and their specific meanings within families. Discourses present in families include everything from basic instructions to discussions about planned family activities or what family members have done or intend to do. It can also include discourses which identify what family members want to do or desire to do as well as information about politics, philosophies and conflicts Thus the term 'socio-linguistic' as I am using it in this chapter, refers to the effects of social language on the family and in turn the ways that the older adult can be influenced in their decision making by the language forms used within the family.

Family discourse is widely portrayed as a major source of caring in the lives of young and old (Dykstra & Hagestad, 2007; Ingersoll-Dayton, Starrels, & Dowler, 1996; Pickard, Wittenberg, Comans-Herrera, Kind, & Malley, 2007; Stein et al., 1998). What is not so widely noted, or acknowledged, is the manner in which that same discourse exerts powerful control over family members in ways that shape, and at different moments, marginalize or assign privilege to the needs of other family members (Finch & Mason, 1990; Gans & Silverstein, 2006).

7.2. Avoidance of Being a Burden

People's lives begin and, for many, end, within the context of family. Family provide the framework for early growth and development, for learning the nuances of societal structure and function within a given culture (McKie & Cunningham-Burley, 2005). Typically, family provide the tangible connections for our emotional support and independence (Bradley, Whiting, Hendricks, & Wheat, 2010; Brett, Humphreys, Fleming, Kraemer, & Drury, 2015). Family are also acknowledged for providing the very backbone (Utrata, 2013) or substance of society in whatever contemporary form the modern family may take; for example, a single parent family, two parent family, same sex parents, inter-generational family or other arrangements of these groupings (Nagel, 2007). Indeed, family represents the stage on which many lives are played out. On this stage it could be reasonably suggested that, for most families, it is the parents as the older, wiser figures who are responsible for making decisions about family matters; and doing so, in ways that honor and give priority to their own interests and needs (Stuifbergen, Ven Delden, & Dykstra, 2008). Decisions about residential living arrangements in the later stages of life would generally be seen as needing to be made on the basis of reflecting on a variety of factors.

Potential factors that give shape to decisions regarding consideration of future accommodation needs for older adults may include general health and wellbeing, mobility, social connections, community involvements, attachments to the family home and possessions, geographical proximity of family and capacity of family to support and assist the older adult (Bookman & Kimbrel, 2011; Johnson & Bibbo, 2014; Shenk, Kuwahara, & Zablotsky, 2004). It could also reasonably be expected that family members' opinions or situations might be one of many factors taken into account in critical decisions such as those related to older adults' living arrangements. The data gathered from the focus groups presented a surprising and somewhat unexpected picture. The 'caring family' at times seemed to influence decisions that served the needs of adult children rather than the older parents (Finch & Mason, 1990; Gans & Silverstein, 2006).

The family discourse clearly played a large, and in some cases, exclusive role in directing the decision to enter residential care for some of the participants in the focus groups. Power and control surfaced overtly and was tangibly evident in the language used by participant "M". She talked of her anguish at being in an aged residential care facility following a fall at her home which had required hospitalization. "M" said that her arrival in the facility occurred in the following way:

I am here because my son won the argument. I was living in my own flat in Stoke and getting along fine. I had a girl come in once a week and do the heavy work and that was great. Then one morning I had a fall and I hit the tallboy with my hip and my ribs. The long and the short of it was that the doctor came and said to my son, "She will have to go into care". I said "no I am not going into care" and my son said "Well I am afraid you will have to and if they say you have to then you have to". He has a lovely home my son with his wife and she is a darling and he said "Look Mum we both work and we can't take time off to care for you". So he beat me in the argument you see...(M)

The statement 'he beat me in the argument' powerfully illustrates the power and control conveyed in words that direct the mother's decision. In spite of the mother arguing against the decision, the combined rhetoric of the doctor and her son won out.

I said "no I am not going into care" and my son said, "well I am afraid you will have to and if they say you have to then you have to" (M)

'They' as used in this instance, was referring to, and drawing from, the discursive authority of the medical profession represented by the doctor's opinion. Medical discourse here is covertly presented as an authority that is not to be questioned or challenged (Clarke, 1991; Phillipson, 1991). The son's closing words made it clear there was no possibility of the mother not going into care:

Look Mum we both work and we can't take time off to care for you.

Here the practical realities of the need for employment and being unable to take time off to care for the mother added a persuasive logic that was hard for "M" to challenge. A discourse of control is clearly at work fueled by reason, logic and the full weight of medical discourse. Finch et al. (1990) suggested that the normative nature of filial obligations clearly have limits when competing obligations, such as those related to children or career responsibilities, are weighted in considerations by adult children of older adult parents.

7.3. Family Conflict Fuels the Need to Escape

From another aged care facility focus group, "H" spoke of her family conflicts that had directly led her into aged residential care. The friction and conflict in her family stemmed from one particular son as she explained:

It doesn't sound very nice to say but he would have me under the ground now if he could. I have been having an awful lot of problems with him and I felt like I was being pulled from pillar to post. And that daughter of mine - well she doesn't know which way to go to sort it out. He's been locking her out of the house so she can't get in and then accusing her of pinching this and that. There is so much friction going on that I just got so tired of it and then I started having panic attacks in the middle of the night and the ambulance would have to come. He wanted the house signed over to him and all as well...

This scenario illustrates how the older mother was caught in the middle of what sounds like difficult family dynamics; moving into residential care was fitting in with her son's desire to own the family home. "H's" family unit had, by her own admission, been "dysfunctional with low levels of cohesion" for some time and this has been escalating since the death of her husband some years before. Lieberman and Fisher (1999) found that the characteristics of family relations significantly impact family decisions to institutionalize an older adult early or late along the spectrum of illness or frailty. A cohesive collective family unit, with a strong family identity and emphasis on strong kinship, has a tendency to wrap closely around an older adult and provide caregiver assistance whilst individualistic families minimize care giving and rely on societal supports. Formal care provision or "institutionalization" would likely resonate with family members such as "H's" where individuals sought to optimize their own journey. In particular, one son had effectively marginalized "H" who then had to resort to formal care options in order to retain a substantive identity and sense of peace or balance.

7.4. Persuasive Manipulation

The focus group data and media advertising illustrated the importance of family in decision making in relation to entry of an older adult into aged residential care. The media advertising below utilizes testimony from two daughters pictured with their mother and talks to the more settled "attitude towards life" being experienced by their mother following a change in her living arrangements. The rhetoric use is both powerful and persuasive in activating inferences underpinning the discourse of aged residential care living such as dependency, management or control of older adults' attitude and their health or adjustment to living as an older person.

The framing used in this endorsement from one daughter as follows:

'We are extremely happy with Mum's new beginning and beautiful journey at….'

This excerpt from the media advertising (Figure 34, p164.) portrays the move out of a family home (after living there for 65 years) in a highly positive light. This is immediately reinforced with assertions about the older mother's changed attitude, better health, and enhanced reasons to get up each day. The implications contained in this media text signal that all these good things cannot or did not exist in the family home in recent times; perhaps since the death of her husband as mentioned by her daughter. Shenk et al. (2004) suggested that for some older adults, death of a spouse is a catalyst for relocation to alternative living arrangements whereby if the older person is intending to move they do this within the first 12 months following death of a spouse. However, the probability of moving from the former home or living situation becomes less likely over time unless an illness incident occurs necessitating this (Willcocks et al., 1987).

The language used in the advertisement in Figure 34 (p. 164) overtly highlights reasons and logic that would be hard to argue against rationally for the mother's movement into aged residential care. The language used also works to manipulate and influence the reader into making referential associations between the living arrangements and achievement of a better life (van Dijk, 2004). Perhaps it is the daughter's comment which tells the real story…

It's a huge relief for the family knowing during the night someone's always around should she need a little extra assistance.

Relief for the family could well be the driving agenda rather than what the mother might really desire, prefer or want. Indeed the responsibility of filial care for older parents weighs heavily on some family members creating a paradox which challenges assumptions regarding the role and function of children and parents and the normative nature of care and affection when vulnerability is present (Connidis & McMullen, 2002).

Retirement Living and Care at its Best!

Joyce:
"I feel like I'm on a cruise ship without the seasickness! Having the marvellous staff around for a bit of assistance with shopping trips and outings I now have a bounce in my step again."

Joyce, Serviced Apartment Resident

Brand New Apartments

Available now are beautiful brand new Independent and Serviced Apartments. Our Independent Apartments are affordably priced from just $259,000* and Serviced Apartments, where a little extra assistance is always close at hand priced from $159,000*. Be in quick as only a few remain! Ask me about our friendly terms.

Ongoing service fees apply.

Ernest Rutherford
RETIREMENT VILLAGE
A Ryman Village

**For more information please phone
Debbie Edwards on 03 538 0882**
49 Covent Drive, Stoke

Above: Resident Joyce and her two daughters Lynley (left) and Heather (right).

After 65 years in the family home we are extremely happy with Mum's new beginning and beautiful journey at Ernest Rutherford Retirement Village.

Joyce's daughter Heather:
"Mums attitude has changed towards life, her health is so much better and she now has so many wonderful reasons to get up each day."

Joyce's daughter Lynley:
"This is a new life for Mum without Dad, so it's a huge relief for the family knowing during the night someone is always around should she need a little extra assistance."

Figure 34. Ernest Rutherford Advertisement, Mudcakes & Roses, (2012)

Persuasively, this advertisement has the mother describe her new life "like being on a cruise ship" whereby the mental model created would no doubt tempt or persuade those who imagine the luxurious nature of such a life. A mental model of holiday or resort style living may be appealing to older adults considering changing their living arrangements. However, unlike a holiday destination, this picture is not transitory but a more permanent shift into institutional living which is not obvious in the advertisement. The permanence requires compliance with mealtimes, house rules, and initiates sharing with strangers versus her former home which may be a core element of her identity and connection to the preserved memories of her life (Shenk et al., 2004).

The visual images of the three women, smiling and happy against a backdrop of garden, sun shining and home-like surroundings, portrays a picture of a socially satisfied family and warm, caring relationships as evidenced with one daughter's arm resting on her mother's shoulder. This

visual image frames up a mental model of a happy family satisfied with the new living arrangements for the individual who is the mother and for the two daughters. Unsaid is the relief of burden of care given by the daughters and the entrusting of care of the mother (herself) and the daughters to a corporate body. Thus the "promise" of care is made.

7.5. The Rhetoric of Deception

For families of older adults, concerns about their ageing parents increase exponentially as they become increasingly frail or experience illness episodes (Lieberman & Fisher, 1999). Offering potential solutions to such concerns of increasing frailty, advertising and media visuals of happy and perceivably healthy older adults evidence the complex interplay between text and images to influence and enhance the "constructed" connection between living arrangements, dependency, frailty and care (Carney, 2010). This portrayal of alignment between older adults enacts a similar or constituent identity between the frail parent and other older adults and draws families in to enhance *their* decision making or to directly influence older adults in relation to peace of mind attainable within institutionalized residential aged care facilities for themselves, or in the case of families, for their older parent (Gee, 2014a, 2014b).

An example of this subject position alignment from the media advertising is contained in the following advertisement, Figure 35 (p. 166), which diffusely structures ageing discourse around the word "warm". Fairclough (1989) suggested that mass media and advertising typically mask the effect of power relations taking a very singular approach to positioning the reader as the ideal consumer. In using the word "warm", three times in this advertisement, it powerfully draws individual older adults or their families in by portraying the *physical* "why not be warm this winter/warm serviced apartment"; *social* "warm welcome" and *emotional* aspects of the aged care facility "…be warm this winter and join our friendly ...community" ensuring connectiveness of this advert to a desired or desirable state for older adults.

Figure 35. Ernest Rutherford, The Nelson Mail (2011)

It is possible that a fourth dimension should be considered as well with the use of the word "warmth" and this relates specifically to the marginalization or exclusion of older people to resources such as money to pay for ongoing home heating (Zaidi, 2012). Lack of financial resources, such as occurs when an individual has an asset in a family home requiring heating but low cash resources, and triggers deprivation where an older person may be unable to maintain their living essentials including expensive electricity or heating costs. Thus the attraction and power of the word "warmth" may catalyze in an older person a desire to change his or her living arrangements and consider aged residential care options.

It seems that this advertisement intends to create and align to societally normative mental models which would enable the individual older person to imagine themselves in an enveloping environment that may reproduce the "family" through community engagement, and to which the actual family might entrust their loved one for care. Thus this advert will enable the individual subject position of an older adult to be influenced by family members who, in turn, are influenced by the constructed discourse of dependency (Fairclough, 1989).

In one of the focus groups, "P" recalled the control exerted by her daughter on the decision to enter aged residential care:

You see my daughter wanted me to go in. She was determined that I was going into care for the past two years. She kept saying to me if you go in now and get yourself organized then when you do have to be there you will be OK. I told her that it doesn't work that way but she couldn't see it. I went into hospital after a fall and then she arranged for me to come here... I haven't been back home since I came here and then my daughter told me Mum we have got rid of all your stuff ...

In this situation the power and control of the daughter over the mother is intense. Determined to locate her mother into aged care, for some considerable time, and awaiting an opportunity as occurred with a hospitalization for a fall, this daughter "managed" her mother's pathway into care. Potentially well intentioned, as evidenced in the statement "if you go in now and get yourself organized then when you have to be there you will be OK", demonstrates a rational argument which the mother was unable to counter. Push back from "P" by stating "that is not how it works" did not resonate with her daughter's determination to relocate her mother. "P" was extremely unhappy and saddened by the loss of her possessions. As noted by Johnson and Bibbo (2014) older adults' possessions are significantly linked to their sense of identity, memories and history. In "getting rid" of these possessions, "P's" history and identity were invalidated by her daughter and she was cast into the foreign realms of an aged residential care facility to reorient who she was, or is, as an older adult. Such control eliminates the agency of the individual and excludes and marginalizes older adults as a function of age and vulnerability.

Families fulfill many of the requirements for older adults including support (Nelson, 2005), assistance (Ingersoll-Dayton et al., 1996), care (Lieberman & Fisher, 1999) and affiliation (Black & Dobbs, 2014). Whether intended or not, at times even those who hold positive attitudes towards older adults can paradoxically use negative communication styles with older adults. This communication can imply hearing loss by talking loudly, cognitive deficit by speaking slowly or infantilism by using baby talk (Marsden & Holmes, 2014; Nelson, 2005). In another of the media advertisements (Figure 36, p. 168), the language use is of interest since it portrays something of a fairy story for consumers of the advertising material as follows:

Figure 36. Oakwoods, Nelson Mail (2012)

In this advertisement (Figure 36) language is used in such a way as to create a fictional story to engage older adult consumers and/or their families in an imaginary journey related to a specific aged residential care facility. The production of this story constructs aged care living arrangements in a manner similar to what one might reasonably expect in a children's fairy tale as follows:

Over the fence were dark green fields with mooing cows and off in the distance rose snowy peaks that seemed to go on forever... It's no wonder the friendly Oakwoods people were always full of smiles.

Patronizing language and elder-speak (baby talk) reinforce stereotypical beliefs regarding older adults and serve to marginalize and devalue these individuals causing loss of personal identity and power (Nelson, 2005). The words contained in this advert construct an imaginary state which is intended to elicit a mental model of a euphoric living for older people where -

People meet up for drinks and dance around.

By portraying older adults' living arrangements in this way, the text contrives societal attitudes and influences perceptions that enhance infantilizing the older adult community feeding off a more generalized association with children or early childhood (Coupland et al., 1991).

165

Intergenerational communication, as has been seen in examples from family members within the context of the focus groups, evidences "power over" older adults and supports the notion of reductionism to childlike direction and care for older people by their adult children. One of the focus group participants talked about her son's withdrawal of ongoing support for her as follows:

Mum we can't go on looking after you, we have our own home, our own children and we have got to spare time for them.

This information meant that this older woman had to consider alternative living arrangements, since she could no longer manage her gardening, home upkeep and normal chores without her son's support. In this instance no alternative was available and so a decision to enter residential aged care was taken. The burden of ageing parents, when contrasted against competing obligations for care and attention of adult children's own families, places significant stress on caregivers (Daatland & Herlofson, 2003).

As a key agent for the support and control of older adults' lives, families exert significant influence and power over decisions impacting living arrangements. Whether remaining in the family home with filial support mechanisms or considering and ultimately moving into some form of institutionalised living arrangement, families represent a key platform from which older people make decisions about their future lives.

Whilst most of the older adults in the focus groups of this study indicated resignation and conceded to the will of others in the decision making to enter residential aged care, a few of the participants were happy to enter into this living arrangement and did so with enthusiasm and apparent independence of thought and direction. One such person told me of her life with her husband in Nelson. As her husband and she became older, her husband had become quite unwell. Unable to manage the garden and the maintenance on their home, "J" and her husband sold their home and leased a village townhouse. After the death of her husband "J" had become lonely and as her health also began to fail she moved from her house in the Village to residential aged care in the Facility. "J" indicated safety and security and the ability to have help close by were important factors for her decision. She indicated she was satisfied with this decision.

Another participant in another focus group of men - "P" indicated that whilst he didn't have the capacity in this situation to make a lot of decisions about his future – he had certainly made the one to come into residential aged care himself. He had had a fall some years ago and struggled

to manage his own care in the community. He acknowledged that the surroundings of the facility were to his liking and that the staff were lovely, kind and thoughtful to his needs. He indicated that the staff now make most of his decisions and he found that was acceptable to him.

Whilst many individuals have lived and worked locally and had high levels of knowledge of the local district, one particular member of the focus groups had moved several times as a result of the earthquakes in Christchurch. Originally from a smaller and more remote South Island community, "S" had moved to Christchurch to be near her sister. This had been managed by her nephew who had secretly organised a bed in a residential aged care facility in Christchurch for her. When the earthquakes occurred "S" had been shifted by the company owning the facility to Nelson since her facility was uninhabitable. She had settled in Nelson and now had capacity to move about on a mobile scooter donated to her. She could attend the local library and visit local shops as well as attending church. These independent activities left her feeling much more satisfied than her previous living arrangements. Indeed, "S" indicated a high level of "peace" with her life at the time of the focus group discussions.

As has been discussed, the decision to enter residential aged care is fraught in multiple ways for older adults. The tension between their former life and the memories of that lifetime are sharply contrasted with the decision to forgo independence and to "fall in" to the structured environment of a multi-person dwelling essentially with strangers. Indeed it is clear that the nature of such a decision is a difficult one for some older adults.

7.6. Conclusion

This chapter has highlighted the power of family in the decision making process of older adults as they consider their future accommodation. Despite the overwhelming evidence that most older adults would choose to age in their own homes, discursive frameworks act to influence family members as to the 'appropriate' or apparently 'normalized' inevitable and necessary trajectory of residential aged care for older adults (Gawande, 2014). Recent research regarding the likelihood of older adults utilizing residential aged care in New Zealand estimated that residential aged care is being utilized by almost half (47 percent) of New Zealanders over age 65 years and 66 percent of those older individuals over 85 years of age (Broad et al., 2015; Care Jobs New Zealand, 2015). Whilst undoubtedly having geographically distant adult children has the potential to

enhance concern for risk and fragmentation in relation to ongoing care for frail older parents, so too does the requirement of contemporary society for adult children to remain employed in roles which may prevent them providing care for older parents (Bookman & Kimbrel, 2011; Stuifbergen et al., 2008). As noted earlier in this thesis, Gawande (2014) suggested that the new age claim for independence by adult children translates into beliefs that reject previous societal expectations for care of an older parent. In turn this means solving the problem and shifting the *burden of care* for the older adult to commercial providers. In such a scenario, media advertising pervasively offer (and construct) their superior aged care delivery of a solution to the problem of an ageing parent (Weerawardena & Sullivan-Mort, 2001). This in turn results in family members simply perceiving that they have multiple commercial residential aged care options (constructed and portrayed by owners of these facilities) to select from and to purchase in order to relieve the encumbrance (of a frail parent) and solve the problem (Gawande, 2014; Townsend, 1981; Weerawardena & Sullivan-Mort, 2001).

Influential discourses from powerful expert voices, such as medicine, exert authority over families with advice which supports the normalized course of residential aged care for accommodating older adults (Cheek et al., 2006; Popejoy, 2005). The positioning of health care team members as experts effectively closes down individual older adult or family opinion regarding alternative options for ongoing accommodation need, as evidenced in this thesis findings. This was supported in the work of Popejoy (2005) who found that, in the face of "expert advice", older adults and family opinion fell into a category of low relevance when considering future accommodation decisions (p. 15). Associated with this, the rhetoric of contemporary commodity advertising related to personalized lifestyle living for older adults in residential aged care is insidious in its potential influence on family members raising the consciousness of commodified possibilities for care of older adults living arrangements. The economic value and signification of language, text and images in the portrayal of homogenized and commodified older adult's lives, and strategically appealing to older adults and their family, is striking in the media material examined in this research. Clearly there is an impact on family members although the impact of this was not tested in this research.

8. CHAPTER EIGHT - DISCUSSION AND CONCLUSION

I'm no prophet. My job is making windows where there were once wall.

(Attributed to Michel Foucault)

8.1. Introduction

In this chapter I bring together the findings of the research and provide thoughtful reflection from my examination of the data in response to the research question "What are the critical discourses influencing older adults entering institutional retirement living arrangements in New Zealand?". At the very heart of this question is an ideological position of social justice which seeks to de-normalize residential care as inevitable for older adults and to seek public awareness for alternative forms of accommodation for elders.

Discourses, by their very nature, are not readily or easily detected within everyday life. Reflecting on the quote above, attributed to Michel Foucault, I have, in this research, looked to create particular windows of light on the discursive frameworks that at once scaffold and then influence and impact the decision making of older adults to enter residential aged care accommodation. As already mentioned, the interpretive framework for this study is indebted to several key theorists; namely Teun van Dijk, Michel Foucault and Norman Fairclough, whose writings provided a fertile ground for exploring the key discourses that influence older adults' decision making in relation to residential aged care. Through these multiple epistemological lens a greater intelligibility has evolved regarding the discursive influences impacting contemporary older adults and which influence their accommodation decisions in later life. These notions and the emergent themes identified throughout this research (see Table 1, p.100) are discussed more fully throughout this chapter.

As noted in the introduction to this thesis, I entered into this research with multiple personal perspectives relating to residential aged care. These perceptions and beliefs had been evolved by my own professional exposure first as a registered nurse but then as a senior professional leader and finally as a manager of multiple residential aged care facilities. My view that contemporary residential aged care for frail older adults need not be the only trajectory and that this current

model of care was beyond its 'use by date' has clearly impacted my research and my views as I have conducted this study. The findings of this study may have therefore been subject to some bias which is acknowledged. However, findings from this study also identified the multiplicity of influences that galvanize the decision of older adults to enter residential aged care.

The findings of this study revealed that older adults are exposed to, and influenced by, a proliferation of active and passive discursive pressures in their daily lives. Some of these discursive frameworks are strikingly strategic in nature, especially those which manifestly attempt to persuasively influence older adults' accommodation choices by offering a simulated resort type *lifestyle.* These strategic semiotics were evidenced in the advertising materials examined in this study. It can be asserted that advertising media, in this sense, enacts its specialized industry focus in the labor of commercial commodity producers' drive to sell products (Comor, 2015). Clearly evident within the proliferation of advertising gathered for this study were salient discourses which not only targeted older adults but also acted to problematize and construct older adult lifestyle options. These constructed and marketed options serve, on the one hand, to position older adults as consumers with the right to choose their life course; whilst, on the other hand, these elders are positioned as helpless, frail and in need of care. Advertisers were found to carefully situate semiotic information creating idealized or synthetic personalization[7] (Fairclough, 1992 a; Kress & van Leeuwen, 1996) of older adults related to residential aged care and need. In many instances they provided contradictory material such as being able to walk to local cafes but with twenty four (24) hour nursing care (Figure 20, p134). These strategic commercial discourses work to evocatively draw in older adults and their families by making a persuasive promise of a consumer lifestyle into which these people can imagine and insert themselves.

---

[7] **Synthetic personalization** occurs where the simulation of interpersonal meaning subordinates all other aspects of discursive practice and meaning to achieve strategic and/or instrumental goals (Fairclough, 1992 a)

8.2. Advertising Construction of Older Age and Residential Care

Findings from this study indicate that consideration needs to be given to the pervasive discourse patterns contained within contemporary social narrative of residential aged care. These discursive frameworks act to problematize, construct and then normalize aged residential care as an appropriate contemporary strategy for older adults' accommodation requirements (Fairclough, 1989, 1992/1992, 1992 a, 1995/2010). It can also be suggested that in problematizing older adulthood, these discourses construct specific stereotyped and distorted representations of older adults' accommodation needs; and present them in a manner which produce and then reproduce *taken for granted* propositions tied to specific social conditions within contemporary society related to ageing individuals (Hugman, 1999; Katz, 2013).

Modern societal discourses normalizing the institutionalization of older adults reinforce the processes of separation, colonization, marginalization and concealment of these individuals away from the broader societal world (Hugman, 1999; Petersen & Warburton, 2012; Phillipson, 2012; Wiersema & Dupius, 2010). It can be argued that contemporary discourses of residential aged care evidence dominant group power over older adults in an attempt to manage the problem of surplus or non-productive elders by identifying an appropriate place for containing them within modern walled communities; providing a continuum of care from independent living to residential aged care (Gawande, 2014; Hugman, 1999; Morgan, Eckert, & Lyon, 1993). The outcome of this marginalization, on the basis of chronological age, acts to effectively position older adults between two worlds of existence; resulting in a situation whereby these individuals do not fully belonging in either their former life or within their new institutionalized life (Hugman, 1999; Morgan, 2010).

It is widely acknowledged that the fear of illness, associated with older adulthood, is not only about the absolute fear of physical loss, degeneration and death but also, for many older adults, the fear of marginalization and isolation (Alcock, 2010; Gawande, 2010; Golant, 2011). As an alternative to isolation and marginalization, residential aged care, which is currently thought to be an *inevitability* for most older adults toward the end of their lives, is not the preferred option of most older people, with the vast majority wishing to remain in their own homes (Cheek & Ballantyne, 2001; Cheek et al., 2006; Dellasega, Mastrian, & Weinert, 1995; Jorgensen et al.,

2009). Recent research estimated lifetime risk and the pervasive use of residential aged care within New Zealand has estimated that as many as 47 percent of the population will access residential aged care after age 65 years and at least two thirds of those aged over 85 years (Broad et al., 2015).

For older adults entering the *institutionalized* living arrangement of residential aged care is counter to the ideal of *home* with its ideal of domesticity, private and personal areas and a concentration of personal memories and artifacts collected throughout life (Gawande, 2014; Hugman, 1999). In turn institutional living challenges personal agency due largely to the significant adjustment to a situation which requires living with strangers within a contrived artificial community and where life control is passed to staff (Willcocks et al., 1987). Thus the contemporary discourse of residential aged care represents the embodiment of older adulthood as a social construction bounded in space and time (Gibson, 1998).

The contemporary socially engineered discourse of ageing translates into older adults taking decisions regarding future aged residential care accommodation needs (a significant life change) at a time when there is potential for extreme vulnerability (Golant, 2011; Martikainen et al., 2009). Associated with this anticipated or realized life change is the prospective loss of identity, personal grief and sadness for a former life, potentiated or realized loss of valued possessions and dislocation from friends, neighbours and all that is, or may be, familiar (Cheek & Ballantyne, 2001; Gamliel & Hazan, 2006; Nolan & Dellasega, 2000; Ogg & Renaut, 2012; Tanner, 2003).

8.3. Biomedical Construction

The findings from most previous research into the determinants or influences on older adults' decision to enter residential aged care have suggested an array of predictors such as serious illness or discharge from hospital following an acute medical event (Cheek & Ballantyne, 2001; Cheek et al., 2006; Davies & Nolan, 2003; Dellasega et al., 1995; Gray & Dakin, 2011; McAuley et al., 1997). Additionally, other factors, such as declining physical capacity and capability including a history of falls (Dwyer, 2005; Gamliel & Hazan, 2006; Hugman, 1999, 2001; Vincent, 2006), social disconnectedness; that is, single (never married), widowed or divorced individuals (Gibson, 1998; Martikainen et al., 2009; Willcocks et al., 1987), caregiver burnout and anxiety (Bell, 1996; Edwards, Courtney, & Spencer, 2003; Gawande, 2010; Gill & Morgan, 2012) and

family dislocation (Gawande, 2010; Jorgensen et al., 2009) have been identified as catalysts for entry decisions for residential aged care. The evidence presented in this research clearly identifies a gap in the contemporary understanding of the influences on older adults' decision making as a precursor to entry into residential aged care by evaluating and making visible the discursive frameworks of power colonized within political, social, commercial and expert discourses.

It appears, from this research, that the prevalence of relevant age related social, political and commercial discourses are underpinned by the continuing evolution of biomedical reductionism and the push for scientific management of age (Gawande, 2014; Gray & Dakin, 2011; Reyna et al., 2007; Tulle-Winton, 1999). This medical discourse is driven off advances in biomedical interventions and emergent models of care for older adults. Supporting and driving these models of care is increasing expert concern (statistical predictions, economic modeling and biomedical science) as to the impending number of older adults likely to ensue in coming generations (Estes, 2001; Estes & Binney, 1989; New Zealand Treasury, 2012b; Phillipson, 1991). Invariably these discourses construct older adulthood as a period of increasing dependency (Townsend, 2006) catalyzing government policy development. Policy informed by statisticians and demographers in turn is intended to "head off" this impending catastrophe of a growing aged demographic with its associated potential for national economic ruin (Gadson, 2003; Katz, 1992; New Zealand Treasury, 2012b; Petersen & Warburton, 2012).

8.4. New Age Social Construction and Individualism

As mentioned earlier, the social construction of the *appropriateness* and *inevitability* of institutionalization for older adult living has been significantly transformed over the past 50 or so years in New Zealand through powerful societal and political discursive frameworks linking older age with dependency and the need for ongoing monitoring and oversight (Townsend, 1981). Paradoxically, discourses of experts (e.g. economists, demographers, bio-sciences and medicine) have collided with a growing ethos of individualization and selfishness within the broader parameters of western society (Gawande, 2010). This new societal culture of individualization is accompanied by a preponderance on autonomy or focus on self versus care of others (including older parents) (Gawande, 2010). This emergent societal *turn* toward a new societal individualism has been recognized and utilized by the increasingly derived commercialization and exploitation

of ageing adults. In his work on neoliberalism and individualism, Peters (2001) suggested that this new age individualism is weakening the social fabric of society and "monetizing" relationships (p.134). This is clearly evidenced within the rapid establishment and expansion of designer retirement older adult landscapes amidst a political agenda focused on economic rationalism and consumerism which visibly supports expedient solutions for older adults *care* (Hendricks, 2004; Petersen & Warburton, 2012).

8.5. Personal Accountability

The discursive construction of contemporary age related accommodation provides a cultural expectation for older adults which portrays a coherent *reality* framed within a context of personal and, increasingly, economic responsibility for *lifestyle choices* as one ages (Gadson, 2003). Superimposed within these discourses is the contemporary commercialization opportunity for residential aged care developers who, despite overwhelming evidence that older adults wish to remain and age in their own homes, continue to build residential aged care institutions and to advertise these within powerfully persuasive messaging regarding the achievement of a glamorized *lifestyle* to be obtained within residential aged care facilities (McHugh, 2003b).

8.6. Family Influence

In this study, family members were found to exert a significant influence in the final decision to relocate into residential aged care. Multiple personal accounts from the focus group participants indicated that family had considerable and *critical* input into the final decision making process. Many potential reasons for this magnitude of influence over older adults' decision making can be asserted, such as inability to provide initial or ongoing care for an older parent or relative. This situation arises from those life choices for families regarding adult children's own family commitments, their financial capacity to provide care and the impact on work life considerations (Dellasega et al., 1995).

Countering the dominant discourse of inevitability of entry into aged residential care is a difficult task for older adults, particularly when family members assert powerful manipulation over their lives in shaping, guiding and influencing behaviours and important decisions (Popejoy, 2005). The contemporary discourse of *family* is constructed in the social world through interpersonal

relationships, talk and events involving family members in a somewhat more fluid arrangement than previous epochs (Bamberg, 2014). How people talk and behave within sense making activities *inside* the family creates a particular framework of order and serves to define the existing construct and understanding of *family* within the private world of the domestic setting (Gubrium, 1993). Within the family, power is enacted through status, roles, language and behaviour, all of which seek to encode, consolidate and renegotiate the family social order conferring agency to family members or denying this through the mechanics of interpersonal and intergenerational exchanges (Sterponi, 2009). Families grow emergent accountability, responsibility and independent decision making in children via a tenuous scaffold of parent child relations and autonomy. In turn, this state reverses in older adulthood to scaffold the accountability of aged parents by the now adult child over the parent through monitoring and interpreting (with guidance from experts) the needs of older parents (Katz, 2007).

Evident in this research was the finding that family exerts power which acts to silence the voice of older adults in their self-determination, personal agency and independence in relation to their life choices for accommodation and care. Families utilise their key role by exerting authoritative voice in the decision making of older adults (Bookman & Kimbrel, 2011; Gawande, 2014; Townsend, 1981). Expectations for compliance by families and docile acceptance by older adults are evident in the final decisions taken by many of the participants interviewed in the focus groups for this research, indicating a powerful influence on ultimate entry into aged residential care.

8.7. Politics

Political discourse regarding chronological age contains key markers in the relationship of the older adult with the state in terms of the social structures established as a conduit for access to economic entitlement, care and to risk (Biggs & Powell, 2001; Bytheway, 2005a; New Zealand Treasury, 2012b). Politically, the utility of age as a social marker is in its potency and capacity for the circulation of power through categorization and bureaucratic management of older adults within society for the purpose of resource distribution and rationing (Walker & Litt, 2000). Such a discursive framework of ageing is useful for dominant groups to exercise power and governance over older adults. In doing so, this discourse widely infuses society with a set of powerfully influential beliefs regarding age and residential aged care through cultural characterizations and

portrayals of normative older adults in language, imagery and via other semiotic representations (Schneider & Ingram, 1993).

Problematizing the needs of older adults for residential aged care is impacted by family and social policy which, in turn, is reliant on expertise such as provided by demographers, bio-science and medicine. In contemporary New Zealand (and globally) alarmist demography creates the threat of unsustainability for the welfare state into the future. High level public anxiety is created from within the threats variously to healthcare provision, pensions and wider financial viability of the governing state (Katz, 1992; New Zealand Treasury, 2012b). The continued invisibility of older adults within the wider New Zealand society and the rendering of this cohort as passive or requiring protection within the walls of residential aged care institutions wears down and silences older adults' voices (Ellor, 2001). Families of older adults, in this study, defined the care of older adult parents as a problem requiring solution; particularly so when faced with enhanced bio-medical intervention which increasingly enhances life years for older adults (Ade-Ridder & Kaplan, 1993; Foucault, 1994b; Popejoy, 2005). Contemporary discourses evident across the social milieu of New Zealand society have normalized residential aged care for specific targeted sub-groups within the European older adult community, largely excluding diverse cultural groups who may be impacted by different social norms and thus different discursive frameworks. This normalization for European, middle class New Zealanders has expanded the uptake of residential aged care living arrangements for older adults, reinforcing decisions taken as appropriate and in many ways reinforcing the inevitability of transitioning into residential aged care as an appropriate solution for monitoring and management in later life (Jorgensen et al., 2009).

Adjustment to becoming older occurs over time, necessitating acceptance of considerations and meaning making of group membership within differing social categories and particularly the "bureaucratic reckoning of age" by the polity as well as the wider society (Bytheway, 2005b, p. 464). At the very heart of this consideration is the notion of what, and more significantly, who, constitutes older agehood - is it the individual who declares *older age* him or herself based on how many years lived, the age felt by the individual, or how society, politics, science and medicine construct age and ageing (Bytheway, 2005a; Vincent, 2006; Yoon & Powell, 2011). Further to this question, one may add another related to the margins of social tolerance for risks associated with ageing at home such as individual, family, expert and public tolerance to risk of falls or even risk of death at home (Gawande, 2010; Popejoy, 2005). Individuals' experiences, their thinking and

interpretations of ageing are mediated socially via their relationships and actions within society, as well as the prevailing societal norms, commitments and entitlements afforded to and appropriate for them socially, politically and economically, setting powerful expectations for the life stage of older adults (Hendricks, 2004).

The impact of the contemporary societal discourse of older age, as evidenced in this research, show internalization of the pervasive stereotypical beliefs associated with the contemporary construction of older adulthood. This construction and acceptance of a specific social *identity* (e.g. "middle aged" or "old") by individuals and groups within a given society infiltrates the discursive frameworks of appropriate accommodation to achieve social order (Bytheway, 2005a). Acceptance and sanction of this discursive construction of age such as exists for those over 65 years also potentiates acceptance and management of one's ageing body (Iliffe & Manthorpe, 2012). In turn older adults respond by (attempting to) manage the older body in sensible and realistic ways for identity maintenance which may include the consideration of a decision to enter residential aged care (Haboush et al., 2012; Hendricks, 2004; Vincent, 2006, 2008).

The personal interpretation of, and adaptation to, the constituently appropriate characterization and construction for older persons on-going living arrangements at the broader level connects to, and is influenced by, explicit and implicit interconnecting socio-political frameworks and utterances of lay, professional and political people/organizations about what is appropriate and desirable for older people and ultimately their accommodation needs (Petersen & Warburton, 2012; Tulle-Winton, 1999). The discourse of age appropriate accommodation in the form of residential aged care has become a powerful one for older adults in contemporary New Zealand society; despite resistance to the notion of institutional care which is evidenced widely in the literature (Dellasega et al., 1995; Hugman, 1999; Nolan & Dellasega, 2000; Ogg & Renaut, 2012; Pearson & May, 2004; Reinhardy, 1995).

Foucault's assertion that individuals absorb ways of being, ways of thinking and ways of acting, constrained within powerful social norms in order to be regarded as responsible and self-regulating people has gained increasing momentum over the past 30 or so years (Armstrong & Murphy, 2011; Biggs & Powell, 2001; Foucault, 1972). According to this view, mechanisms of power colonize the influential societal norms emanating from government and the wider society including experts such as medicine, demographers and commercial aged residential care

providers and these then act to constrain the ways in which older people behave and think (Gilbert, 2005).

Contemporary commercial entities effectively deploy discursive frameworks to transcend former societal boundaries for older adults and their families in relation to normative expectation for living arrangements from a supposedly value free and stereotype free perspective, as well as culturally inclusive stand point (McGannon & Spence, 2012; McHugh, 2000, 2003b). These discourses achieve saliency through their subtle influences and innuendo embedded within mediatised marketing and advertising technologies which act to reinforce adaptive individual interpretation of normative conditions for subject position and/or role of expert in the conduct of their life and living arrangements (Fairclough, 1992 a; Sawchuk, 1995; Tulle-Winton, 1999).

Power and domination of older people emerges from the pervasive social, political and commercial discourses and normalization of *appropriate* age related accommodation. In turn, these discourses have a significant part to play in the production of *truth* by silencing messages which may contradict the dominant discourse emanating from politicians, experts and commercial aged residential care providers in relation to residential aged care living. Supporting this notion Foucault suggested that:

The manifest discourse ...is really no more than the repressive presence of what it does not say; and this 'not said' is a hollow that undermines from within all that is said. (Foucault, 1972, p. 28)

Power is enacted in the discourse of residential aged care through (and confirmed within) everyday conversational talk and text which infuses ordinary daily activities via national politics, television portrayals of elders, local, regional and national newspaper and magazine articles as well as mediatised advertising as evidenced in this research study (Fairclough, 1992 a; Yoon & Powell, 2011). From this perceivably *ordinary* semiosis of talk and text (including images) a dominant discourse emerges which is premised on ostensibly valid and legitimate ideologies and attitudes related to older adulthood, including age *appropriate* behaviours for accommodation requirements appropriate for older adults (Katz, 1992; Petersen & Warburton, 2012).

This research examination of the discursive frameworks evident in New Zealand society, related to influences catalyzing decisions for entry into residential aged care for older adults, supports the notion that the buoyancy and optimism inherent within the commercial and political determinants of ageing has become organized around priorities of late capitalist society consumerism. The

evocative messaging and imagery contained within the powerful technologies of advertising and marketing have provided a salient construction of age appropriate accommodation for older adults "uniting multiple discursive strands and normalizing these" so they appear inherently sensible and mask counter discourse structures (Katz & Marshall, 2003, p. 4).

The evidence from this study, regarding the intersect between power/knowledge relations which prevails within New Zealand society in relation to older adults, does not necessarily suggest legitimate apportioning of blame for the negative positioning of older peoples' accommodation requirements within some clearly identifiable political governing body exercising its might in a top-down direction. In considering this situation it is timely to recall Foucault's analysis of power which suggests that power is dispersed throughout the social organisation and that this very dispersion opens up the possibility for resistance and social change. According to Foucault (1994):

Power can be analysed at three levels: (i) as strategic relations, (ii) as techniques of government and (iii) as states of domination. Power is therefore more than the gross power which the state, embodied in the head of state, exerts over its subjects. It is more diffuse and it is processual. It operates as a network in which all participants in the social body take part and it manifests itself in the ways in which social relations are played out. Therefore it constantly has to be negotiated and renegotiated through the practice of social relations and through practices of legitimation.

Lending support to the notion of the dispersion of power and potential for resistance, this research found that the stories of older adults participating in the focus group interviews evidenced initial resistance. This resistance was at first attempted in the form of asserting a strident and independent stance by individual older adults. Ultimately, however, this resistance gave way to surrender in the face of the powerful influences of medicine and family. Resistance to the inevitability of entering aged residential care was eroded when faced with a dominant discourse such as that of expert medical advice or family determination of the *appropriateness* of residential aged care for their family member.

Some of the participants in the focus groups indicated that the decision to enter residential aged care was a key marker of the *final phase* of life. This *final journey* or *end state* is a finding supported by Reed et al. (2003) who, in their research, found that older adults assume that the move into residential aged care is congruent with the notion of a closing stage in the life journey (Reed et al., 2003b).

Visual images contained within the advertising within this study identified a largely female, European portrayal of older adults. Segmenting the market or targeting specific cohorts within

society is at the very core of harmonizing and aligning products with potential consumers of services. This study finding confirms that contemporary advertising and media colonize strategic discourse in order to construct aged residential care candidacy from within specific socio-economic groups of older adults (Agha, 2011; Yoon & Powell, 2011). These mediatized strategic discourses act to commodify aged accommodation through targeting or segmenting the older adult cohort of society to attract the *right* sort of older adults such as those of European ethnicity with sufficient affluence (i.e. middle class citizens) or those who have children who are likely to be able to pay for enhanced care accommodation such as private rooms, ensuites and the like (Baig, 2013; McHugh, 2003b).

While segmentation of the market persuasively targeting older European adults of middle class status was evident within this study, older adult participants of the focus groups participants who may have read these advertisements did not appear to be specifically impacted by them. Families on the other hand seemed to be the recipients of the discursive messaging from these media and advertising communication formulations and were referred to by the older adult participants as having been a consideration in the family search for placement and subsequent decision making.

As a result of the commercial segmentation and strategic discourse related to residential aged care in New Zealand, it appears to be a largely monocultural business similar to that evidenced in other jurisdictions (Gadson, 2003). My search of the literature did not locate any published research in relation to the uptake of residential aged care by Māori, Pacifica or other diverse multi-cultural groups within New Zealand.

As a professional leader working within this area of contemporary healthcare, my experience has been that very few individuals from cultures, other than those of European descent, have taken the decision to enter residential aged care. Given the increasingly diverse cultural background of the older population within New Zealand, it can be suggested that this lower than expected use of residential aged care by cultures other than European may represent resistance to discursive frameworks of appropriate accommodation for elders. Culturally based disengagement from the prevailing discourse related to residential aged care may be associated with discourses of family for other non-European cultures spurning this commodified approach to accommodation in later life for older adults.

Decisions to enter residential aged care taken by older adults in this study occurred as a result of powerful family influences that, in turn, had been directly influenced by medicine in many cases. Distributed discursive messaging across the wider society, normalizing residential aged care as a recognizable and appropriate strategy, appeared to influence family and medicine by indirectly constructing older adults within a web of diffuse power as dependent and needing constant monitoring and ongoing care. Family, in turn, were found to impose or manipulate the decision of the older adult; in many instances of those individuals participating in this research. Once a decision was taken regarding residential aged care being required (inevitable) the media discourses resonated reflexively to support choice of facility for family members largely.

8.8. Research Limitations

Family and the powerful influence of the family in the decision to enter residential aged care requires further research. Similarly the impact of media on family members as they assert their influence on elders. Further research should examine the segmentation of the aged care market and identify from the residential aged care developers themselves who they are targeting with their media advertising within the New Zealand landscape.

8.9. Conclusion

The evidence obtained in response to the research question in this thesis indicates that older adults are influenced to enter residential aged care on multiple levels and via multiple discourses across various semiotic genre within contemporary New Zealand society. Multiple social, political, commercial and economic discourse frameworks exert seductive persuasion regarding the *inevitability* and *appropriateness* of a life within the confines of residential aged care. This occurs through a variety of power and power relations most strongly evidenced via family but also through the power exerted by the ongoing and ever increasing bio-medicalization of age.

Media and advertising play an increasingly significant role in social life via their contemporary practice of disseminated discursive messaging. This diffuse messaging enhances uptake of residential aged care by reflexively linking processes contained within social discourses of ageing to the more contemporary commercial discursive construction and commodification of age occurring in the development of purpose built walled complexes exclusively institutionalizing older

adults. The influence of the media is perhaps most prevalent on families and experts rather than on the older adults themselves, although elders were aware of this within the gambit of their social relations and social awareness.

Dominant mediatized discourses paint a picture of the reasons for older people deciding to go into residential care as being similar for all older adults but in this research evidenced that the drivers may be quite different. The unfolding of an older person's life leading to entry into residential care decision making take many different trajectories and, as found in this study, these involved serious illness of a primary caregiver, dysfunctional family dynamic, family inability (or wish) to provide care and the strength of medicine as the key drivers for participants.

From this research it appears that whilst older adults themselves were aware of media and advertising contained within local newspapers and magazines in relation to aged care this did not have a major impact on their ultimate ability to take a personal decision to enter such a facility. Many of the older adult participants in this study had visited and knew of the various residential aged care facilities locally as friends or former family had been domiciled in these. Thus they could express comments about their perceptions of the quality and likelihood of taking up residence in some of these facilities themselves.

The socially relevant elements involved in the marketing rhetoric contained within media advertising (including images) in this study was persuasive in the primacy of salient messages predominantly relating to *professional nursing care, safety* and *lifestyle.* These discourses have a particular resonance with European, middle class elders as a result of marketing segmentation and portrayals of this cohort within the advertising examined in this study.

It appears that family and medicine are likely to be the most receptive and responsive to mediatized messages contained within these advertising discourses. Media and advertising socialization and normalization impact, therefore, appears to be on the family of elders regarding the appropriateness and normalization of the residential aged care solution to ongoing care, security and oversight of an older adult within the context of contemporary New Zealand society within Nelson region. From the standpoint of a family member, such a construction of key focal points provides a readymade solution to the *problem* and *burden* of ageing elders.

The emergence of ageing as a social problem has occurred not as a discourse of resistance by ageing adults themselves but as a response to dominant social norms failing to take account of older adults unique, particular and specific needs in contemporary society. This discourse operates through a web of social practices reaching into the very corners of contemporary New Zealand society as a direct result of dominant groups such as politicians, demographers and other experts (e.g. medicine). These powerful groups appear to support the notion of ageing as a public issue of accentuated dependency and social control rather than a private issue of unique adjustment to age (Gibson, 1998; Townsend, 1981; Willcocks et al., 1987).

Clearly the continued need of developers to build expansive, self-identified *resort style living* and lifestyle accommodation for older people, and offering a trajectory from retirement to death, needs to be re-thought. Continuing to construct these walled communities reinforces the exploitation and separation of older people from the wider community rather than integrating them into a full social life. It assumes generic similarities exist amongst older adults and that living with strangers in older age is acceptable and appropriate. In contrast, entry into residential aged care has the potential to exacerbate dependency by slowing the tension of the independent/dependent dichotomy and removing the former interdependency on family. It also creates a dichotomy of *good ageing* versus *bad ageing*; with good ageing being responsible and accepting the inevitability of residential aged care as the course of ageing.

This research identifies a clear gap in the contemporary literature regarding the discursive influence and impact of mediatized discourse on older adults entering aged residential care in New Zealand. Throughout this research the identification of the importance of discourses emanating from political, family and expert sources has been located and explored. The impact of unequal power relations in the decision making process for entry into residential aged care was evidenced in this research. The uncovering of influences on older adult decision making contained within powerful social and political discourses of *appropriate* management of the older body are evidenced.

Finally this study was limited by its localization in a medium sized city with a demography of largely middle class European citizens. A further limiting factor relates to the non-inclusion of family members regarding the decision of older adults to relocate to residential aged care. Further research would also be enhanced by reviewing general practitioners' understanding of their

impact on residential aged care decision making by families and elders. Rather than reinforcing this as an expedient solution, general practitioners could consider supporting families to explore other alternatives to support aged parents or important others. In the words of Bob Dylan, "Older people gotta be more wise" if they are to lay claim to their own destiny as they age.

The journey of this thesis has been a powerful one. It began out of a deeply personal and passionate concern for the too-frequently negative experiences of older adults who I have observed up-close in residential care settings of different kinds. It was further stimulated by what became increasingly clear as a diverse range of powerful historical, political, social, economic and commercial discourses that insidiously brainwash, coerce, manipulate and seduce older adults into deciding to enter some form of residential living arrangement. It was informed by an awareness that the very people at the core of all this, older adults themselves, generally have minimal say in the process when faced with the authority of medical doctors combined by the pressure of family. In undertaking this research I acknowledge my biases which have emerged from my history with older adults in residential aged care and my personal experiences within my own family. I have endeavored to remain open to all new understandings throughout the process of this study. This was profoundly coloured by my own identification with the positions, concerns and experiences of those older adults I have met and been involved with personally and professionally. It is not possible to be detached and objective when confronted with such personally concerning or connected issues. I believe that there are older adults who are entirely happy and satisfied in their residential aged care environment. However, I also believe that the number of these individuals is outweighed by the majority of older adults who have perhaps conceded defeat in the face of powerful discourses from government, society generally, family and medical experts. These discursive frameworks act to entrance or enhance decision making such that it seems the "right" and "proper" approach to care of older adults within New Zealand society.

Throughout this thesis I have sought to enable older adult voices to be heard. The importance of their voice having 'air-time', so to speak, takes on greater significance given the plethora of media enticements that skillfully sell well a commodified product to this very specific, largely silent, consumer group. My abiding intention has been to contribute insights, understandings, and critical analysis into how these discursive influences limit choices and largely go un-noticed by most

people. This is an act of resistance, an act of revealing hidden forces, an act of solidarity and inspiration with others who need to take up the issues identified.

Finally in the words of one of the participants in this study -

I came here because I knew I had to come but I don't think I will ever get over having to leave my own home – I don't think you do. This is the end of my journey – and you have to accept it.(N.R.)

REFERENCES

Ade-Ridder, L, & Kaplan, L. (1993). Marriage, spousal caregiving and a husband's move to a nursing home: A changing role for the wife? *Journal of Gerontological Nursing, 19*(10), 13-23.

Agha, A. (2011). Meet mediatization. *Language and Communication, 31*, 163-170.

Ainsworth, S. (2007). The construction of the older worker: Privilege, paradox and policy. *Discourse and Communication, 1*(3), 267-285.

Ainsworth, S, & Hardy, C. (2004). Critical discourse analyses and identity: Why bother. *Critical Discourse Studies, 1*(2), 225-229.

Alcock, C. (2010). Shades of grey: Housing and ageing. *Australian Planner, 42*(2), 24-26.

Allan, V. (1996). *Nurse Maude: The first 100 years*. Christchurch, New Zealand: Nurse Maude Foundation.

Allmark, P, Boote, J, Chambers, E, Clarke, A, McDonnell, A, Thompson, A, & Tod, A.M. (2009). Ethical issues in the use of in-depth interviews: Literature review and discussion. *Research Ethics Review, 5*(2), 48-54.

Altman, T.K. (2007). An evaluation of the seminal work of Patricia Benner: Theory or philosophy. *Contemporary nurse, 25*(1-2), 114-123.

Andrews, M. (1999). The seductiveness of agelessness. *Ageing and Society, 19*, 301-318.

Armstrong, N., & Murphy, E. (2011). Conceptualising resistence. *Health, 16*(3), 314-326.

Arnould, E, J, Price, L, & Zinkhan, G. (2004). *Consumers* (2nd ed.). New York: McGraw Hill.

Ashton, T. (2000). New Zealand: Long-term care in a decade of change. *Health Affairs, 19*(3), 72-81.

Auditor General. (2009). *Effectiveness of arrangements to check the standard of service provided by rest homes*. Wellington, New Zealand: New Zealand Government.

Baars, J. (1991,). The challenge of critical gerontology. *Journal of Aging Studies, 5*(3), 219-243.

Badkar, J., Callister, P., & Didham, R. (2009). *Ageing New Zealand: The growing reliance on migrant caregivers*. Wellington, New Zealand: IPS Working Paper 09/08, Institute of Policy Studies.

Baig, M. (2013). Analyzing the advertising discourse. A journey from sight to mind. *International Journal of Applied Linguistics and English Literature, 2*(1), 126-135.

Bamberg, M. (2014). Invited commentary: Narrative practices versus capital D-discourses: Ways of investingating family. *Journal of Family Theory and REview, 6*(March), 132-136.

Barford, V. (2013, 8 April, 2013). Is modern life making us lonely? [Magazine Article]. *BBC News Magazine*. Retrieved from http://www.bbc.com/news/magazine-22012957 Accessed 07 March2016

Barletta Manjarrés, N. (2011). Critical discourse analysis: A review of the critique. *Lenguage, 35*(1), 219-242.

Barnett, P., & Jacobs, K. (2000). Policy-making in a restructured state: The case of the 1991 health reform policy in New Zealand. *Australian Journal of Public Administration, 59*(1), 73-86. doi:10.1111/1467-8500.00141

Barry, C.L, Brescoll, V.L, Brownell, K.D, & Schlesinger, M. (2009). Obesity metaphors: how beliefs about the causes of obesity affect support for public policy. *Millbank Quarterly, 87*, 7-47.

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

Basel Al-Sheikh, H, & Ibrahim, A. (2014). A critical review of Ferdinand de Saussure's linguistic theory. *Studies in Literature and Language, 8*(1), 57-61. doi:10.3968/j.sll.1923156320140801.3909

Beard, J.R, Biggs, S, Bloom, D. E , Fried, L.P , Hogan, P, Kalache, A, & Olshansky, S.J (2012). *Global population ageing: Peril or promise*. Geneva, Switzerland: World Economic Forum. Retrieved from http://www3.weforum.org/docs/WEF_GAC_GlobalPopulationAgeing_Report_2012.pdf Accessed 07 March 2016

Beattie, J.J. (2011). Making home, making identitites: Asian garden making in New Zealand, 1850-1930's. *Studies in the History of Gardens and Designed Landscapes, 31*(2), 139-159.

Bell, J. (1996). Decision making in nursing home placement. *Journal of Women & Aging, 8*(1), 45-60. doi:10.1300/J074v08n01_06

Biedenham, P.J., & Bastlin, N. J. (1991). Elderly community residents' reactions to the nursing home: An analysis of nursing home-related beliefs. *The Geronotologist, 31*(1), 107-115.

Biedenham, P.J., & Normoyle, J. B. (1991). Elderly community residents' reactions to the nursing home: An analysis of nursing home related beliefs. *Gerontologist, 31*(Special Issue), 149-151.

Biggs, S. (2014). Adapting to an ageing society: The need for cultural change. *Policy Quarterly, 10*(3), 12-16.

Biggs, S., Phillipson, C., Leach, R., & Money, A.M. (2007). The mature imagination and consumption strategies: Age and generation in the development of the United Kingdom baby boomer identity. *Journal of Ageing and Later Life, 2*, 13-30.

Biggs, S., & Powell, J. L. (2001). A Foucauldian analysis of old age and the power of social welfare. *Journal of Aging and Social Policy, 12*(2), 1-19.

Binstock, R.H, George, L, K , Cutler, S.J, Hendricks, J, & Schulz, J. H (Eds.). (2011). *Handbook of Aging and the Social Sciences* (Vol. 7th ed). London, UK: Academic Press.

Black, K, & Dobbs, D. (2014). Community-dwelling older adults' perceptions of dignity: Core meanings, challenges, supports and opportunities. *Ageing & Society*, 1-22.

Blakely, T, Atkinson, J, Kvizhinadze, G, Nghiem, N, McLeod, H, & Wilson, N. (2014). Health system costs by sex, age and proximity to death, and implications for estimation of future expenditure. *New Zealand Medical Journal, 127*(1393), 12-25.

Bockerman, P, Johannsson, E, & Saarnie, S. (2011). *Institutionalisation and quality of life for elderly people in Finland*. Finland: European Network of Economic Policy Research Institutes. Retrieved from 978-94-6138-118-7

Boje, D., Oswick, C., & Ford, J.D. (2004). Language and the organisation:: The doing of discourse. *Academy of Management Review, 29*(4), 571-577.

Bookman, A., & Kimbrel, D. (2011). Families and elder care in the twenty-first century. *The Future of Children, 21*(2), 117-140.

Borowski, A, Encel, S, & Ozanne, E (Eds.). (1997). *Ageing and social policy in Australia* (1st ed., Vol. 1). Cambridge, UK: Cambridge University Press.

Borowski, A, & Hugo, G. (1997). Demographic trends and policy implications. In A. Borowski, S. Encel, & E. Ozanne (Eds.), *Ageing and Social Policy in Australia* (1st ed., pp. 2-19). Cambridge: Cambridge University Press.

Boudiny, K. (2013). 'Active ageing': From empty rhetoric to effective policy tool. *Ageing & Society, 33*(6), 1077-1098.

Bourdieu, P. (1984). *Distinction: A social critique of the judgement of taste*. Cambridge MA: Harvard University Press.

Bowers, H. , Clark, A., Crosby, G. , Easterbrook, L., Macadam, A. , MacDonal, R. , . . . Smith, C. (2009). *Older people's vision for long term care*. London, UK: Joseph Rowntree Foundation. doi:http://www.jrf.org.uk/publications/older-people-vision-long-term-care Accessed 07 March 2016

BPAC New Zealand. (2012). Managing medicines in older people. *Best Practice Journal, 47*(October), 1-13.

Bradley, L. J., Whiting, P. P., Hendricks, B., & Wheat, L. S. (2010). Ethical imperatives for intervention with elder families. *The Family Journal, 18*(2), 215-221. doi:10.1177/1066480710364507

Braidotti, R. (1991). *Patterns of Dissonance*. Cambridge, UK: Polity Press.

Brett, Z. H., Humphreys, K. L., Fleming, A. S., Kraemer, G. W., & Drury, S. S. (2015). Using cross-species comparisons and a neurobiological framework to understand early social deprivation effects on behavioral development. *Development and Psychopathology, 27*(2), 347-367. doi:10.1017/S0954579415000036

Broad, J. B., Ashton, T, Lumley, T., Boyd, M., Kerse, N, & Connolly, M. (2014). Biases in describing residents in long-term residential aged care. *The New Zealand Medical Journal,, 127*(1402), 50.

Broad, J. B., Ashton, T., Gott, M., McLeod, H., Davis, P. B., & Connolly, M. J. (2015). Likelihood of residential aged care use in later life: a simple approach to estimation with international comparison. *Aust N Z J Public Health, 39*(4), 374-379. doi:10.1111/1753-6405.12374

Brunton, M, Jordan, C, & Fouche, C. (2008). Managing public health care policy: Who's being forgotten? *Health Policy, 88*, 348-358.

Bryant, J., Teasdale, A., Tobias, M., & McHugh, M. (2004). *Popultion ageing and Government health expenditures, 1951 - 2051*. Wellington, New Zealand: The Treasury.

Buckle, R.A., & Creedy, J. (2014). Population ageing and long-run fiscal sustainability in New Zealand. *New Zeraland Economic Papers, 48*(2), 105-110.

Butler, R.N. (1969). Age-Ism: Another form of bigotry. *Gerontologist, 9*, 243-246.

Butler, R.N. (1995). Ageism. In G. L. Maddox (Ed.), *The Encyclopaedia of Ageing: A comprehensive resource in gerontology and geriatrics* (3rd ed., Vol. 1, pp. 38-39). New York: Springer.

Bytheway, B. (2005a). Age-identities and the celebration of birthdays. *Ageing and Society, 25*(04), 463-477.

Bytheway, B. (2005b). Ageism and age categorisation. *Journal of Social Issues, 61*(2), 361-374. doi:10.1111/j.1540-4560.2005.00410.x

Bytheway, B. (2011). *Unmasking age: The significance of age in social research*. Bristol, UK: Policy Press.

Care Jobs New Zealand. (2015). Half of New Zealand aged population use residential aged care. 2. Retrieved from http://www.carejobz.com/#!Half-of-New-Zealand-aged-population-use-residential-care/c10qd/557a0bec0cf2eb01de3acf28 Accessed 07 March 2016

Carney, G. (2010). Citizenship and structured dependency: The implications of policy design for senior political power. *Ageing & Society, 30*(2), 229-251. doi:10.1017/S0144686X09990110

Carpinter, P. (2012). *History of the welfare state in New Zealand*. Wellington, New Zealand: New Zealand Treasury.

Carrigan, M, & Szmigin, I. (1998). The usage and portrayal of older models in contemporary consumer advertising. *Journal of Marketing Practice, 4*(8), 231-248. doi:10.1108/EUM0000000004544

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research*. London, UK: Sage.

Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research, 14*, 1140-1150. doi:10.1177/1049732304266820

Cheek, J, & Ballantyne, A. (2001). Moving them on and in: The process of searching for and selecting an aged care facility. *Qualitative Health Research, 11*, 221-236. doi:10.1177/104973201129119064

Cheek, J, Ballantyne, A, Byers, L, & Quan, J. (2006). From retirement village to residential aged care: What older people and their families say. *Health and Social Care in the Community, 15*(1), 8-17. doi:10.1111/j.1365-2524.2006.00646.x

Cheek, J., & Porter, S. (1997). Reviewing Foucault: possibilities and problems for nursing and health care. *Nursing Inquiry, 4*(2), 108-119 112p.

Cheyne, C., O'Brien, M, & Belgrave, M. (2008). *Social policy in Aotearoa New Zealand* (Vol. 4th ed.). London, UK: Oxford University Press.

Chouliaraki, L, & Fairclough, N. (2010). Critical discourse analysis in organizational studies: towards an integrationist methodology. *Journal of management studies, 47*(6), 1213-1218. doi:10.1111/j.1467-6486.2009.00883.x

Chouliaraki, L, & Fairclough, N. (1999). *Discourse in late modernity: Rethinking critical discourse analysis*. Edinburgh, Scotland: Edinburgh University Press.

Clarke, A. E, Shim, J.K, Mamo, L, Fosket, J. R, & Fishman, J. R. (2003). Biomedicalization: Technoscientific transformations of health, illness and US medicine. *American Sociological Review, 68*, 161-194.

Clarke, J.N. (1991). Media portrayal of disease from the medical, political economy and life-style perspectives. *Quality Health Research, 1*, 287-308. doi:10.1177/104973239100100302

Comfort, A. (1979). *A good age*. Melbourne, Australia: Macmillan.

Comor, Edward. (2015). Revisiting Marx's value theory: A critical response to analyses of digital prosumption. *The Information Society, 31*(1), 13. doi:10.1080/01972243.2015.977627

Connell, J. (2006). Medical tourism: Sea, sun, sand and … surgery. *Tourism Management, 27*(6), 1093-1100. doi:http://dx.doi.org/10.1016/j.tourman.2005.11.005

Connidis, I, A, & McMullen, J.A. (2002). Sociological ambivalence and family ties: A critical perspective. *Journal of Marriage and the Family, 64*(August), 558-567. doi:10.1111/j.1741-3737.2002.00558.x

Connolly, M, Broad, J. B, Boyd, M., Kerse, N., & Gott, M. (2014). Residential aged care: The de facto hospice for New Zealand's older people. *Australasian Journal on Ageing, 33*(2), 114-120. doi:10.1111/ajag.12010

Conrad, C. (1998). Old age and the health care system. In P. Johnson & P. Thane, *Old age from antiquity to modernity* (1st ed., pp. 132-145). London, UK: Routledge.

Cook, L. (2009). The New Zealand family from 1840: A demographic history by Ian Pool, Dharamlingchan Arunachalam & Janet Sceats. *Social Policy Journal of New Zealand, 35*, 173-177.

Cora, V.L., & Luther, C. (2014). Community Health Nursing. In K. S. Lundy, U. C. Fan, R. F. Conner, L. P. Villarreal, P. D. Repovich, D. A. Babcock, S. Janes, R. Pickering, K. A. Edwards, & A. P. Agarwal (Eds.), *Community Health Nursing: Caring for the public's health* (pp. 983). Burlington, MA: Jones & Bartlett Learning. Retrieved from https://books.google.co.nz/books?id=OYAmBgAAQBAJ Accessed 07 March 2016

Coupland, J. (2009). Time, the body and the reversibility of ageing: Commodifying the decade. *Ageing & Society, 29*, 953-976. doi:10.1017/S0144686X09008794

Coupland, J. (2013). Dance, ageing and the mirror: Negotiating watchability. *Discourse and Communication, 7*(3), 1-24.

Coupland, N, & Coupland, J. (1993). Discourses of ageism and anti-ageism. *Journal of Aging Studies, 7*(3), 279-301. doi:10.1016/0890-4065(93)90016-D

Coupland, N, Coupland, J, & Giles, D. (1991). *Language, society and the elderly*. Oxford, UK: Blackwell.

Coupland, N, & Ylanne-McEwan, V. (1993). Discourse, institutions and the elderly. *Journal of Ageing Studies, 7*(3), 229-235. doi:10.1016/0890-4065(93)90012-9

Creedy, J, & Ball, C. (2013). *Population ageing and the growth of income and consumption tax revenue* (WP 13/09). Wellington, New Zealand: Treasury NZ.

Cuddy, A.J.C, Norton, M.I, & Fiske, S, T. (2005). This old stereotype: The pervasiveness and persistence of the elderly stereotype. *Journal of Social Issues, 61*(2), 267-285. doi:DOI 10.1111/j.1540-4560.2005.00405.x

Cumming, A, & Moore, T. (1984). Educational research - two paradigms: Two epistemologies. *Australian Journal of Teacher Education, 9*(2), 49-59.

Daatland, S.O, & Herlofson, K. (2003). "Lost solidarity" or "changed solidarity": A comparitive European view of normative family solidarity. *Ageing & Society, 23*(5), 537-560.

Dalziel, L. (2001a). *The New Zealand Positive Ageing Strategy*. Wellington: Ministry of Social Policy.

Dalziel, L. (2001b). *The New Zealand positive ageing strategy*. Wellington, New Zealand: Ministry of Social Policy. doi:0478251041, 9780478251043

Davey, J. (2002). Active ageing and education in mid to later life. *Ageing & Society, 22*(1), 95-113. doi:DOI 10.1017/S0144686X02008528

Davey, J., & Glasgow, K. (2006). Positive ageing: A critical analysis. *Policy Quarterly, 2*(4), 21-27.

Davies, S., & Nolan, M. (2003). 'Making the best of things': Relatives experiences about aged care-home entry. *Ageing & Society, 23*, 429-450.

Dellasega, C., Mastrian, K., & Weinert, C. (1995). The process and consequences of institutionalising an elder. *Western Journal of Nursing REsearch, 17*(2), 123-140. doi:10.1177/019394599501700202

Directions. (2011). It's not just the garden that's thriving. *Directions Magazine*.

Dorothy. (2001, 20 November 2010). *Growing Up in New Zealand: 1925 - 1950.* [Feature]. Retrieved from NZine:http://wwwnzine.co.nz/features/guinz25-50_part11.html Accessed 7 March 2016

Dwyer, S. (2005). Older people and permanent care: Who's decision? *The British Journal of Social Work, 35*(7), 1081-1092. doi:10.1093/bjsw/bch214

Dykstra, P.A, & Hagestad, G.O. (2007). Roads less taken: Developing a nuanced view of older adults without children. *Journal of Family Issues, 28*(10), 1275-1310. doi:10.1177/0192513X07303822

Dyson, R. (2002). *Health of older people strategy*. Wellington, New Zealand: Ministry of Health. doi:9780478270600, 0478270607

Dyson, R. (2004). *Guideline for specialist health services for older people*. Wellington, New Zealand: Ministry of Health.

Edwards, H., Courtney, M., & Spencer, L. (2003). Consumer expectations of residential aged care: Reflections on the literature. *International journal of nursing practice, 9*(2), 70-77. doi:10.1046/j.1322-7114.2003.00415.x

Ekerdt, D. (2010). Frontiers of research on work and retirement. *Journal of Gerontology, 65*(1), 69-80.

Ellis, J.M. (2010). Psychological transition into a residential care facility: Older people's experiences *Journal of Advanced Nursing, 66*(5), 1159-1168. doi:10.1111/j.1365-2648.2010.05280.x

Ellor, J. W. (2001). *Aging, spirituality, and pastoral care: A multi-national perspective*. New York: The Hawarth Pastoral Press.

Engel, G.L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(8 April), 129-196.

Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: Norton.

Estes, C.L. (1979). *The aging enterprise*. San Francisco: Jossey Bass.

Estes, C.L. (2001). Political economy of aging: A theoretical framework. In C. L. Estes (Ed.), *Social policy & aging: A critical perspective* (pp. 1-23). Thousand Oaks, CA: SAGE Publications. Retrieved from http://dx.doi.org/10.4135/9781452232676. doi:Retrieved from http://dx.doi.org/10.4135/9781452232676. Retrieved from SAGE knowledge database 07 March 2016.

Estes, C.L., & Binney, E. (1989). The biomedicalization of aging: Dangers and dilemmas. *The Geronotologist, 29*(5), 587-596.

Estes, C.L., Wallace, S.P., Linkins, K.W., & Binney, E. (2001). *The medicalization and commodification of aging and the privatization and rationalization of old age policy. Social policy & aging: A critical perspective*. In C.L. Estes (Ed.), Social Policy & Aging: A critical perspective (pp. 45-61) Thousand Oaks, CA: SAGE Publications. Retrieved from http://dx.doi.org/10.4135/9781452232676. doi:Retrieved from http://dx.doi.org/10.4135/9781452232676. Retrieved from SAGE knowledge database 07 March 2016.

Fairclough, N. (1989). *Language and power* (2nd ed.). London, UK: Longman.

Fairclough, N. (1992). *Media discourse*. London, UK: Edward Arnold. (Original work published 1992) (Reprinted from 1995)

Fairclough, N. (1992 a). *Discourse and social change*. Cambridge, UK: Polity Press.

Fairclough, N. (1993). Critical Discourse Analysis and the marketization of public discourse: The Univestities. *Discourse & Society, 4*(2), 133-168.

Fairclough, N. (1998). Political discourse in the media: Analytical framework. In A. Bell & P. Garret (Eds.), *Approaches to media discourse* (pp. 142-`162). Oxford, UK: Blackwell.

Fairclough, N. (2002). Language in new capitalism. *Discourse & Society, 13*(2), 163-166.

Fairclough, N. (2005). Critical discourse analysis in trans-disciplinary research. In R. Wodak & P. A. Chilton (Eds.), *A new agenda in (critical) discouse analysis* (pp. 17-32). Amsterdam, Holland: Benjamin Publications.

Fairclough, N. (2010). *Critical discourse analysis: : the critical study of language* (2 nd ed.) [Book]. Harlow, England: Longman. (Original work published 1995)

Fairclough, N., Graham, P, Lemke, J, & Wodak, R. (2004). Introduction. *Critical Discourse Studies, 1*(1), 1-7.

Fairclough, N., Mulderrig, J, & Wodak, R. (2011). Critical Discourse Analysis. In T. A. van Dijk (Ed.), *Discourse studies: A multidisciplinary introduction* (2nd ed., pp. 357-378). London, UK: Sage.

Fairclough, N., & Wodak, R. (1997). Critical discourse analysis. In T. A. van Dijk (Ed.), *Discourse as social action* (Vol. 2, pp. 258-284). London, UK: Sage.

Faulkner, M., & Davies, S. (2006). The CARE (Combined Assessment Of Residential Environhments) profiles: A new approach to improving quality in care homes. *Quality in Ageing and Older Adults, 7*(3), 15-25. doi:10.1108/14717794200600016

Fealy, G, McNamara, M, Treacy, M.P, & Lyons, I. (2012). Constructing ageing and age identitities: A case study of newspaper discourses. *Ageing & Society, 32*, 85-102. doi:10.1017/S0144686X11000092

Featherstone, M, & Hepworth, M. (2005). *Images of ageing: Cultural representations of later life* (Retrieved from http://ezproxy.aut.ac.nz/login?qurl=http%3A%2F%2Fwww.credoreference.com/entry/cupage/images_of_ageing_cultural_representations_of_later_life Accessed 7 March 2016)(Original work published 2005)

Fetzer, A, & Weizman, E. (2006). Political discourse as mediated and public discourse. *Journal of Pragmatics, 38*, 143-153. doi:10.1016/j.pragma.2005.06.014

Finch, J, & Mason, J. (1990). Filial obligations and kin support for elderly people. *Ageing & Society, 10*(2), 151-175. doi:10.1017/S0144686X00008059

Foddy, B. (2012). The right and wrong of growing old: Assessing the argument from evolution. *Philosophy & Technology, 12/12*(25/4), 547-560. doi:10.1007/s13347-012-0066-7

Fornet Betancourt, R, Becker, H, Gomes Meuller, G, & Gauthier, J.D. (1987). The ethic of care for the self as a practice of freedom: An interview with Michel Foucault on January 20, 1984. *Philosophy and Social Criticism, 12*, 112-131. doi:10.1177/019145378701200202

Foucault, M. (1970). *The order of things*. Nerw York, USA: Routledge.

Foucault, M. (1971). *The archaeology of knowledge ; and, the discourse on language* (A. M. Sheridan Smith, Trans.). New York, USA: Pantheon Books.

Foucault, M. (1972). *The archeology of knowledge* (A. M. Sheridan Smith, Trans.). London, UK: Tavistock.

Foucault, M. (1973). *The birth of the clinic* (A. M. Sheridan, Trans.). London, UK: Routledge.

Foucault, M. (1977). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York, USA: Random House.

Foucault, M. (1978b). Politics and the study of discourse. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 307): University of Chbicago Press Books.

Foucault, M. (1980). *Power/Knowledge.* Harvester Press: Brighton.

Foucault, M. (1994a). Power. In J. D. Faubion (Ed.), *Essential works of Foucault* (2nd ed., Vol. 3, pp. 477). London, UK: Penguin Books.

Foucault, M. (1994b). The risk of security: Security and dependency : A diabolical pair. In J. D. Faubion (Ed.), *Michel Foucault: Essential works of Foucault 1954 - 1984* (2nd ed., Vol. 3, pp. 349-381). London, UK: Penguin.

Foucault, M. (1994c). The subject and power. In J. D. Faubian (Ed.), *Michel Foucault: Power. Essential works of Foucault 1954 - 1984* (2nd ed., Vol. 3, pp. 326- 348). London, UK: Penguin.

Fracchia, Joseph. (1995). Time, labor and social domination: A reinterpretation of Marx's critical theory. *History and Theory, 34*(4), 355-371.

Frame, J. (1961). *Faces in the Water*. Wellington: The Women's Press.

Friedman, S. M., Steinwachs, D.M., Rathouz, P. J., Burton, L.C., & Mukamel, D.B. (2005). Characteristics predicting nursing home admission in the program of all-inclusive care for elderly people. *The Gerontologist, 45*(2), 157-166. doi:10.1093/geront/45.2.157

Gadson, A. D. (2003). Neither hearth nor home: The (un) making of elder care responsibility. *Journal of Aging Studies, 17*(3), 17-29. doi:10.1016/S0890-4065(02)00087-7

Gamliel, T, & Hazan, H. (2006). The meaning of stigma: Identity construction in two old-age institutions. *Ageing & Society, 26*, 355-371. doi:10.1017/S0144686X0500454X

Gamson, W.A. (1992). *Talking politics* (1st ed.). Cambridge, UK: Cambridge University Press.

Gans, D, & Silverstein, M. (2006). Norms of filial responsibility for aging parents across time and generations. *Journal of Marriage and the Family, 68*(November), 961-976.

Gauld, R. (2009). *Revolving doors: New Zealand's health reforms - The continuing saga*. Wellington, New Zealand: Health Services Research Centre and Institute of Policy Studies.

Gawande, A. (2010, 22). Letting go: What should medicine do when it can't save your life? [Magazine Article]. *The New Yorker,* p. 1.

Gawande, A. (2014). *Being mortal*. London, UK: Profile Books.

Gee, J.P. (2014a). *How to do discourse analysis; A toolkit* (2nd ed.). New York: Routledge.

Gee, J.P. (2014b). *An Introduction to discourse analysis: Theory and method* (4th ed.). Abington, UK: Routledge.

Gergen, K.J, & Gergen, M, M. (2000). The new aging: Self construction and social values. In K. W. Schaie (Ed.), *Social structures and aging* (pp. 224). New York: Springer.

Gibbs, A. , Fraser, D., & Scott, J. (1988). *Unshackling the hospitals*. Wellington, New Zealand: New Zealand Government. Retrieved from 0477045200, 9780477045209

Gibson, B. (1998). *Aged care: Old policies, new problems*. Cambridge, UK: Cambridge University Press.

Giddens, A. (1994). *Beyond left and right: The future of radical politics*. Stanford, USA: Stanford University Press.

Gigerenzer, G., Hoffrage, U., & Kleinbfilting, H. (1991). Probabilistic mental models: A Brunswikian theory of confidence. *Psycholgical Review, 98*(4), 506-528. doi:10.1037/0033-295X.98.4.506

Gilbert, T.P. (2005). Trust and managerialism: Exploring discourses of care. *Nursing and Healthcare Management and Policy, 52*(4), 454-463. doi:10.1111/j.1365-2648.2005.03611.x

Gill, E. A., & Morgan, M. (2012). Older parents and adult daughters: A comparison of communication and coping during the decision to move to a care facility. *Research on Aging, 34*(6), 714-737.

Gilleard, C, & Higgs, P. (2010a). Aging without agency; Theorising the fourth age. *Aging and Mental Health*, 121-128.

Gilleard, C. , & Higgs, P. (2000). *Cultures of ageing. Self, citizen and the body*. Harlow, UK: Prentice Hall.

Gilleard, C. , & Higgs, P. (2005). *Context of ageing: Class, cohort and community*. Cambridge, UK: Polity Press.

Gilleard, C. , & Higgs, P. (2010b). Aging without agency: Theorizing the fourth age. *Aging and Mental Health, 14*(2), 121-128. doi:10.1080/13607860903228762

Gilleard, C. , & Higgs, P. (2013). *Ageing, corporeality and embodiment*. London: Anthem Press.

Golant, S. M. (2011). The quest for residential normalcy by older adults: Relocation but one pathway. *Journal of Aging Studies, 25*(3), 193-205. doi:10.1016/j.jaging.2011.03.003

Grant, B.C. (2008). Should physical activity be on the healthy ageing agenda. *Social Policy Journal of New Zealand*(33), 163-177.

Grant Thornton Report. (2010). *Aged residential care service review*. Wellington, New Zealand: New Zealand Aged Care Association.

Gray, L., & Dakin, L. (2011). Australian and New Zealand Society for Geriatric Medicine. Position statement--Older persons in acute hospitals awaiting transfer to a residential aged care facility. *Australasian Journal on Ageing, 30*(1), 43-46. doi:10.1111/j.1741-6612.2011.00512.x

Greypower Magazine. (2014, November 2014). BPW NZ calls for the Minister of Health to be *accountable for aged care workers pay* [Update]. *The Greypower Magazine, 20*(20)*,* 21.

Gros, F., Ewald, F., Fontana, A., & Davidson, A.I. (Eds.). (2010). *The government of self and others - Lectures at the College De France 1982 - 1983* (G. Burchell, Trans., Second ed.). Basingstoke, UK: Palgrave MacMillan.

Gubrium, J.F. (1993). Family discourse, organisational embeddedness and local enactment. *Journal of Family Issues, 14*(1), 66-81. doi:10.1177/0192513X93014001006

Haboush, A., Warren, C.S., & Benuto, L. (2012). Beauty, ethnicity, and age: Does internalization of mainstream media ideals influence attitudes towards older adults? *Sex Roles, 66*(9-10), 668-676. doi:10.1007/s11199-011-0102-6

Hammersley. (1997). On the foundations of critical discourse analysis. *Language & Communication, 17*(3), 237-248. doi:10.1016/S0271-5309(97)00013-X

Haraway, D. (1991). *The cyborg manifesto: Science, technology and socialist feminism in the late twentieth century*. London, UK: Routledge.

Harrison, S., & McDonald, R. (2003). Science, consumerism and bureaucracy: New legitimations of medical professionalism. *The International Jouranl of Public Sector Management, 16*(2), 110-121. doi:10.1108/09513550310467966

Hayman, K.J, Kerse, N, Dyall, L, Kepa, M, Teh, R, Wham, C, . . . Jantrana, S. (2012). Life and living in advanced age: A cohort study in New Zealand - Te Puawaitanga o Nga Tapuwae Kia Ora Tonu, LiLACS NZ: Study Protocol [Cohort Study predicting healthy ageing]. *BMC Geriatrics, 12*(33). doi:10.1186/1471-2318-12-33

Hays, J.C. (2002). Living arrangements and health status in later life: A review of recent literature. *Public Health Nursing*, 136-151. doi:10.1046/j.1525-1446.2002.00209.x

Heenan, B. (1993). Population patterns. In P. G. Koopman-Boyden (Ed.), *New Zealand's ageing society: The implications* (pp. 29-54). Wellington, New Zealand: Daphne Brassell Associates Press.

Henderson, R. (2004). Educational issues for children of itinerant seasonal farmworkers: A case study in an Australian context. *International Journal of Inclusive Education, 8*(3), 293-310. doi:eprints.qut.edu.au/2068/1/2068.pdf

Hendricks, J. (2004). Public policies and old age identity. *Journal of Aging Studies, 18*, 245-260. doi:10.1016/j.jaging.2004.03.007

Hendricks, J (Ed.). (1995). *Age identification* (3rd ed.). New York: Springer.

Heppenstall, C. P., Hanger, H. C., & Wilkinson, T. J. (2009). Predictors of discharge stability in the first year following hospital admission for a frail elderly population. *Internal medicine journal, 39*(3), 170. doi:10.1111/j.1445-5994.2008.01697.x

Heppenstall, C. P., Keeling, S., Hanger, H. C., & Wilkinson, T. J. (2014). Perceived factors which shape decision-making around the time of residential care admission in older adults: a qualitative study. *Australasian Journal on Ageing, 33*(1), 9-13. doi:10.1111/j.1741-6612.2012.00644.x

Heppenstall, C. P., Wilkinson, T. J., Hanger, H. C., Keeling, S., & Pearson, J. (2011). Factors related to care home admission in the year following hospitalisation in frail older adults. *Age and Ageing, 40*(4), 513-516. doi:10.1093/ageing/afr045

Hodges, B. D, Kuper, A, & Reeves, S. (2008). Qualitative research: Discourse analysis. *British Medical Journal, 337*(a879), 570-572. doi:10.1136/bmj.a879

Horvath, M. (2013). The silver tsunami is coming, Are we ready? *Huffington Post*.

Howden-Chapman, P. (2004). Housing standards: A glossary of housing and health. *Journal of Epidemiology & Community Health, 3*, 162-168. doi:10.1136/jech.2003.011569

Huckin, T.N. (1997). Social approaches to critical discourse analysis. In T. Miller (Ed.), U. S. I. Agency, *Functional approaches to written text: Classroom applications* (1st ed., pp. 78-92)

Huckin, T.N., Andrus, J, & Clary-Lemon, J. (2012). Critical discourse analysis and rhetoric and composition. *Language, 300.*(64), 107-129.

Hugman, R. (1994). *Ageing and the care of older people in Europe*. Basingstoke, UK: MacMillan.

Hugman, R. (1999). Embodying old age. In E. K. Teather (Ed.), *Embodied geographies: Spaces, bodies and rites of passage* (pp. 193-207). London, UK: Routlege.

Hugman, R. (2001). Looking to the future: Ageing in space. *Australasian Journal on Ageing, 20*(3), 57-65. doi:10.1111/j.1741-6612.2001.tb00400.x

Human Rights Commission. (2012). *Caring counts*. Wellington, New Zealand: New Zealand Human Rights Commission.

Hunter, M. (2014a, 16 January 2014). Australia's aging tsunami and the coming aged care catastrophe. *Independent Australia*.

Hunter, T. (2014b, 23 November 2014). Arvida thickens the plot [Business Opinion]. *Sunday Star Times,* p. D11.

Hurd-Clark, L, Bennett, E.V, & Liu, C. (2014). Aging and masculinity: Portrayals in men's magazines. *Journal of Aging Studies, 31*, 26-33. doi:10.1016/j.jaging.2014.08.002

Hurd-Clarke, L, & Griffin, M. (2008). Visible and invisible ageing: Beauty work as a response to ageism. *Ageing & Society, 28*(5), 653-674. doi:10.1017/S0144686X07007003

Hurnard, R. (2005). *The effect of New Zealand Superannuation eligibility age on the labour force participation of older people* (05/09). Wellington, New Zealand: New Zealand Treasury.

Hyden, L. (1997). Illness and narrative. *Sociology of Health and Illness, 19*(1), 48-69. doi:10.1111/1467-9566.00040

Iliffe, S, & Manthorpe, J. (2012). Healthy ageing, unhealthy politics. *Policy and Politics, 52*(52), 75-87.

Ingersoll-Dayton, B, Starrels, M.E, & Dowler, D. (1996). Caregiving for parents and parents-in-law: Is gender important? *The Geronotologist, 36*(4), 483-491. doi:10.1093/geront/36.4.483

Janks, H. (1997). Critical discourse analysis as a research tool. *Discourse: Studies in the Cultural Politics of Education, 18*(3), 329-342. doi:10.1080/0159630970180302

Jeannot, T. M. (1994). After "The Darkness at Noon": A biographical study of Marxism as critical theory. *International Journal of Social Economics, 21*(2-4), 81. doi:10.1108/EUM0000000003947

Jefferys, M. (1991). Growing old in the twentieth century. London, UK: Routledge.

Jiwani, Y., & Richardson, J.E. (2011). Discourse, ethnicity and racism. In T. A. van Dijk (Ed.), *Discourse Studies* (pp. 241-262)

Johnson, R. . (2011, Oct 31, 2011). Staying fit - A nip and a tuck: The 65-plus crowd is signing up for cosmetic surgery, but may not recognize the risks. [Business And Economics]. *Wall Street Journal,* p. R11. Retrieved from Retrieved from http://ezproxy.aut.ac.nz/login?url=http://search.proquest.com/docview/900997379?accountid=8440 Accessed 7 March 2016

Johnson, R.A, & Bibbo, J. (2014). Relocation decisions and constructing the meaning of home: A phenomenological study of the transition into a nursing home. *Journal of Aging Studies, 30*, 56-63. doi:10.1016/j.jaging.2014.03.005

Johnston, M. (2008, June 30 2008). PM slams gagging of rest home patient [Newspaper Article]. *New Zealand Herald*.

Jorgensen, D. (2006a). *Factors influencing entry to residential care among older people* (Unpublished doctoral thesis). University of Auckland, Auckland, New Zealand.

Jorgensen, D, Arksey, H., Parsons, M, Senior, H., & Thomas, D. (2009). Why do older people in New Zealand enter residential care rather than choosing to remain at home, and who makes that decision? *Ageing International, 34*(1-2), 15-32. doi:10.1007/s12126-009-9034-7

Jorgensen, D. M. (2006b). *Factors influencing entry to residential care among older people*. University of Auckland, Auckland.

Jungers, C. M. (2010). Leaving home: An examination of late-life relocation among older adults. *Journal of Counseling & Development, 88*(4), 416-423. doi:10.1002/j.1556-6678.2010.tb00041.x

Kanfer, R., & Ackerman, P.L. (2004). Aging, adult development, and work motivation. *Academy of Management Review, 29*, 440-458.

Katz, S. (1992). Alarmist demography: power, knowledge and the elderly population. *Journal of Aging Studies, 6*(3), 203-225. doi:10.1016/0890-4065(92)90001-M

Katz, S. (2000). Busy bodies: Activity, aging, and the management of everyday life. *Journal of Aging Studies, 14*(2), 135-152. doi:10.1016/S0890-4065(00)80008-0

Katz, S. (2007). Thinking of age: Personal reflections on critical gerontology. *Journal of Aging Studies, 22*, 140-146. doi:10.1016/j.jaging.2007.12.012

Katz, S. (2013). Active and successful aging. Lifestyle as a gerontological idea. *Recherch sociologiques et anthropologiques (En ligne), 44*, 33-49. doi:10.4000/rsa.910

Katz, S., & Marshall, B. (2003). New sex for old: Lifestyle, consumerism and the ethics of aging well. *Journal of Aging Studies, 17*(1), 3-16. doi:10.1016/S0890-4065(02)00086-5

Kaufman, C. (2005). *Introduction in Australian New Urbanism - A guide to projects* Melbourne, Australia: ECD. Retrieved from www.acnu.org.au/australian-projects-book-2006/ doi:www.acnu.org.au/australian-projects-book-2006/Accessed 7 March 2016

Kedgely, S., & Laban, W. (2010). *A Report into aged care: What does the future hold for older New Zealanders*. Wellington, New Zealand: New Zealand Labour Party & Green Party of Aoteoroa New Zealand,.

Kendig, H, & Gardner, I. L. (1997). Unravelling housing policy for older people. In A. Borowski, S. Encel, & E. Ozanne (Eds.), *Ageing and social Policy in Australia* (pp. 174-193). Cambridge, UK: Cambridge University Press.

Kendig, H., Crisp, D., Gong, C., Conway, E., & Squires, E. (2014). *An investigation of the IRT retirement community landscape: A pilot study*. Wollongong, NSW, Australia: Centre for Research on Ageing, Health and Wellbeing, The Australian National University. Retrieved

from
http://www.irtfoundation.org.au/images/Research_files/Investigation_of_the_IRT_land
scape_-_Pilot_research_report_Oct.2014.pdf Accessed 07 March 2016

Kensington Court. (2012a, 03 April). Advertisment [Advertisement]. *Nelson Weekly*.

Kensington Court. (2012b, 3 April 2012). Advertisment. *Nelson Mail*.

Kermode, S., & Brown, C. (1996). The postmodern hoax and its effects on nursing. *International Journal of Nursing Studies, 33*(4), 375-384. doi:10.1016/0020-7489(95)00072-0

Kirkwood, T. (2001, 09 October 2014). *The end of age* [Audio Lecture]. Retrieved from http://www.bbc.co.uk/radio4/reith2001

Koopman-Boyden, P.G., & Waldegrave, C. (2009). *Enhancing wellbeing in an ageing society*. Hamilton, New Zealand.: University of Waikato.

Kozakowska-Molek, K. (2013). Towards a pragma-linguistic framework for the study of sensationalism in news headlines. *Discourse and Communication, 7*, 173-197.

Kress, G. (2010a). *Multimodality*. London

Kress, G. (2010b). *Multimodality: A social semiotic approach to contemporary communication*. London, UK: Routledge.

Kress, G, & van Leeuwen, T. (1996). *Reading Images*. London, UK: Routledge.

Krueger, R.A. (1994). *Focus groups: A practical guide for applied research* (2nd ed.). Thousand Oaks, CA: Sage

Krueger, R.A., & Casey, M.A. (2009). *Focus groups: A practical guide for applied research* (4th ed.). Thousand Oaks, CA: Sage.

Lascoumes, P, & Le Gales, P. (2007). Introduction: Understanding public policy through its instruments - from the nature of instruments to the sociology of public policy instrumentation. *Governance, 20*(1), 1-21. doi:10.1111/j.1468-0491.2007.00342.x

Laslett, P. (1989). *A fresh map of life*. London, UK: Weidenfield and Nicholson.

Lassen, A.J, & Moreira, T. (2014). Unmaking old age: Political and cognitive formats of active ageing. *Journal of Aging Studies, 30*, 33-46. doi:10.1016/j.jaging.2014.03.004

Laws, G. (1996a). A shot of economic adrenalin: Reconstructing "The Elderly" in the retiree-based economic development literature. *Journal of Aging Studies, 10*(3), 171-188.

Laws, G. (1996b). Spatiality and age relations. In A. Jamieson, S. Harper, & C. Victor (Eds.), *Critical approaches to ageing and later life* (pp. 90-101). Buckingham, UK: Open University Press.

Lemke, T. (2000, 21-24 September 2001). *Foucault, governmentality and critique*. presented at the meeting of the Rethinking Marxism, University of Amherst. Retrieved from http://www.thomaslemkeweb.de/publikationen/Foucault,%20Governmentality,%20and%20Critique%20IV-2.pdf Accessed 07 March 2016

Lieberman, M. A, & Fisher, L. (1999). The effects of family conflict resolution and decision making on the provision of help for an elder with Alzheimer's disease. *The Geronotologist, 39*(2), 159-166. doi:10.1093/geront/39.2.159

Livingston, G. (2005). *Too soon old, too late smart*. Sydney, Australia: Hodder.

Lloyd-Sherlock, P., Barrientos, A., & Mase, J. (2012). Social inclusion of older people in developing countries: relations and resources. In T. Scharf & N. Keating (Eds.), *From exclusion to inclusion in old age* (pp. 51-69). Bristol, UK: The Policy Press.

Locke, L. (1996). Dr Lewin's little liver patties: A parable about encouraging healthy lifestyles. *Quest, 48*, 422-431.

Lui, Chai-Wai, Warburton, J. , Winterton, R. , & Bartlett, H. (2012). Critical reflections on a social inclusion approach for an ageing Australia. *Australian Social Work, 64*(3), 266-282. doi:10.1080/0312407X.2011.573860

Luke, A. (1997a). The material effects of the word: Apologies, "Stolen Children" and public discourse. *Discourse: Studies in the Cultural Politics of Education, 18*(3), 343-368. doi:10.1080/0159630970180303

Luke, A. (1997b). Theory and practice in critical science discourse. In L. Saha (Ed.), *International Encyclopaedia of the Sociology of Education* (pp. 50-56). New York: Pergamon. Retrieved from Retrieved from http://pages.gseis.ucla.edu/faculty/kellner/ed270/Luke/SAHA6.html Accessed 07 March 2016

Luke, A. (2002). Beyond science and ideology critique: Developments in critical discourse analysis. *Annual Review of Applied Linguistics, 22*, 96-110. doi:10.1017/S0267190502000053

Lumme-Sandt, K. (2011). Images of ageing in a 50+ magazine. *Journal of Aging Studies, 25*, 45-51. doi:10.1016/j.jaging.2010.08.013

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health, 16*, 145-150.

MacDonald, M. (2003). *Exploring media discourse*. Oxford, UK: Oxford University Press.

Machin, D. (2013). What is multimodal critical discourse studies? *Critical Discourse Studies, 10*(4), 347-355.

Malone, E. (1821). *The plays and poems of William Shakspeare*. London, England: Baldwin Prister.

Malterud, K. (2001). Qualitative research: Standards, challenges and guidelines. *The Lancet, 358*, 483-488.

Manzo, L. C. (2003). Beyond house and haven: Toward a revisioning of emotional relationships with places. *Journal of Environmental Psychology, 23*(1), 47-61. doi:http://dx.doi.org/10.1016/S0272-4944(02)00074-9

Marsden, S, & Holmes, J. (2014). Talking to the elderly in New Zealand residential care settings. *Journal of Pragmatics, 64*, 17-34. doi:10.1016/j.pragma.2014.01.006

Marshall, B., & Rahman, M. (2014). Celebrity, ageing and the construction of 'thrid age' identities. *International Journal of Cultural Studies*(June), 35-47. doi:1367877914535399

Martikainen, P., Moustgaard, H., Murphy, M., Einio, E.K., Koskinen, S., Martelin, T., & Noro, A. (2009). Gender, living arrangements, and social circumstances as determinants of entry into and exit fron long-term institutional care at older ages: A 6 year follow up study of older Finns. *The Geronotologist, 49*(1), 34-45. doi:10.1093/geront/gnp013

Matthijs Bal, P., De Lange, A. H., Jansen, P. G. W., & ven Der Velde, M. E. G. (2008). Psychological contract breach and job attitudes: A meta-analysis of age as a moderator. *Journal of Vocational Behaviour, 72*, 143-158. doi:10.1016/j.jvb.2007.10.005

Maturo, A. (2012). Medicalization: Current concepts and future directions in a bionic society. *Mens Sana Monographs, 10*(1), 122-133. doi:10.410/0973-1229.91587

McAllen, J., & Steward, I. (2014, October 12 ,2014). Drugs "straightjacket" for elderly [News]. *Sunday Star Times,* p. 5.

McAuley, W., Travis, S., & Safewright, M. (1997). Personal accounts of the nursing home search and selection process. *Qualitative Health Research, 7*(2), 236-254. doi:10.1177/104973239700700205

McCallum, J. (1997). Health and ageing: The last phase of the epidemiological transition. In A. Borowski, S. Encel, & E. Ozanne (Eds.), *Ageing and Social Policy in Australia* (pp. 54-73). Cambridge, UK: Cambridge University Press.

McDaniel, S. A., & Zimmer, Z. (2013). *Global aging in the twenty first century: Challenges, opportunities and implications*. Burlington, UK: Ashgate.

McDonald, E. (2012). Aristotle, Saussure, Kress on speech and writing: Language as paradigm for the semiotic? *Language & Communication, 32*(3), 205-215. doi:10.1016/j.langcom.2012.04.007

McDonald, P. (1997). Older people and their families: Issues for policy. In A. Borowski, S. Encel, & E. Ozanne (Eds.), *Ageing and social policy in Australia* (pp. 194-210)

McGannon, K.R, & Spence, J.C. (2012). Exploring news media representations of women's exercise and subjectivity through critical discourse analysis. *Qualitative Research in Sport, Exercise and Health, 4*(1), 32-50. doi:10.1080/2159676X.2011.653503

McGregor, S. (2004). Critical Discourse Analysis - A Primer. *Critical Science and Critical Discourse Analysis, 15*(1). Advance online publication. electronic article

McHugh, K.E. (2000). The ageless self? Emplacement of identities in Sun Belt retirement communities. *Journal of Ageing Studies*, 103-109. doi:.1016/S0890-4065(00)80018-3

McHugh, K.E. (2003a). Three faces of ageism: society, image and place. *Aging & Society*, 165-185.

McHugh, K.E. (2003b). Three faces of ageism: Society, image and place. *Ageing & Society, 23*(2), 165-185. doi:10.1017/S0144686X02001113

McKie, L., & Cunningham-Burley, S. (2005). *Families in society: boundaries and relationships*. Bristol, U.K: Policy Press.

McLean, F. S. (1966, 20 June 2013). *Medical Services* [Electronic article]. Retrieved from
        http://www.teara.govt.nz/en/1966/medical-services/3 Accessed 07 March 2016

McNeil, C, & Hunter, J. (2014). *The generation strain: Collective solutions to care in an ageing
        society*. London, UK: Institute for Public Policy Research.

Medical Council of New Zealand. (2010). Statment on advertising (pp. 1-3). Wellington, New
        Zealand: Medical Council of New Zealand.

Mercer, G. (1985). Exploring the secret caves of language: Janet Frame's poetry. *Meanjin, 44*(3).

Metlifecare. (2011, November). Advertisement. *Sunday Star Times*.

Metlifecare Oakwoods. (2011, October 2011). Advertisment. *Nelson Mail*.

Miles, R. (2013). Connected community. *Long Term Living, 62*(9), 35-36.

Miller, E. A., Booth, M., & Mor, V. (2008). Meeting the demographic challenges ahead: Toward
        culture change in an ageing New Zealand. *Australia and New Zealand health policy, 5*(1),
        5-5. doi:10.1186/1743-8462-5-5

Minichiello, V., Browne, J., & Kendig, H. (2000). Perceptions and consequences of ageism: Views
        of older people. *Ageing & Society, 20*, 253-278. doi:10.1017/S0144686X99007710

Ministry for Culture and Heritage. (2014). *Old-age Pensions Act becomes law*. Wellington, New
        Zealand: New Zealand Government. Retrieved from http://www.nzhistory.net.nz/old-
        age-pensions-act-passes-into-law Accessed 07 March 2016

Ministry of Business Innovation and Employment. (2014). *Exceptions to the retirement age rule*.
        Wellington, New Zealand: Ministry of Business, Innovation and Employment. Retrieved
        from http://www.dol.govt.nz/infozone/businessessentials/manage/ending-
        relationships/retirement-age-rule-exceptions.asp Accessed 07 March 2016

Ministry of Health. (1999). *Population ageing and health spending: 50-year projections*.
        Wellington, New Zealand: Ministry of Health.

Ministry of Health. (2004). *Guideline for specialist health services for older people*. Wellington,
        New Zealand: MInistry of Health.

Ministry of Health. (2006). *Health of Older People Information Strategic Plan Directions to 2010
        and Beyond*. Wellington: Ministry of Health.

Ministry of Health. (2011a). *Advance care planning: A guide for the New Zealand health
        workforce* (ISBN 978-0-478-37326-4 (Print)). Wellington, New Zealand: Ministry of
        Health. Retrieved from ISBN 978-0-478-37332-5 (online) Accessed 07 March 2016

Ministry of Health. (2011b). *Needs Assessment and Support Services for Older People: What you
        need to know*. Wellington, New Zealand. Retrieved from ISBN 978-0-478-37443-8 (Print)

Ministry of Health. (2013). *Showcasing aged care nursing*. Wellington, New Zealand

Ministry of Social Development. (2014). New Zealand positive ageing strategy action plan and
        annual report.

Minkler, M. (1989). Gold in gray: Reflections on business' discovery of the elderly market. *The
        Gerontological Society of America, 29*(1), 17-23.

Moore, J. (2000). Placing home in context. *Journal of Environmental Psychology, 20*(3), 207-217. doi:10.1006/jevp.2000.0178

Moreira, T., & Palladino, P. (2009). Ageing between gerontology and biomedicine. *Biosocieties, 4*(4), 349-365. doi:10.1017/S1745855209990305

Morgan, A. (2010). Discourse analysis: An overview for the neophyte researcher. *Journal of Health and Social Care Improvement*(May), 1-7.

Morgan, G, & Simmons, G. (2009). *Health Cheque*. Auckland, New Zealand: Phantom House.

Morgan, L.A., Eckert, J.K., & Lyon, S. M. (1993). Social marginality: The case of small board and care homes. *Journal of Aging Studies, 7*(4), 383-394. doi:10.1016/0890-4065(93)90006-6

Muralikrishnan, T. R. (2011). Critical discourse analysis: Politics and verbal coding. *Language in India, Special Volume*, 20-29. doi:www.languageinindia.com

Nadesan, M, H. (2008). *Governmentality, biopower and everyday life* (Vol. 57). New York: Routledge.

Nagel, J. (2007, 09/16/2007). Families changing size, shape. *The Tri City News,* p. 4. Retrieved from http://aut.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwnV3PT4MwFH4xMzGe3KLir5n-AYKUkhZORqfLEj162G1hUKLJwthgF_96v5b1YMgunqABwis03_f19fU9IsYzBVIpuVR5jPO8gMQoBl9MKqswycq__lxyKSD2v9YhooXpYp0bD_mjUHEq8Xz0VG98UzLKLK3u62cAf4HDJpxPzV8cChsatdI3MSudKuY9rLUEMj0jFwvaDxzp5WX8r4VDGhrIqrNab9lzNyJGdKSrcxrb-haYFDO70Rd0xZrvH_3Ami_cfUH307fPycx3r1wUq9UC00oJYQxlIi5pUK0r7dFxidGKIxjEQ9c8OpmnH6_J7H3SNUeuGTR2N1ewaT18KmueLwN1RayEdsqF5mWkTVY-IHIolpwvI6FjFYbZNXkHzLg5eOWWTjtnaOpzeUeDdrvTY-iAXfsLRpcCbsA Accessed 07 March 2016

National Centre for Chronic Disease Prevention and Health Promotion. (2013). *The state of aging and health in America 2013*. Washington, USA: US Department of Health and Human Services.

National Institute on Aging. (2007). *Why population aging matters: A global perspective*. Bethesda: US Department of State. Retrieved from https://www.nia.nih.gov/sites/default/filesWPAM.pdf Accessed 07 March 2016

Navarro, V., Muntaner, C., Borrell, C., Benach, J., Quiroga, A., Rodriguez-Sanz, M., . . . Pasarin, M.I. (2006). Politics and health outcomes. *Lancet, 368*(9540), 1033-1037. doi:10.1016/S0140-6736(06)69341-0

Nelson, T. (2005). Ageism: Prejudice against our feared future self. *Journal of Social Issues, 61*(2), 207-221.

Netton, A., Darton, R., Baumker, T., & Callaghan, L. (2011). *Improving housing with care choices foir older people: An evaluation of extra care housing*. Kent, United Kingdom: University of Kent. Retrieved from http://www.housinglin.org.uk/_library/Resources/Housing/Research_evaluation/PSSRU summary.pdf Accessed 07 March 2016

Neugarten, B. (1974). Age groups in American society and the rise of the young-old. *Annals of the American Academy of Political and Social Sciences, 9*(2), 187-198. doi:10.1177/000271627441500114

New Zealand Healthcare. (2012, April). Advertisment. *Mudcakes and Roses*.

New Zealand Treasury. (2005). *Population ageing and government health expenditure*. Wellington, New Zealand.

New Zealand Treasury. (2009). *Challenges and Choices: New Zealand's Long-tern Fiscal Statement*. Wellington: NZ Treasury.

New Zealand Treasury. (2012a). *Long-term care and fiscal sustainability*. Wellington, New Zealand: New Zealand Government.

New Zealand Treasury. (2012b). *Long-term care and fiscal sustainability*. Wellington, New Zealand: New Zealand Treasury.

Ng, Sik Hung, & McCreanor, Tim. (1999). Patterns in discourse about elderly people in New Zealand. *Journal of Aging Studies, 13*(4), 473-489. doi:10.1016/S0890-4065(99)00022-5

Nightingale, F. (1859). *Notes on hospitals*. London, UK: Longman.

Nikander, P. (2009). Doing change and continuity: Age identity and the micro-macro divide. *Ageing & Society, 29*(6), 863-881. doi:10.1017/S0144686X09008873

Nolan, M., Davies, S., & Brown, J. (2006). Transitions in care homes: Towards relationship-centred care using the 'Senses Framework". *Quality in Ageing, 7*(3), 5-14.

Nolan, M., Davies, S., Brown, J., Keady, J., & Nolan, J. (2003). Beyond 'person centred' care: a new vision for gerontological nursing. *International Journal of Older People Nursing, 13*(3), 45-53.

Nolan, M., & Dellasega, C. (2000). "I really fell I've let him down": Supporting family carers during long-term placement for elders. *Journal of Advanced Nursing, 31*(4), 759-767. doi: 10.1046/j.1365-2648.2000.01346.x

Norman, D. A. (1983). Soime observations on mental models. In D. Gentner & A. L. Stevens (Eds.), *Mental models* (pp. 7-14) (Reprinted from 2014)

O'Keefe, V. (2014). *Quality jobs, quality care*. Adelaide, Australia: University of South Australia. Retrieved from http://www.qualityjobsqualitycare.com.au/wp-content/uploads/2012/04/2014_QJQC_Perceptions_final.pdf Accessed 07 March 2016

O'Shea, E. (2006). Developing a heathy ageing policy for Ireland: The view from below. *Health Policy, 76*, 93-105.

Oakwoods. (11 November 2011). Write your own MetlifeCare story [Adverrtisement]. *Nelson Mail*.

Oakwoods. (2012, 2012). Advertisement. *The Leader*.

Ochs, E. (2011). Narrative in everyday life. In T. A. Van Dijk (Ed.), *Discourse Studies* (pp. 64-84). London: Sage.

OECD. (2005). *The OECD health project: Long-term care for older people.* Paris. France: Organisation For Economic Cooperation and Development.

OECD. (2011). *Paying for the past, providing the future*. Paris. France: OECD.

OECD. (2014). *OECD factbook 2014: Economic, environmental and social statistics*. doi:http://dx.doi.org/10.1787/factbook-2014-en

Office for Senior Citizens. (2013). *Older New Zealanders: Healthy, independent, connected and respected*. Wellington, New Zealand: NZ Government.

Office for Senior Citizens. (2015). *2014 Report on the positive ageing strategy* Wellington, New Zealand: Office for Senior Citizens,. Retrieved from 978-0-478-32369-6 (online)

Office of the Auditor General. (2009). *Effectiveness of arrangements to check the standard of services provided by rest homes*. Wellington, New Zealand: Office of the Auditor General.

Office of the Health and Disability Commissioner. (2009). *Case: 08hdc15931*. Auckland, New Zealand: Health & Disability Commissioner.

Ogg, J, & Renaut, S. (2012). Social inclusion of elders in families. In T. Scharf & N. Keating (Eds.), *From exclusion to inclusion in old age: A global challenge* (pp. 89-107). Bristol, UK: The Policy Press.

Older People's Commission for Wales. (2014). *A place to call home*. Cardiff, Wales: Older People's Commission for Wales. Retrieved from http://www.olderpeoplewales.com/Libraries/Uploads/A_Place_to_Call_Home_-_A_Review_into_the_Quality_of_Life_and_Care_of_Older_People_living_in_Care_Homes_in_Wales.sflb.ashx Accessed 07 March 2016

Oliver, W.H. (1988). *Social policy in New Zealand: An historical overview. In: The April report*. Wellington, New Zealand: Royal Commission on Social policy.

Park, R.E. (1950). *Race and culture*. New York: The Free Press.

Parliamentary Library Research Paper. (2009). *New Zealand health system reforms*. Wellington, New Zealand: Parliamentary Library.

Parsons, M., Senior, H. E. J., Kerse, N, Chen, M.H., Jacobs, S., Vanderhoorn, S., . . . Anderson, C. (2012). The assessment of services pomoting independence and recovery in elders trial (ASPIRE): A pre-planned meta-analysis of three independent randomised controlled trial evaluations of ageing in place initiatives in New Zealand. *Age and Ageing, 41*(6), 722. doi:10.1093/ageing/afs113

Patterson, A. (1997). Critical discourse analysis: a condition of doubt. *Discourse: Studies in the Cultural Politics of Education, 18*(3), 425-435. doi:10.1080/0159630970180307

Patterson, L.G, Forbes, K.E, & Peace, R. M. (2009). Happy, stable and contented: accomplished ageing in the imagined futures of young New Zealanders. *Ageing & Society, 29*(3), 431-454. doi:10.1017/S0144686X08007940

Pearson, A, & May, R. (2004). Relatives' expereince of nursing home admissions: Preliminary study. *Australasian Journal on Ageing, 23*(2), 86-90. doi:10.1111/j.0141-6790.2004.02701007_1.x

Pennycook, A. (1994). Incommensurable discourses? *Applied Linguistics, 15*(2), 115-138. doi:10.1093/applin/15.2.115

Penrose, G. (2014). No doubt - we are living longer. *Greypower Magazine*(21)*,* 11.

Perry, D.P. (2009). In the balance: Silver tsunami or longevity dividend? *Quality in Ageing, 10*(2), 15-22. doi:10.1108/14717794200900013

Peters, M.A. (2001). *Poststructuralism, Marxism, and neoliberalism: Between theory and politics*. New York: Rowman & Littlefield,.

Petersen, M., & Warburton, J. (2012). Residential complexes in Queensland, Australia: A space of segregation and ageism? *Ageing and Society, 32*, 60-84. doi:10.1017/S0144686X10001534

Petriwskyj, A., Gibson, A., & Webby, G. (2014). Participation and power in care: Exploring the "client" in client engagement. *Journal of Aging Studies, 31*, 119-131. doi:10.1016/j.jaging.2014.09.007

Phillipson, C. (2012). Globalisation, economic recession and social exclusion: Policy challenges and responses. In T. Scharf & N. Keating (Eds.), *From exclusion to inclusion in old age: A global challenge* (pp. 17-32). Chicago: The Policy Press.

Phillipson, C (1991). The social construction of old age: Perspectives from political economy. *Reviews in Clinical Gerontology, 1*(4), 403-410. doi:10.1017/S0959259800002902

Pickard, L, Wittenberg, R, Comans-Herrera, A, Kind, D, & Malley, J. (2007). Care by spouses, care by children: Projections of informal care for older people in England to 2031. *Social Policy and Society, 6*(3), 353-366. doi:10.1017/S1474746407003685

Pierce, M, & Timonen, V. (2010). *Theories of ageing and approaches to welfare in Ireland, North and South*. Dublin: Centre for Ageing Research and Development in Ireland.

Popejoy, L. (2005). Health-related decision-making by older adults and their families. *Journal of Gerontological Nursing, 31*(9), 12.

Powell, J., & Biggs, S. (2000). Managing old age: The disciplinary web of power, surveillance and normalization. *Journal of Aging and Identity, 5*(1), 3-13.

Powers, P. (2007). The philosophical foundations of Foucaultian discourse analysis. *Critical Approaches to Discourse Analysis across Disciplines, 1*(2), 18-34.

Pranger, R. J. (1968). Marx and political theory. *The Review of Politics, 30*(2), 191-208.

Preston, D. (2008). *Retirement income in New Zealand: The historical context*. Auckland, New Zealand: Retirement Commission. Retrieved from www.cffc.org.nz/assets/.../RI-Review-BP-Retirement-Income-History-2008 Accessed 07 March 2016

Prime Ministerial Taskforce on Positive Ageing. (1997). *Facing the future: A strategic plan. The final report*. Wellington, New Zealand: Department of the Prime Minister and Cabinet,.

Pryor, J. (2009). The family in social policy: an introduction to the families commission special issue. *Foreword, iv*(1).

Pylypa, J. (1998). Power and bodily practice: Applying the work of Foucault to an anthropology of the body. *Arizona Anthropologist, 13*, 21-36. doi:http://hdl.handle.net/10150/110194

Rabinow, P (Ed.). (2010). *Michel Foucault: The Foucault Reader* (Vol. 1). New York: Random House.

Ranzijn, R. (2010). Active ageing - Another way to oppress marginalized and disadvantaged elders: Aboriginal elders as a case study. *Journal of Health Psychology, 15*(5), 716-723. doi:10.1177/1359105310368181

Rea, D. (2009). Government expenditure and revenue in New Zealand: A brief overview. *Policy Quarterly, 5*(3), 58-67.

Reed, J., Cook, G., Sullivan, A., & Burridge, C. (2003a). Making a move: Care-home residents' experiences of relocation. *Ageing & Society, March*, 225-241. doi:10.1017/S0144686X02001101

Reed, J., Cook, G., Sullivan, A., & Burridge, C. (2003b). Making a move: care home residents' expereinces of relocation. *Ageing & Society, 23*, 225-241.

Reinhardy, J.R. (1995). Relocation to a new environment: Decisional control and the move to a nursing home. *Health & Social Work, 20*(1), 31-38.

Reyna, C., Goodwin, E.J., & Ferrari, J.R. (2007). Older adult stereotypes among care providers in residential care facilities: Examining the relationship between contact, education, and ageism. *Journal of Gerontological Nursing, 33*(2), 50.

Richards, R. (1993). *Closing the door to destitution: Shaping of the Social Security Acts in the United States and New Zealand*. Pensylvannia, USA: Penn State University.

Rolfe, G., & Davies, R. (2009). Second generation professional doctorates in nursing. *International Journal of Nursing Studies, 46*, 1265-1273. doi:10.1016/j.ijnurstu.2009.04.002

Rowe, J.W, & Kahn, R.L. (1987). Human aging: Usual and successful. *Science, 237*(Jult), 143-149. doi:10.1126/science.3299702

Ryall, A. (2012). *Health report*. Wellington, New Zealand: New Zealand Government.

Ryall, A. (2014a, 22 August 2014). *Midwinter Dialogues Speech*. Ministerial Speech presented at the meeting of the Midwinter Dialogues University of Otago, Christchurch New Zealand.

Ryall, A. (2014b, 11 June 2014). *Speech to Healthcare Congress in Auckland*. Ministerial Speech presented at the meeting of the Healthcare Congress in Auckland New Zealand, Auckland.

Ryall, A., & Goohew, J. (2014). *Funding boost for rest homes and dementia care*. Wellington, New Zealand: New Zealand Government.

Ryman. (2011a). Advertisement. *Mudcakes and Roses*.

Ryman. (2011b, 17 November). Advertisement. *The Leader*.

Ryman. (2012a, 12 January). Advertisement. *The Leader*.

Ryman. (2012b, 26 March). Advertisment. *Nelson Mail*.

Ryman. (2012c, April). Advertisment. *Mudcakes and Roses*.

Ryman. (2012d, 8 January). Advertisment. *Sunday Star Times*.

Salmon, P, & Hall, G.M. (2003). Patient empowerment and control: a psychological discourse in the service of medicine. *Social Science & Medicine, 57*, 1969-1980. doi:10.1016/S0277-9536(03)00063-7

Salter, C.I, Howe, A, McDaid, L, Blacklock, J, & Lenaghan, E. (2011). Risk, significance and biomedicalization of a new population: Older women's experience of osteoporosis screening. *Social Science & Medicine, 73*, 808-815. doi:10.1016/j.socscimed.2011.06.030

Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description. *Research in Nursing & Health, 23*, 334-340. doi:10.1002/1098-240X(200008)

Saville-Smith, K. (1993). The state and the social construction of ageing. In P. G. Koopman-Boyden (Ed.), *New Zealand ageing society*. Wellington, New Zealand: Daphne Brassell Associates Press.

Sawchuk, K.A. (1995). From gloom to boom: Age identity and target marketing. In M. Featherstone & A. Wernick (Eds.), *Images of Aging: Cultural representations of later life* (pp. 175-190). London: Routledge.

Scannell, P. (1998). Media-language world. In A. Bell & P. Garret (Eds.), *Approaches to media discourse* (pp. 252-267)

Schaffner, C. (1996). Editorial: Political speeches and discourse analysis. *Current Issues in Language and Society, 3*(3), 201-204.

Schaffner, C, & Bassnett, S (Eds.). (2010). *Political discourse, media and translation*. Newcastle on Tyne, UK: Cambridge Scholars Publishing.

Scherger, S., Nazroo, J., & P., Higgs. (2011). Leisure activities and retirement: Do structures of inequality change in old age? *Ageing & Society, 31*(1), 146-172. doi:10.1017/S0144686X10000577

Schiffrin, D. (1997). Theory and method in discourse analysis: What context for what unit? *Language and Communication, 17*(2), 75-92. doi:10.1016/S0271-5309(97)00002-5

Schneider, A, & Ingram, H. (1993). Social construction of target populations: Implications for politics and policy [Political Discourse]. *The American Political Science Review, 87*(2), 334- 347.

Schofield, V., Davey, J., Keeling, S., & Parsons, M. (2006). Ageing in place. In J. Boston & J. Davey (Eds.), *Implications of populatin ageing: Oppoprtunities and Risks* (pp. 275-306). Wellington, New Zealand: Institute of Pollicy Studies.

Schumpeter. (2010, 04 February 2010). The silver tsunami. *The Economist, 394*(8668 February 4th 2010)*, 1.

Shenk, D, Kuwahara, K, & Zablotsky, D. (2004). Older women's attachment to their home and possessions. *Journal of Aging Studies, 18*(2), 157-169. doi:10.1016/j.jaging.2004.01.006

Siegal, M. (2014). *Australia to raise retirement age to 70 by 2035, Treasurer says*.

Simpson, M., & Cheney, G. (2007). Marketization, participation, and communication within New Zealand retirement villages: A critical-rhetorical and discursive analysis. *Discourse & Communication, 1*(2), 191-222. doi:10.1177/1750481307076006

Sinnerbrink, R. (2005). From Machenschaft to biopolitics: A genealogical critique of biopower. *Critical Horizons: A Journal of Philosophy & Social Theory, 6*(1), 239-265. doi:10.1163/156851605775009447

Smirnova, M. H. (2012). A will to youth: The woman's anti-aging elixer. *Social Science & Medicine, 75*, 1236-1243. doi:10.1016/j.socscimed.2012.02.061

Smith, B., Kerse, N, & Parsons, M. (2005). Quality of residential care for older persons: Does education for healthcare assistants make a difference? *The New Zealand medical journal, 118*(1214), 1-11.

Smith, R. (1984). The Structured Dependence of the Elderly as a Recent Development: Some Sceptical Historical Thoughts. *Ageing and society, 4*(4), 409-428.

Sneed, J.R., & Krauss Whitbourne, S. (2005). Models of the aging self. *Journal of Social Issues, 61*(2), 375-388. doi:10.1111/j.1540-4560.2005.00411.x

Somers Cocks, E. (1987). *A friend in need: Nurse Maude her life and work* (3rd ed.). Christchurch, New Zealand: Printpac Print Group.

Sonerson, A, Bryant, J, Tobias, M, Cheung, J, & Mchugh, M. (2005). *Population ageing and government health expenditure* [Treasury Working Papers]. Wellington, New Zealand: New Zealand Government.

Stafford, P. B. (Ed.). (2003). *Gray areas: Ethnographic encounters with nursing home culture*. Santa Fe, USA: School of American Research Press.

State Services Commission. (1998). *New Zealand's State Sector Reform: A decade of change* Wellington, New Zealand: New Zealand Government.

Statistics New Zealand. (2002). *A changing New Zealand*. Wellington, New Zealand: New Zealand Government.

Statistics New Zealand. (2007). *2006 Census data - Quick stats about New Zealand's population and dwellings*. Wellington, New Zealand: Statistics New Zealand.

Statistics New Zealand. (2009a). *The impact of structural population change: Structural change and the 65+ population*. Wellington, New Zealand: Statistics New Zealand.

Statistics New Zealand. (2009b). *The legacy of past childbearing decisions* Wellington, New Zealand: Statistics New Zealand.

Statistics New Zealand. (2014). *2013 Census QuickStats about culture and identity*. Wellington, New Zealand: New Zealand Government. doi:www.stats.govt.nz.

Stein, C.H, Wemmerus, V. A, Ward, M, Gaines, M.E, Freeberg, A.L, & Jewell, T, C. (1998). "Because they're my parents": An international study of felt obligation and parental caregiving. *Journal of Marriage and the Family, 60*(August), 611-622.

Stenner, P, McFarquhar, T, & Bowling, A. (2010). Older people and "active ageing": Subjective aspects of ageing activity. *Journal of Health Psychology, 16*(3), 467-477.

Stephenson, J, & Scobie, G. (2002a). *The Economics of Population Ageing*. Treasury, Welliington.: New Zealand Treasury Working Paper.

Stephenson, J., & Scobie, G.M. (2002b). *The economics of population ageing*. Wellington, New Zealand: New Zealand Government.

Sterponi, L. (2009). Accountability in family discourse: Socialisation into norms and standards and negotiation of responsibility in Italian dinner conversations. *Childhood, 16*(4), 441-449.

Stillwater Gardens. (2012a, March). Advertisement. *The Leader*.

Stillwater Gardens. (2012b, May). Advertisment. *Mudcakes and Roses*.

Stuifbergen, M.C, Ven Delden, J.J.M, & Dykstra, P.A. (2008). The implications of today's family structures for support giving to older parents. *Ageing and Society, 28*(3), 413-434. doi:10.1017/S0144686X07006666

Tanner, D. (2003). Older peopole and access to care. *British Journal of Social Work, 33*, 499-515.

The Leader. (2011, 17 November). Positive aging in the leafy heart of Nelson. *The Leader*.

The Royal Commission on Social Policy. (1988). *The April Report: New Zealand Today* (Vol. 1). Wellington, New Zealand: New Zealand Government.

The Wood. (2011, 17 November). Advertisement. *The Leader*.

The Wood. (2012, April). Advertisement. *The Leader*.

Thomas, D. (1952). *In Country Sleep*. London, England: New Directions.

Thompson, N. (1998). The ontology of ageing. *British Jounral of Social Work, 28*, 695-707.

Thomson, D. (1998). *A world without welfare: New Zealand's colonial experiment*. Auckland, New Zealand: Auckland University Press.

Townsend, P. (1981). The structured dependency of the elderly: A creation of social policy in the twentieth century. *Ageing & Society, 1*(01), 5-28. doi:10.1017/S0144686X81000020

Townsend, P. (2006). 25th Volume celebration paper policies for the aged in the 21st century: more "structured dependency" or the realisation of human rights? *Ageing and Society, 26*(2), 161-179. doi:10.1017/S0144686X05004666

Treasury, New Zealand. (2012). *Long term fiscal external panel - Session two - Framework for policy analysis of long term fiscal issues*. Welliington, New Zealand: Victoria University.

Tulle-Winton, E. (1999). Growing old and resistance: Towards a new cultural economy of old age? *Ageing and Society, 19*, 281-299. doi:10.1017/S0144686X98007193

Twigg, J. (2007). Clothing, age and the body: A critical review. *Ageing & Society, 27*(2), 285-305. doi:10.1017/S0144686X06005794

Twigg, J, & Majima, S. (2014). Consumption and the constitution of age: Expenditure patterns on clothing, hair and cosmetics among post war 'baby boomers'. *Journal of Aging Studies, 30*, 23-32. doi:10.1016/j.jaging.2014.03.003

Upton, S. (1991c). *Your health and the public health: A statement of Government health policy* (0477075576). Wellington: NZ Government.

Utrata, J. (2013, 09/2013). The backbone of Russia. *Russian Life 56*(5)*,* 40. Retrieved from http://aut.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwnV1LT8MwDLbQkBCnb bAFxkM5cWvpi2Q9IRhMk- AC4rDbFJrmwrSy0R7277ETgoSqXTilURXJSRzbsR1_ADxWEpWKiYUsMvwuNJoYOo0TKmU VjZX56891L_jJLeC21ktEK6Z1VZCH_Bq1Ol3O0yS__VwHhBlFsdUfAA0SwGgWU95e9PIbQki ExePEK48I0Aqat4St1SDTLvggfztzpFWY8d8k9qDrC0bzO8cSfdgrV0cwcOVAtvyKU61ZZfF8t 8cwRDbh96r4eK9wTGX4a4OHRA3gcvr4NpkFnoaFXi4XeFBFZuHE0iF0VjiCwb5B_sUWdQr DuTI4mOfPD-PZ08R1-74bftn3XeG6Zrh2ltxAhPIE- E2uZBRpbXD9MjQt85KCfnmidFqWIpWnwHaQMdr55wwOE4soQWla59CpN015gZZBU38 DZoGgRA Accessed 07 March 2016

van Dijk, T.A. (1982). Opinions and attitudes in discourse comprehension. In J. F. Le Ny & W. Kintsch (Eds.), *Language and comprehension* (pp. 35-51). Amsterdam, Holland: New Holland Publishing Company.

van Dijk, T.A. (1989a). Race, riots and the press: an analysis of editorials in the British press about the 1985 disorders. *Gazette, 43*(3), 229-254.

van Dijk, T.A. (1989b). Structures of discourse and structures of power. In J. A. Anderson (Ed.), *Communication Yearbook* (pp. 18-59). Newbury Park, CA: Sage.

van Dijk, T.A. (1990a). *Discourse and inequality*. presented at the meeting of the Conference of the International Communication Association, Dublin, Ireland.

van Dijk, T.A. (1990b). Social cognition and discourse. In H. Giles & W. P. Robinson (Eds.), *Handbook of Language and Social Psychology* (pp. 163-183). London, UK: Wiley and Sons Ltd.

van Dijk, T.A. (1993a). *Elite discourse and institutional racism*. California: Sage.

van Dijk, T.A. (1993b). *Elite discourse and racism*. California: Sage.

van Dijk, T.A. (1993 b). Principles of critical discourse analysis. *Discourse and Society, 4*(2), 249-283. doi:10.1177/0957926593004002006

van Dijk, T.A. (1994). Discourse and inequality. *Lenguas Modernas, 21*, 19-37.

van Dijk, T.A. (1995a). Discourses of domination or diversity? . *Javnost/The Public (Ljubljana), 2*(2), 27-45.

van Dijk, T.A. (1995b). The mass media today: Discourses of domination of diversity. *Javnost, 2*(2), 27-45. doi:10.1080/13183222.1995.11008592

van Dijk, T.A. (1995c). On macrostructures, mental models, and oher inventions: A bief personal history of the Kintsch -van Dijk theory. In C. Weaver, S. Mannes, & C. R. Fletcher (Eds.), *Discourse comprehension: Essays in honor of Walter Kintsch* (pp. 383-410). Hillsdale, USA: Erlbaum.

van Dijk, T.A. (1995d). Power and the news media (pp. 9-36).

van Dijk, T.A. (1997). Cognitive context models and discourse. In M. Stamenow (Ed.), *Language structure, discourse and the access to consciousness* (pp. 189-226). Amsterdam, Holland: Benjamins.

van Dijk, T.A. (2001). Critical discourse analysis. In D. Tannen, D. Schiffrin, & H. Hamilton (Eds.), *Handbook of discourse analysis* (pp. 352 - 371). Oxford: Blackwell.

van Dijk, T.A. (2004). *From text grammar to critical discourse analysis: A brief academic autobiography*. Barcelona, Spain: Universitat Pompeu Fabra.

van Dijk, T.A. (2006). Discourse and manipulation. *Discourse & Society, 17*(2), 359-383. doi:10.1177/0957926506060250

van Dijk, T.A. (2011a). Discourse and ideology. In T. A. van Dijk (Ed.), *Discourse Studies* (pp. 379-407). London, UK: Sage.

van Dijk, T.A. (2011b). Discourse studies and hermeneutics. *Discourse Studies, 13*, 609-621.

van Dijk, T.A. (2011c). Introduction: The study of discourse. In T. A. van Dijk (Ed.), *Discourse Studies* (2nd ed., pp. 1-7). Los Angeles, CA: Sage.

van Dijk, T.A. (2012). Discourse and knowledge. In J. P. Gee & M. Handford (Eds.), *Handbook of discourse analysis* (pp. 587-603). London, UK: Routledge.

van Dijk, T.A (Ed.). (2011d). *Discourse studies: A multidisciplinary introduction* [Edited Book]. London: Sage.

van Leeuwen, T., & Kress, G. (2011). Discourse semiotics. In T. A. Van Dijk (Ed.), *Discourse Studies* (pp. 107-125). London, UK: Sage.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy*. London, Ontario, Canada: The Althouse Press.

Vasquez, D. (2013). Behind the widening newspaper generation gap. *Media Life Magazine*(28 March 2013), 1-3.

Vincent, J.A. (2006). Ageing contested: Anti-ageing science and the cultural construction of old age. *Sociology, 40*(4), 681-698. doi:10.1177/0038038506065154

Vincent, J.A. (2008). The cultural construction age as a biological phenomenon: Science and anti-aging technologies. *Journal of Aging Studies*, 331-339. doi:10.1016/j.jaging.2008.05.006

Von Lanthen, K. (2004). *The long term funding of New Zealand healthcare*. Wellington, New Zealand: Health Funds Association of New Zealand

Walker, A. (2005). Re-examining the political economy of aging: Understanding the structure/agency tension. In J. Baars, D. Dannefer, C. Phillipson, & A. Walker (Eds.), *Aging, globalisation and inequality: The new critical gerontology* (pp. 59-80). Amityville, USA: Baywood Publishing Company.

Walker, A. (2009). Commentary: The emergence and application of active aging in Europe. *Journal of Aging & Social Policy, 21*, 75-93. doi:10.1080/08959420802529986

Walker, A., & Litt, D. (2000). Public policy and the construction of old age in Europe. *The Geronotologist, 40*, 304-308.

Weerawardena, J., & Sullivan-Mort, G. (2001). Learning, innovation and competitive advantage in not-for-profit aged care marketing: A conceptual model and research propositions. *Journal of Nonprofit & Public Sector Marketing, 9*(3), 53-73. doi:10.1300/J054v09n03_04

Weintraub, A. (2010). *Selling the fountain of youth: How the anti-aging industry made a disease out of getting old, and made billions*. New York , USA: Basic Books. Retrieved from http://aut.summon.serialssolutions.com/2.0.0/link/0/eLvHCXMwY2BQSDFJNTBITDU1Sz NINTdPSkxOTDRNSzEzS0xMNUg2Ah86jxjPRSrN3YQYmFLzRBmk3FxDnD10E0tL4qFjGPGg Y9BAR1mJMbAAe8WpEgwKRpbJqYbJicDWsxHoOExTS5MUU8tUYIM6OcUoydjMVJJBGIsB AOLxJ3Q Accessed 07 March 2016

Wetherell, M. , Taylor, S. , & Yates, S. (2001). *Discourse as data: A guide for analysis*. London, UK: Sage.

Whitfield, C. (2001). Benign or malign: Media stereotyping. *Nursing Older People, 13*, 10-13.

WHO. (2011). *Global Health and Aging*. Geneva, Switzerland: World Health Organisation. doi:http://www.who.int/ageing/publications/global_health/en/Accessed 07 March 2016

Wiersema, E, & Dupius, S.L. (2010). Becoming institutional bodies: Socialisation into a long-term care home. *Journal of Aging Studies, 24*, 278-291. doi:10.1016/j.jaging.2010.08.003

Wilcock, A.A. (2007). Active ageing: Dream or reality. *New Zealand Journal of Occupational Therapy, 54*(1), 15-20.

Wiles, J.L., Allen, R.E.S., Palmer, A. J., Hayman, K.J., Keeling, S., & Kerse, N. (2009). Older people and their social spaces: A study of well-being and attachment to place in Aotearoa New Zealand. *Social Science & Medicine, 68*, 664-671. doi:10.1016/j.socscimed.2008.11.030

Wiles, J.L., Leibing, A., Guberman, N., Reeve, J., & Allen, R.E.S. (2011). The meaning of "ageing in place" to older people. *The Gerontologist Advance Access, Advance Access Publication*, 1-10. doi:10.1093/geront/gnr098

Wilinska, M., & Cedersund, E. (2010). "Classic ageism" or "brutal economy"? Old age and older people in the Polish media. *Journal of Aging Studies, 24*, 335-343. doi:10.1016/j.jaging.2010.07.003

Willcocks, D., Pearce, S., & Kellaher, L. (1987). *Private lives in public places*. London, UK: Tavistock.

Willetts, D. (2010). *The pinch: How the baby boomers took their children's future and why they should give it back*. London, UK: Atlantic Books.

Williams, M.A. (2011). Hospitalist down under. *The Hospitalist*(February), 1-2.

Wilson, C. (2003). *Descartes's meditations*. Cambridge, United Kingdom: Cambridge University Press.

Wilson, J. (2009). *Failing to care: More rest homes have been found providing substandard care*. Wellington, New Zealand: Consumer Organisation New Zealand.

Wilson, J. (2014, 06 August 2014). Compromised care: Rest home audits continue to show failings in care [Report]. *Consumer, 549*(549)*,* 12-14.

Wisman, J. D. (2013). Why Marx still matters. *International Journal of Pluralism and Economics Education, 4*(3), 229-242.

Wodak, R. (2005). Aspects of Critical Discourse Analysis. doi:http://userpages.uni-koblenz.de/~diekmann/zfal/zfalarchiv/zfal36_1.pdf Accessed 07 March 2016

Wodak, R. (2007). What is critical discourse analysis. *Forum: Qualitative social Research, 8*(2), 1-7.

Wodak, R. (2009b). Prejudice, racism and discourse. In A. Pelinka, K. Bischof, & K. Stogner (Eds.), *Handbook of prejudice* (pp. 409-443). Amherst, New York: Cambia Press.

Wodak, R, & Meyer, M. (2009a). Critical discourse analysis: history, agenda, Theory and methodology. In R. Wodak & M. Meyer (Eds.), *Methods for critical discourse analysis* (2nd ed., pp. 1-33). London, UK: Sage.

Wodak, R, & Meyer, M (Eds.). (2009b). *Methods of critical discourse analysis* (Second ed.) [Qualitative Methods]. Los Angeles, USA: Sage.

World Bank. (2010). *Some economic consequences of global aging*. Washington, USA: World Bank.

Wright St Clair, V., Grant, B.C., & Smythe, E. A. (2014). Narratives in research: Story as "showing" the eminently ordinary experience of ageing. *Australisian Journal on Ageing, 33*(2), 132-135. doi:10.1111/ajag.12132

Yoon, H, & Powell, H. (2011). Older consumers and celebrity advertising. *Ageing & Society, 32*(8), 1-18. doi:10.1017/S0144686X1100095X

Young, S. (2011, 03 September 2011). Support sought for aged care charter [News]. *The Nelson Mail,* p. 5.

Zaidi, A. (2012). Exclusion from material resources: poverty and deprivation among older people in Europe. In T. Scharf & N. Keating (Eds.), *From exclusion to inclusion in old age: A global challenge* (pp. 71-83). Bristol, UK: The Policy Press.

Zola, I.K. (1972). Medicine as an institution of social control. *Sociological Review*(20), 407-504. doi:10.1111/j.1467-954X.1972.tb00220.x

APPENDIX

APPENDIX A: IWI ETHICS APPROVAL

Karake Consultancy
POLICY & RESEARCH
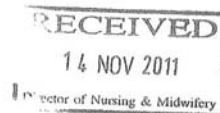
Blenheim 7240
Phone: 03 570 5262
Mobile: 027 483 0128
Web: melissa.cragg@xnet.co.nz

9th November 2011

Robyn Henderson
Director of Nursing and Midwifery
Braemar Campus
Nelson Hospital
NELSON

Tēnā koe Robyn,

Letter of Support for research study: The Choices and Voices of Institutional Aged Care in New Zealand: A Critical Discourse Analysis

Your request for support was considered by Karake Consultancy on behalf of the Iwi Health Board after an evaluation of the information that you provided. The Iwi Health Board supports your research proposal with the request that if a co-hort of Māori are identified through the research process, they be recruited as a case study and that regular updates are provided in terms of the study findings and outcomes.

The Iwi Health Board understands that the research proposes to examine the key influences for elderly people entering into institutional care within New Zealand through a purposive sample. The study will utilise critical discourse analysis to expose social dominance, potential marginalisation, stigmatisation, exclusion and other power relations as enacted with our older citizens to regulate and normalise institutionalising aged care.

You have stated that the study will involve the utilisation of two data gathering methods. Firstly, the researcher will 'listen' to the voices of aged care recipients to make visible those discourses influencing their choice to enter into residential aged care. Following this, mass media and advertising related to aged care will be reviewed to establish public discourse access and control and who the powerful speakers are in relation to aged care. This will illuminate potential influence and manipulation of aged care in the minds and subsequent decisions of aged individuals.

It is understood that:

1. In terms of ethnicity data: no ethnicity data will be collected through the current study.

215

2. It is planned that a focus group approach be taken to data collection where two focus groups each containing up to 10 people will enhance the ability of all members to participate and have their voice heard. It is proposed to have single gendered focus groups to ensure homogeneity of participants and optimization of participation.

3. The location of the study is the Nelson region as it is acknowledged as having a significant demographic of older people aged 65 years and over. Nelson has a significant number of aged care facilities (18) catering for residential aged care individuals.

4. As a large component of the study will be completed through focus group sessions. It is highly unlikely that Kaumatua or Maori health providers will be involved with the research unless a large cohort of elderly Māori is identified during the course of the research.

5. CDA provides for cultural difference to occur. The model itself allows for views and opinions to be explored through the mechanisms of social power and abuse that is based on dominance, inequality, and marginalization within society. Room is available for cultural difference to be raised without there being any disadvantage.

6. Where possible, an update on the research will be provided early in 2012.

Thank-you for submitting your research proposal for consultation, please contact Karake Consultancy if any further assistance is required regarding this study.

Please forward updates for the IHB to the NMDHB Director of Maori Health,

Naku na,

Dr Melissa Cragg

APPENDIX B: UPPER SOUTH REGIONAL ETHICS COMMITTEE

Health and Disability Ethics Committees

Upper South B Regional Ethics Committee
c/- Ministry of Health
6 Hazeldean Road, Level 1 Montgomery Watson Building
Addington, Christchurch
PO Box 3877
Phone: (03) 974 2305
Email: uppersouthb_ethicscommittee@moh.govt.nz

18 June 2012

Robyn Henderson
123 Panorama Drive
Enner Glynn
Stoke
Nelson

Dear Robyn

Ethics ref: **URB/12/EXP/034** (please quote in all correspondence)
Study title: Media, advertising and other influences on decisions to enter
                              aged care
Principal Investigator: Robyn Henderson

The above study has been given ethical approval by **Deputy Chairperson** of the Upper
South B Regional Ethics Committee.

Approved Documents
Focus Group Protocol dated 15 May 2012
Information sheet version dated 15 May 2012
Consent form version dated 14 June 2012
Invitation to be involved in health research dated 15 May 2012
Focus Group Agenda dated 15 May 2012
Focus Group Preparatory Information dated 15 May 2012

Progress Reports
The study is approved until **28 February 2015**. The Chairperson will review the approved
application annually and notify the Investigator if they withdraw approval. It is the
Investigator's responsibility to forward a progress report prior to ethical review of the
project in **18 June 2013**. The report form is available on
http://www.newhealth.govt.nz/ethicscommittees. Please note that failure to provide a
progress report may result in the withdrawal of ethical approval. A final report is also
required at the conclusion of the study.

Amendments
It is also a condition of approval that the Committee is advised if the study does not
commence, or is altered in any way, including all documentation eg advertisements,
letters to prospective participants.

Health and Disability Ethics Committees

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. The organisation may specify their own processes regarding notification or approval.

On behalf of the committee, I would like to take this opportunity to wish you all the best with your research.

Yours sincerely

Diana J. Whipp

Mrs Diana Whipp
Administrator Upper South B Regional Ethics Committee
Email: Diana_Whipp@moh.govt.nz

APPENDIX C: AUTEC ETHICS APPROVAL

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

MEMORANDUM
Auckland University of Technology Ethics Committee (AUTEC)

To:	Valerie Wright-St Clair
From:	Rosemary Godbold, Executive Secretary, AUTEC
Date:	3 July 2012
Subject:	Ethics Application Number **12/151 Media, advertising and other influences on decisions to enter aged care.**

Dear Valerie

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Chair of the Auckland University of Technology Ethics Committee (AUTEC) and myself in my memo of 26 June 2012, and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 25 June 2012.

Your ethics application is approved for a period of three years until 3 July 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 3 July 2015;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 3 July 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEC Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at http://www.aut.ac.nz/research/research-ethics/ethics).

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Robyn Henderson robyn.henderson@nmdhb.govt.nz

From the desk of ...	Private Bag 92006, Auckland 1142	Tel: 64 9 921 9999
Dr Rosemary Godbold	New Zealand	ext 8860
Executive Secretary	E-mail: ethics@aut.ac.nz	Fax: 64 9 921 9902
AUTEC		page 1 of 1

APPENDIX D: AUTEC APPROVED LOCALITY AGREEMENT

LOCALITY ASSESSMENT – by Locality Organisation

Refer to Guidelines for Completion of the National Application Form
for Ethical Approval of a Research Project

Full Project Title: **Media, advertising and other influences on decisions to enter aged care**

Short Project Title: Media, advertising and other influences on decisions to enter aged care

Brief outline of study:

A study of how New Zealand has a large number of older adults in residential aged care facilities. Recent research indicated that around 33,000 New Zealanders have taken up the option to live in residential aged care facilities across the nation. While some people may enter aged residential care because they are unwell or suffering from Alzheimer's disease or dementia, many others also enter residential aged care facilities for an array of other reasons.

Research has usually looked at conditions or illnesses as a reason for entering into a residential aged care facility or an aspect of aged care such as how residential aged care is provided by nurses, doctors and allied health workers. This research proposes to look at how media and advertising may influence peoples' decisions to move into residential aged care.

Principal Investigator:
Robyn Henderson Doctor of Health Sciences Student
Department of Health and Environmental Sciences
Auckland University of Technology
Contact details:
Private Bag 92006
Auckland 1142
Ph: 09 921 9999   0272350605
Local investigators:
As above

Contact details:
As Above
Locality Organisation signoff
Ethics committees review whether investigators have ensured their studies would meet established ethical standards, if conducted at appropriate localities; each locality organisation is asked to use the locality assessment form to check that the investigator has also made the appropriate local study arrangements.

Ethics approval for study conduct at each site is conditional on favourable locality assessment at that locality.

Locality issues: *(see guidelines for more information and examples)*

Identify any local issues and specify how they will be addressed.

## 1.	Suitability of local researcher

Are all roles for the investigator(s) at the local site appropriate (eg has any conflict the investigator might have between her or his local roles in research and in patient care been adequately resolved)?

The researcher is independent to *name of Residential Aged Care Provider*and is currently employed by Nelson Marlborough District Health Board as a senior nurse. As such, potential conflicts may arise in relation to any care aspects an individual participant may raise during this research. All such issues raised will be addressed with the Facility Manager and Clinical leader on completion of the Focus Group session in which they are raised.

## 2.	Suitability of the local research environment

Have the resources (other than funding which is conditional on ethical approval) and/or facilities that the study requires locally been identified? Are they appropriate and available?

The researcher will liaise with *name of Residential Aged Care Facility* for assistance with the set up of the focus group session and for use of a room in which this focus group session will take place. No charge will be made for room utilization.

The Facility Manager can assist by posting the Invitation to Participate in Research on the resident's notice board and advising residents of an initial overview of the research meeting to be held in the Facility. This individual may also give potential participants a copy of the letter of information and consent form and answer routine questions about the study.

Advice will be given on interpretation of research findings where relevant.

## 3.	What are the specific issues relating to the local community?

Are there any cultural or other issues *specific* to this locality, or to participants for whom study recruitment or participation is primarily at this locality? If so, how have they been addressed?

Residents in aged care facilities are vulnerable and elderly. The potential issues related to appropriateness of participation have been discussed and addressed in the study's design. *Name of Aged Care Facility* are involved as a support partner of the research, and as such will work with the researcher to ensure procedures are conducted sensitively and findings are interpreted appropriately.

## 4.	Information sheet/consent form contact details:
Contact details for Health & Disability Consumer Advocates:
Nelson Office
Ph: 03544 4166

Contact details for any other important local services:

I understand that I may withdraw locality approval if any significant local concerns arise. I agree to advise the Principal Investigator and then the relevant ethics committee should this occur.

Signature:						**Date:**

Name:							**Position:**

Contact details:

APPENDIX E: AUTEC FOCUS GROUP PARTICIPANT INFORMATION FORM

AUT
U N I V E R S I T Y
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

An Invitation to be involved in Health Research

Media, advertising and other influences on decisions to enter aged residential care

My name is Robyn Henderson. I am a Registered Nurse and a Doctor of Health Sciences candidate at Auckland University of Technology researching the individual influences of media and advertising on decisions to enter into aged residential care.

Aged residential care is an option for older adults in New Zealand. Many of the providers of residential aged care widely use advertising and print media to offer their services to older adults and I am interested in how publicly available information and advertisements for aged care services influence older adults' choices to take up residential aged care.

I will be inviting individuals who are resident in a Nelson aged care facility to participate in a group discussion on some of the influences which preceded their decision to enter an aged care facility.

I am seeking interested participants from this Facility to participate in this study.

If you:

- Feel comfortable to join a small group for discussion
- Are prepared to reflect on the drivers or influences of your decision to enter aged residential care
- Feel comfortable to participate in discussions related to aged care influences and choice

Please contact me to obtain further details of this research.

I can be contacted on: Phone: 027 235 0605 (mobile) or (03) 547 3838

Robynhenderson1@xtra.co.nz

Thank you for supporting this important research

APPENDIX F: AUTEC FOCUS GROUP PARTICIPANT CONSENT FORM

RESEARCH STUDY PARTICIPANT CONSENT FORM

Media, advertising and other influences on decisions to enter aged residential care

Do you require an interpreter to complete this form?   **Yes ☐**   **No ☐**

You are welcome to have a family member with you to support you through

this Focus Group. Do you wish to have a family/whanau member with you?
                                               Yes ☐   **No ☐**

I, [PRINT NAME], give consent to my participation in this research project.

In giving consent I acknowledge that:

1. The procedures required for this research project and the time involved have been explained to me, and any questions I have about the research have been answered to my satisfaction.

2. I have had time to consider whether to take part in this study or not.

3. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher.

4. I understand that my involvement is strictly confidential and no information about me will be used in any way that will reveal my identity.

5. I understand that I can withdraw from this research study at any time, without affecting my relationship with the researcher or with the Residential Aged Care Facility now or in the future.

6. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

7. I understand that I can stop any conversation or follow up at any time.

8. If I do not wish to continue the audio recording once the focus Group has commenced, this will benoted on the recording and my comments will not be transcribed and included in this research.

9. I understand that if I identify as Maori, I may ask for whanau to support me within the Focus Group situation.

10. I know who to contact if I have any concerns regarding this study.

11. I understand that the identity of my fellow participants in the focus groups is confidential to the group and I agree to keep this information confidential

12. I consent to:
i) Small Group participation   **YES ☐**   **NO ☐**

ii)   Audio-taping of Group discussion   **YES ☐**   **NO ☐**

Signed: ……………………………………………………………………

Name: ……...………………………………………………………….

Date: ……………………………………………………………………

Full Name of Researcher: Robyn Henderson

Contact Phone Number: 547 3838 or 027 235 0605

Signature: _____ **Date:** _____

APPENDIX G: AUTEC APPROVED FOCUS GROUP AGENDA

FOCUS GROUP AGENDA

Media, advertising and other influences on decisions to enter aged residential care

Light refreshments will be provided during the focus group

1)   Welcome, and a brief round of introductions for those who may not know each other.

2)   Brief overview, and explanation of the process

3)   Your responses to the following questions:-

- What were some of the key influences for you to enter into residential aged care?

- What kinds of information did you use to support your decision to enter aged residential care?

- What kinds of media or advertising were you aware of in making your decision to enter aged residential care?

- What stories in local magazines or papers related to residential aged care were you aware of in making your decision to enter into residential aged care?

4)   Discussion

5)   A closing round along the lines of ...." for me interesting things I have become more aware of in the course of preparing for and participating in this focus group have been....."

6)   Acknowledgment and appreciation for your participation and contribution to this research.

Robyn Henderson

APPENDIX H: AUTEC FOCUS GROUP PROTOCOL

Media, advertising and other influences on decisions to enter aged care

Focus Group Protocol

TASK	CHECKLIST
Pre-focus group	
Check in with facility manager that venue and date has been arranged	
Check refreshments for participants have been organised	
Check digital audio recorder has batteries and spare batteries/tapes	

TASK	CHECKLIST
Focus group	
Arrive at venue half an hour early and ensure that everything is ready	
Ensure sufficient copies of information sheets and consent forms	
Introduce myself as facilitator and the transcriber who is to take notes. Begin with welcome and explain that we are going to go through some "housekeeping". Then introductions - then they will be asked to respond to some questions.	
Explain that you will ask participants to introduce themselves on tape later	
Check everyone has an information sheet and consent form	
Go through the information sheet to explain the purpose of the research	
Explain that participant's contributions will be anonymous in terms of name (we only want first names)	
Remind participants that they can withdraw at any stage with no penalty and that audiotapes will be destroyed at the end of the study	
Invite questions about the research process	
• Ask people to sign the consent form and hand in to note taker (they keep one consent form for themselves and give us one)	
Explain the process for the focus group and expected timeframe. Set guidelines for the group as follows: • Discuss ground rules (including confidentiality and only using first names) • There are no right or wrong answers and we are interested in what everyone has to say • Participants are encouraged not to criticize or argue with other people have to say	
Issues might come up that you didn't expect, please discuss with us after the group and we can refer you to some helping agencies	
Turn on the tape recorders x2	
Facilitator and note taker and participants introduce themselves use an icebreaker (e.g. name and how long they've been in Nelson)	
Facilitate discussion on the research topics, note areas of consensus and any outlying points of view	
Monitor the participants for any signs of distress. If needed check in with the participants and provide them with the option of leaving the group if necessary	
During discussion some of the discussion points may merge or be discussed spontaneously without prompting. As much as possible allow a natural flow of the discussion, prompting if necessary to have all the points covered	
Thank participants for their time, energy and ideas and tell them that they will be mailed a summary report of the focus group results if they wish	
Leave venue tidy and clean	

TASK	CHECKLIST
After the group	
Following each focus group meeting, facilitator and transcriber meet for 10 minutes to discuss their overall impressions and key ideas and insights from the interview (keep the tape on and record)	
Facilitator to identify any unexpected issues arising and contact Robyn to discuss/debrief if necessary	
Notify Facility Manager/Clinical leader when focus group has been completed	