Toward a Good Life in Later Life: Perspectives, Problems, and Responses

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of The Ohio State University

By

Robert Ross Klein, M.A.

Graduate Program in Geography

The Ohio State University

2013

Dissertation Committee:

Edward J. Malecki, Advisor

Nancy Ettlinger

Virginia Richardson
ABSTRACT

America is aging. The older share of the U.S. population is expected by 2030 to reach 72 million, almost 20% of the country’s total population. What will the experiences of later life be like for this group of people? In order to answer this question, one must consider different perspectives on what it means to age well. One influential definition of aging well is Rowe and Kahn’s concept of “successful aging,” consisting of three dimensions: avoidance of disease and disability, high physical and cognitive functioning, and active engagement with life. The successful aging paradigm emerged out of a sense of optimism about the new possibilities for older adults today, yet the paradigm also raises fundamental questions about the ability of different actors in society to define standards that can carry important ethical implications and practical consequences. Indeed, empirical research employing Rowe and Kahn’s successful aging framework finds that only about 11% of older adults in the US would be considered successful, implying that the vast majority are failures. Similarly, using multilevel modeling for small area estimation and data from the 1999 National Long-Term Care Survey and the Behavioral Risk Factor Surveillance System Survey, this dissertation’s quantitative state-level analysis shows that fewer than 150 older adults in 1,000 would be deemed successful agers in Wisconsin, the state found here to have the highest rate of
successful aging. In short, the successful aging paradigm is well-intentioned, but far too exclusive to serve as a normative model for later life. In order to work toward a more inclusive vision for later life, one might alternatively seek out the perspectives of nursing home residents. What does a good life in later life look like from the standpoint of elders facing the challenges of nursing home life and what can such views tell us about a broader notion of aging well? Qualitative analyses, consisting of secondary qualitative data analysis and meta-ethnography, of interviews with nursing home residents suggest that an inclusive definition of aging well should include at least three components: defining oneself more than being defined by others, acting to realize preferences, and receiving the care one wishes.

However, for a variety of reasons, it can be difficult to have the kind of later life one desires. By connecting archival research on a nursing home in Cleveland and its long-term care organization with an account of the growing use of technology in the hospital beginning from 1900 to 1925, the critical historical method of genealogy offers insights into the ways in which societal processes of medicalization and commercialization have impacted eldercare in the nursing home and end-of-life care in the hospital throughout the 20th century and up to the present. Suggestions for possible individual and societal responses to the problems of achieving one’s own idea of aging well are offered. One hopes that the quality of aging experiences will be improved in time to benefit the largest group of older adults in US history.
DEDICATION

I would like to dedicate this dissertation to my parents Jim and Mary, my fiancé Christiana, my sister Jenny, and my grandparents Paul and Kathleen, who taught me a great deal about living, aging, and dying.
ACKNOWLEDGMENTS

I would like to thank the following people whose help made it possible to complete this dissertation. First, I would like to thank my advisor Ed Malecki for his guidance and encouragement in the planning, research, and writing of this dissertation. Many thanks also to the other members of my dissertation committee – to Nancy Ettlinger for her extraordinary patience and support and to Virginia Richardson for her generous help and her mastery of social gerontology. The insightful feedback from and steadfast support of my committee allowed me to move forward with the dissertation.

I am grateful to the Research Center staff at the Western Reserve Historical Society in Cleveland, to the Center for the Study of History and Memory at Indiana University and to a visiting researcher (Hans Peter Lütjen) whose conversations with nursing home residents saved this dissertation at a crucial point, and to the Interuniversity Consortium for Political and Social Research (ICPSR) for access to the National Long-Term Care Survey.

I would also like to thank The Ohio State University Graduate School for grant funding and the Department of Geography for its support.
VITA

2004 ..............................................B.A. Economics, St. Olaf College

2004 ..............................................B.A. Philosophy, St. Olaf College

2007 - 2012 .................................Graduate Teaching Associate, The Ohio State University

2009 ..............................................M.A. Geography, The Ohio State University

2012 ..............................................Summer Intern, Centers for Medicare and Medicaid Services

2013 ..............................................Graduate Research Associate, Ohio Colleges of Medicine Government Resource Center

Publications


Fields of Study

Major Field: Geography
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I began the PhD program in Geography at The Ohio State University in the Summer of 2009 after finishing a Master’s degree in the same department. As I thought about what I wanted to study over the next several years, a topic seemed to be emerging in the context of my own extended family. The only grandfather I had ever known had passed away in April 2009 at the age of 98 – in the same hospital where I had been born almost 30 years earlier - and his wife, the only grandmother I had ever known, would follow in August 2011 at 93 in the long-term care facility where she had been living for several years.

Fortunately for me, my grandparents had moved from the small town in which they had raised their family to my hometown, about 4 hours away, just in time to see me grow up. They were - and still are - an important part of my life. After living independently for many years in a duplex, my grandparents eventually relocated to a well-regarded continuing care retirement community nearby, where they shared an independent-living apartment before health problems led one to move to the assisted living side, although there were also occasional stays in the hospital and a number of nursing homes in the area.

Needless to say, during this time, aging, health care, and long-term care were constant topics of conversation in our family and could be sources of both heartfelt
appreciation and grinding frustration for my parents and extended family. My mother acted as an informal caregiver for my grandmother - my mother’s mother-in-law - even while my grandmother received care in formal settings, because even the unusually attentive professional caregivers my grandmother was fortunate to have were no substitute for the loving, personal, and empathetic touch of a close family member. As a son living somewhere else, too far away to help on a regular basis, my main contact with these experiences was through conversations, but I also saw things firsthand during in-person visits, usually over the holidays. What I saw - especially what was considered normal in “great” facilities and with an extended family better informed than many - was often shocking. While I could give many examples from even my relatively short firsthand exposure to eldercare, the one that sticks out most is my grandmother being told by nurses - in an exceptional care facility – that she would have to wait for as long as 1 hour after asking a nurse for assistance to go to the bathroom to actually be helped. This was facility policy because, with the staff available, it was more efficient to help a resident get cleaned up after the fact than to take that person to the bathroom when the need first arose. My grandmother was a humble woman, but she took great pride all her life in the appearance of the home she kept and of herself. She loved gardening - a favorite picture in the family shows her smiling with the beautiful red roses of her garden in the background. Having the basic personal need of getting to the bathroom go unmet on a regular basis was a devastating affront to her sense of self and personal dignity and undoubtedly made her feel very helpless. This fundamental structural failure to be able to recognize and satisfy my grandmother’s unique care preferences seemed at times to
overshadow the otherwise wonderful job the staff in the care facility did to meet my grandmother’s other needs.

Family experiences with aging and care first led me to study these issues at the national level, where there was no shortage of doomsday projections about the number of aging Baby Boomers and the impacts that their growing older would have on the country. Interested in gaining a more organized understanding of aging and care, and with the support of my advisor Ed Malecki, I benefited greatly from enrolling in and completing the Graduate Interdisciplinary Specialization in Aging at Ohio State from Spring 2010 through Autumn 2011. Through coursework for the Specialization, I met Virginia Richardson, who became part of my dissertation committee, and learned about different research approaches and pressing policy issues in social gerontology. I remember an early class where we discussed trends in national-level surveys that seemed to be good or bad news for older adults and their families. I valued the information that such quantitative aggregate accounts provided, yet coming from coursework with Nancy Ettlinger, I also sought to bring a critical perspective, especially based in the work of Michel Foucault, to these topics and to try to imagine alternative models of eldercare. I learned that many Baby Boomers – including my own parents - were not going to passively accept the services and care arrangements that their parents encountered. One example of an attempt to re-imagine eldercare that I learned of was the overall long-term care culture change movement, including specific visions such as the Eden Alternative and Green House Project. At the same time, I read critiques of the movement and accounts of systemic obstacles to the movement’s progress. I felt that exploring
questions about aging and care by drawing on many of the different philosophical perspectives and methodological approaches I had been exposed to in my graduate studies would make for a challenging, intriguing, and timely dissertation topic.

This dissertation arose from my attempts to pull together these personal experiences and academic interests. As I write in chapter 2, I believe in the importance of both problematization and reconstruction, of critique and critically-informed action, as an overarching framework. I see crystallization as a useful (meta-)epistemology to put this normative framework into practice. Crystallization is about breadth as well as depth, so I thought it would be important to try to address a wide variety of scenarios of aging and care in this country. Therefore, in the three empirical research chapters (3, 4, and 5) of the dissertation, I have used both traditional and critical methods to explore issues of aging and care in the United States across a variety of settings, from aging in place in one’s own home to nursing homes to end-of-life care in the hospital. My goal is to use different research strategies to highlight the complexity of eldercare in the United States. In the conclusion, I have tried to move from problematization to reconstruction, offering suggestions informed by my research for eldercare in the future.

I recognize that, as a white well-educated male from a middle-class Catholic background who was born and raised in the Midwestern US, my experience is anything but universal. However, I believe that my own personal experiences with chronic health issues and with (temporary) limitations of mobility have offered some insights into matters of care and quality of life. Far from claiming to provide the definitive account of eldercare in the US based on my point of view, this dissertation seeks to emphasize the
individualized care preferences of older adults themselves. If my work here can
eventually play some part in helping older adults and the organizations that serve them
improve elders’ chances of realizing their own “good life in later life” – something I wish
I could have helped my own grandparents achieve – then the effort will have been
worthwhile.
CHAPTER 1: INTRODUCTION

America is aging. The older proportion of the U.S. population will rise from a 2011 level of about 13% (over 41 million) (US Census Bureau 2012) to roughly 20% (72 million) of the total by 2030 and then remain near that percentage through 2050, when 86.7 million older adults are projected to be living in the US (He et al. 2005, 6).

Relatively soon, then, about one in five people will be 65+, a dramatic change from the beginning of the twentieth century, when those 65 and over made up only 4% (3.1 million) of the national population (He et al. 2005, 1). Population aging has received a great deal of attention, often in terms of a looming, if not already present, crisis, an example of what Robertson (1990) calls “apocalyptic demography.” While the numbers are indeed striking, this dissertation primarily explores questions about the quality of experiences of aging and care for older adults in this country.

Many factors affect the quality of later life experiences. This dissertation will focus on how individuals and larger societal processes can impact daily life in one’s later years. Toward that end, societal processes of normalization, medicalization, and commercialization are reviewed in this chapter in order to better understand how these processes can influence discursive (changes in thought) and material (physical changes) possibilities in later life. It is observed, first, that normalization denigrates aging and older adults by making negative comparisons to youth and, second, that medicalization
and commercialization serve to (re)construct later life and elders in narrowed terms. The “successful aging” paradigm serves as an example of these processes in action. The chapter concludes with a short research agenda, previewing the research projects contained in this dissertation.

Limiting Possibilities in Later Life: A Review of Normalization, Medicalization, and Commercialization

Normalization: Unfavorable Comparisons

Normalization can be defined in different and even contradictory ways depending on one’s intended meaning of the “norm.” Merriam-Webster (2012) defines the “norm” as both typical and yet ideal, where the former usage refers to “an established standard or average,” and the latter describes “a principle of right action binding upon the members of a group and serving to guide, control, or regulate proper and acceptable behavior.” Foucault emphasizes the comparative character of the norm and normalization.1 However, he also notes that normalization can involve achieving a preferred objective or standard.2

Previous research on the normalization of aging and older adults draws on both of the meanings of the norm described above, as average or typical while also ideal. For example, Lee et al. (2002) study how to most effectively “normalize” elders in China in the process of adjusting to nursing home life, attempting to approximate the pre-institutional daily routine of the elders as closely as possible. For the purposes of this dissertation, however, critical research on normalization is of greater interest as scholars
question underlying assumptions and expectations and scrutinize power relations. The main, though not the only, theme in the critical literature on the normalization of aging appears to be that older adults are often found to be deficient when compared with the idealized standards of youth. This negative judgment often leads to explicit or implicit “anti-aging” efforts to be, or at least appear to be, more youthful.³

As a widely-cited account of normalization in later life, Katz (2000) provides a good starting point for the following discussion and warrants an extended summary. Katz (2000) explains how older adults can feel pressured to conform to the ideal of being active (“busy bodies”) in later life, a reflection of broader societal values in the West. Activity has become “an antidote to pessimistic stereotypes of decline and dependency” (Katz 2000, 135), “the ‘positive’ against which the ‘negative’ forces of dependency, illness, and loneliness are arrayed” (Katz 2000, 147). Activity then represents a shift from one set of extremes to another, “the normalization of old age through activity regimes” (Katz 2000, 136). With the contemporary focus on activity, “the aged subject becomes encased in a social matrix where moral, disciplinary conventions around activity, health, and independence appear to represent an idealized old age” (Katz 2000, 140). Drawing on the Foucauldian idea of problematization, Katz critiques activity’s rise in gerontology through historical, social, cultural, and political contextual analysis, concluding that activity first rose to prominence as the conceptual solution for earlier problems within gerontology regarding issues of adjustment in later life. He asks the question “how, why, and in what forms was active adjustment to old age constituted as an ethical domain, and
why has this ethical form become so persistent despite its varying forms and intensity?”
(Katz 2000, 137).

The ascendancy of activity in gerontology has great consequences for how older adults think about themselves, how professionals (from researchers to activity directors in residential care facilities) study aging and interact with elders, and how policies and programs intended to help older adults are designed. However, Katz (2000, 143) also notes that older adults can resist the kinds of “normalizing activity practices and inflexible scheduling” often found, for example, in senior centers. Instead of continuing to objectify elders, Katz interviews older adults themselves to understand how they think about and practice “activity” in their own lives and he finds that retirees hold complex and sometimes conflicted views on activity. One participant emphasizes that she wants to control how, when, and in what ways she is active: “It isn’t that I want to be nonactive, though, it is that I want to choose” (Katz 2000, 145). Katz (2000, 147) closes by linking the pressure on seniors to be active to the wider political context:

The older social tension between productivity and unproductivity is being replaced with a spectrum of values that span activity and inactivity. To remain active, as a resource for mobility and choice in later life, is thus a struggle in a society where activity has become a panacea for the political woes of the declining welfare state and its management of so-called risky populations.

Physical appearance in one’s later years has also received attention in the critical literature on the normalization of aging. As with activity above, the problem identified by researchers is that older adults are compared to idealized standards of youth and youthful beauty and found wanting. Through a content and discourse analysis of
magazine advertisements, Smirnova (2012) challenges the “cosmeceutical” industry and the “will to youth” she argues the industry, paradoxically constructing women as both inevitable victims and potential heroines of their bodies, imposes on aging women. Brooks (2004) examines cosmetic surgery, providing a content analysis of articles in several magazines and highlighting idealized aspects of cosmetic surgery that stress scientific and technological innovation as well as positive personal accounts of the experience. Blaikie (1999), through a novel study of various visual representations of elders over a long historical period, and Del Casino (2009), connecting Virginia Blum’s (2003) *Flesh Wounds: The Culture of Cosmetic Surgery* to geographical gerontology (Andrews and Phillips 2005; Andrews et al. 2007; Andrews et al. 2009), have also underscored troubling issues regarding normalization, appearance, and cosmetic surgery in later life.

Normalization surrounding age-, gender-, and/or health-related changes in identity, sexuality, and reproduction forms another theme in the critical literature. Burrell (2009) performed a discourse analysis on the subject of menopause and hormone therapy, questioning how the natural process of menopause has been constructed as abnormal (“a deficiency disease”) and something to be treated via hormone therapy. Gannon et al. (2010) conducted interviews on complex interpretations of masculinity after experiencing erectile dysfunction as a side effect of prostate surgery. Friese et al. (2008) studied experiences of older motherhood and fatherhood by interviewing couples who conceived using a donor egg.
The literature also includes theoretical (Tulle and Mooney 2002) and, via interviews, empirical (Tulle-Winton 1999) perspectives on relocation to “age-appropriate housing.” “Age-appropriate housing” is defined in this case in terms of accommodations to meet growing health and personal care needs, while also offering ongoing opportunities for activity and leisure opportunities. This definition combines two interpretations of aging, one of aging as decline and the other of aging as anti-aging or active aging, that can impose conflicting expectations on older adults.

Other contributors have provided accounts of normalization in relatively more abstract terms. Jones and Higgs (2010) draw on the notion of the “normalization of diversity” from the sociologists Ulrich Beck and Zygmunt Bauman to critically engage the multiple and contradictory meanings of aging in contemporary society. Carroll (2007) offers a wide-ranging and critical discussion of aging, informed by experiences from her longitudinal qualitative doctoral research on women and retirement. Katz (1996) critiques the construction of the normal/pathological binary in the development of gerontology itself.

While Foucault has implicitly or explicitly influenced much of the critical work cited above, Jason L. Powell and colleagues - who have gone so far as to adopt the label of “Foucauldian gerontology” (Powell 2001; Powell and Biggs 2003; Powell and Wahidin 2006) - have written repeatedly about normalization in aging and of older adults from a Foucauldian perspective. Research has covered topics such as population control and aging in China (Powell and Cook 2000; Powell 2006), the treatment of older prisoners in “special hospitals” in the UK (Wahidin and Powell 2001), and social policy
for and the practice of social work with older adults (Powell and Biggs 2000; Biggs and Powell 2001; Powell 2001).

Normalization, then, involves a comparison with a standard, whether a typical or ideal one. The critical literature has explored how different elements of aging identities and experiences measure up against various reference points, often characteristics of youth or a youth-oriented version of later life such as active or productive aging. Nonetheless, the characterization of elders and the nature of the idealized standards to which older adults – and the individuals and organizations that seek to help elders - are pressured to conform can be further analyzed. In particular, this dissertation argues that the influence of (bio)medicine and markets in constructions of aging deserves greater attention. Toward that end, (bio)medicalization and marketization of later life are reviewed in the next section.

**Narrowed Redefinition: Growing (Bio)Medical and Commercial Influence**

Estes et al. (2001) connect the biomedicalization of aging with related processes that shape older adults and aging according to economic, business, and financial values:

> Old age, aging, and the policies designed for the elderly in the United States are profoundly shaped by four social processes: (a) the biomedicalization of aging, (b) the commodification of aging, (c) the privatization of old age policy, and (d) the rationalization of old age policy.

Likewise, Conrad (2005, 10) views (bio)medicalization and commercialization as interrelated processes:
The engines behind increasing medicalization are shifting from the medical profession, interprofessional or organizational contests, and social movements and interest groups to biotechnology, consumers, and managed care organizations. Doctors are still gatekeepers for medical treatment, but their role has become more subordinate in the expansion or contraction of medicalization. In short, the engines of medicalization have proliferated and are now driven more by commercial and market interests than by professional claims-makers.

If medicalization and commercialization have been deemed to be key interrelated factors affecting aging and older adults, these terms must be described in greater detail. The following sections will, respectively, review research on (bio)medicalization, commercialization, and the two processes in tandem.

**(Bio)Medicalization**

According to Conrad (1992, 211), medicalization “consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it.” Conrad and Schneider (1980) suggest that medicalization can proceed on at least three levels (conceptual, institutional, and interactional). These three levels vary in terms of the formal involvement of medical professionals and the tangible application of medical interventions, from the entirely discursive to the doctor-patient encounter itself. Clarke et al. (2003) offer a broader treatment of “biomedicalization,” arguing that scientific innovations in biotechnology have altered and intensified what they consider to be the predominantly 20th-century process of medicalization. One analysis (Conrad, Mackie, and Mehrotra 2010) estimates the cost of medicalization, based on available data on
twelve medicalized conditions, at roughly $77 billion, or 3.9% of total US health care spending, in 2005. Nonetheless, processes of medicalization began far earlier in other parts of the world, as Foucault documented in *The Birth of the Clinic* (1994) and other studies in which he analyzes processes of medicalization (of the body, of society, of the hospital, etc.) occurring in Europe across several centuries.

(Bio)medicalization in the specific context of aging is a strength of critical gerontology and the contributions of that sub-discipline must be examined further. Adding to Estes and Binney’s (1989) account, Estes et al. (2001, 46) emphasize the discursive and material features of the “biomedicalization of aging”:

the social construction of aging as a medical problem – that is, thinking of aging itself primarily as a disease and/or medical problem as defined by medical practitioners – and, second, the praxis (or practice) of aging as a medical problem and the behaviors and policies growing out of thinking of aging in this way.

Regarding more specific topics, a great deal of work in the literature engages the (bio)medicalization of sexuality and reproductive changes. For instance, many authors have challenged a medicalized characterization of menopause among women (Davis 1997; Vertinsky 1998; Woods and Mitchell 1999; Banks 2002; Hust and Andsager 2003; Bernis and Reher 2007; Remennick 2008; Burrell 2009; Utz 2011) and also of male climacteric (Oudshoorn 1997; Vainionpaa and Topo 2005; Marshall 2007; Watkins 2007) in a wide variety of contexts. One also finds critiques of medicalized notions of erectile dysfunction (Rosen 1996; Wentzell and Salmeron 2009) and of sexual health for older adults (Marshall 2011, 2012).
The literature includes critical examinations of the medicalization of community-based services for older adults (Estes and Wood 1986; Wood and Estes 1988; Binney, Estes, and Ingman 1990) and of health care for elders in Japan (Lock 1984) and Switzerland (Morabia, Loew, and Takla 1986). The medicalization of more specific practices, such as geriatric assessment (Kaufman 1994a) and anti-aging hormone replacement therapy (Conrad and Potter 2004; Mbongue et al. 2005), has also received attention. Differential rates of medication use have been studied to explore the socially-uneven medicalization of unhappiness of older adults (Norris et al. 2011). Researchers have conducted critical analyses of cognitive conditions and related behaviors, including the social construction of Alzheimer’s disease (Robertson 1990; Beard et al. 2009; Chaufan et al. 2012), of dementia in India (Brijnath and Manderson 2008) and of dementia-related wandering (Wigg 2010). The literature contains arguments against the medicalization of dying and death (Madan 1992; McCue 1995) and a study of different preferences about medicalized end-of-life care (Seymour et al. 2007). Finally, scholars have critically engaged the medicalization of more general concepts and conditions associated with older adults. Examples include work on frailty (Kaufman 1994b), comorbidity (Williams 2004), suffering (Black 2007), sleeplessness (Moloney, Konrad, and Zimmer 2011), conceptions of aging in Brazil (Leibing 2005), anti-aging generally (Mykytyn 2008), and anti-aging sports activity (Tulle 2008).
**Commercialization**

Whereas medicalization refers to the growing influence of medicine and medical authority in life, marketization or commercialization speaks to the material and discursive spread of markets and commerce, most often in the context of changes in the nonprofit sector. Salamon (1993, 17) points to the “marketization of welfare” in the US since the 1980s, defined as “the penetration of essentially market-type relationships into the social welfare arena,” and describes a series of crises facing nonprofits in America (Salamon 1999). Eikenberry and Kluver (2004) spell out the implications of marketization trends, such as commercial revenue generation, contract competition, the influence of new and emerging donors, and social entrepreneurship, for nonprofits and suggest that these trends threaten to undermine the longstanding role of nonprofits in US society (Table 1).

Eikenberry (2009, 586) states that

> a normative ideology surrounding market-based solutions and business-like models has become pervasive in the thinking and management of nonprofit and voluntary organizations. They are increasingly adopting the language of business, including emphasizing efficiency, customer, and profit.

This dissertation uses the term commercialization to encompass multiple processes, including commodification, privatization, and rationalization discussed by Estes et al. (2001) as well as the description of marketization above. These ideas address different aspects of the same core phenomenon: social issues – here, those that involve aging and older adults - becoming economic issues. This transformation is evident, for example, in the definition of “the commodification of old age and aging” from Estes et al. (2001, 49):
the shift in the mode of production of medical goods and services from an orientation of fulfilling human needs (such as food, shelter, or functional assistance for the disabled) to a mode of medical production oriented toward monetary exchange for the creation of private profit and increasingly enormous private wealth.
Table 1. The nonprofit sector's contributions to civil society.

<table>
<thead>
<tr>
<th>Marketization trends</th>
<th>Value guardians</th>
<th>Service and advocacy</th>
<th>Social capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial revenue generation</td>
<td>• Shift away from goals and mission</td>
<td>• Shift from serving poor to serving those who can pay</td>
<td>• Less need to rely on traditional stakeholders and networks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Imperative to weed out those difficult to serve</td>
<td>• Discourage civic participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Less likely to provide services that do not cover marginal cost</td>
<td>• Recruit board members with connection to revenue generation rather than to community</td>
</tr>
<tr>
<td>Contract competition</td>
<td>• Competition replaces benevolent spirit</td>
<td>• Focus on client demands rather than community needs</td>
<td>• Threaten interorganizational networks</td>
</tr>
<tr>
<td></td>
<td>• Mission made to be consistent with performance-based contracts</td>
<td>• Increased emphasis on management and public relations at expense of service delivery</td>
<td>• Devalue work of volunteers</td>
</tr>
<tr>
<td>New and emerging donors</td>
<td>• Difference in purpose and social expectations</td>
<td>• Encourage provision of reimbursable services that can be measured</td>
<td>• Focus on bottom line instead of strengthening social capital</td>
</tr>
<tr>
<td>Social entrepreneurship</td>
<td>• Essential value and mission compromised</td>
<td></td>
<td>• Less need to rely on traditional stakeholders and networks</td>
</tr>
<tr>
<td></td>
<td>• Not enter into mission-related activities if unprofitable</td>
<td>• Advocacy not supported</td>
<td>• Discourage civic participation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Concentration of power with larger service providers</td>
<td>• Focus on bottom line instead of strengthening social capital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Eliminate unprofitable services</td>
<td>• Recruit board members with connection to business rather than to community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Only enter into profitable markets</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not support change in status quo</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Recreation of Table 1 in Eikenberry and Kluver (2004, 135).*
Estes presented an earlier version of her critique in *The Aging Enterprise*, where her diagnosis of problems facing older adults in the US and the inability of a wide variety of individuals and organizational entities to solve those problems mentions treating older adults and aging as a “commodity” (Estes 1979, 2).

**Connecting (Bio)Medicalization and Commercialization**

While rare, some researchers have dealt with both (bio)medicalization and commercialization of aging in empirical work.\(^5\) Simpson and Cheney (2007) employ rhetorical criticism and critical discourse analysis to study resident participation in New Zealand retirement communities. They (Simpson and Cheney 2007, 191) write that marketization

may be considered as a *framework* of market-oriented principles, values, practices, and vocabularies; as a *process* of penetration of essentially market-type relationships into arenas not previously deemed part of the market; or as a *universal discourse* that permeates everyday discourses but goes largely unquestioned.

They (Simpson and Cheney 2007, 195) then suggest that medicalization of aging can lead to marketization of older adults and organizations:

Medicalization may be seen as a ‘stepping stone’ to the marketization of aged care for two reasons: (1) the housing of older people within a designated and segregated location has become normalized; and (2) with the emerging reaction *against* medicalization, marketization gained traction through the characterization of ‘positive’ and ‘active’ aging of people ’55-plus’.

Based on their qualitative analysis of data collected through interviews, focus groups, and retirement village brochures, the authors assert that medicalization has given way to
marketization in New Zealand’s residential care sector, “a shift from ‘hospital’ to ‘hospitality’ services: the rest home resident has been superseded by the retirement village customer” (Simpson and Cheney 2007, 196). In the end, the researchers (Simpson and Cheney 2007, 217) found a combination of medicalization and marketization at work in their study: “a partial colonization of traditional medicalized residential aged-care by a marketized model of service.”

Drawing on a political economy of health framework and both qualitative (interviews) and quantitative (financial and statistical analysis) research methods to triangulate insights, Daly (2007) presents a case study on the commercialization and medicalization of home-based long-term care in Canada following major “managed competition” reforms in the 1990s. Findings include that “Nearly a decade since market-oriented policies were implemented, non-profits still providing home care services operate more as for-profit businesses” (Daly 2007, 72), that “long-term care policy is increasingly focused on health care, obscuring social care, and creating social exclusion with serious implications for the large numbers of service users, and paid and unpaid care providers.” (Daly 2007, 68), and that “public funding is directed only to the most medically oriented health care services and [reforms] eradicated funding to non-profits unable to conform to the new model” (Daly 2007, 72).

In her nursing home ethnography, Farmer (1996) finds that the long-term care organization in her study actively promotes commercialization in an attempt to combat an institutional model associated with medicalization. The owner of the organization sought to create an atmosphere resembling a luxury hotel (Farmer 1996, 51 and 96), rather than a
nursing home, while a nursing home administrator in charge of one of the organization’s nursing homes wanted to make the facility “like a good restaurant” (Farmer 1996, 52). In both cases, the emphasis was on “customer service” for residents constructed as “customers,” a philosophy that “stemmed from a business perspective in which customer satisfaction was the driving force” (Farmer 1996, 51). Farmer concludes that “Although a hotel/business model of service delivery may be an improvement over the traditional medical model of institutional care, such a model does not reflect the unique needs of this particular organization called a nursing home” (Farmer 1996, 104) and that the organization’s philosophy fails to meet the daily challenges of eldercare.

(Bio)medicalization and commercialization have a wide range of consequences for older adults and eldercare. Older adults may adopt medicalized and value-laden interpretations of themselves that have entered popular culture and that stigmatize elders (Goffman 1963). Organizations that work to help older adults can find their overall mission, day-to-day operations, and interactions with seniors redefined in narrower terms that can weaken organizational effectiveness. The next section will discuss how processes of normalization, medicalization, and commercialization function in the context of “successful aging.”

Successful Aging: An Example of Limiting Later Life Potential

Many of the various strands of the literature summarized above coalesce in the example of the “successful aging” paradigm and critiques of the paradigm. The successful aging concept, therefore, offers a means of engaging what can be larger and
often quite wide-ranging processes of normalization, medicalization, and marketization. The mainstream “successful aging” (Rowe and Kahn 1987, 1997) paradigm defines “success” as the avoidance of disease and disability, high physical and cognitive functioning, and active engagement with life. In Successful Aging (1998), Rowe and Kahn see signs of great hope for what it means to grow old(er) in America and they present successful aging as a core theme within “the new gerontology.”

The criteria for “success” in the successful aging paradigm illustrate the influence of broader societal processes of normalization, medicalization, and commercialization. First, taken as a whole, the three criteria are characteristics usually associated with youth or middle age, not later life: successful aging is apparently not aging at all. The theme from the literature on the normalization of aging of an inevitable and unfavorable comparison with youth is clear. Second, two of the three criteria involve medical concepts and part of the second (high physical functioning) is often operationalized in terms of activities of daily living (ADLs) (e.g., Katz 1983), addressed by Katz (2000, 141-142) in his larger critique of the notion of activity in gerontology. Finally, the successful aging paradigm has been challenged for measuring later life by a standard more often suited to economic matters. For instance, Bartlett and Peel (2005, 99) write that “success in Western culture is usually associated with economic achievement, employment status, income and assets” and question the successful aging paradigm’s middle-class focus. McHugh (2000, 2003) and Lucas (2004) critique the commercialized vision of successful aging embodied in retirement communities and promoted by the retirement industry.
If successful aging can be critiqued for holding older adults to an idealized standard they might not endorse themselves, the paradigm can also be faulted for its sheer exclusivity. When a key component of “success” is defined as the avoidance of long-term illness, it would seem that the 80% of older adults in the US who have at least one chronic disease (National Center for Chronic Disease Prevention and Health Promotion 2011, 2) are automatically deemed “unsuccessful.” Moreover, there is a potential for stigmatization (e.g., Dobbs et al. 2008) and for different “landscapes of ageing” (Kearns and Andrews 2005), such as skilled nursing facilities, associated with “unsuccessful agers” to become, or have their status reinforced as, spaces of exclusion. In short, the extremely high bar set for “success” in the paradigm is itself problematic.

Successful aging is one of a number of related “positive aging discourses” (Dillaway and Byrnes 2009, 703), such as productive aging, healthy aging, aging well, and civic engagement, that seek to emphasize greater possibilities for elders in contrast to earlier themes of decline. Yet, by highlighting a particular goal to be achieved in later life (e.g., “success”), successful aging and other positive aging discourses imply a value-laden or normative vision for and assessment of one’s later years. The crucial issue is that normative visions of later life from researchers, administrators, and policymakers rarely represent the preferences of all older adults and instead seem to assume a great deal about what many people want as they grow older.

Studies in the field of critical gerontology, which seeks to identify and question underlying assumptions and values (Cole et al. 1993; Minkler and Estes 1999), clarify that these normative assumptions may not actually reflect all elders’ priorities. Critical
gerontologists have, more specifically, questioned the exclusivity of the “new gerontology” (Holstein and Minkler 2003), linked the values represented in successful aging to the political-economic context within which the paradigm was produced (Dillaway and Byrnes 2009), challenged the new responsibilities for older adults that go along with successful aging (Angus and Reeve 2006; Martinson and Minkler 2006), and problematized the identities constructed for seniors within the discourse of successful aging (Rudman 2006).

Authors who might not consider themselves “critical gerontologists” have nonetheless offered their critiques of successful aging. Riley (1998, 151) called for greater attention to “the social structural opportunities necessary for realizing success,” noting “the interplay between lives and the complementary dynamic of structural change,” and arguing that “well-known experiments have demonstrated that various improvements in older people’s lives are contingent upon structural interventions—intellectual functioning upon special training programs, productivity upon challenging work environments, and physical stamina upon targeted exercise regimes.” Moody (2005, 62) encouraged an expanded view of aging well in the form of “conscious aging” that would conceive of later life as “an opportunity for spiritual growth.” Seeking to “[underscore] the human capacity to adapt and survive in the face of adversity,” Harris (2008) suggested “resilience” as a more inclusive alternative to successful aging. Liang and Luo (2012) revealed “hidden codes” within the successful aging paradigm that point to ageism and commercialization, a narrow Americanized view of aging well, and a prioritization of quantifiable activities over the quality of experiences and they introduced
“harmonious aging” as a replacement for successful aging in social gerontology. Friedman and Ryff (2012, 542) noted that “many older adults who do not meet Rowe and Kahn standards consider themselves to be aging successfully” and their research results indicated that “even high levels of multiple comorbidities do not preclude high levels of subjective well-being.” Both critical and, increasingly, more traditional approaches (e.g., Phelan et al. 2004) seek to include the voices of older adults themselves in defining what it means to age successfully in order to avoid normalizing old age according to a narrow standard imposed on older adults (O'Rourke and Ceci 2011).

**Agenda**

The critical literatures on normalization, medicalization, and commercialization as well as successful aging cover a substantial range of topics. However, there are also areas in which additional research might advance existing critiques in or introduce new perspectives to the literature. This section will describe this dissertation’s contributions to the literature.

As the U.S. undergoes significant demographic change (He et al. 2005), the ability of individuals, families, organizations, and society at large to achieve desired outcomes and experiences related to aging is in question. Realizing one’s preferences is, ideally, something to be pursued throughout the entirety of life, although retirement may offer a unique opportunity to make good on the values society claims to hold. Instead, as work on cumulative disadvantage (Crystal and Shea 1990) suggests, inequality actually worsens in later life, potentially threatening the fulfillment of one’s desired experiences.
The material reviewed above suggests that the values of various claims about older adults and their aging experiences are at the heart of crucial debates about the nature of later life in this country. “Scientific” and objective measures of health and functioning and of social interaction from medical authorities can certainly be important to monitor and improve quantifiable goals. However, these characteristics are only the beginning of a search for deeper meaning in later life. A more inclusive meaning, in two senses, of “a good life in later life” is needed.

First, a framework for later life should address the entire range of aging experiences, offering a positive vision of the kind of life and death that one desires. Without connecting with thinking about the end of life, there is a great potential for unpleasant surprises in chaotic times. Each person would, ideally, have an idea of their own “good death” (Steinhauser et al. 2000), understanding that there may be a slow decline in which one’s quality of life continues to change (Baltes and Carstensen 1996). If achieving that goal requires substantial preparation and planning, this would encourage those involved to complete advanced directives, etc., with the input and support of loved ones, or at the very least, thoughtful conversation partners (e.g., spiritual advisors, social workers, etc.). Though answers for individual people and their families cannot be predetermined, the act of thinking through difficult questions would create the opportunity to develop or clarify one’s own principles. A better understanding of one’s values could inform one’s strategy for navigating the process of decline and death in a way that would hopefully be more consistent with the wishes of the older adult.
Second, a positive vision for later life should be inclusive of all people across the whole spectrum of later life experiences, so that no one should be counted out, certainly not at the outset. For example, those with chronic diseases are automatically excluded from “success” in the Rowe and Kahn (1997) framework. By contrast, a highly-, if not totally-, individualized vision of realizing one’s preferences in later life is needed.

Phelan et al. (2004) offer the views of “ordinary” people (Table 2) on the importance of various aspects of “successful aging” identified in the literature based on participants’ responses to a mailed survey distributed to two cohorts (Japanese-American and Caucasian-American) of individuals 65+ in Washington state, although the study excluded nursing home residents (Phelan et al. 2004, 212). Going beyond deductive research designs and samples that bypass elders in institutional settings, priority should be given to the actual voices of elders undergoing the broad range of later life experiences. This point could be considered as a need for “humanistic” perspectives on elders’ ideas of “the good life.” The humanistic dimension has to do with the art of living, with making sense of the human experience. Cole (1992), for example, regrets that the perceived value of later life has decreased as aging has become less of a mystery.
Table 2. Perceptions of older adults about successful aging.

<table>
<thead>
<tr>
<th>Living a very long time.</th>
<th>75% or more respondents in both cohorts (Japanese-American and Caucasian-American) rated this item as important in successful aging.</th>
<th>75% or more respondents in the Caucasian-American cohort rated this item as important in successful aging.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remaining in good health until close to death.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Feeling satisfied with my life the majority of the time.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Having the kind of genes (heredity) that help me age well.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Having friends and family who are there for me.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Staying involved with the world and people around me.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Being able to make choices about things that affect how I age, like my diet, exercise, and smoking.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Being able to meet all of my needs and some of my wants.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Not feeling lonely or isolated.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Adjusting to changes that are related to aging.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Being able to take care of myself until close to the time of my death.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Having a sense of peace when thinking about the fact that I will not live forever.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling that I have been able to influence others' lives in positive ways.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having no regrets about how I have lived my life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being able to work in paid or volunteer activities after usual retirement age (65).</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Feeling good about myself.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Being able to cope with the challenges of my later years.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Remaining free of chronic disease.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Continuing to learn new things.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Being able to act according to my own inner standards and values.</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Partial recreation of Phelan et al.’s (2004, 213) Table 1.*

If the points above reinforce the importance of scientific and humanistic perspectives, the literatures reviewed earlier in this chapter underscore the need for critical perspectives as well. Without “critical” perspectives, awareness of likely threats
to one’s goals – defined with input from both scientific and humanistic domains - will be insufficient. For instance, the structural constraints, such as discrimination based on age, gender, race, or class, on individual action may not be given enough attention (Minkler and Estes 1999). In general, from a critical standpoint, there is a need to understand how power, in two, arguably complementary, senses, affects older adults’ ability to realize their desired later life experiences. One, power in political economy is similar to the point above about structural forces. Estes’ (1979) critique of the “aging enterprise” is a key example of this approach in critical gerontology. In her view (Estes 1979, 1-2), “the key determinants of the standard of living enjoyed or endured by the aged are national social and economic policies, political decisions at all levels of government, the power of various organized interest groups, and the policies of business and industry.” As this quote implies, analyses rooted in political economy tend to be top-down and the focus on the individual can be lost. However, a second view of power is much more bottom-up, reflected epistemologically in the form of “ascending analysis” (Foucault 1980b, 99-100). Foucault (1975/1995, 26) analyzes a “micro-physics” of power relations in which networks of individuals and other entities are continually maneuvering, working to shape one another’s thoughts and actions to certain ends. Importantly, in his later work on ethics, Foucault (2005) allows for the possibility of meaningful individual-level resistance, whereas Estes (1979, 15) does not, based on Estes’ statements such as “Older persons individually are powerless to alter their social status and condition.”

This dissertation’s three research projects (quantitative analyses of Rowe and Kahn’s concept of “successful aging,” qualitative analyses of interview data that provide
broader views on aging well, and historical exploration of medicalization and
commercialization in long-term care and end-of-life care) will now be summarized in
terms of contributions to the literatures reviewed in the earlier sections of the chapter. In
their own way, all three projects seek to be critical and sensitive to context. Some of the
projects also engage scientific and humanistic perspectives as well. When taken together,
the projects aim to speak to a broad range of later life experiences.

First, the exclusivity of the successful aging paradigm at a general level is well
known, yet the implications of this narrow normalized, medicalized, and commercialized
vision can be spelled out in much greater detail. The profile of various people and places
constructed as “unsuccessful” by the paradigm is one area that deserves greater attention.
In particular, documenting the varying rates of “success” of even those older adults aging
in place – considered by many, despite critiques (e.g., Golant 2008), to be the ideal
context for later life – can connect the shortcomings of the paradigm to actual later life
settings, a sensitivity to context sometimes missing in the literature. If those elders
considered “best off” are portrayed as failures, the outlook for older adults in more
challenging situations, for example, in nursing homes, would seem to be hopeless.
Because individuals can internalize concepts that have entered popular culture,
envisioning later life as hopeless for the vast majority of elders, especially those in long-
term care settings, could damage individuals’ understandings of themselves and also
affect practice. Moreover, the different fortunes of US states as “landscapes of ageing”
(Kearns and Andrews 2005) hold implications for a retirement industry linked to the
successful aging paradigm (McHugh 2000, 2003; Lucas 2004). From a critical
perspective, chapter 3 presents a large-scale analysis of “successful aging” and constructs a map of (un)successful aging to help clarify the flaws of the paradigm in an easily understandable format.

Second, if the definition of “success” offered by the successful aging paradigm is unacceptable, more research is needed to understand the later life preferences of older adults. In particular, if one wants to create an alternative framework that embraces possibilities in one’s later years, turning to older adults facing the most challenging situations, such as nursing home life, could offer unique insights. Chapter 4 provides an analysis of interviews with nursing home residents in order to shed light on their self-understandings and values, which may or may not be consistent with normalized, medicalized, and commercialized visions. Furthermore, the analysis follows an inductive approach to highlight the voices of older adults themselves.

Third, more research is needed on the impacts of larger societal processes of medicalization and commercialization on different eldercare settings, from nursing homes to end-of-life care in the hospital, over time. Such an inquiry would connect societal-level processes with individual-level experiences. Historical research could advance understanding of what can, unfortunately, be unsatisfactory experiences of later life today. Importantly, outlining the significant challenges facing long-term care organizations may also offer clues to effectively redefine priorities and ultimately improve elders’ quality of life. Chapter 5 uses the critical historical method of genealogy to examine long-term processes of medicalization and commercialization and connect problems of nursing home life to end-of-life care experiences in the hospital.
Conclusion

This chapter has reviewed the literatures on normalization, medicalization, and commercialization, discussed the successful aging paradigm, and provided overviews of the empirical research found within this dissertation. Chapter 2 introduces the normative ontology and epistemology that will guide the dissertation research. These perspectives and approaches can inform efforts to define and achieve one’s good life in later life.

Notes

1 “In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialities and to render differences useful by fitting them one to another. It is easy to understand how the power of the norm functions within a system of formal equality, since within a homogeneity that is the rule, the norm introduces, as a useful imperative and as a result of measurement, all the shading of individual differences” (Foucault, 1975/1995, 184).

2 “Disciplinary normalization consists first of all in positing a model, an optimal model that is constructed in terms of a certain result, and the operation of disciplinary normalization consists in trying to get people, movements, and actions to conform to this model, the normal being precisely that which can conform to this norm, and the abnormal that which is incapable of conforming to this norm. In other words, it is not the normal and the abnormal that is fundamental and primary in disciplinary normalization, it is the norm. That is, there is an originally prescriptive character of the norm and the abnormal becomes possible in relation to this posited norm” (Foucault, 2007a, 57).

3 Because youth is often associated with health and health is linked to medicine, there can be significant overlap between research on the normalization of aging and work that examines the medicalization of aging, covered later on in this chapter. As a result, the categorization of sources in this chapter is intended to be instructive, but not definitive.

4 While the literature presents an overwhelmingly critical view of (bio)medicalization of aging and older adults, one also finds rare perspectives (Sadler et al. 2009) that advocate for a careful bioethical assessment of medicalization in particular cases instead of condemning medicalization at the outset, that challenge explanation in terms of medicalization alone for a greater tendency for individuals with the same symptoms as those decades ago to report poor health today (Schnittker 2009), and others that explicitly call for more, not less, medicalization (Ebrahim 2002).

5 While not empirical research, Estes et al. (2001, 49) do offer a concrete example of how medicalization and commodification - a form of commercialization - can be closely intertwined: “Although helping an ill loved one bathe and dress does not involve a commodity relationship, hiring a personal care worker to do
those same tasks commodifies it. Medicalization is involved because these new goods and services have been defined as medically related, and, therefore, medical providers serve as gatekeepers.”

It should be noted that the term “successful aging” means different things to different people. Phelan and Larson (2002) review a range of definitions from 11 sets of researchers, while Ford et al. (2000) trace the spirit of the idea back to Cicero in ancient Rome. Some authors, perhaps most notably Baltes and Carstensen (1996), continue to use the term “successful aging” while breaking from Rowe and Kahn by defining “success” as a continual process, where “success” is something to which all people aspire and is thought of as a continuum, rather than a binary state. Broadly speaking, one’s quality of life in later life can be viewed as one component of the “good life,” a topic of conversation for thousands of years that appears to have been originally associated with Aristotle and his idea of eudaimonia, translated as “human flourishing” (e.g., Cooper 1975, 89).
CHAPTER 2: DISSERTATION ONTOLOGY AND EPISTEMOLOGY

This chapter will present a normative ontology for the empirical research in this dissertation that seeks to critically synthesize, while also addressing problems identified in, the material reviewed in chapter 1. The ontological framework discussed below is normative because it is argued that one ought to help older adults to realize their preferences. Stated differently, this dissertation suggests that social science research can and often should be both critical (highlighting and understanding problems) and reconstructive (offering responses if not complete “solutions”), a philosophical perspective that Koopman (2011b) calls “genealogical pragmatism” and which this chapter explores in the thought of Foucault and John Dewey. Foucault and Dewey offer complementary contributions to this ontology, informing understanding of how, through multidimensional and multi-scalar processes, preferences can be produced (through a tension between objectification and subjectification), frustrated (through issues of identity on the one hand and practical everyday problems on the other), and realized (mainly by acting on expressed preferences). Responses may be discursive (change in thought or self-interpretation) or material (physical changes, including even mundane actions such as fixing cracks in the sidewalk, giving someone the right food, and so on). Responses rooted in good intentions and informed by critical research must effectively deal with
existing power structures, costs/financing, and other demands in order to succeed. After developing this ontology, this chapter then turns to crystallization, an epistemology that delivers on the ontology because crystallization purposefully engages multiple dimensions of a phenomenon. Crystallization is described and then operationalized via overviews of this dissertation’s three research strategies: multilevel modeling, analyses of interview data, and genealogy.

Preferences, Power, and Problems: A Normative Ontology

Preferences and Multiple Scales

Two points should be recognized at the outset for the following ontology. First, the realization of personal preferences is crucial. For example, the “living will” or “advanced directive” (e.g., American Academy of Family Physicians 1999) seeks to ensure that the preferences of older adults at the very end of their lives will be honored.2 Yet, elders’ preferences, like those of people of all ages, are surely not limited to matters of terminal care. Imperfect as these documents are (e.g., Ryan 1996), they suggest that elders, usually through conversations with loved ones and other trusted advisers, can clarify their “best guess” of their preferences through reflection and discussion. Because elders’ preferences go beyond end-of-life issues, working to realize a far broader range of considered preferences becomes a possible normative goal for caregivers, policymakers, and researchers alike. Personal preferences influence how one interprets experiences of daily life and vice versa. Furthermore, what one wants is closely intertwined with one’s identity and one’s past and imagined future can inform and act as reference points when
evaluating everyday experiences (e.g., Gubrium 1993). Continuity theory in social gerontology proposes that “change and evolution are usually perceived against a backdrop of considerable connection to the individual’s past” (Atchley 1989, 184) and that “adults employ concepts of their past to conceive of their future and structure their choices in response to the changes brought about by [usual, commonly encountered patterns of human aging]” (Atchley 1989, 183). The realization of one’s preferences for later life – what, upon reflection, matters most to one at that time in life - is both fundamental and constantly at risk. Despite cause for optimism, such as a falling rate of chronic disability among older adults (e.g., Manton, Gu, and Lowrimore 2008), worrying signs about the discursive and material state of aging and eldercare in the US are all too prevalent.  

Second, various factors and actors at different levels can have an impact on one’s experiences as one ages. For example, ageism can refer to a broader societal set of beliefs about a group of people, yet the process can be (re)produced through daily interactions between as few as two individuals or even a single person’s thoughts about him- or herself. This dissertation seeks to ultimately connect societal processes with the everyday lives of individuals and their personal preferences, in part by including an analysis of changes within organizations. The result is a perspective that incorporates multiple scales.

The two points above suggest that preferences can be frustrated – a problem understood here as those times when preferences have not been realized or when possibilities for the realization of preferences have been narrowed - in at least two general
ways and also offer clues as to how preferences might be realized. First, the formation of a preference may not be authentically one’s own, where the preference is imposed upon one from the outside and is not something one would choose upon reflection. Second, the preference is authentically one’s own or is one that one would choose again upon reflection, but the realization of that preference is frustrated by circumstances in and during the course of one’s daily life. Conversely, the realization of preferences can be aided, first, by promoting the ability for individuals to decide what they want for themselves (resistance) and, second, seeking to shape the world (e.g., healthcare system) to meet one’s preferences (reconstruction). Foucault’s concepts of objectification and subjectification and Dewey’s notion of reconstruction help to make sense of this discussion of preference formation, realization, and frustration. See Figure 1 for a graphic depicting this dissertation’s ontology.
Objectification, Subjectification, Resistance, and Reconstruction

This normative ontology turns to Foucault primarily for his perspectives on objectification and subjectification. Objectification refers to the way in which different authorities construct others. Objectification occurs through different processes and in myriad forms, but this dissertation focuses on processes of normalization, medicalization, and commercialization. Subjectification, on the other hand, is how individuals understand themselves, and subjectification can, importantly, serve to resist objectification.
Foucault is probably best known among geographers for his earlier work on objectification, where he shows how individuals are at the mercy of interpretations of themselves that have been imposed on them by others: “it is not that the beautiful totality of the individual is amputated, repressed, altered by our social order, it is that the individual is carefully fabricated in it, according to a whole technique of forces and bodies” (Foucault 1975/1995, 217). In this sense, Foucault seems to emphasize issues of identity, although he explained that “regimes of practices” were the primary focus of his analyses: “It is a question of analyzing a “regime of practices” – practices being understood here as places where what is said and what is done, rules imposed and reasons given, the planned and the taken-for-granted meet and interconnect” (Foucault 2000b, 225). Preferences may be problematic because they have been constructed by an “external gaze” that runs counter to our “internal gaze” (Foucault 1975/1995; O’Grady 2004; Foucault 2005).\(^5\) Indeed, this dissertation has already explained how larger processes of normalization, medicalization, and commercialization come together in the successful aging paradigm and how this paradigm defines most older adults as “unsuccessful” in ways an individual might not accept.

Fortunately, the “internal gaze” need not always be defeated. Near the end of his life, Foucault (e.g., 1988, 2005) developed his views on subjectification, resistance, and ethics. For the later Foucault, individuals can resist norms, discourses, and mentalities and create new critically-informed interpretations of themselves (Foucault 2000e; Taylor and Vintges 2004; Foucault 2007c; Ettlinger 2011, 549-51). An older adult may reject a characterization of him- or herself as “unsuccessful” when measured by the narrow
criteria of the successful aging framework and instead embrace other values, from
continuing to enjoy personal interests to cultivating and maintaining inter-generational
relationships, in later life. At the same time, even after critical reflection, preferences
may sometimes remain in line with normative standards valued in processes of
medicalization, commercialization, and normalization. Concern arises when individuals
do not support these values, but are nonetheless trapped by them.

This dissertation’s normative ontology draws from Dewey mainly with respect to
his ideas about action and reconstruction, which he defines at one point as “resolving a
problematic situation” (Dewey 1929/1960, 237). For Foucault, material change is not
required for resistance; a change in thought “counts” (Foucault 2000c, 2005). Dewey,
however, appears to focus more than Foucault on attending to material problems and, at
times, even one’s very survival (Dewey 1929/1960). According to Cutchin (2008, 1567):

the goal of a Dewey-informed geography is an improvement in the
conditions of people and places. It aims to meliorate the problematic in
undetermined situations, and it attempts to lay the groundwork…for
populations to intelligently resolve conflicts and problems as they arise.

Dewey (1938/1964) highlights action informed by inquiry as the way to temporarily
resolve problems. For the purposes of this dissertation, problems arise when continually
changing circumstances, a fundamental feature of existence for Dewey (1925/1929;
Cutchin 2004), potentially or actually frustrate the realization of elders’ preferences. For
older adults, “emergent problems of place” include “uneven sidewalks, changing social
composition of the neighborhood, and increasing costs of living” (Cutchin 2001, 36).
Resolution comes in the form of reconstruction or what, in a more geographical sense,
Cutchin (2001, 36) calls “integration,” described as “a short-term elimination of present conflicts in place and the creation of new meanings and values.”

In summary, Foucault and Dewey offer a way to think about preferences, problems, and “making a difference” (Allen 2008) through at least partial “solutions” that involve both immaterial (e.g., a critical re-thinking of the self and the system) and material (e.g., physical changes) issues. This dissertation understands Foucault to be saying that problems demand, first and foremost, critical conceptualization and clarification and, later, critically-informed changes in thinking and, perhaps, in material circumstances. Dewey, on the other hand, puts a greater emphasis than Foucault on material change: after all, Dewey is the pragmatist. Resistance is necessary, but not sufficient, for reconstruction. Resistance and reconstruction both target objectification, viewed in this dissertation as a process that defines others based on the influence of larger phenomena of normalization, (bio)medicalization, and commercialization that have themselves come together in the successful aging paradigm. In the next section, this dissertation’s ontology is linked to crystallization, a useful epistemology for exploring the ontology. The three research strategies outlined below target different scales (micro, meso, and macro) within the production, frustration, and realization of elders’ preferences.
Genealogical Pragmatism, Power, and Crystallization

Genealogical Pragmatism and Power

Recent scholarship outside of the geographic literature suggests that the ideas of Foucault and John Dewey can prove complementary along several lines. Koopman (2011a, 2011b) presents “genealogical pragmatism” as a form of critical inquiry rooted in the two thinkers’ similar perspectives on history and an approach that emphasizes the strengths of both figures. Speaking of the benefits of bringing Foucauldian problematization and Deweyan reconstruction together, Koopman (2011b, 537) writes:

I address some of the key deficiencies at the heart of both philosophical traditions: in the case of genealogical problematization there is insufficient attention to the positive work of formulating viable alternatives to existing problematic conditions, and in the case of pragmatic reconstruction there is insufficient thematization of the genesis of the problematic conditions which act as an impetus to pragmatic inquiry. In other words, there is a normative deficit in genealogy that pragmatism can help rebalance just as there is an excessive instrumentalism in pragmatism that genealogy can help temper. The result is a clear view of the need on the part of both traditions for philosophical-historiographical conceptions that are clearly featured in the other.

May (2011) and Gayman (2011) echo Koopman’s view of the complementary nature of problematization and reconstruction. Rabinow (2011) finds common ground between Foucault and Dewey in their belief that thinking was driven by problems. Colapietro (2011, 25) identifies both theorists as “radical experimentalists” who were interested in experience, while May (2011) draws attention to Foucault and Dewey’s emphasis on the importance of everyday practices.
Foucault and Dewey seem to appear together quite rarely in the work of geographers. Allen’s (2008) contribution to a special issue of *Geoforum* does, however, offer a precedent for the purposes of this dissertation/chapter. Allen connects power, as conceived in Foucault and pragmatism, with a relational view of space, focusing on the complex and precarious configurations that emerge to “make a difference” or not. For Allen, a practical treatment of power must be goal-driven and must recognize that various available tools will be more or less effective in achieving a certain goal.

May (2011, 61), like Allen, welcomes the critical perspective of Foucault on the pragmatic “effectiveness” of reaching a goal in order to “deepen pragmatism without violating any of its central commitments”: “We cannot, then, take the notion of success or the idea of navigating the world more successfully at face value. We must see it as the name of a problem to be investigated rather than a solution to be attained.” According to Koopman (2011b), “genealogical pragmatism” is an iterative interplay of problem and response, of advancing and critiquing alternative visions for the future.

This dissertation wants to follow Allen’s (2008) practical account of power by provisionally working toward a goal (realizing elders’ preferences) and putting the complementary ideas of Foucault and Dewey (also borrowing from Koopman’s “genealogical pragmatism”) in a geographic light (specifically, engaging the multi-scalar nature of problems). Responding to the critique that one can find all one needs in either Foucault or Dewey, Koopman (2011b) notes that Foucault and Dewey may have offered at least some discussion of enough relevant topics in their massive bodies of work, but that they did not develop all of their ideas in equal measure. Therefore, Koopman
highlights the benefit of drawing on one thinker to fill out the relatively under-treated areas of the other’s thought and vice versa.

**Crystallization and Summary of Dissertation Research**

If genealogical pragmatism serves as the normative motivation for this dissertation research, crystallization can fruitfully translate that spirit into actual research strategies. In order to deal with the complexity of the immaterial and material aspects of preferences and problems, processes of objectification and subjectification, and multiple scales of analysis, this dissertation offers an interpretation of crystallization (Ellingson 2009) to problematize eldercare. The ultimate goal is to work toward the redefinition and reconstruction of eldercare and to identify pragmatic ways to improve it.

According to Ellingson (2009, 4),

Crystallization combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers’ vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them.

Ellingson questions what she views as the excessively-rigid social construction of qualitative research categories, perhaps most notably calling on researchers to imagine a continuum that would span art and science. This continuum would accommodate everything from established qualitative approaches such as grounded theory to novel – at least for social science researchers – creative forms such as poetry. She suggests that the approaches contained within this continuum would offer productive means of
interpretation and representation to better engage the complexity of phenomena. Ellingson presents crystallization as a boundary-crossing (meta-)epistemology well-positioned to realize the promise of her broader vision for qualitative research.

Ellingson devotes attention to the normative dimensions of crystallization, primarily focusing on the ethically-fraught nature of representation in qualitative research. Ellingson (2009, 38) also identifies the pragmatic ethical benefits of crystallization as, first, giving voice to the silenced, especially through artistic expression and, second, promoting social change by employing diverse media to potentially reach and influence wider audiences. This dissertation seeks to build on the pragmatic normative potential of crystallization described by Ellingson. However, in doing so, it must be noted that this dissertation employs this dissertation author’s own interpretation of crystallization, departing in important ways from Ellingson’s vision. For example, this dissertation likely incorporates more quantitative work than Ellingson would find useful and does not substantively incorporate any forms of artistic expression. Nonetheless, the rationale for the use of crystallization in this dissertation’s epistemology consists of invoking the pragmatic ethical justification for crystallization identified by Ellingson as well as the spirit of crystallization, specifically, drawing on multiple genres of representation to engage complexity and reach wider audiences.

One of Ellingson’s most important ideas may be her recommendation that one should use a variety of research approaches to uncover many dimensions of a topic (Ettlinger 2013). Rather than being reduced to a singular Truth, the multiple truths that are produced should be valued and allowed to co-exist, whether in a single work, a
strategy Ellingson (2009, 14) calls “integrated crystallization,” or across several works, known as “dendritic crystallization” (15). One can envision this dissertation’s research strategies as one overall project on issues of aging and care, although each study could potentially be considered, and perhaps published, on its own. This dissertation mixes methods not for the purposes of triangulation or “validation,” but instead to “enhance the explanatory power of [the] research, because different data types and modes of analysis interrogate different processes and interactions” because, following Haraway (1988), this dissertation accepts “knowledge as situated and different ways of knowing as inherently partial” (Elwood 2010, 96).

Different methods and data are used in this dissertation to engage different issues within the larger context of elders and their wellbeing (or lack thereof). A variety of research strategies are employed in a series of studies to critique the narrow definition of aging well found in the successful aging paradigm and then to begin to define a broader alternative vision, while also seeking to understand issues that can frustrate good intentions. In short, the approach taken here is not one of eclecticism, but rather an attempt to begin to realize the pragmatic normative potential of crystallization by mixing diverse research strategies not simply to bring out and explore the complexity of a topic, but to do so in order to advance a larger ethical argument.

Ellingson accepts that numbers may be included among the multiple truths in crystallization, yet only if one views “statistics as careful measurements that inevitably are expressed in language, grounded in culture, and represent (only) one form of knowledge construction” (Ellingson 2009, 23). This quote from Ellingson speaks to
some of the fundamental inconsistencies between inferential statistics, on the one hand, and common principles of qualitative and/or poststructural research (e.g., Brown and Colton 2001; Ettlinger 2013) on the other.⁹ Lawson (1995, 454) helps to illustrate the conflicts between inferential statistics and critical perspectives (in this case, feminist geography):

The assumptions and purposes underlying inferential statistics – of normalcy, representativeness, generalization, replicability, etc. – return us to an atomistic, closed system world view of individuals statically classified and assumably replaceable, one for another. If samples can produce knowledge that is representative of populations, then we deny the role of history, context, and the positions of subjects within webs of social relations that constitute the meaningful subjects of feminist studies.

While the debate continues over the ability to employ quantitative methods in critical research, one can find views that do support the incorporation of quantitative analyses, depending on the conceptualization with which and purposes for which numbers are used. For example, in the same article cited above, Lawson (1995, 454) finds descriptive statistics acceptable, concluding that “[i]n designing research that involves counting, our challenge is to think carefully about how what we can see and count reflects that which is theorized and that which is imagined in places.” Developments in critical geographic information systems (GIS) (e.g., Pavlovskaya 2006) and discussions of the use of quantitative methods for critical objectives (Kwan and Schwanen 2009; Wyly 2009) indicate that the underlying mindset of and goals for the research can matter more than the particular techniques employed. As another example, Popay et al. (2003, 57) used existing “small-area data” as a point of departure for quantitative and qualitative analyses that critically explored health inequalities associated with “normative guidelines” in
places that were constructed as “proper” or “improper.” Nonetheless, when small-area estimates of a phenomenon of interest do not already exist, this dissertation suggests that employing inferential statistics to construct such estimates for critical purposes is not only acceptable, but useful in order to visualize and draw attention to a troubling state of affairs. With these insights in mind, this chapter now turns to one quantitative method.

The normative ontology developed above casts the mainstream “successful aging” paradigm (Rowe and Kahn 1997) in serious doubt because the paradigm ignores elders’ preferences. In chapter 3, multilevel modeling (Raudenbush and Bryk 2002) and small area estimation (Rao 2003) are used for critical purposes to construct a “field of visibility” (Dean 2010, 41) that reveals the exclusivity of the successful aging paradigm and the problems with objectification in the form of normalizing techniques of biopower (Foucault 2003) that target a population. Foucault explains that statistics are an important technique of biopower that are used to construct a population (Foucault 2007a) to more effectively manage it in order to serve the interests of the state (Foucault 1980a).

Quantitative methods are instead employed here to subvert the objectifying technique of biopower and draw attention to the misconceptions that have been generated with successful aging. This dissertation’s analysis (chapter 3) of the 1999 Community Survey within the National Long-Term Care Survey (Manton 2010) as well as the Behavioral Risk Factor Surveillance System Survey (Centers for Disease Control and Prevention, 2008-2010) shows that very few individuals 65+ in every US state meet the high standard for “success” in later life as defined by an operationalization of the successful aging paradigm. Indeed, fewer than 150 older adults in 1,000 were
considered “successful” in Wisconsin, the US state with the highest estimated rate of successful aging in the study, and the national average stood at about 108 successful agers per 1,000 older adults. The paradigm therefore constructs the vast majority of older adults, even those living outside of institutions, as “unsuccessful.” Paradoxically, then, the results of this quantitative analysis reveal that the “majority of older adults become abnormal” (O'Rourke and Ceci 2011, 6). Presumably, no one has a preference to be a “failure” in later life, so this empirical study thus clarifies the need to develop a much more flexible framework than “successful aging.”

While the quantitative results do, therefore, shed light on some notable issues within a larger process (Elwood 2010), other methods can begin to address remaining gaps; namely, the need for firsthand perspectives and expressed preferences of older adults themselves. Furthermore, because preferences are formed, realized, and frustrated in a context, this dissertation proposes that the realization of elders’ preferences involves issues that can fruitfully be conceived of in terms of relational space (Massey 1993, 2005) and multiple scales. Foucault (1980b, 99) suggests that research would benefit from “ascending analysis,” a bottom-up approach that first identifies everyday practices of individuals and then ultimately connects micro-scale findings with macro-scale societal norms (see also Ettlinger 2011, 548). In chapter 4, this dissertation turns to interview data in the spirit of ascending analysis to better understand the views of nursing home residents about their lives.

In order to explore what may be the greatest challenges to realizing preferences in later life, this dissertation has sought out the voices of elders living in particularly
difficult situations, using two analyses of interview data to examine their firsthand accounts of their lives. The set of interviews comes from the 1981 Hamburg University Nursing Home Study housed at Indiana University’s Center for the Study of History and Memory (2012). The interviews are a unique source for at least three reasons. First, the interview transcripts include over 125 pages of conversations with both nursing home residents (five women and three men) and staff members (four women). Second, the participants go beyond oral history to talk about their thoughts and feelings about daily life in a nursing home in a small city in Indiana. Third, perhaps because the interviews were conducted by a visiting scholar (Hans Peter Lütjen) from Germany, the interview data appear never to have been analyzed for publication.

Interviews with residents showed convergence with medicalized, if not always commercialized, notions of eldercare, as well as alternatives. Staff consistently referred to residents as “patients” and one resident observed that staff members put the wishes of residents’ doctors over those of the resident: “When your doctor say you can’t have anything then you can’t have anything.” Another resident consciously adopted the position of “the good patient,” but felt conflicted about embracing this submissive identity when she strongly disliked some of the things that were done to her in the course of her “care,” specifically having to let a man give her a bath.

However, despite evidence of convergence, surprising pictures of aging (e.g., several older adults did not consider themselves to be “old”), care, and nursing home life also emerged. Defying gender stereotypes as well as medicalized and commercialized notions of care, one male resident described how he acted as an advocate and informal
caregiver for another male resident who showed his appreciation in ways that challenged
traditional gender norms, for instance, by kissing the back of the first man’s hand. In
addition, a nurse’s aide described care in a way very different than the medical “charting”
and distributing of prescriptions that were the focus of the registered nurses who were
interviewed, expressing her feeling instead that staff and residents could be like
“substitute families.” Perhaps most striking of all were expressed desires to be in, not out
of, the nursing home.\(^\text{13}\)

Interviews offer vital firsthand accounts of the experiences and preferences of
older adults in nursing homes, including stories that can challenge prevailing
assumptions. However, interview data alone lack crucial historicized contextual
information. For example, how have medicalized notions of eldercare come to the fore,
impacting the daily lives of nursing home residents such as those cited above? Why are
alternative possibilities expressed above, including prioritization of expressed preferences
and friendly relationships among staff and residents, the exception, rather than the norm?
Moreover, understanding of experiences in one institution can be improved by connecting
that site with larger processes in the societal context, including the processes reflected in
the genealogy in chapter 5.

Focusing on present-day preferences overlooks how people, their preferences, and
settings are constructed over time (e.g., Dickie, Cutchin, and Humphry 2006; Byrnes
2011). Therefore, historical analysis provides additional insight into the long-term
formation of current preferences and how and why preferences may or may not be
realized. In its third and final empirical study, this dissertation turns to the critical
historical method of genealogy (Foucault 1998) to examine the long-term connection between contemporary problems of nursing home life and the emergence of expensive high-tech end-of-life care in the hospital.14

From a Foucauldian perspective, actors are in some way, consciously or otherwise, enrolled in re/producing norms, even when those norms may actually victimize the very people involved in their re/production (Foucault 1975/1995, 2000e). Foucauldian genealogy can be used to problematize troubling present-day institutional conditions by highlighting contingencies (Foucault 1998) and multiple causation (Foucault 2000b). By engaging what Foucault (1998, 81) calls “the exteriority of accidents” and seeking to explain a phenomenon in terms of other phenomena rather than itself, genealogy can explain how problems of long-term care articulate with different parts or sectors of society over time; of greatest interest here is the relationship between long-term care and unwanted intensive end-of-life care that mistakes quantity of life for quality. As part of the overall context of eldercare in US society, nursing homes and hospitals have been shaped by some related values as well as processes of medicalization and commercialization, yet have also had very different experiences. Ultimately, this dissertation argues that “success” in aging should not be a narrow standard imposed on older adults from the outside, as in “successful aging,” but instead that we should judge the “success” of all actors – from the elder to the entire health system – in realizing the highly-individualized preferences of older adults.

In the US, the experiences of later life that many people desire often prove unattainable, suggesting that preferences regarding aging and care are not always being
met. Conditions in nursing homes remain troubling: sizable shares of US nursing homes are considered deficient in terms of their accident environment (45%), food sanitation (40%), and quality of care (36%) (Kaiser Family Foundation 2009). In addition, unwanted aggressive end-of-life care (Field, Cassel, and Committee on Care at the End of Life 1997) poses other problems.\textsuperscript{15} This dissertation suggests that these phenomena are connected, most clearly through the unequal allocation of resources between acute care and long-term care, and that they may both endanger the experiences of aging and care that many older adults may desire. Depending on the end-of-life time period used (either one or two years before death), Medicare spending during the very end of life stands at an estimated 72\% to 92\% of the total $129.8 billion spent on nursing homes in 2005 (Komisar and Shirey Thompson 2007).\textsuperscript{16} How has this particular distribution of funds between end-of-life care and nursing home care arisen in our society? To begin to answer this question, this dissertation turns to historical analysis.

Histories of a maturing US health care industry show that things have not always been the way they are today. Howell (1995) documents the “messy” rise of technology within US hospitals between 1900 and 1925. He argues that the greatest impact on U.S. hospitals was the “efficiency craze” (Howell 1995, 30) that was imported into health care from business. Closely tied to this business mindset was a faith in science and, later, in scientific medicine and medical technology as the best way to achieve progress in almost all parts of life. Business donors to hospitals and business-based members of hospital boards pressured hospitals to operate as efficiently and effectively as businesses. Increasing commercialization resulted in changes in hospital management, especially
with the rise of accountants as hospital administrators who used the innovative method of cost accounting to identify the specific parts of a hospital that were making money and the ones that were losing money. In Foucauldian terms, cost accounting might then function as a technique of disciplinary power, a form of panopticism (Foucault 1975/1995), through which accountants/administrators could monitor the profitability of the whole hospital as well as the profitability of each and every department within the hospital, pressuring individual hospital staff members to consciously or unconsciously change their behavior once they became aware of this form of surveillance. Howell (1995) also argues that, in the early stages, the main value of medical technology, such as the x-ray machine, had nothing to do with clinical practice, but rather with attracting patients who could actually pay for at least some of their health care. Commercialization transformed the hospital from an institution providing charity care for poor, dependent populations to a large-scale, fragmented, moneymaking enterprise.

To complement Howell’s (1995) account of the technologization of the hospital and acute care, a case study of a single long-term care organization that has adapted throughout key periods in the history of US long-term care can highlight how processes of medicalization and commercialization that affected the overall health sector “touched down” in different ways in particular institutions. In addition to the interviews in the previous section, archival materials can help to represent the perspectives of as many actors as possible – from residents and their families to staff and administration – in order to provide a better understanding of the meanings of preferences, practices, policies, and social roles within long-term care organizations.
Informed by Gibson’s (2001) approach, interview material can motivate and serve as a lens into historical work. Relevant archival records include discussions of the perceived mission of the organization and the organization’s philosophy of care, publications of practice guidelines, and available primary or secondary accounts of the institution’s quality. The transformation of one long-term care organization (the Margaret Wagner House nursing home operated by the Benjamin Rose Institute) in Cleveland in the years following the passage of Medicare and Medicaid in 1965 offers a sense of the changes that have occurred in eldercare on a larger scale and suggests a growing concern over commercial matters. For instance, a report from this organization from 1957 lists principles that express the organization’s desire to build a new nursing home that is anything but institutional (“a home [that]…differs in every respect from a hospital” and that will be “conducive to living, not vegetating”), medicalized (“the Home gives solace and comfort”), and commercially-orientated (“Emphasis will be on service -- to provide care, prevention and protection”).17

In contrast, while internal debate persisted, organizational memos and reports in the mid- to late-1970s repeatedly emphasize concerns over costs (“cost cutting,” “cost effectiveness,” controlling “non-recurrent expenditures,” and minimizing “uncompensated services”) and the need to take advantage of government programs (Medicaid, Hill-Burton construction funds, Medicare, etc.) to subsidize the organization’s costs as much as possible. The shift culminated in a re-envisioning of the whole organization in the late 1970s as a “scientific experimental service agency,” a change that added research on and the development of cost-effective demonstration projects to the
organization’s long-time role of direct service provider. Within the research component of the organization, the primary aim would be “[t]he cost-analysis, and where possible, the cost-benefit of programs and services from the vantage point of the consumer as well as providers.” Interestingly, given Howell’s (1995) discussion, a 1958 letter from the Executive Director of the organization praising the method of “cost accounting” as a way to effectively document the true cost of providing high-quality care in order to support requests for greater public funding may have foreshadowed, though not determined, the changes within the organization decades later.

High-tech equipment in hospitals re/produces the superiority of acute care over long-term care in terms of status and funding (Stanton Chapple 2010), despite the widespread adoption of the medical model in nursing homes (e.g., Schwarz 1996). One symptom of this imbalance is that Medicaid, not Medicare, has long been the largest source of public funding for long-term care (Vladeck 1980; Feder, Komisar, and Niefeld 2000). The resulting association of long-term care with poverty and a perceived unproductiveness has led to the stigmatization of long-term care.

As government agencies compete for funding to serve those elders most in need, policymakers seek to control entitlement spending and reduce the national debt, and businesses and retirement destinations vie for the market of healthy and wealthy elders (McHugh 2003), social issues of aging and care are recast in economic terms (O'Rourke and Ceci 2011). Indeed, Foucault argues that within neoliberalism, “there is only one true and fundamental social policy: economic growth” (2008, 144). While medicalization and instrumental economic perspectives shape views of both acute care
and long-term care, such characterizations may simply be another form of the long-running disparity between the two or a debate in which that inequality may be further exacerbated, with consequences for all. In short, the past and present of long-term care may be more complicated and conflict-ridden than some accounts would suggest.

Conclusion

The epistemological strategy of integrating otherwise-separate projects provides ontological insights into how elders’ preferences are shaped and how the satisfaction of preferences can be aided or impeded. Genealogy can connect micro-scale, place-specific interview data to other sites of eldercare and also to macro-level processes in the larger context in which numerous actors within the “aging enterprise” (Estes 1979) have promoted medicalized and commercialized views of aging and care. Multilevel modeling can render visible the meso-scale spaces of exclusion that result from a narrow definition of “success” in aging imposed on older adults as a population. Within a particular institution, analysis of interview data can examine multiple views of later life that may follow or, as some of the quotes above suggest, diverge from the dominant models and alternative perspectives may be more responsive to elders’ preferences. What actors at the micro level see as important may offer a critique of the macro-scale processes that have helped to shape daily life in local settings over time. As these currents intersect in particular ways, the potential consequences for the kinds of lives (and death) we desire are great. If obstacles to realizing preferences are to be removed, they must first be understood; as Koopman (2011b) argues, reconstruction requires problematization just as
problematization demands reconstruction. Whether something as simple as giving a nursing home resident different food or as profound as honoring end-of-life decisions, satisfying expressed preferences is a worthy reason to act, to exercise power to “make a difference” despite uncertain and potentially problematic outcomes (Allen 2008).

Without crystallization, at least some of the insights indicated above would likely be missed. The rich detail of everyday life in long-term care institutions and the historical production of identities and values within different sites of eldercare are strengths of interview data and genealogy, but well beyond the reach of multilevel modeling. On the other hand, a series of mappable estimates, derived via multilevel modeling and small area estimation, can subvert the technique of biopower, offering a large-scale view of the problems of objectification, and provide a contribution unavailable from interview data or genealogy. Ultimately, the three specific research strategies (multilevel modeling, analyses of interview data, and genealogy) and the overall epistemological framework (crystallization) discussed here arguably go some ways toward delivering on this dissertation’s ontology as well as common poststructuralist principles (Ettlinger 2013). The overall research strategy, if not each individual methodology, presented here allows one to take important steps toward honoring these principles, even if the challenges posed can never be fully resolved.

Notes

1 This dissertation author understands the term “normative ontology” to mean a statement not only about what is, but also about what should be. Specifically, this dissertation argues that the goal of eldercare, defined broadly, should be to realize the considered preferences of older adults.
There would seem to be a connection between conversations about end-of-life issues and Foucault’s discussion of relationships focused on “truth-telling” and parrhesia (Foucault 2005). Reflection is also closely related to the ascetic practices of the self, part of Foucault’s understanding of “spirituality” (Foucault 2005, 15). This conversational and reflective model may then be one way of operationalizing Foucault’s ideas about subjectification and resistance.

A personal essay is included as a Preface to this dissertation to explain how the author’s own experiences motivated this dissertation research.

Here is one description of the multiple levels of ageism from the person who coined the term (Butler 1980, 8): “Since the attitudes of the members of a society shape the policies that govern it, bias, prejudice, and stereotypes can interfere with effective policy formulation. Through their effect on social policy, attitudes become institutionalized. This has been true with racism and sexism, and so it is with ageism as well…There are three distinguishable yet interrelated aspects to the problem of ageism: 1) Prejudicial attitudes toward the aged, toward old age, and towards the aging process, including attitudes held by the elderly themselves; 2) discriminatory practices against the elderly, particularly in employment, but in other social roles as well; and 3) institutional practices and policies which, often without malice, perpetuate stereotypic beliefs about the elderly, reduce their opportunities for a satisfactory life and undermine their personal dignity. The attitudes and beliefs, the discriminatory behaviors, and the institutional norms and policies are related and mutually reinforcing to one another. All three have contributed to the transformation of aging from a natural process into a social problem in which the elderly individual bears the detrimental consequences.”

May (2011, 61) raises issues surrounding externally-defined goals: “what are the self-understandings tied up with particular senses of success? If, for instance, we are produced to one extent or another as psychological beings with personalities of the type that psychotherapy promotes, then success will be defined in psychotherapeutic terms. This, in turn, has its own political effects…These effects are not always ones we would, upon reflection, seek to ratify.” For the purpose of clarification, May is not referring to successful aging in the preceding quote.

A well-meaning “external gaze,” perhaps operating as a form of biopolitics (e.g., promoting the health of older adults), would be welcome if the definition of the goal (e.g., “health”) is consistent with elders’ unique preferences. Similarly, expressing a mix of criticism of and support for new responsibilities for older adults linked to the successful aging paradigm, Martinson and Minkler (2006, 323) suggest that “although volunteerism and other forms of civic engagement should not be required of older adults, those who are interested in participating should be encouraged and enabled to do so.”

Dewey (1938/1964) writes that “inquiry effects existential transformation and reconstruction of the material with which it deals; the result of the transformation, when it is grounded, being conversion of an indeterminate problematic situation into a determinate resolved one” (159) and that “All controlled inquiry and all institution of grounded assertion necessarily contains a practical factor; an activity of doing and making which reshapes antecedent existential material which sets the problem of inquiry” (160).

“Whilst it is important to distinguish the ‘power to’ act with others from the more familiar exercise of ‘power over’ others, what appears to mark out a practical account of power, to my mind, is, first, that it is exercised with a purpose in mind: be it the pursuit of a political goal, the drive to end some form of global injustice, the demand for cultural recognition and identity, or simply the need to put ‘wrongs’ right. And second, that whatever the purpose in mind, some ways of exercising power always seem to work better than others to secure it. Power may be a useful means to get things done, a capability that enables us to intervene, but some actions appear more suited to given ends than others” (Allen 2008, 1615). On the
precariousness of a more fully spatially-oriented power to “make a difference,” Allen (2008, 1622-23) writes: “…a pragmatic reading of power is not simply there for geographers to adapt and mould. A more refined sense of the difference that space and spatiality make to the way that power works is what geography can offer pragmatism in return. Moving away from the notion that space is merely some kind of contextual backdrop towards an appreciation that the far reaching relations through which places are actively constructed can make a difference to the exercise of institutional authority or corporate dominion, for example, is precisely what geography may tell us. The significance of wider geographies to how power exercises us in place, the manner in which events elsewhere are folded into the here and now, are part of a geographical reconfiguration of power that both context and contingency strain to convey. What is perhaps often missed or overlooked is that it is the ‘global’ thrownntogetherness of events which actually accounts for much of the provisionality of power and, indeed, why it comes without guarantees.”

9 Brown and Colton (2001, 800) outlined the competing epistemologies of “scientific” and poststructural geographies: “For scientific geography (with its foundational epistemology), an ultimate stability between reality and representation is presumed, which therefore sanctions methods that positively reveal patterns and associations as geographies. Poststructuralism is not an alternative method, but an alternative epistemology. Its theory of knowledge rejects the faith in a mirror correspondence between representation and reality and so its aim is not to represent, but to critique all representations for their inevitable hubris, irony, and silences…This orientation means its scholarly projects have different objects and aims from modernist social science, but most importantly it has a different relationship with knowledge – which makes any attempt at reconciling or harmonizing it directly with spatial science impossible…[A]lthough the debate cannot be resolved, working within it can produce insight and clarify the debate.”

10 This dissertation ultimately employed subjective health data in the second multilevel model in chapter 3 to construct small area estimates for older adults, an approach that is consistent with this dissertation ontology’s focus on subjectification. In addition, rather than using results of one research approach to reject those of another, the discussion section of chapter 3 explicitly raises questions about competing claims of the importance of gender and race in experiences of aging arising from quantitative and qualitative studies.

11 In this sense, the multilevel modeling study also relates to Wyly’s (2009) vision for “strategic positivism.” The ability to speak in “scientific” terms with quantitative, mappable results may help researchers present their work to different groups, perhaps as a form of “guerilla scholarship” (Ellingson 2009, 134-36), where unconventional views are presented in conventional ways to reach new audiences. Of course, guerilla scholarship may also be a means of promoting dialogue across the inevitable boundaries within one’s discipline. For instance, gerontologists who may not have read or been persuaded by critical scholarship about “successful aging,” may find themselves more convinced by “hard” numbers and/or maps.

12 The Community Survey in the 1999 National Long-Term Care Survey is relatively large (n ~ 5,000), nationally representative, and contains extensive health and socioeconomic information on individuals “aging in place” in non-institutionalized settings (e.g., one’s own home), as well as a reasonably high level of geographic detail.

13 A surprisingly wide range of environments may help and/or hinder the realization of elders’ preferences in both immaterial and material ways. These possibilities are addressed in the therapeutic landscapes literature (e.g., Williams 1999; Gesler 2003; Williams 2007) and in recent work on the meaning of “home” in settings that present challenges for seniors (e.g., Leith 2006; Byrnes 2011; Cristoforetti, Gennai, and Rodeschini 2011). In addition, thought-provoking work (Leith 2006; Golant 2008; Byrnes 2011) has unsettled the view of “aging in place” as the unquestioned ideal for later life.
As “landscapes of ageing” (Kearns and Andrews 2005, 20) caught up in discourses and mentalities about later life, nursing homes, hospitals, and one’s own residence are connected within the larger context of eldercare in US society, yet these sites involve a different set of preferences and problems. From a Foucauldian perspective, societal depictions of aging and older adults (Blaikie 1999; Rudman 2006; Rozanova 2010) construct and convey norms, while actors in different aging and care settings—from one’s own home to nursing homes to hospitals—reflect and reproduce societal norms while also potentially diverging from those norms. Societal problems take on unique characteristics in particular parts of society. Nonetheless, specific problems in distinct sectors of society are recognizable in the larger context and vice versa (Foucault 2000a, 285-87).

Field et al. (1997 52-59) offer several “illustrative cases” to highlight issues surrounding “overtreatment.” In one of these cases, a 74-year-old man has a heart attack and is put in intensive care, where he suffers and cannot communicate with his daughter. He dies while being prepared for an emergency surgery to which his daughter consents after feeling pressured by a physician. For the daughter, “the intensive care environment…subjected her father to intrusive tests and interventions that would make her memory of his dying a continuing source of guilt and regret” (55). At the same time, interviews with a range of people about death and dying highlight the extremely difficult nature of end-of-life care decision-making, offering insights into why someone might respectively opt for or against intensive care at the very end of life (e.g., Pimple et al. 1998).

Comparisons remain problematic because there is no way to know how much of this estimated figure represents “unwanted” and/or “aggressive” end-of-life care, which is the real issue at hand. In any case, the suggestion here is not that a “small” amount of money is spent on nursing homes, but rather that additional funds could help to address—if not entirely resolve—challenges, such as staff shortages, that appear in firsthand accounts of nursing home life from both residents and staff members. Resources that could go toward apparently straightforward measures (increasing numbers of staff, paying higher wages, offering benefits, etc.) to improve nursing home conditions are compared with the amount of money spent on aggressive and expensive end-of-life care that, reportedly, few people want. The goal of this section of the chapter is to question and begin to understand how this state of affairs came to be.

There is a notable similarity between many of these principles and those found in “new” visions, such as the Eden Alternative (e.g., Thomas and Johansson 2003), that form part of the larger long-term care culture change movement (e.g., Kane 2001).
CHAPTER 3: REVEALING UNEVEN GEOGRAPHIES OF “SUCCESSFUL AGING”: A MULTILEVEL ANALYSIS

America is experiencing remarkable population aging (He et al. 2005), yet what this demographic trend means for older adults and the United States (US) remains a matter of much debate, with interpretations ranging from optimistic (e.g., Manton, Gu, and Lowrimore 2008) to apocalyptic (Robertson 1990). Within this variety of perspectives, the “successful aging” framework of Rowe and Kahn (1987, 1997, 1998), who envision “success” as the intersection of three dimensions consisting of the avoidance of disease and disability, high physical and cognitive functioning, and active engagement with life, has been among the most influential in traditional gerontology. This chapter seeks to draw attention to a troubling phenomenon implied by the very optimism tied to such a narrow definition of “success” in later life. Using the 1999 National Long-Term Care Survey, this chapter employs multilevel modeling, also known as hierarchical linear modeling, and geographic information systems (GIS) to explore spaces of exclusion across the US that are implied by the Rowe and Kahn definition of “success.” In doing so, the chapter also contributes to recent debates in academic geography regarding the use of quantitative methods for “critical” aims (Kwan and Schwanen 2009) that might also fruitfully inform social gerontology.
The analysis proceeds in three stages. The first operationalizes “successful aging” at the individual level using the 1999 National Long-Term Care Survey (NLTCS) (Manton 2010) and employs multilevel modeling (Raudenbush and Bryk 2002) to explore how person- and community-level characteristics affect an individual’s chances of aging successfully. The second draws on another data source, the Behavioral Risk Factor Surveillance System Survey (BRFSS) (Centers for Disease Control and Prevention 2008-2010), and a second multilevel model intended for small area estimation (Rao 2003), to improve rates of successful aging for US states - the most-detailed “coherent” geographic scale for which rates can be calculated due to concerns about individual privacy - beyond what the information available in the NLTCS offers on its own.¹ Finally, rates are mapped in a geographic information system (GIS) and spatial patterns (e.g., global and local measures of spatial autocorrelation) among state-level rates are examined on an exploratory basis. The chapter then discusses the findings and considers directions for future research on later life in an aging US society. The limitations of the analysis are summarized before the chapter’s conclusion.

**Methods**

**Defining and Operationalizing Successful Aging**

Data from the community survey in the 1999 NLTCS are used in this chapter. The NLTCS is a longitudinal survey, periodically covering the years 1982 to 2004, of older Medicare enrollees (65+) living in the US. It is based on a two-stage sampling design and is representative of both institutionalized and non-institutionalized elders from

¹
the national level down to the four US Census Regions (National Long Term Care Survey 2006). The community survey portion of the dataset has a relatively large sample size \( (n \sim 5,000) \) and includes extensive health and socioeconomic information on individuals “aging in place” in non-institutionalized settings (e.g., one’s own home), as well as a reasonably high level of geographic detail.\(^2\)

McLaughlin et al. (2010) operationalize successful aging based on five criteria: no chronic disease, no activities of daily living (ADL) disability, high physical functioning, high cognitive function and active engagement. Their approach is followed as closely as possible here, though another study (Meisner et al. 2010) also served as a guide at times.\(^3\) First, an individual could not have any condition in a sub-set of chronic diseases (cancer, chronic bronchitis, emphysema, diabetes, heart attack or any other heart problems and stroke) that are major causes of death for older adults and, in addition, could not be depressed. No formal instrument for measuring depression is included in the NLTCS, so a person was classified as depressed in this case if he or she answered yes to any of three questions based on feeling so “sad, blue, or depressed” that this affected daily activities, sleep or appetite. Second, an older adult could not have any ADL disability, where relevant activities include bathing, dressing and feeding oneself. Third, in another necessary departure from McLaughlin et al. (2010), but drawing on Meisner et al. (2010), an individual could have no more than one problem with instrumental activities of daily living. These include preparing meals, grocery shopping, getting around outside, doing light and heavy housework and paying bills. Fourth, a person had to score at the (imputed) median (27) or above (out of 30 possible) points on the Mini-Mental State
Examination (MMSE) (Folstein, Folstein, and McHugh 1975), a different instrument than the one used in McLaughlin et al. (2010). Fifth, a person was considered actively engaged if he or she met any condition within one set (doing work for pay at the present time, going to a religious service or being involved in civic or other kinds of organizations) and any condition within another set (being married or seeing friends at least once a month). Again, this operationalization of active engagement deviates somewhat from McLaughlin et al. (2010) due to differences in the variables included across data sets.

**Independent Variables and Geographic Units**

Person-level covariates, following McLaughlin et al. (2010), include: age group, educational attainment, woman, household income group and white. Obesity, subjective health and life satisfaction serve as additional binary independent variables. Table 3 displays categories and sample characteristics for the individual-level variables.

Given the exclusivity of the Rowe and Kahn definition of successful aging, it should perhaps be no surprise that there turned out to be little to no significant between-group variation to model in the analyses shown here. Nonetheless, even when there were no significant area-level (e.g., number of health care facilities in the community) effects on a person’s chances of aging successfully, multilevel modeling makes it possible to identify the respective person-level (e.g., age) effects, while accounting for geographic clustering of cases. The qualification is that, in order to create a multilevel model that includes an approximation of the “communities” in which older adults live,
the NLTCS must be re-arranged in a way that undermines the survey’s representativeness. Still, it was felt that even this less than ideal approach would begin to inform uneven geographies by examining how long-studied differences across space in terms of age, gender, race and ethnicity and socioeconomic status may be linked to yet another kind of inequality that combines health and social characteristics.
Privacy concerns appear to be making detailed geographic analyses of health surveys increasingly difficult. By contrast, the 1999 NLTCS provides some information about the “community,” a scale that can be linked to “place” data from the US Census (Hanlon, Vicino, and Short 2006), for those older adults who took the community survey. It is still impossible to associate individuals with specific areas, so the best available compromise is a division into metropolitan-central city, metropolitan-suburban, nonmetropolitan-micropolitan and nonmetropolitan-nonmicropolitan portions of each US

---

### Table 3. Sample characteristics of the individual-level variables (%).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pooled imputed datasets (N=5,044 each)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Person-level variable (Category value)</strong></td>
<td></td>
</tr>
<tr>
<td>Successful aging (1)</td>
<td>10.9</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
</tr>
<tr>
<td>65-74 (0)</td>
<td>28.4</td>
</tr>
<tr>
<td>75-84 (1)</td>
<td>50.0</td>
</tr>
<tr>
<td>85+ (2)</td>
<td>21.5</td>
</tr>
<tr>
<td>Educational attainment</td>
<td></td>
</tr>
<tr>
<td>Not finishing high school (0)</td>
<td>45.5</td>
</tr>
<tr>
<td>High school graduate (1)</td>
<td>26.6</td>
</tr>
<tr>
<td>Some college (2)</td>
<td>11.5</td>
</tr>
<tr>
<td>College graduate or higher (3)</td>
<td>16.4</td>
</tr>
<tr>
<td>Woman (1)</td>
<td>65.1</td>
</tr>
<tr>
<td>Household income group</td>
<td></td>
</tr>
<tr>
<td>Under $3,000 to $9,999 (0)</td>
<td>24.0</td>
</tr>
<tr>
<td>$10,000 to $14,999 (1)</td>
<td>20.6</td>
</tr>
<tr>
<td>$15,000 to $24,999 (2)</td>
<td>23.6</td>
</tr>
<tr>
<td>$25,000 to $100,000+ (3)</td>
<td>31.8</td>
</tr>
<tr>
<td>White (1)</td>
<td>90.0</td>
</tr>
<tr>
<td>Subjective health, high (1)</td>
<td>57.2</td>
</tr>
<tr>
<td>Life satisfaction (1)</td>
<td>90.4</td>
</tr>
<tr>
<td>Obesity (1)</td>
<td>43.5</td>
</tr>
</tbody>
</table>

*Note: 11.0 percent of the sample were successful agers in the state-level model (N=5,090 each).*
state.\textsuperscript{6} However, insignificant variation of successful aging across these “communities” meant that variables based on data from the State of the Cities database (US Department of Housing and Urban Development 2011), used in Hanlon, Vicino and Short (2006), and other sources were insignificant in exploratory models.

Presenting results in terms of relatively vague and fragmented geographic units is not very satisfying. Therefore, prevalence rates of successful aging were also estimated for US states. Initial analyses (not shown here) looked at relationships between successful aging and state-level indicators for the 65+ population related to chronic disease and disability, mental health, self-defined measures of wellbeing, employment and marital status. However, the percent of the older population with high subjective health was found to be the only area-level predictor of individual successful aging with even borderline statistical significance. The median percent of older adults with high subjective health, from the 2008-2010 BRFSS, was then used as a single area-level covariate, and the only independent variable, in a very basic multilevel small area estimation model that combined information from the NLTCS with the “auxiliary” data just described (Rao 2003). Table 4 presents descriptive statistics for area-level variables.
Table 4. Characteristics of area-level variables (mean and standard deviation).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Community-level data (1999 NLTCS)</th>
<th>State-level data (2008-2010 BRFSS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age group</td>
<td>0.96 (0.30)</td>
<td>Median percent of 65+ with high subjective health 73.83 (4.49)</td>
</tr>
<tr>
<td>Mean educational attainment</td>
<td>1.04 (0.55)</td>
<td></td>
</tr>
<tr>
<td>Mean household income group</td>
<td>1.68 (0.59)</td>
<td></td>
</tr>
<tr>
<td>Mean subjective health</td>
<td>0.60 (0.21)</td>
<td></td>
</tr>
<tr>
<td>Mean life satisfaction</td>
<td>0.94 (0.08)</td>
<td></td>
</tr>
</tbody>
</table>

Note: The values for the community-level variables above indicate where the area-level means fall with respect to the categories (2 for the binary variables, 3 for age group, and 4 for educational attainment and household income group) for the relevant categorical individual-level variables in Table 3. For example, a mean area-level age group of 0.96 shows that the community average is closest to the category represented by the number 1 (75-84 age group) for individual-level age group, while a value of 1.68 for area-level household income group suggests that the community average is closest to the category for individual-level household income group referenced by the number 2 ($15,000-$24,999). J=183 for the community-level model and J=51 for the state-level model.

Data Analysis

The method employed in the analysis is multilevel modeling, also known as hierarchical linear modeling (Raudenbush and Bryk 2002). More specifically, a hierarchical generalized linear model with a logit link serves as the main analytical method for this study (Raudenbush and Bryk 2002, 291-301). HLM 7 software (Scientific Software International 2011) with Laplace approximations to maximum likelihood estimation was used for all models presented here.

Two distinct two-level models were created. The first two-level model offers “clean” person-level effects, distinguishing between composition and context (e.g., Duncan, Jones, and Moon 1998), on successful aging and nests individuals within
geographic units intended to represent “communities.” Composition refers to characteristics of individuals in a given area, while context would then be the features of that area, apart from those of the individuals living there. In multilevel modeling, the terms composition and context also have technical definitions. Through different steps involving centering (by group mean, grand mean, or leaving variables uncentered) and aggregation, it is possible to obtain the unconfounded, or “clean,” compositional and contextual effects, respectively (Raudenbush and Bryk 2002, 139-41). This is a key advantage of multilevel modeling over standard regression which ignores clustering and, therefore, produces coefficients that are an uninterpretable blend of within- and between-group effects (Raudenbush and Bryk 2002, 135). While multilevel modeling can disentangle these influences, some researchers (e.g., Cummins et al. 2007) have also argued against conceptually dividing up people from the places they inhabit.

The second two-level model seeks to estimate the prevalence of successful aging for US states. Techniques of small area estimation (Rao 2003) allow one to make statistical claims about groups or geographic areas with few to no sample observations by incorporating information from additional data sources. Multilevel modeling has been used for small area estimation (e.g., Moura and Holt 1999; Twigg, Moon, and Jones 2000), as have multilevel models employing only area-level covariates (e.g., Bajekal et al. 2004, 13-14). This chapter draws on a very simple two-level model in which the median 2008-2010 BRFSS state-level percent of the 65+ population with high subjective health is used to predict individual-level chances of successful aging based on the 1999 NLTCS community survey. The Empirical Bayes, or “conditional shrinkage,” composite
estimator (Raudenbush and Bryk 2002, 47-48) for each state is then used to calculate the rate of successful aging per 1,000 people aged 65+ for all US states as well as 95 percent confidence intervals for the estimated state-level rates. These composite estimates, which combine information from the 1999 NLTCS and 2008-2010 BRFSS, improve upon the estimates one would produce based on the 1999 NLTCS alone.

**Missing Data and Multiple Imputation**

Missing data is an issue with the NLTCS. For reference, the total sample size for the entire 1999 National Long-Term Care Survey is 19,907 and the original sample size for the community survey is 5,147. Some variables, such as household income, have missing values for about 30 percent of community survey respondents. In order to preserve as much information as possible, multiple imputation was performed, following McLaughlin et al. (2010). Five data sets were generated using detailed cross-sectional weights and the multiple imputation tool in SPSS 19 (IBM 2010). After performing multiple imputation and excluding respondents who lacked sufficient geographic information, the analytical sample size for the first multilevel model, spread across 183 geographic units, is 5,044. The second multilevel model has a sample size of 5,090 individuals nested in 51 US states, including Washington, DC. The multilevel modeling software employed here allows pooling of up to ten imputed datasets at the first level of the model, but only one file at higher levels. In practice, this meant using the modes of categorical person-level variables to create a single summary file of aggregated level-1
indicators (descriptive statistics shown in Table 4) for the higher level in the first two-level model.

Results

The results of this chapter highlight uneven geographies of successful aging in two senses. First, geographic disparities at the individual level are evident. Second, variation across US states is also shown. The details of these uneven geographies are discussed below.

Estimating “Clean” Person-Level Effects on Successful Aging

An unconditional or “empty” model (Raudenbush and Bryk 2002, 23-24), equivalent to a one-way analysis of variance with random effects, of successful aging was run (not shown) as a starting point for the analysis. For a geographic unit with a “typical” rate of successful aging (i.e., a geographic unit with a random effect of zero), the expected log-odds of successful aging are -2.12, corresponding to an odds ratio of 0.12, or about 3 in 25. The predicted probability of successful aging would then be 10.67 percent, with 95 percent of geographic units expected to have rates of successful aging within the range of 6.91 percent to 16.14 percent. The value of the level-2 variance component was 0.059 and statistically insignificant ($p$-value: 0.114), suggesting that no significant variation exists across the geographic units in the model in the average log-odds of successful aging.
Model 1 has three noteworthy features. First, it incorporates the closest-possible approximation of the McLaughlin et al. (2010) model as a base, while accounting for clustering. Second, it adds new independent variables: subjective health and life satisfaction in the spirit of critiques of successful aging for a lack of self-defined measures (Phelan et al. 2004) as well as obesity. Third, Model 1 obtains the “clean” person-level effects on successful aging by exploiting a unique capability of multilevel modeling to obtain unconfounded effects of independent variables (age group, educational attainment, household income group, subjective health and life satisfaction) that had consistently significant associations with the outcome in exploratory models (not shown here). “Unconfounded” is meant here in a technical sense, as there are surely other factors (e.g., utilization of health care services) that have not been included in the model, but may still be important. By group-mean centering these five variables in the level-1 equation and including their uncentered aggregations (by mean) in the level-2 equation, the so-called “clean” individual effect is isolated (Raudenbush and Bryk 2002, 139-41). The intercept and the level-1 coefficients for age group, educational attainment, household income group, subjective health and life satisfaction are significant, as is the level-2 coefficient for aggregated (mean) subjective health (see Table 5 for odds ratios and 95 percent confidence intervals). The level-1 coefficients are interpreted here as the “clean” person-level effects on the log-odds of successful aging, or “the level-1 relationship net of any group-membership effects” (Raudenbush and Bryk 2002, 135). The level-2 coefficient for mean subjective health is the between-group effect of
subjective health on successful aging, or the expected difference on mean successful aging for two geographic units which differ by one unit in mean subjective health.

Table 5. The results of two multilevel models of successful aging.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>CI</td>
<td>OR</td>
<td>CI</td>
</tr>
<tr>
<td><strong>Constant</strong></td>
<td>0.01</td>
<td>(0.000-0.108)</td>
<td>0.12</td>
<td>(0.108-0.139)</td>
</tr>
<tr>
<td><strong>Person-level variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td>0.49</td>
<td>(0.414-0.577)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational attainment</td>
<td>1.33</td>
<td>(1.160-1.527)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>1.01</td>
<td>(0.793-1.298)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household income group</td>
<td>1.29</td>
<td>(1.101-1.502)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>1.27</td>
<td>(0.677-2.385)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective health</td>
<td>5.98</td>
<td>(3.646-9.809)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>11.48</td>
<td>46.580</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>1.02</td>
<td>(0.785-1.334)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community-level variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age group</td>
<td>0.45</td>
<td>(0.165-1.250)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean educational attainment</td>
<td>1.33</td>
<td>(0.797-2.223)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean household income group</td>
<td>1.35</td>
<td>(0.777-2.357)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean subjective health</td>
<td>10.49</td>
<td>45.992</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean life satisfaction</td>
<td>2.41</td>
<td>43.174</td>
<td></td>
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</tr>
<tr>
<td><strong>State-level variable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median percent 65+ with</td>
<td></td>
<td></td>
<td>1.03</td>
<td>(0.997-1.063)</td>
</tr>
<tr>
<td>high subjective health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Variance component</strong></td>
<td>0.017</td>
<td></td>
<td>0.043</td>
<td></td>
</tr>
</tbody>
</table>

*Notes: OR=odds ratio, CI=95 percent confidence interval. Model 1 identifies unconfounded person-level effects on successful ageing. Model 2 is a simple multilevel small area estimation model.*
Estimating the Prevalence of Successful Aging for US States

Small Area Estimation via Multilevel Modeling

A second two-level multilevel model, with individuals nested within US states, was estimated in order to produce state-level prevalence rates of successful aging. The between-group variance in the unconditional model (not shown) was small (0.054), but significant ($p$-value of 0.012). In the conditional model (Model 2), the state-level percent of older adults with high subjective health, taken from the 2008-2010 BRFSS, predicted an individual’s chances of successful aging (see Table 5 for odds ratios and 95 percent confidence intervals) with a barely-significant effect ($p$-value of 0.073). The Empirical Bayes coefficients from this model, included in the level-2 residual file, are the log-odds of successful aging for each state, reflecting “shrinkage” (Raudenbush and Bryk 2002, 48). Converting the log-odds to a predicted probability yields a proportion that can then be multiplied by the 65+ population for each state, offering the estimated count of successful aging for the older population. Dividing the count by the total 65+ population (in terms of 1,000 older persons) produces the number of older adults aging successfully per 1,000 elders in each state. 95 percent confidence intervals for these state-level prevalence rates were also calculated (Figure 2).
Figure 2. Point estimates and 95 percent confidence intervals for 1999 state successful aging (SA) rates per 1,000 older adults, with reference line for the US average. Data from 1999 National Long-Term Care Survey (Manton 2010) and Behavioral Risk Factor Surveillance System (Centers for Disease Control and Prevention 2008-2010). Sample of non-institutionalized older adults (65+). Own calculations, N = 5,090.

**Spatial Patterns of Successful Aging**

State-level prevalence rates of successful aging were then imported into GeoDa (Anselin, Syabri, and Kho 2006) and ArcGIS 9.3 (ESRI 2008). Using first-order queen contiguity weights, univariate global Moran’s I for the prevalence of successful aging per 1,000 older adults was 0.43, with 1.0 indicating perfect spatial similarity of neighboring areas and -1.0 perfect dissimilarity, and highly significant (pseudo $p$-value of 0.001).
Univariate local indicators of spatial autocorrelation point to two significant clusters, a small one in the upper Midwest of the US associated with high values of successful aging and a much larger second cluster linked to low rates of successful aging and primarily covering the Southeast. A standard deviation map (Figure 3) highlights the variation of successful aging across US states around the national mean, with Wisconsin as an upper outlier and Mississippi and West Virginia as lower outliers. Figure 4 shows the US states that were, on the one hand, below or equal to the national average prevalence rate of successful aging or, on the other, above the national mean.
Figure 3. Standard deviation map of 1999 state rates of successful aging per 1,000 older adults, showing distribution around the US average.
Discussion

The previous section indicates that successful aging varies by person and US state. This section of the chapter discusses these results in light of diverse research approaches and considers the potential for critical quantitative methods, the subject of recent debates in academic geography, in future studies of successful aging. Zolnik (2009, 337) argues for the potential of multilevel models “to promote dialogue across the quantitative-qualitative divide in human geography” on how to appropriately define and operationalize “context.” Multilevel analyses can also be “complemented by qualitative
work on the lived experiences of individuals in their daily lives” (Kwan and Schwanen 2009, 288). In the remainder of this section, this chapter seeks to extend these views with regards to successful aging.

First, prospects may exist for using unconfounded person-level effects from multilevel modeling to connect with qualitative research on the aging body. The significant variables in Model 1 are consistent with those of other cross-sectional analyses reported in a meta-analysis of successful aging studies (Depp and Jeste 2006), but the insignificance of gender and race/ethnicity in the quantitative results is striking when compared to the importance of these characteristics in qualitative research on identity and aging. Critical gerontologists view “the intersections between race, class, gender, and aging” to be “interlocking systems of inequality” (Minkler and Estes 1999, 1) that substantially influence experiences of later life. Mowl, Pain, and Talbot (2000, 192) observe that aging is inextricably intertwined with the body and its myriad social constructions, noting that “the function and appearance of the body have different meanings for men and women in identifying what it is to be ‘old’, influenced by ideologies around gender and sexuality.” Similarly, Charmaz (1999) and Clarke, Griffin and the PACC Research Team (2008) emphasize the role of gender in shaping the self-perceptions of people suffering from chronic illness. If Zolnik (2009) focuses on context and Kwan and Schwanen (2009) see an opportunity for multilevel analyses and qualitative methods to inform one another, the results of this chapter regarding uneven geographies at the level of the person also suggest possible benefits of dialogue between
quantitative and qualitative researchers about composition, the individual, and the body in later life. What could each side learn from the other?

Second, Zolnik’s (2009) point about using multilevel analyses as an opportunity to discuss how one defines and operationalizes “context” can be reframed to further encourage the ongoing exchanges between geography and gerontology (Andrews et al. 2007; Andrews et al. 2009). Multilevel modeling, a tool some gerontologists already use for longitudinal research, could offer supposedly non-geographic disciplines such as gerontology a way to constructively engage with geography and different notions of “context” in more meaningful ways. Rowe and Kahn (1998) emphasize that successful aging is about *individual* control, which they are at pains to distinguish from one’s genes, leaving many questions of human-environment interaction and successful aging to be explored. Picking up on critiques of the Rowe and Kahn definition of “successful aging” that seek more subjective input from older adults themselves (Phelan et al. 2004), what insights would qualitative research with “successful agers” in states below and above the national average tell researchers about “success” in later life and its relationship, if any, to one’s broader environment? For instance, the southern Appalachian states of the US are all below the national average of successful aging, and West Virginia has the lowest prevalence rate of all, yet a number of individuals are still successfully aging in these states. Rowles’ (2000) work in Appalachia on how older adults effectively adapt with their environment over time could be explored for evidence that supports or challenges the vision of Rowe and Kahn.
Third, authors (e.g., Ellis 2009; Wyly 2009) have maintained the importance of quantitative evidence in supporting critiques of social injustice. The state-level successful aging results of this chapter could inform critical research on the political economy of retirement. Assuming successful aging is, for at least some individuals, a justifiable approximation of aging well and that the numbers here are reasonably trustworthy, the low rates of successful aging in the southeastern US shown in Figures 3 and 4, including in traditional retirement destinations such as Florida, raise questions about who benefits from certain conceptions of aging and retirement: how well are states promoting themselves as the places to age well living up to this claim? For example, one wonders how much of a leap would be required to go from McHugh’s (2003) account of the extraordinary efforts of some retirement destinations to attract “healthy and wealthy” elders to the stigmatization and perhaps outright exclusion of “unsuccessful agers.”

**Limitations**

While this chapter represents a first step toward a more explicitly geographic understanding of successful aging, it has substantial limitations. There is no consensus on how to operationalize successful aging, so findings might differ based on the operationalization used. In addition, the NLTCS is not representative at the scales analyzed here, so results should not be generalized beyond the sample, although the significant independent variables in this study are consistent with those reported in a successful aging meta-analysis (Depp and Jeste 2006). There could also be issues with the geographic units in the multilevel models related to the modifiable areal unit problem.
(MAUP) in geography. One goal in this chapter was to approximate “communities” in the tradition of neighborhood health research (Meade and Emch 2010, Chapter 9), but the lack of significant variation across communities stands in contrast to the significance of differential successful aging rates across US states. Results may, therefore, be scale-dependent.

The approach adopted in this chapter for multiple imputation was just one of many alternatives, as there are different modeling strategies available and multiple imputation procedures in other software packages or tools offer much more flexibility than the feature in SPSS. Ideally, one would also be able to pool imputed datasets at all levels of a multilevel analysis, but HLM 7 software allowed this to be done only at level 1 in this analysis. State-level estimates of successful aging based on the percent of 65+ with a high subjective health should be received with caution, as confidence intervals are reported for the BRFSS data used here and confidence intervals are also associated with the point estimates produced in this analysis, making rankings uncertain. A range of opinion exist on the data requirements necessary for sufficient statistical power in multilevel modeling (e.g., Bowers and Drake 2005), although one can find analyses employing multilevel models for small area estimation with US states as the highest level, for example, in political science (e.g., Park, Gelman, and Bafumi 2004). Many other small area estimation techniques are available as well (Rao 2003). Finally, as a cross-sectional analysis, this study cannot answer questions of causality, as it confounds age effects and cohort effects, even if it does avoid period effects (Whitbourne 2008).
Conclusion

The national prevalence of successful aging in the US in 1999 is estimated here at roughly 11 percent, consistent with the reported numbers between 1998 and 2004 (McLaughlin et al. 2010). Is such an exclusive notion of “success” in later life acceptable for our loved ones and, one day, for us? If not, defining and pursuing our own “good life in later life” should arguably become a high priority. This chapter sought to draw out some of the geographic implications of the Rowe and Kahn definition of successful aging in order to highlight the uneven geographies associated with the concept. Multilevel models were used to explore variation at the level of individuals and of US states. Whether one agrees with the normative vision of later life offered by Rowe and Kahn or not, it is hoped that this chapter has made a small contribution in a much larger effort to productively engage the opportunities and challenges of later life in the US.

Notes

1 “Coherent” here simply refers to a geographic unit that can be unambiguously identified. For example, the US state of Ohio as opposed to the less clear, if more detailed, geographic units, such as “Metropolitan-central city Ohio,” found in the “community” multilevel model.

2 The relatively detailed metropolitan/nonmetropolitan breakdown (survey variable “HNC_CK2”) of each respondent’s geographic area was last available in the 1999 NLTCS, explaining why data from that year, rather than from 2004, were used in this analysis.

3 In order to perform national and state-level (as opposed to the more coarse level of US Census Regions consisting of multiple states) quantitative and spatial analyses that examined the Rowe and Kahn paradigm, it was necessary to follow operationalizations from previous researchers of the components of successful aging that could be constructed using the NLTCS.

4 While a meta-analysis by Depp and Jeste (2006) of quantitative studies of successful aging found a mean rate of successful aging of 35.8 percent, McLaughlin et al. (2010) report that the national prevalence of successful aging in the US varied between 10.9 percent and 11.9 percent from 1998 to 2004.
5 Among the requirements for de-identification of protected health information listed in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is the removal of “all geographic subdivisions smaller than a state, including county, city, street address, precinct, zip code, and their equivalent geocodes,” with some exceptions regarding zip codes (Centers for Disease Control and Prevention 2003, 4).

6 The “community” types this study sought to construct bear some resemblance to those often found in research on race- and class-related geographic variations in health and health care access. For example, regarding urban-suburban inequalities in particular, Schulz et al. (2002) examined the history of Detroit, particularly the different experiences of the suburbs and the city, since the 1950s to present evidence that residential segregation by race – as well as socioeconomic status - is a fundamental determinant of racial health disparities. The situation for older adults appears to be complex and may, in effect, offer a complementary spatial perspective on cumulative disadvantage theory (Crystal and Shea 1990). Wallace (1990) showed racial segregation in nursing homes and hospitals in a case study of St. Louis, while Wallace et al. (1998) found racial differences in nursing homes and hospitals in a case study of St. Louis, while Wallace et al. (1998) found racial differences in long-term care use, especially between older African Americans and non-Latino whites. Robert and Ruel (2006) observed little evidence of a link between racial segregation and subjective health, although their results pointed to associations between class and racial health disparities at multiple scales. Beyond urban-suburban differences alone, health disparities have also been identified among rural, suburban, and urban areas (Eberhardt and Pamuk 2004).

7 In this case, the Empirical Bayes estimator shrinks the mean of successful aging for each state toward its predicted value based on the percent of older adults with high subjective health, taken from the BRFSS, where the degree of adjustment is weighted by the number of individuals in each state in the NLTCS.

8 The analytical sample sizes differ between the two separate two-level models because six NLTCS communities did not line up with geographic units in the community-level data file, created from sources other than the NLTCS, meaning that all individuals in the NLTCS who lived in those six communities were dropped. This issue did not arise for the state-level model.

9 The full mixed model employed to estimate the individual log-odds of successful aging (η_y) was:

\[
\eta_y = \gamma_{00} + \gamma_{01}(\text{MeanAgeGroup}) + \gamma_{02}(\text{MeanEducationalAttainment}) + \gamma_{03}(\text{MeanHouseholdIncomeGroup}) + \gamma_{04}(\text{MeanSubjectiveHealth}) + \gamma_{05}(\text{MeanLifeSatisfaction}) + \gamma_{10}\text{AgeGroup}_{ij} + \gamma_{10}\text{EducationalAttainment}_{ij} + \gamma_{20}\text{HouseholdIncomeGroup}_{ij} + \gamma_{20}\text{Race}_{ij} + \gamma_{30}\text{SubjectiveHealth}_{ij} + \gamma_{30}\text{LifeSatisfaction}_{ij} + \gamma_{40}\text{Obesity}_{ij} + \mu_{ij}, \]

where \(\gamma_{00}\) is the intercept (constant), \(\gamma_{ij}\) are the main effects of uncentered community-level variables on a person’s log-odds of successful aging, \(\gamma_{ij}\) represent main effects of individual-level variables (variables shown in italics have been centered around their group mean), and \(\mu_{ij}\) is the community-level error term.

10 In this case, the combined model used to estimate the individual log-odds of successful aging (\(\eta_y\)) was:

\[
\eta_y = \gamma_{00} + \gamma_{01}(\text{PERCENT 65+ HIGH SUBJECTIVE HEALTH}) + \mu_{ij}, \]

where \(\gamma_{00}\) is the intercept (constant), \(\gamma_{01}\) is the main effect of the state-level percent of older adults with high subjective health (variable name capitalized to represent grand-mean centering) on an individual’s log-odds of successful aging, and \(\mu_{ij}\) is the state-level error term.

11 The spatial patterns of successful aging shown in this chapter suggest avenues for further study in the vein of social injustice, exploring potential relationships between uneven geographies of successful aging and poverty or inequality, perhaps in the future also involving race. An initial analysis finds a statistically-significant correlation at the 0.05 level of -0.296 between the rate of successful aging per 1,000 older adults across the US, including the District of Columbia, and the 2010 poverty rate among seniors per 1,000 older adults (US average of 119.80), calculated based on data from the Kaiser Family Foundation (2011).
correlation between the successful aging rate and the 2010 Gini index of inequality (rounded US average of 0.454, where a value of 1.0 indicates perfect inequality), taken from Noss (2011), was -0.303 and statistically significant at the 0.05 level. Both correlations are considered “moderate” negative relationships according to rules of thumb for interpreting correlations. For the sake of comparison, the correlation between the 2010 poverty rate among seniors per 1,000 older adults and the Gini index of inequality was 0.576, statistically significant at the 0.01 level, and would be deemed a “strong” positive association. Critical GIS (e.g., Pavlovskaya 2006) may be able to productively explore these relationships in the future, offering new insights into uneven geographies of aging in America.
CHAPTER 4: AGING IN ONE’S OWN WORDS:

SUBJECTIVE VIEWS FROM NURSING HOME RESIDENTS AND STAFF

Despite critiques (e.g., Golant 2008), aging in place – living one’s later years in one’s own home – continues to be viewed by many as the ideal later life setting. However, the previous chapter showed that, at least according to one influential definition of “success” in later life found in the successful aging paradigm of Rowe and Kahn (1987, 1997, 1998), the overwhelming majority of older adults aging in place would be portrayed as “unsuccessful,” whether one looks at the rate for the country as a whole or rates for individual US states. This already troubling finding bodes still worse for elders facing even greater challenges. At the outset, the successful aging concept excludes nursing home residents, who likely have at least one chronic disease or disability or have experienced a decline in physical or cognitive functioning.

Confronted with this finding, one might choose to reject objectification in the form of a narrow vision of “success” from researchers and instead seek out the perspectives of older adults themselves, particularly those dealing with great adversity. If one is looking for difficult experiences of aging and care, the nursing home may be the setting that first comes to mind for many Americans. Despite the promise of the long-term care culture change movement (e.g., Kane 2001), the thought of institutional
eldercare remains an unpleasant one for many, perhaps most, people in the United States. Keith (2005, 125) reviews public perceptions of nursing homes and finds that the picture is still a generally negative one, including “the now familiar view that older persons ‘would rather die than go to a nursing home.’” While the proportion of individuals 65 and over residing in institutional care facilities is quite small, only about 4% in 2009 (Administration on Aging 2011, 5), nursing homes will almost certainly continue to play a part in the “landscapes of care” (Milligan and Wiles 2010) for seniors as the older share of the US population rises.

Through an emphasis on subjectification, the experiences and views of nursing home residents might offer unique insights into a more inclusive and positive alternative vision for later life. In addition, because the narrow successful aging model might have very little relevance for daily life in the world of institutional long-term care, an understanding of well-being that would be more compatible with the specific advantages and disadvantages of the nursing home setting should arguably be informed by inductive research based on the views of residents and perhaps other actors, such as family members and long-term care staff. Inductive designs, including but not limited to grounded theory (e.g., Glaser and Strauss 1967/2006), may be one way in which researchers could support the “person-centered” (Koren 2010) principles of long-term care culture change, rather than deductively imposing existing theoretical categories on interview content. Work (Phelan and Larson 2002; Phelan et al. 2004) that calls for a revision of the Rowe and Kahn definition of successful aging or that seeks to modify the concept by incorporating the views of older adults is welcome, but these efforts have not
focused on the particularities of life for elders in the nursing home setting. In short, a normative view of later life should be broad enough to include nursing home residents and the successful aging paradigm appears to be too narrowly defined for this goal, so a bottom-up look at nursing home life would begin to offer a sense of what really matters to the people who actually reside in that setting.

Capturing rich firsthand experiences has long been seen as a unique feature of qualitative research approaches. In particular, ethnography, consisting of specific methods of intensive interviewing, participant observation, and archival research according to Wolcott (2008), has traditionally been the method of choice for many qualitative researchers across diverse disciplines. Nonetheless, some scholars (e.g., Valentine 2006) interested in ethnography have also acknowledged the difficulties of executing an ethnographic research project, with one issue having to do with gaining access to sensitive populations, including older adults with significant care needs (e.g., Chew-Graham et al. 2012). In such cases, secondary analysis of qualitative data (Heaton 1998) and meta-ethnography (Noblit and Hare 1988) may prove to be appealing, if not ideal, alternatives.

In addition to the normative argument for a more inclusive vision for aging and care, the practical research challenges described above motivated this study. After encountering obstacles to conducting a primary qualitative project in a care facility, “reworking” (Heaton 2004) a unique set of interviews collected by another researcher still seemed to offer a rare and helpful opportunity to answer questions about experiences of nursing home life, based on the personal views of both residents and staff. After
discussing the methods of secondary qualitative data analysis and meta-ethnography in more depth, subsequent sections of this chapter will, first, present findings from an analysis of a series of interviews conducted by another researcher with residents and staff in a Midwestern nursing home in the early 1980s and, second, offer an interpretive synthesis of those findings with key themes in an existing ethnography.¹ For the former study, material from a contemporaneous report on long-term care in the nursing home’s state will be cited occasionally to offer additional contextual information. While the qualitative data analyzed here are not new, it should be noted that the original researcher, who was from a country other than the United States, executed the early 1980s project and appears never to have published anything based on the information collected. In other words, this chapter is the first to bring the findings from these interviews conducted decades ago to light.

**Secondary Qualitative Data Analysis**

Secondary analysis of qualitative data has received greater attention since the mid-1990s and has been employed a number of times in recent health and care literature (Egerod, Storli, and Åkerman 2011; Kovandžić et al. 2011; Weitzner et al. 2011), but the method remains a topic of ongoing debate. Heaton (2004, 8-12) identifies three broad uses of the method: investigation of new or additional research questions; verification, refutation, and refinement of existing research; and synthesis of research. Disadvantages of analyzing secondary qualitative data include “[using] answers to interview questions that [the researcher] did not ask and on which [the researcher] could not follow up;
further, [the researcher is] not in a position to examine the multiple texts apparent in an interview (e.g. body language and the like)” (Fraser and Ettlinger 2008, 1648). The former point greatly reduces the possibility of theoretical sampling (Charmaz 2006), a staple of grounded theory and qualitative methods more broadly, while the latter points to “the problem of not having ‘being there’” (Heaton 2004, 60), the inability of secondary research strategies to fully capture the context in which interviews took place, a hallmark of ethnography. Nonetheless, as this study seeks to show, the fact that secondary analysis of qualitative data is not ethnography does not mean that secondary analysis is useless. On the contrary, several studies of late (Skinner, Yantzi, and Rosenberg 2009; Waterworth et al. 2011; Chew-Graham et al. 2012) suggest that secondary analysis of qualitative data can offer worthwhile insights into the experiences of older adults as well as professionals and organizations who serve elders, despite the approach’s admitted limitations. Heaton (2004, 28-31) summarizes the respective benefits and drawbacks of secondary qualitative data analysis. The approach taken in this chapter would fall under the “supra analysis” type that “transcends the focus of the primary study from which the data were derived, examining new empirical, theoretical or methodological questions” (Heaton 2004, 38).
Sample and Data Collection

Sample selection in secondary analysis of qualitative data is constrained by the availability of relevant “pre-existing” content (Heaton 2004, 2). Here, an extensive search for archival materials in WorldCat, an online catalog of numerous kinds of resources offered by OCLC Online Computer Library Center, Inc., through this author’s university library returned several promising collections of interviews, usually, oral histories. The qualitative data analyzed in this chapter come from the 1981 Hamburg University Nursing Home Study housed at Indiana University’s Center for the Study of History and Memory (2012). These data were selected after examining the “fit” between the available materials and this author’s research goals based on a series of criteria (Hinds, Vogel, and Clarke-Steffen 1997, Appendix A), classified by Heaton (2004, 93) into questions of accessibility, quality, and suitability, commonly employed to evaluate qualitative data for secondary analysis. In particular, the inclusion of both nursing home residents and staff members in a conversation about nursing home life, rather than a singular retrospective review of the lives of participants, was considered extremely useful for the purposes of this study. The collection of interviews would be “non-naturalistic or artefactual data” according to Heaton (2004, 5) because the data were specifically “solicited for research studies.” Access to restricted content was obtained through “formal data sharing” (Heaton 2004, 12) based on an agreement with the Center for the Study of History and Memory.

Little information exists in terms of the sampling strategy and sample selection criteria used by the original researcher, Hans Peter Lütjen, a married man and father in
his mid-30s from Hamburg in what was, at the time, West Germany. For example, it is unclear if questions in the semi-structured interviews about whether the resident being interviewed knows other residents on the floor were intended to explore the social network of residents in the nursing home, reflections of an attempt to conduct snowball sampling, both, or neither. Ultimately, the sample consisted of 8 residents, 3 men and 5 women, ranging in age from 56 (the only resident under the age of 65) to 93, as well as 4 staff members, all women, of ages 21 to 51. The average age of the seven residents who provided a specific age (one would only acknowledge being in his 80s) was 76. For reference, a staff member (nurse’s aide, JA2) interviewed gave an account of the general age distribution of the nursing home: “Most of our patients here are way over 60. The majority of them are over 70. We’ve got some that’s 85, we got one that’s 101.”

Interview length ranged from 16 to 88 minutes or, once transcribed, from 4 to 36 pages. No information on race or ethnicity of participants is available. The actual number of residents and staff in the nursing home at the time is also unknown.

Additional Contextual Information from a State Report

The setting in which the interviews were conducted was a member of the group of "Comprehensive Care Facilities" in the state of Indiana (Indiana Association for Health Planning 1982). Such a facility would usually [be] known to the general public by the name convalescent center or, more simply, nursing home. Unlike the Residential Facility or the Boarding Home for the Aged, state licensure law and regulation specifically require Comprehensive Care Facilities to provide 'nursing care and treatments' in addition to room, food, laundry, administration of

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medications, and special diets (Indiana Association for Health Planning 1982, v).

In the year before the interviews were conducted, there were approximately 37,500 residents and 39,780 beds spread across 450 nursing homes in the state in question, translating into a rough average of about 83 residents and 88 beds per nursing home. Older adults living in nursing homes constituted 81% of elders in all long-term care facility types in the state.

With regard to the state as a whole as well as its northern, central and southern regions, the numbers of nursing home beds per 1,000 residents 65 and over were in general accordance with what is accepted in the nursing home field nationally as a reasonable range, namely, 50 to 85 beds per 1,000 persons age 65 and over (Indiana Association for Health Planning 1982, xi).

The multi-county health planning sub-area in which the nursing home of interest here was located had 68.3 beds per 1,000 older adults. Regarding composition of the state’s nursing home residents, 84.8% were 65 and older, 71.4% were women and 66.9% were over the age of 75. Women 75-84 and women 85+ were by far the two largest age/sex groups, with the third highest being women 65-74, and the fourth highest men 75-84 (8.6% of all residents).

There were only 4 nursing homes and a total of 435 residents and 484 nursing home beds in the county of interest for an approximate average of 109 residents and 121 beds per facility. There were 67 beds per 1,000 older adults in the county. 88.7% of nursing home residents in the county of the nursing home in question were from that same county, with almost all of the rest of the residents coming from adjacent counties.
With respect to employment, the report cites 24,812 full time equivalent employees in the state’s nursing home industry, with shortages of full-time Registered Nurses and Licensed Practical Nurses compared to the US average, where statewide ratios of each category of nursing occupation per 100 nursing home beds (3.7 and 4.5) was 29.7% and 35.6% below the US average of 4.8 and 6.1, respectively. Nurse’s aides made up 48.4% of the nursing home industry's entire labor force in the state. The authors of the report were especially worried by the shortage of mental health staff in the state’s nursing home industry, commenting at one point that “It is not a bright picture” (Indiana Association for Health Planning 1982, 173). In the multi-county state sub-region in which the nursing home of interest was located, only 4.6% of full-time equivalent employees were “non-white” (Indiana Association for Health Planning 1982, 174). In terms of funding, Medicaid provided 62% of the state nursing home industry’s daily revenue, while 35.2% came from “Private or Self-Pay, namely, the private resources of the patient or the patient's family” (Indiana Association for Health Planning 1982, xvi), and Medicare accounted for only 2%.

Data Analysis

Interview transcripts were inductively coded following the constant comparative method (Glaser and Strauss 1967/2006). Coding proceeded in two stages, first with line-by-line coding and then focused coding (Charmaz 2006). The most promising codes were developed into greater levels of abstraction through memoing. ATLAS.ti 6.2 software (ATLAS.ti GmbH 1993-2012) was used in the process of coding and memoing.
The nature of the original study ruled out many traditional strategies, such as member checking, employed to maximize the trustworthiness of qualitative data (Lincoln and Guba 1985). Nonetheless, peer debriefing and inter-rater coding agreement were determined to still be possible under the circumstances and were practiced.

**Results from a Secondary Analysis of Qualitative Data**

The interviews highlighted the complexity of nursing home life. Hundreds of codes derived from line-by-line analysis were sorted into 121 focused codes. Focused codes were ultimately categorized into a series of themes involving interrelated issues of identity, activity, and care. Three overarching, and typically overlapping, concepts seemed to be present: 1) identifying/understanding oneself, 2) engaging in meaningful activity, and 3) being cared for.

**Identifying/Understanding Oneself**

The interviews often began with introductions by the interviewer and participant. The deceptively simple act of identifying oneself may point to a deeper self-understanding, an attempt to make sense of oneself and one’s life. Residents described themselves in a variety of ways, including references to one’s age, family relationships, and places. This theme emphasizes thought.
Relating Differently to One’s Chronological Age

Participants appeared to interpret aging in dissimilar ways. Some residents refused to see themselves as “old” or even to provide their exact age. By contrast, a few residents playfully engaged the topic, some appearing to do so more readily than others.

“I’ve got a lot of friends, young ones and old ones. And…I don’t count myself as getting old, you know. I don’t want to get old. But I know I’m not going to give up till I have to.” (Female Resident, FX2, italics added)

“I’m going to give you the answer I give everybody. And you aren’t going to like it. I’m 49 and still holding. [Chuckles] But I will say one—in the 80s, but I’m not going to tell you where…I don’t tell them around here because they’re so damn curious…” (Male Resident, VE2, when asked his age)

I: Yeah, may I ask you how old you are?
“Well, now you guess, and see how many you can guess on a hog’s weight. [Chuckles]”
I: Ninety.
“Older.”
I: [laughs] Ninety-one?
“Older.”
I: Two?
“Yep.”
I: Ninety-two! Oh yeah. [Chuckles] Yeah, you, you could be my grandmother.
“Huh?”
I: You could be my grandma.
“Yes, I could.”
I: Yes, it’s lovely. [Chuckles] (Interviewer and Female Resident, NR2-3)

Identifying Oneself and Others through Family Relationships

Valuing family, from one’s grandparents and parents, children and grandchildren, to a lost spouse, was another central theme. A nurse summarized the main things that residents remember and discuss with her: “Oh, they talk about families, their careers, if
they’ve worked, uh, you know, in some of the stone mills around here, some at the furniture factories around here. Uh, the women talk of children and their achievements, and grandchildren and things like that” (Female Staff Member, Nurse, GD4). Residents regularly gave unprompted accounts of their children and grandchildren, emphasizing how well their family members have taken care of them. One of those interviewed (Female Resident, NR3) said

“I’ve had 6 children. And I’ve had 2 that died, 2 nice boys. I’ve got the best family in the world, really because let me tell you, I’ve been here 5 years, here at the place. And my children’s been to see me every night since I’ve been here. Because I had to be put to bed. And some of them _______ their time and they’re here every night. So that’s pretty good, ain’t it?”

Having family or not was another way in which participants made distinctions about residents.

“…my daughters come after me. Oh no, I don't go on any of the staff trips because I think, well, I do think the activities directors here, they I think they do a marvelous job for the people that don’t have families or you know but--well, that’s the only recreation they have. They, but they do, this summer they were always taking them someplace for recreation. Course, I didn't go on any of them because I have my own family that supplies me with all those activities.” (Female Resident, XK3, italics added)

However, tensions with family members, usually with adult children involving struggles over independence, were also evident.

“…what you [addressing the interviewer] just said now is the very thing that the, the, the older generation is fighting against all the time, see. Now, she [his adult daughter] doesn’t realize she’s saying that. She doesn’t say it hurt me, but that’s the way they feel, they feel that we [older adults] don’t know anything, that we’re past. We’ve had our life and that’s the end of it…you [the younger generation] want to tell them how to
run their lives. You want to tell them what to say and what not to say.”
(Male Resident, VE9-10)

For many residents, remembering was both a daily practice and a way of reinforcing one’s sense of self. In general, identity was something residents appeared to define relationally, in social, temporal, and geographical terms, through associations with their past lives and with their present family, friends, and interests that went far beyond the nursing home walls. Several individuals interviewed interpreted questions in a way that allowed them to enter into detailed descriptions of their own parents, a sibling, a roommate, children, or grandchildren. For instance, a male resident (WV) gave a rich historical account of a “real” father he had never known and expressed gratitude and surprise at how well his stepfather had cared for him.

Residents at times seemed to use descriptions of their previous home or personal items as a metaphor for their identity.

“...the first house we had that was 16 rooms and 4 bathrooms. Very modern, not old stuff. And it was beautifully decorated, and we had a beautiful front yard. And uh—that’s the kind of a life I led, see. But I had friends from all walks of life. And we enjoyed that in fact, we went with younger people than our ourselves. And we always liked that. And the younger people always invite us to their parties and stuff like that. And they always had parties that were parties, you know. And uh, then we, ________ were then ready for high school, and so we sold that house—was in the suburbs of Milwaukee, the largest city in Wisconsin. And we sold that house and we moved to the country 30 miles west of Milwaukee. And we bought a piece of property out there that had a house on it, but it was kind of run down. It was a 16-room _________. We bought it and we had it all fixed over. It was just magnificent, so beautiful. And we had 2 ½ acres. We were on a lake, and in the lake, I had a CrissCraft boat. Not an outboard, which is a popular boat today of course. And uh—it was just a little _________, and that’s the kind of life I led _________.“
(Male Resident, VE14-15, italics added)
However, other residents stated that they actively tried to avoid remembering the past, in an attempt to accept their current situation, with one participant saying that dwelling on the past under the circumstances would only be a “nightmare” (Female Resident, NR6). Another resident blamed herself for being unable to forget the past. One staff member (Nurse’s Aide, JA5) believed that residents who “still have their minds” accept that “this is really the best place for them to be,” while residents who are “going senile” are unable to do so.

Examining the Relationship between Person and Place Identities

Participants also turned their thoughts to their residence and its fit, or lack thereof, in their larger personal story. One theme coming out of most of the interviews was a divergence between person and place identities, how who one is relates to where one is. A state report from the time period briefly discussed situations in which older adults who did not yet need to be in a nursing home were prematurely placed there (p. vi). Many residents – and sometimes staff – believed certain residents (sometimes including the speaker) did not need to be in the nursing home at all, while also recognizing the facility was useful for others.

“I wish things was different than what they are now. I’ve got one son. I don’t know, him and my doctor put me in here after I lost my wife. But I’d take care of myself if they’d let me…” (Male Resident, FP3)

“And there’s many people that is been in bad condition, they’ve had strokes, you know. They can’t use but one hand, some of them has to be wheeled down. Now I wheel myself down in the chair.” (Female Resident, EE15-16)
“...working in a health care facility like this I do see, uh, older people that have deteriorated mentally and physically that needed care. And that’s one of my positions here, caring for them. Uh, even here, uh, a lot of our patients have been residents for some time.” (Female Staff Member, Nurse, GD2)

“...a lot of our patients here have had a lot of physical problems and that’s why they’re, why they’re here. A lot of them cannot be cared for at home, uh, maybe because it’s a 24-hour duty thing, for maybe children, and it’s just too much for a family to take care of. And then maybe it’s too much of an inconvenience for families also, that it’s more convenient having them here and they’re willing to pay the price. But I feel a lot of them could be cared for at home.” (Female Staff Member, Nurse, GD2, italics added)

“...I feel like if she would’ve had someone to—that could’ve looked after her, it looked like she could’ve been home or something, you know. But—I guess she needed too much care or there wasn’t anyone that could take care of her.” (Female Resident, TR4, describing her perception of the condition of another resident who had been in the nursing home for many years)

“I enjoy working with them, there's a lot of them that don't even need to be here. If it was my mother and father, they wouldn’t be here. But I think that—it’s getting better, life is getting better for them because they’re—I, I don’t feel like that when my parents are 60 years old they’re going to be in a place like this.” (Female Staff Member, Nurse’s Aide, JA2, italics added)

“Lot of them, lot of them on this floor don’t need, you know, very much assistance, you know, just whatever they want you to do to help them.” (Female Staff Member, Nurse’s Aide, LX2)

In contrast, other participants indicated that they did feel they belonged in the care facility.

“This is a nice place for people that’s crippled up and [can’t] get around much and for older people. And I don’t know what we would do if it
wasn’t for places like this.” (Female Resident, EE14, after describing herself as “kind of crippled” – EE2 — and “right smart crippled up” – EE3 — earlier in the interview, italics added)

“Well, concerning my health, there’s—why I am here, I was ill and I had to have someone to be in my home with me all the time. I lived with my daughter and she and her family were—and I would prefer this place to being at home and having to have just a continual nursery. Much prefer this.” (Female Resident, XK4, italics added)

Given the variety of resident care needs in the nursing home, there appeared to be some tension about even temporarily mixing residents across the spectrum of care levels. A staff member described the usual segregation of residents with different care needs in the nursing home.

“I feel like [this nursing home] is better than the other nursing homes in [the city]—because it’s, I don’t know how you explain it…it’s—it’s more like a hospital, but then this floor is more like a resident home. The patients here are treated more like, they’re encouraged to do things on their own, and most of them do do things on their own. They don’t have to, at least on this floor. That’s the reason why, I, I like [this nursing home] better than I would [another] nursing home, because they put all kinds of patients together and one of them can’t even talk and the other one maybe just blind, and everything else is just fine with him. Whereas on this floor, everybody is able to help themselves for the most part, and they’re separated by levels of floors.” (Female Staff Member, Nurse’s Aide, JA2-3)

Nonetheless, when the normal order was relaxed during meal times, a resident expressed great frustration about being in the same room with people who were unable to change out of their pajamas.

“They come to breakfast, oh god, it’s just awful. They’re too—they’re either too tired, too sick, too messy, if they’re too sick, they shouldn’t come in the dining room.” (Male Resident, VE23)
Length of time in the nursing home ranged from about 6 months (FP2) to 7 years (FX1) for those interviewed. Duration of stay served as another way for residents to distinguish among themselves. One resident pointed to a difference between staying in the nursing home and “living” there.

“…but I just rather be home because it’s, to me, you know you get the feeling it’s been too long, you know. Because it’s been since—since January, see.”
I: Yeah. [Another resident] has been here for seven years.
“You know I think—what I think of that, I think, well, it’s just like she’s lived here, that’s a long time, 7 years.” (Interview and Female Resident, TR4, italics added)

Descriptions of the respective journeys of residents into the nursing home revealed a range of reasons for the transition, from inadequate self-care

“Well, after about a year of that [living on his own], I got so sick of it, I got so sick of it, you know. Uhh—the idea of going out and buying, going, cooking, that after awhile, I quit.” (Male Resident, VE4)

to catching pneumonia while on vacation (TR2). A report from the time period indicated that, for nursing home residents in the state, “the leading primary illness was senility (23.6% of all residents), followed by heart disease and post stroke (17.9%), diabetes (8.8%), mental retardation/developmental disability (8.0%) and mental illness (7.7%)” (Indiana Association for Health Planning 1982, xviii). However, the catchall category of “other” problems made up 31.1% of all primary conditions, so the report authors cautioned against making definitive conclusions based on the numbers.

A hospital stay, as long as 3 weeks for one resident interviewed, frequently preceded placement in the nursing home. That same resident had been mistakenly moved into the wrong nursing home for 2 weeks, just long enough to get “all settled” (Male
Resident, VE5), before his doctor realized the error and had the person relocated to the
study nursing home. Several participants lived with their adult children, while others
lived alone in an apartment, before coming to the nursing home. Residents expressed
different feelings about various living arrangements prior to entering the nursing home
and, according to some of those interviewed, staying with family was not without its
problems either. One older adult was troubled by a sense of guilt over being a burden on
his family, even while enjoying where he was living.

“And I, I lived with her [his daughter] and...her husband. And they had 3
growing daughters. And they have a large home, and believe it or
not...my son-in-law, was the one that asked me to come and live with
them. As a rule, son-in-laws want the old man as far away as possible
[chuckles], you know, let him come and visit once in awhile, but don’t live
here. But he was wonderful about that. And they took their family room,
and they took all their stuff out of it, and repainted it, redecorated it. And
they have—the kind of heat they like, they like it cold in the house. I can’t
stand that, so he had electric baseboard heat put in for me. And I had a
bath in connected—this was the family room, they gave me. On the first
day a private house and this was on the first level. And it had, it was a
large room, it had a bath and a wood burning fireplace. And uh I had all
my own things in there the day when I sold my home. I gave most of the
furniture to my 3 children, but I kept back some in case I ever took an
apartment. And uh—so I brought that down, I just brought pictures,
everything. So it was home to me...Right off this room was a large deck, I
could go out there. And their land slanted down to their own woods and
beyond the woods was a running creek. It was lovely, it was a lovely
location. And uh—I, I stayed with them two years, I think. And my belief
is that no parent should live with his daughter or son-in-law, and they
should not live with the father, either, when they’re grown unless it’s
absolutely necessary. So I didn’t think it was right that I was living with
Judy and Don because they were raising their ______ children without—
and we never had a fuss or anything like that. And uh—went to South
Carolina for a year, and when I got back, I said to my daughter, I said I
think I should get a one-bedroom apartment, and uh let you people have
your home to yourself. Well, the children cried, they didn’t want me to go,
and [his daughter and her husband] both simply said, oh, stay here, you
don’t have to go. No, I said, I would feel better, I would feel better if I had
“a place of my own. So we hunted around and I found a one-bedroom apartment.” (Male Resident, VE3-4, italics added)

**Identifying/Understanding Oneself by Engaging in Meaningful Activity**

Self-understanding, the first overarching theme, was closely related to meaningful activity for many of the residents interviewed. Issues of declining mobility and functional health were coupled with great efforts to maintain independence as much as possible in a supportive care setting. Some residents, while explicitly describing actions, seemed to be asserting their continued independence, despite changes, to show that they remained a capable person who still had agency. The speaker indicated what he or she still could do, even if some familiar actions were no longer possible. Far from the avoidance of disease and disability, such experiences were actually the preconditions for proving one’s resiliency, an important part of one’s self for these participants. Staff practices and environmental features that facilitated continued independence were appreciated.

“…I was in perfect health, except for the arthritis in my knees and ankles. And that keeps me from walking, so I’m learning to walk all over again.” (Male Resident, VE2-3, italics added)

“And then after I left the hospital over there, why I went up on 4, and course I was awful weak [voice drops] _____________. They had to give me that blood back, you know, and they put it in my veins. And I was very weak, I had to be led to the bathroom, _______________ for a long time. And then I finally got to where I could use this walker. And—so that’s the way I got around when I was up there. But I just, they don’t have any dining room up there. We have a dining room down here. And I can’t walk, if I want to walk to the dining room, well, I go in my wheelchair down there. But I walk around here, you know, in this room. And I get out there in the hall, walk down just a little bit for exercise. I have arthritis now pretty bad in my knees. And—of course, at times, it’s
pretty bad. Many times, they don’t [voice drops, background voices] 
__________. But I’m kind of crippled, I can’t get around—only in that 
wheelchair. And uh—since I’ve been here, why I’ve gone in a wheelchair 
to my meals down there. And when I have sick spells, why, now and then 
they bring my meals to me, but I go down there if I possibly can.” (Female 
Resident, EE2, italics added)

“We don’t do no housework. Neither one of us are, you might say, able to 
do that. But we’re able to fix our own clothes, to put our clothes off and 
everything to go to bed, and a lot of people here is not able to do that. We 
undress, you know. But we both, so far, been able to do that.” (Female 
Resident, EE3, also talking about her roommate, italics added)

As several of the quotes cited above also suggest, identity was comparative, as 
residents tried to determine how their own level of independence matched up with that of 
other residents, usually ones with greater health needs than their own.

“Well, if you’re talking about the [nursing home], they can’t do enough 
for the people of our age. Some of them is sicker than I am, needs more 
attention than I do, need more help. But they get it at the [nursing 
home].” (Female Resident, FX2, italics added)

**Being More or Less Active**

Participants dealt with changes in health and independence, as well as adjusting to 
their new physical and social environment, in different ways. Being active was believed 
by several residents and staff members to lead to greater well-being, in a kind of 
subjective “explanatory model” (e.g., Gesler 2003, 89), of why some residents are doing 
better than others. One male resident in particular took on many new roles, including 
sorting and delivering the mail for the entire nursing home, greeting visitors to the 
nursing home, joining advocacy and support groups, writing for the nursing home 
newsletter, and acting as informal caregiver for and motivator of other residents, while
also developing new friendships and seeking to learn new things. Another resident appeared to be feeling down, having lost the desire to do or being prevented from doing the things that she once enjoyed, such as watching TV, reading, or enjoying the outdoors. Level of activity was a common characteristic by which participants differentiated among nursing home residents.

“All of them [the residents] just sitting in their room doing nothing. And some of them want something to do.” (Female Staff Member, Nurse’s Aide, LX3)

“…I will say on level 2 we have fine activities. There's usually something going on that they could take part in—most of the time, time if they're inclined to be that type of person. But some of the people that have been most unhappy are people who have never had any kind of hobbies or really done anything in their life except just had their families maybe, and live for themselves. But uh--the people who had hobbies or listened to music or anything are happier, because they're more occupied.” (Female Staff Member, Nurse, CJ4, italics added)

“All I addressed people, the older people, how to keep busy and keep well at the same time, and not lay around their rooms, not sit in a chair and look out the window, but to do something, become active in some way, which I had intended to do. And I was doing it then at that time.” (Male Resident, JF2, italics added)

A related idea suggested that putting more effort into one’s appearance would be beneficial.

“We have quite a few people that are in bed all the time, or sit in a chair in their room with just their nightgown on. One time when I had to read a chapter in, in front of all the, the residents in the dining room, I said, when you have through with your bath in the morning, get dressed, get out of your nightclothes. Get dressed. And if you can get out of your room, get out of your room. If you can’t, have a pretty nightgown for a woman, or a man can have pajamas, and he looks like something, takes a little pride in himself. And that bit of pride will help him get well, not when you lob
[sic] around and wear these awful looking clothes and slippers.” (Male Resident, VE23)

Some residents used humor to deal with what were likely to be stressful experiences. Others spoke of their religious faith. Formal activities, from exercising and making cookies, quilts, and pillows to going on organized trips and enjoying pianists that were brought into the nursing home, tended to receive high praise, though not in all cases.

On the less active side, one resident summarized her daily routine as “Sittin’ and lookin’ and thinkin’” (Female Resident, NR5). A lower level of activity did not seem to bother many residents, while others appeared to describe feeling bored and alone, including "I'm just same old thing over and over" (Male Resident, FP7) and “That’s the, really the loneliest time of my life, is the weekends. They’re dead here” (Male Resident, VE17). Another resident described one of her primary daily activities as “passing,” a term to which she seemed to attribute some special but unclear personal meaning: “…afternoons I read or watch TV or just, pass. I don’t say pass the time because I don’t feel like I’m passing time” (Female Resident, XK5). Reading, watching TV, listening to the news, lying down, relaxing in a chair, and napping were commonly mentioned practices that involved little to no exertion.

**Engaging in Meaningful Activity and Being Cared For**

It seems that it is often easier to engage in meaningful activity once one’s basic needs are met. In the nursing home setting, residents are formally cared for by staff, yet the quality of interactions with other actors, such as visitors and other residents, can also
have a tremendous effect on whether a resident feels adequately cared for or not. In broad terms, the overlap between these two overarching themes highlights the importance of action and reaction or “give and take” to signal one’s involvement in meaningful relationships.

Residents Receiving and Providing Care

Just as identifying/understanding oneself can be closely related to meaningful activity, experiences of being cared for and caring for others closely shaped participants’ perspectives of nursing home life. One would expect interviews with nursing home residents and staff to include accounts of older adults being cared for by staff. For example, one staff member said “… they’re just—they feel like they just sort of have to sit in their rooms or in their bed and wait for us to take care of them” (Female Staff Member, Nurse, CJ4).

However, a few residents actually acted as informal caregivers and even advocates for other residents.

“…But since I'm here, it's taught me a lot, and right now I have a man I don't--well, he could be fifty, he could be sixty, ages fool me--and uh he was uh paralyzed, across here, and across his mouth, and across here. And he was like a lone duck around here. So I took him over, and I asked the supervisor if I could do that. And [a staff member] called him and asked, asked her if I could do that, that I wanted to have him eat his meals with me, some breakfasts that you eat up-stairs. He hadn't eaten--he hadn't eaten a full meal in weeks, in weeks. All he did was drink coffee. He couldn't, he couldn't express himself. And it was so sad. [chuckles] I took him under my wing. [chuckles] And uh like yesterday was the first day all day when I...when I took him over, I took him in the dining room and uh--they had meat and stuff like that that he couldn't possibly eat. And I said to the women, I said, he can't eat that kind of stuff. You ought to give him something soft that will pass down his throat because he's had--a part of a
stroke has landed in his throat. So that night they gave him a soft, like a soft diet. He ate three-quarters of a meal. So I felt very gratified. And he was so gratified and so thankful, he could not thank me. He would take my hand and kiss the back of my hand. He would kiss me on the arm, anyplace, or touch my head, anything to show the appreciation which was wonderful.” (Male Resident, JF9, note that the speaker’s “chuckles” appear to be due to holding back tears as this happens again in the interview before the speaker openly expresses his emotions)

**Having Different Experiences with and Reactions to Social Interaction**

Participants had generally positive views of residents and staff in the nursing home. One resident, in particular, described valuing the ability to develop friendships, even expressing surprise at how well forming new relationships had gone as a resident. Yet, when asked directly about knowing other residents, some responses diverged from the very optimistic perceptions of some staff members about the social lives of residents, indicated difficulties and dissatisfaction with social interaction.

“Oh—in general, I think they’re very happy here. They have their friends here…” (Female Staff Member, Nurse, GD5, talking about residents)

“Seem like, seem like—well, here, seem like I can’t get in touch with the people like I’d like to. I don’t know why, I’m a big talker and I want them to talk too, and it’s hard to get acquainted with them.” (Female Resident, NR4-5)

“Well, I just sit around here and go downstairs and find somebody to talk to if I can and that’s hard to do. [Some of the] people around here don’t want to talk to you or something, they a lot of them can’t talk or they don’t feel like talking. And I like people to talk to. We’ve got all kinds of them here.” (Male Resident, FP5)

“I think most of the patients feel like that. They’re not here to live, they’re here to die.” (Female Staff Member, Nurse, CJ3)
One resident even described having his property stolen by another resident who entered the first resident’s private room, culminating in the first resident allegedly being assaulted by the second. A brief discussion about having the right to hate some residents followed, though the speaker then minimized this comment. The topic of sexuality seemed to come up implicitly, and dating explicitly, with one resident telling several stories about immensely enjoying interactions with the opposite sex, while being frustrated that the relationships did not progress in the way desired.

Feeling Valued for Identity and Activity

Different examples of receiving recognition for one’s actions and efforts came up in the interviews, for instance, with one resident (TR7) displaying a collage of magazine clippings on a bulletin board in the nursing home hallway. Another resident relished the multiple signs he received of being appreciated by others, specifically by both staff within and visitors to the nursing home.

“…what do you think if I was the greeter out front, greet the people, make them feel very welcome when they come here, when they leave, say goodbye to them? _______ And I said all right. So she [a staff member] said, I’ll order a badge for you. And I says, a badge, surely. And we’ve never done anything like that before. And it has paid off so beautifully, and I have made such wonderful, wonderful friends on the outside that this seemed, just seems impossible that people could reach that state. But when they come here and I’m not down in front or inside, they go to the desk and say, where’s _______? And they tell ‘em where I am. And sometimes they can’t find me, they come to my room. The other night I was—came up about 7:00, which was early for me, and I was tired, and I was relaxing on my chair. And there was a knock at the door, and I said come in, and in walks 3 people, two women and one man. And said, we couldn’t find you. You weren’t out in front, where were you? We think you’re a very important person. And I said, I got tired so I came in. And they stood and they visited, finally said, here this is for you. And they had
a bag full of peaches, apples, and tomatoes from their garden. *And I was very appreciative for that.*” (Male Resident, JF3-4, italics added)

**Appreciating, while Criticizing, Care in the Nursing Home Setting**

Residents expressed both gratitude for and dissatisfaction with nursing home life, including the care they received as well as their new social and physical environment. Positive descriptions of the nursing home, the staff, and the care received included statements such as “everything’s been all right” and “I’m pretty well satisfied,” accounts of being treated “pretty good” by “nice,” “friendly,” and even “wonderful” staff, expressions of thanks for activities and entertainment made available and for “nice care” and “really good care,” an enjoyment of the simplicity of nursing home life (“I’m beginning to like it, you know, it’s simple. As long as everything runs all right, I’ll get along, I won’t mind it so much,” Male Resident, VE15), a reference to a former administrator as “an excellent man” and mentioning “a lovely nurse,” praise for the nursing home for meeting higher levels of need, liking “how clean this place is” (Female Resident, XK5), and a story of the staff giving a resident a birthday party. A resident shared another positive comment: “I like it here. I wouldn't move away from here unless I have to, to get more care” (Female Resident, FX4). One resident had many complimentary things to say:

“…I am satisfied and I'm happy with where I am. This is just like a, this place is just like a glorified babysitter for me. They are just so good to me. Have my meals and my medicine and everything taken care of…And I'm, well I just, I'm very content where I am. And I don't, really I don't believe that this place here could be beat for care, concern” (Female Resident, XK2)
and “…I never felt neglected or abused in any way whatsoever” (Female Resident, XK5).

A resident appreciated when management would listen to residents’ ideas and when the nursing home administrator would even help serve residents in the dining room.

Related to this appreciation of nursing home life was residents’ understanding of the challenges that the nursing home administration and various staff members faced in caring for residents. For instance, one resident sympathized with the job of the cook:

“Of course, it’s a tremendous thing I think for a, a cook to cook for a, a bunch like this. She has the, the ones that are diabetic, she has the ones that have been paralyzed, she has the ones that are something else, she has somebody like me that is on a diet. And, and she’s got to do that all the time, all that” (Male Resident, VE20).

Another example involved the pressure put on the nurses: “And if they’re [certain residents are] too tired [to get dressed], the nurse should see that they are dressed. But they [the nurses] don’t have time for it. That’s a great trouble. And uh—there’s a lot of good in all of them [the nurses], but they’re pushed pretty hard” (Male Resident, VE23).

Similarly, a staff member emphasized that work responsibilities made it nearly impossible to engage with the residents as the staff member or the residents might wish: “Yes, some of the times, if we have time to talk about, and they really enjoy that, but actually as a nurse, I don’t have the time to take to talk with them, which I enjoy doing but, you know, with all the work I have to do, I have to cut them off short or just try and get away from them as quickly as possible” (Female Staff Member, Nurse, CJ2). One resident recognized the general difficulties of operating a nursing home and praised the nursing home for the care provided there:
“Of course, it don't run smooth all the time. There's no place that runs smooth, not even your own home. [Clears throat] But--if I was a-picking, if I was out there in the world and I had relation that I would have to put into a nursery home, then I would the [nursing home]. It's not because I live here, it's not on account of the staff or the administrator or nothing about it, but it's the way the place is run. And the treatment that you get while you're here” (Female Resident, FX6).

Another resident said: “…they’re good to me, I couldn’t ask for them to be any better, they’re good to me, uh-huh, __________ goodness, __________ they do the best they can, under circumstances, I know they do” (Female Resident, NR6).

A staff member suggested that residents actually missed the nursing home:
“…sometimes when they go home, they're anxious to get back to the center. Uh, yes, they do, some of them do--want to go home, but they don't have people to care for them at home. So this is the be--next best thing” (Female Staff Member, Nurse, GD5). This statement is supported by the perspective of a resident, already quoted, who said she wanted to live in the nursing home rather than outside, apparently for fear of becoming a burden on family, a sentiment that came up several times: “Well, concerning my health, there’s—why I am here, I was ill and I had to have someone to be in my home with me all the time. I lived with my daughter and she and her family were—and I would prefer this place to being at home and having to have just a continual nursery. Much prefer this” (Female Resident, XK4).

Despite the statements above, residents and even staff were also well aware of the negative aspects of nursing home life. Over and over again, residents and staff indicated that residents frequently missed family, home, independence, and working. In terms of daily life, staff members described residents as “restrained” (Nurse, GD4) and
“restricted” (Nurse, CJ3). Almost all residents reported a big difference between their lives before entering the nursing home and their lives inside the nursing home. A lack of privacy was another issue: “…being around all the people and everything. You know, it bothers me” (Female Resident, TR4). Living on the institution’s schedule, in which meal times served as the primary activity around which daily life revolved, frustrated several residents. Staff members were aware of the dissatisfaction.

“…no place like home, I’ll tell you that right now…I’ve always been used to going and coming whenever I want to, and here you can’t” (Male Resident, FP4)

“…it’s [missing] family…and being home and doing what you used to do, you know, what you’re accustomed to doing” (Female Resident, TR8)

“…it [nursing home life] changed their routine, you know, the way they like to do things” (Female Staff Member, Nurse’s Aide, LX3)

“They’re told when to come to supper, and when to come to breakfast, and when they can take a bath” (Female Staff Member, Nurse’s Aide, JA4)

“A lot of them think they had freedom before they came here, you know. They like to do things when they want to do them. When you got this many people together, you know everybody’s got to eat at the same time or you know take their baths when we can help them. Now I guess they don’t like that.” (Female Staff Member, Nurse’s Aide, LX2)

However, one resident did not feel that the nursing home schedule interfered with her own, suggesting that residents were free to do what they wanted between meals.

“And I get up just whenever I want to…Your time is your own” (Female Resident, XK5)
Residents wanted the chance to do something outside the nursing home (“…they would like to get out or like to—wish they could, you know, live out on their own, wish they could go visit their families more often or go out for dinner or, you know, anything. Go shopping, a lot of the patients would love for somebody just to take them shopping,” Female Staff Member, Nurse, CJ4), disliked the décor of the nursing home rooms (“I just don’t like the colors of the walls and floors—drapes and everything,” Female Resident, TR10), and were dissatisfied with the quality and quantity of food (though other residents said some residents just complained too much).

Another resident, a woman, described having to be given a bath by a male staff member, despite her objections, partly out of fear that the staff would punish her by relocating her to a different floor.

“…finally I just had to give in to them, and a man had to give me a bath. Well, I didn’t like it very well…That’s one thing I didn’t like very well. But I thought, well now, maybe they’ll get peevved at me and maybe send me up to the fourth floor, and I didn’t want to go to the fourth floor. I wanted to stay on the ground if it was possible. But I don’t know what to do, I can’t get too contrary. I’ve got to cooperate and do want to cooperate, and they say I’ve been awful good to do that. Said, you’ve been unusually good and do what we want you to do. But I want to be that way, I made that expectation when I before I come in here. I says, I’m going to try and be the good patient. I’m going to try to work with them as much as I can and make them satisfied and me too.” (Female Resident, NR5-6)

Evidence that the nursing home operated according to “the medical model” (e.g., Schwarz 1996) seemed to be present. Staff consistently referred to residents as “patients,” as did a state report on the nursing home industry published around the same
time. One resident observed that staff members prioritized the wishes of residents’ doctors over those of the resident: “But they go by the doctor’s orders, too, you know. When your doctor say you can’t anything then you can’t have anything. But otherwise, they do, just about let you run your own life” (Female Resident, FX4). However, there were also times in which residents and staff resisted the rules. In one example, gifts of food from new acquaintances and as occasional favors from staff allowed at least one resident to indulge a love of unhealthy desserts, violating the dietary restrictions intended for the person’s good health.

Care staff had distinct views of their respective roles in the nursing homes. Nursing aides emphasized developing relationships with residents. One nurse’s aide described a great closeness between herself and residents.

“…And I think they use people like me and the other aids, especially the aids 'cause the nurses are always so busy, as substitute families, for the most part. And a lot of them, I will get very attached to, and I will consider them, I usually call a lot of them ‘grandma’ all the time, you know.” (JA3)

Similarly, the same nurse’s aide said residents missed her when she had been off for a few days.

“I will go around and say hi to everybody, you know, 'cause if I don't and they don't see me for three days, then when they do see me they jump all over me, well, you haven't been here--you know, where you been. That's what I usually do, and then I just start doing my job and make sure I go in and talk to everybody for a little bit. That's about it.” (JA4)

Nurses, in general, seemed to be too busy to form relationships with residents in the way nurse’s aides claimed to do. However, a nurse (GD3) spoke of the life
experience and wisdom of residents, saying residents had a lot to teach others. Nurses focused mainly on “charting” (CJ1), entering medically relevant information on residents’ charts, distributing medications, and completing related activities. Charting could have important consequences for one’s identity and reputation. For example, one resident identified herself as an alcoholic to the interviewer and indicated, without any apparent reaction, that her doctor and nursing home staff all used this label to describe her “in a kidding way” because the term was included in her chart (Female Resident, FX5).

Staff expressed what could be interpreted as troubling views about residents and residents’ families. One staff member suggested that residents’ families simply did not want to take care of their loved ones and tied this lack of caring to the unhappiness of many residents.

“...I think it’s just that most of the people now don’t want to take care of their families, so they need places like this. Because people are too busy with their own lives, you know, doing the things they want to do, which is fine. And when they used to keep the people in the homes, and I think that’s why a lot of our patients are unhappy because they’d rather be in anybody’s home than to be here. Any relative or anything than—the American people are more the type people who live for themselves. And in a way when they care about their people, they do, they’d rather pay somebody to take care of them than take care of them—themselves, is the way I see it. And for that reason, a lot of our patients are unhappy. And I think a lot of them are here that doesn’t have to be here, only for that reason, they have really no place to stay. There probably some of them could even have a small apartment of their own, or a room or two, and do fine, with no more medications than they take.” (Female Staff Member, Nurse, CJ2)

The same nurse suggested that staff were "nice" to resident before adding that many staff were "just here for the money" and did not really care about the patients: “It's just a job to
them, and the quicker they get out, the better” (Female Staff Member, Nurse, CJ5).

Another staff member also concluded that much of nursing home life operated based on what was most convenient for the staff, not the residents: “So really, they—when they come, they, you know, they adjust the routine to the way we can do things” (Female Staff Member, Nurse’s Aide, LX3, italics added). Perhaps most noteworthy of all, staff members repeatedly stated that they would not put their loved ones in a nursing home like the one where the staff members work, despite other quotes in which participants said the nursing home was the best one in the city.

“But for myself, I will keep my own parents and those I really love home as long as possible.” (Female Staff Member, Nurse, GD2)

“If it was my mother and father, they wouldn’t be here.” (Female Staff Member, Nurse’s Aide, JA2)

**Meta-ethnography**

Meta-ethnography is a means of producing an “interpretive synthesis” of otherwise independent ethnographies (Noblit and Hare 1988, 31). Ulsperger and Knottnerus (2008, 363) used a somewhat similar approach called “literary ethnography” to examine an exhaustive list of published ethnographies, autobiographies, and biographies of daily nursing home life, finding troubling evidence of processes that make life difficult for long-term care staff and, in turn, hurt elders themselves. Meta-ethnography consists of 7 phases (Noblit and Hare 1988, 26-29): 1) getting started, 2) deciding what is relevant to the initial interest, 3) reading the studies, 4) determining how the studies are related, 5) translating the studies into one another, 6) synthesizing
translations, and 7) expressing the synthesis. The phases, sometimes grouped together in the explanation that follows, are described below.

**Getting Started**

In the first phase of meta-ethnography, one decides upon the research question one seeks to answer. While the author originally hoped to integrate the views of older adults experiencing great difficulties (nursing home residents), families, long-term care staff, and management into an overarching framework of aging well, another course was ultimately taken. Previous research (Gubrium 1975; Farmer 1996) highlighted conflicting views among these actors, raising difficult questions about how to weigh one set of perspectives against another. In the end, this author concluded that, to better understand subjectification in later life, the priority should be given to the voices of older adults themselves. This chapter will, therefore, begin to answer the question, “What is a good life in later life, according to nursing home residents?”

**Deciding What is Relevant to the Initial Interest**

In the second phase of meta-ethnography, one selects the individual ethnographies that one hopes to synthesize. The goal is not to produce an exhaustive summary or to arrive at “gross generalizations” that would yield “trite conclusions” (Noblit and Hare 1988, 27-28). Instead, the researcher determines the objectives of the meta-ethnography and decides on a reasonable means of finding ethnographies to synthesize. In this case, the interest is to explore the detailed views of older adults facing significant challenges.
about later life. Therefore, a review of nursing home ethnographies in books or journal articles commenced.

Gubrium’s *Speaking of Life* (1993) emerged as the best candidate for this meta-ethnography. His book includes many verbatim interview transcript excerpts, offering a richness and depth of conversational context not found in journal articles. In addition, Gubrium (1993, xvi) explicitly states his interest in emphasizing the subjective views of nursing home residents themselves, seeking “to highlight participants (in this case, nursing home residents) as more active conveyors of meaning, less conditioned by circumstances than taking circumstances into account in telling their stories.” Other ethnographies published as books (Gubrium 1975; Farmer 1996) sought to provide overall accounts of the nursing home as an organization, while still others focus on the experiences of direct-care staff (Diamond 1992). These other works represent different, if related, purposes than the goals of this meta-ethnography.

*Speaking of Life* (Gubrium 1993) presents interviews with 24 nursing home residents, out of 58 interviewed in all, in a total of 6 facilities in Florida. Most participants had lived in a nursing home for at least 1 year, with one resident residing in a nursing home for 12 years, but Gubrium’s design also included a longitudinal aspect, following some participants after discharge from a nursing home. Most of the sample consisted of widowed white women, although some African-American women were also included. Gubrium and his research assistant Carol Ronai each completed the interviews in conversations ranging from 30 to 120 minutes.
Reading the Studies and Determining How the Studies Are Related

Detailed notes were taken on Gubrium’s (1993) *Speaking of Life*. After reading the book, it was decided that the best description of the relationship between that book and the interviews summarized above was the “reciprocal” type (Noblit and Hare 1988, 38-47). Indeed, a remarkable degree of overlap in content (e.g., the thoughts and feelings expressed by participants about aging and nursing home life) exists between the two, despite different geographic locations and more than a decade of separation in time.

Translating the Studies into One Another, Synthesizing Translations, and Expressing the Synthesis

When translating the studies into one another, the ethnographies are treated as uniquely-related analogies. “An adequate translation maintains the central metaphors and/or concepts of each account in their relation to other key metaphors or concepts in that account” (Noblit and Hare 1988, 28). Two levels of translation exist in the initial comparisons and then, in some cases, a higher level of categorizations of these initial translations into groups (Noblit and Hare 1988, 28). The presentation and discussion of results later in this chapter is the expression of the synthesis. However, Noblit and Hare (1988, 29) recognize the value of forms of expression other than the written word, an interesting similarity with crystallization (Ellingson 2009).
Meta-ethnography Results

This section of the chapter will build upon the previous findings by performing a meta-ethnography between the themes identified above and the main metaphors in Gubrium’s *Speaking of Life* (1993).

As an early step in meta-ethnography, Noblit and Hare (1988, 28) recommend creating “a list of the key metaphors, phrases, ideas, and/or concepts (and their relations) used in each account and to juxtapose them,” typically in the form of a table. Table 6 presents the key themes found in the previous analysis and Gubrium’s ethnography as well as an interpretive synthesis. Gubrium categorizes the interviews in his book into “narrative types” according to different “horizons of meaning.” The narrative types – the subjective contexts from which stories are told - may be summarized for present purposes as worrying, adapting, accepting, looking beyond, watching out, and unique situations.

A “reciprocal” translation treats the ethnographies as analogies in order to integrate the major concepts from the ethnographies one wishes to synthesize (Noblit and Hare 1988, 38). The following description summarizes the collective account created from the synthesized ethnographies. Older adults offer insights into how they identify/understand themselves through the ways they introduce themselves and the stories they tell. Extreme emotions or religious faith can be immediately evident. Elders engage in meaningful thought and activity, sometimes despite and at other times because of the range of challenges they face. Indeed, meaningful activity is not necessarily pleasant activity, for example, as the weight of a perceived mission drives one on while also placing a person under stress and strain or the memories of lost loved ones color
one’s daily life. Physical and emotional suffering may be unavoidable, but, at best, pain and loss can create opportunities for meaningful experiences. For some older adults, one such meaningful experience is being cared for, offering a chance to form positive relationships with staff and to gain a new appreciation for one’s life. However, the experiences of other elders suggest that later life can be a bleak and bitter time. In short, every individual’s journey – not simply those of, say, sisters who end up living in the same nursing home room - is unique and the existing eldercare system struggles to meet the great variety of preferences rooted in diverse life experiences. The account above can inform the beginnings of an inclusive normative vision for later life that is sensitive to individual wishes.

Table 6. Themes for subjective meaning of nursing home life according to residents.

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<td>Identifying/Understanding Oneself</td>
<td>• “Worried to Death”</td>
<td>• Worrying</td>
<td>• Defining Oneself More than Being Defined By Others</td>
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<tr>
<td>Engaging in Meaningful Activity</td>
<td>• &quot;Making a New Home&quot;</td>
<td>• Adapting</td>
<td>• Acting to Realize Preferences</td>
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<td>Being Cared For</td>
<td>• &quot;It's Come to This&quot;</td>
<td>• Accepting</td>
<td>• Being Cared For As One Wishes</td>
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<td>&quot;Lovin' the Lord&quot;</td>
<td>• Looking Beyond</td>
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<td>&quot;The Vigilant&quot;</td>
<td>• Watching Out</td>
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<td>&quot;Special Circumstances&quot;: Travelers</td>
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Defining Oneself More Than Being Defined By Others

Gubrium (1993, 181) notes that the nursing home resident participants in his study often rejected this portrayal, instead offering a range of alternative identities and challenging the research assumption that “A sample of nursing home residents is taken to respond as nursing home residents.” For instance, contrast any of Gubrium’s opening characterizations (centered on age, gender, marital status, race and ethnicity, and chronic conditions) with the “self-portrait” offered by the participant. Opportunities for self-definition – or subjectification - should be increased for their own sake as well as for likely practical implications.

Acting to Realize Preferences

More opportunities should be made available for individuals to live the kind of lives they want, regardless of the level of formal activity. Through conversation and assessment, one would hope that distinctions could be made, for example, between simply wanting to nap regularly and depression. Of course, preferences also change over time for each person, so that even the infamous snow-skiing octogenarian of Rowe and Kahn (1998, xii) might be in the mood to listen to the radio or rest quietly later in the day. When preferences conflict with medical and health goals, discussion and negotiation should guide decision-making in order to temper what is often the default of objectification and create opportunities for subjectification.
Being Cared For As One Wishes

Both sets of interviews show that at least some nursing home residents can receive the kind of care they want in a nursing home setting, to the point that some elders actually miss the nursing home. For other older adults, however, almost nothing can be done right in the care they receive. Yet, for still others, care is not a major concern in relation to a personal quest for salvation in heaven. The great extent of individual care preferences creates huge challenges for health care and long-term care systems.

Discussion

Toward a Normative Theory of Well-Being in the Nursing Home Setting

Findings from the analysis of interviews and the meta-ethnography above highlight the need to frame an understanding of well-being in the institutional long-term care environment in terms broader than those found in the Rowe and Kahn definition of successful aging. Certainly, conversations touched on chronic disease, disability, and functional health, but these topics did not appear to be paramount for nursing home residents. Indeed, an emphasis on continued independence and agency, despite growing care needs, would suggest that residents would not accept being labeled as “unsuccessful” and that experiences of disease and disability created the possibilities for other kinds of meaningful experiences and caring relationships. Of the three dimensions of successful aging outlined by Rowe and Kahn (1997), active engagement with life would seem to be most relevant for the participants of this study. Positive past and present social relationships with immediate and extended family, friends, and staff were
highly valued. Beyond this, there were clear tensions between what was “best” for the resident, where the resident would express what could be deeply individualized preferences involving everything from one’s daily schedule and activities to the food one consumed and the appearance of one’s room, and would find that personal desires often clashed with the demands of running an institution or with the judgment of a medical authority. From the standpoint of “person-centered care,” maximizing resident preferences, subject to institutional and medical constraints, would appear to be the goal, but achieving this objective is easier said than done (Koren 2010). Future research should seek to explore the psychological, social, medical, and environmental aspects of a “good life” in the nursing home setting, attempting - until realizing individual resident preferences becomes the central focus of eldercare - to maximize the flexibility to honor diverse preferences with the current difficulties of doing so in the context of staff shortages, budget pressures, and regulations rooted in the medical model of long-term care.

The Need for a Meta-Theory of Nursing Home Life

Existing theory in gerontology offers many useful insights with which to confront the complexity of nursing home life. Yet, no single theoretical point of view seems to completely capture the sorts of experiences reported above. For example, of the most common perspectives in social gerontology in relatively recent years (Alley et al. 2010), role theory and activity theory appear to be extremely relevant for some, but not all, of the residents in this study. While condemning a neutral eclecticism, Ettlinger (2009) has
suggested that, by critically situating diverse perspectives, researchers might productively draw on multiple theories when seeking to understand as much as possible about a complex phenomenon. Therefore, an integration or at least a combination of existing and new theory might offer the greatest potential for making sense of nursing home life in hopes of improving it. How could a variety of theoretical perspectives be brought together to begin to construct a meta-theory of nursing home life, rather than “only” advancing understanding of parts of the institutional long-term care experience?

**Examining Objectification in the Nursing Home**

The findings above suggest that residents and staff draw on a range of labels to distinguish among different “types” of individuals. These distinctions deserve more attention. While not documented in the interviews analyzed here, research (e.g., Chung 2010) has found that social distinctions can be associated with moral judgments that, in turn, can affect the kind of care provided. A belief that a resident is in the nursing home simply because the person’s family did not want to take care of the person could serve to stigmatize the resident, perhaps also linked to a broader ageism in long-term care (Dobbs et al. 2008). Even if one were to accept the claim that residents were “put” in the nursing home by uncaring family, accusing supposedly selfish families for outsourcing care of loved ones to others seems to be hypocritical given later statements justifying a staff member’s own self-interest in deciding not to take residents out shopping.

Differentiating based on level of activity is complicated by the fact that the desire to engage in activities varies over time for the same person. Glimpses of healthism
(Crawford 1980; Clarke, Griffin, and the PACC Research Team 2008) appeared in the interviews in comments on segregation of residents with different levels of care in the nursing home and frustration when deviations from the usual social and spatial organization of nursing home life occurred. While not observed in the interviews analyzed here, it should be noted that other researchers (e.g., Diamond 1992) have documented unique challenges faced by Medicaid (as opposed to private-pay) nursing home residents and one could imagine that such distinctions could also be tied to stigmatization, discrimination, and objectification in long-term care.

**Limitations**

As a secondary analysis of qualitative data, this study carries the disadvantages of that approach, such as the inability to conduct theoretical sampling to saturate categories (Charmaz 2006) and the problem of not having “been there” (Heaton 2004). It is difficult to determine exactly how the study relates to traditional criteria for the evaluation of qualitative research (Lincoln and Guba 1985). In addition, issues could be raised regarding the primary research on which this secondary analysis is based. For instance, given the small number of days over which the interviews were completed, one does not know whether additional rounds of conversations would have been consistent with the ones recorded.

The meta-ethnography presented in this chapter also suffered from limitations. There appears to be no “fully-formed” analysis of the interviews, such as those used in the examples of reciprocal translation provided by Noblit and Hare (1988, 40-47), from
the original researcher. Therefore, the dissertation author’s own themes from the secondary analysis of qualitative data were used for the meta-ethnography, but these themes may have differed from the original researcher’s concepts. In addition, a larger number of ethnographies could have been synthesized.

Conclusion

As the numbers and proportion of the older population in the United States rise, nursing home care, despite the ongoing efforts of the long-term care culture change movement, remains a troubling prospect for many people. Unfortunately, the successful aging paradigm appears to have little to offer in terms of a normative model for later life in an institutional long-term care environment. Therefore, this study has presented two qualitative studies - an inductive secondary analysis of the views of older residents and staff members in one Midwestern nursing home and a meta-ethnography - in hopes of beginning to envision what an inclusive “good life in later life” might be. In the end, this goal may have profound consequences for our own experiences of later life and those of our loved ones.

Notes

1 A departure from the traditional organization of the middle of a research article, with one methods section followed by one results section, seemed necessary for this chapter because the meta-ethnography actually incorporates the findings from the secondary analysis of qualitative data. Therefore, it seemed important to present the results of the secondary qualitative analysis before turning to the meta-ethnography.

2 To protect anonymity, quotes from participants will be cited here using two randomly generated letters to refer to the transcript and a page number or page range to refer to the relevant transcript section(s).
CHAPTER 5: CARE RECONFIGURED: EXAMINING HISTORICAL PROCESSES OF COMMERCIALIZATION AND MEDICALIZATION IN TWO ELDERCARE CONTEXTS

The older share of the U.S. population is rising, expected by 2030 to reach 72 million and to account for almost 20% of the country’s total population (He et al. 2005, 12). While only 4% of individuals age 65 and over live in a nursing home at a given time (Administration on Aging 2011), roughly 40% of those who reach the age of 65 may find themselves in a nursing home at least once over their remaining lives (Murtaugh, Kemper, and Spillman 1990). Over the past several decades, long-term care reform efforts, including the overall long-term care culture change movement (e.g., Kane 2001) and specific models such as the Eden Alternative (e.g., Thomas and Johansson 2003), have improved the nursing home experience. However, according to long-time commentators such as Vladeck (1980, 2003), major problems continue to plague eldercare and, in particular, long-term care in the institutional setting.

Societal processes of objectification, such as commercialization and medicalization, have influenced the entire range of aging experiences, from institutional settings to aging in place in one’s own home and even death and dying. However, similar
processes have evolved in and affected diverse aging contexts in different ways. In order to better understand current difficulties in eldercare, such as efforts to enrich nursing home life as well as end-of-life issues, that can prevent elders from living their own “good life in later life” – perhaps linked to the inclusive principles that were introduced in the previous chapter - it would seem necessary to put current contemporary challenges in historical perspective. This chapter contributes to this goal by connecting historical changes within long-term care and end-of-life care. First, long-term changes are explored within one Cleveland nursing home - the non-profit Margaret Wagner House (Case Western Reserve University 1997), which was owned and operated by the Benjamin Rose Institute. Margaret Wagner House opened in 1961, just a few years before the passage of the Medicare and Medicaid programs in 1965, health insurance for seniors and people with low incomes, respectively, forever changed health care and long-term care in the U.S. The building was converted into apartments for low-income older adults in 1997 and is still standing today (Figures 5 and 6). Second, historical changes in US acute care hospitals, traced as far back as the 1900s, are reviewed using secondary literature. These changes have ultimately impacted end-of-life care for older adults and, in addition, have indirectly affected long-term care through an unequal allocation of resources.
Figure 5. Plaque on exterior of Margaret Wagner House, Spring 2012. Photo by the author.

Figure 6. A view of Margaret Wagner House, Spring 2012. Photo by the author.
The two studies provide perspectives from different scales on societal processes of commercialization/marketization (e.g., Salamon 1993; Eikenberry and Kluver 2004; Simpson and Cheney 2007) and medicalization (Crawford 1980; Conrad 1992), the ways in which commercial and medical values and practices have increasingly entered into wider domains of social life. In particular, the first study examines how an institution may have generally followed, while at times also departing from, broader trends in society. Such departures point to possibilities for alternative - and potentially better - models of eldercare. The need for this work could not be more urgent, as the largest group of older adults in U.S. history approaches later life and, for some, the prospect of a long-term care experience that many in this country believe would be worse than death (e.g., Keith 2005).

**Methods**

**Foucauldian Genealogy as Overarching Research Strategy**

The social theorist Michel Foucault, in addition to his many other contributions, offers researchers a unique approach to history known as genealogy (1998), a method he developed from Nietzsche. In contrast to “traditional history,” genealogy does not seek a single origin for later events, rejects the idea of progress, and upsets supposed continuities in developments over time. Where others might look for a single cause, Foucault urges scholars to search for “numberless beginnings” (1998, 374) in a process of “causal multiplication” (2000b, 227). Instead of progress, Foucault points to change
characterized by ambiguity. Rather than determinism and continuity, he stresses chance and winding, even broken, paths.

Instead of explaining the sad state of nursing homes (Kaiser Family Foundation 2009) by examining the history of nursing homes themselves, Foucault would look elsewhere. By engaging what Foucault (1998, 81) calls “the exteriority of accidents” and seeking to explain a phenomenon in terms of other phenomena rather than itself, genealogy can explain how problems of long-term care articulate with different parts or sectors of society over time. For example, Foucault showed in Discipline & Punish (Foucault 1975/1995) how similar techniques for the control of individuals and groups appeared in different parts of society, from prisons to schools, hospitals, and the military.

Vladeck’s Unloving Care (1980) is not the sort of “traditional history” disparaged by Foucault above, but rather a critical and complex account of the emergence of the nursing home sector in the US that achieves some of the same goals as genealogy and also offers a foundation for further study. Among his other points, Vladeck argues that contemporary nursing home conditions emerged as an afterthought of public policies targeted at health care and poverty as well as the sometimes antagonistic relationship (e.g., cost-shifting) between hospitals and nursing homes. According to Vladeck and others, the institutional approach to long-term care for older adults originated in public almshouses or poorhouses. Public almshouses held a diverse group of dependents of all ages, including poor children, the disabled, and the mentally ill. Over time, Progressive Era reformers created specialized institutions for most of these sub-groups. Eventually, older adults who were poor and/or had no family or others to care for them were the only
ones left in the almshouses. Officials recognized this and re-named the almshouses, for
instance, as “Homes for the Aged.” Not-for-profit, often religiously-affiliated
benevolent homes were also created under these and similar names. These institutions,
especially existing for-profit models, came to increasingly resemble the nursing homes
we know today (see also Schwarz 1996). The passage of Social Security, pensions for
older adults, and the Older Americans Act in 1935 gave those elders with no other
support a means of paying for private care. However, arguably the most important point
came in 1965 with the passage of Medicare, health insurance for older adults, and
Medicaid, health insurance for the poor. These programs opened up reliable sources of
funding and a nursing home building boom followed from the mid- to late-1960s, a
period that also saw the large-scale entrance of for-profit firms into long-term care.
There have been several nursing home reform efforts over the years, including the
relatively recent “long-term care culture change movement” (e.g., Kane 2001), involving
umbrella groups such as the Pioneer Network and particular visions such as the Eden
Alternative (Thomas and Johansson 2003). Nonetheless, the fundamental structure of
long-term care remains very much the same as it has been for decades (Vladeck 2003).

This dissertation suggests that empirical research in the form of genealogy can
complement widely influential critical historical accounts such as Unloving Care
(Vladeck 1980). In particular, this chapter seeks to understand the development of
current nursing home conditions in terms of what appears to be a little-explored
relationship between long-term care and unwanted intensive end-of-life care that
mistakes quantity of life for quality. The remainder of this chapter will first seek possible
answers to the question “How did nursing homes come to be this way?” through a historical case study of one institution in Cleveland before turning to a critical analysis of the allocation of resources tied to older adults, specifically on spending on unwanted aggressive end-of-life care within hospitals. Regarding the latter, in general, far more funds are directed to acute care than long-term care (Estes 1979, 23). This practice, guided by prevailing mentalities in American life, arose from and is reinforced by uneven power relations between acute care and long-term care. In particular, this disparity is closely connected to technology in the hospital, a phenomenon with a history that must also be explored.

In the spirit of Foucault, the goal of this chapter is to understand how all parties are, consciously or unconsciously, caught up in a network or system that is producing an outcome that most find undesirable (Foucault 1975/1995). Crucially, in his later work on ethics, Foucault (2005) does allow room for meaningful individual-level resistance, whereas Estes (1979, 15) does not: “Older persons individually are powerless to alter their social status and condition”. Resistance is beyond the scope of this chapter, but the topic is discussed in the dissertation’s conclusion. In addition, it should also be noted that, given the limited focus of this chapter, there are surely many other factors that have contributed to the poor conditions in nursing homes that could be studied. These include, broadly, changes in the ability of families to provide informal care. To name a few related factors, these involve suburbanization, the proportion of women working, pressures on the middle class, and even changes in house designs. Borrowing a phrase from Massey (2005, 4), in her work on a non-Euclidean, \textit{relational} view of space, nursing
homes are seen here as one intersection in a “meeting-up of histories,” where relevant histories range from the transformation of the hospital through its increasing “technologization” to the non-medical factors listed in the previous sentence. The decision to emphasize end-of-life spending here is based on a desire to aim for depth, rather than breadth, in this chapter.

**Analyzing Archival Materials**

Qualitative research strategies provide a richness and depth of understanding appropriate to what are fundamentally changes of kind, rather than degree (Lofland et al. 2006). This chapter’s original research contribution examines societal processes of commercialization/marketization and medicalization that transformed one case study institution over time. The main method employed for the study was thematic analysis (Boyatzis 1998) of hundreds of pages of historical documents from the Benjamin Rose Institute collection housed at the Western Reserve Historical Society in Cleveland. Along with intensive interviewing and participant observation, archival research is considered one of the core methods of ethnography (Wolcott 2008), a research strategy known for getting as close as possible to an insider’s view of a phenomenon (Spradley 1979). While archival analysis is quite different than intensive interviewing and participant observation, historical research offers a long-term perspective on changes within one institution.
Commercialization and Medicalization at Margaret Wagner House

This section summarizes processes of commercialization and medicalization within Margaret Wagner House. In general, it appears that commercialization and medicalization developed indirectly within Margaret Wagner House and the Benjamin Rose Institute the context of attempts to solve perceived problems of the time. However, these “solutions” then contributed to other problems.

Initial Problems and Margaret Wagner House as Apparent Solution

Three main problems were identified by the Benjamin Rose Institute in the 1950s and all three motivated construction of Margaret Wagner House. The first problem was one of quantity: there were simply not enough nursing homes in Cleveland. Drawing on earlier research, the city was said to have a troubling shortage of nursing home beds. Second, the needs of a certain group of “deserving” people were not being met. This point paralleled the mission of the Benjamin Rose Institute as stated in the 1908 Articles of Incorporation: “to provide relief and assistance so far as he [Benjamin Rose] was able for respectable and deserving needy aged people, as far as practicable, and mostly of the Anglo-Saxon race…” According to the Institute’s own historical account (Beal 2008, 9), Rose was moved by the suffering he witnessed of the formerly well-to-do winding up poor in later life due to economic crises and the lack of a social safety net: “The most unfortunate, disconsolate person in the world is one who has had advantages and
comforts, but who has been brought by force of circumstances to rely upon charity or perhaps some distant relative.”

The third problem focuses on the quality of existing nursing homes, especially those in Cleveland, but also long-term care institutions across the country. For instance, a 1956 summary of the state of Cleveland nursing homes for the Board of the Institute described the mostly disconcerting findings of a 1944 report:

conditions in these proprietary nursing homes are close to a public scandal…(some good homes)…For the most part these licensed nursing homes are dirty, cluttered, rundown houses where old sick people are packed in as closely as possible and receive the least possible attention, until their lives run out.

The problem of quality was often described in terms of a lack of “standards.” Margaret Wagner mentioned several of these three initial problems noted above in a 1957 letter to the Chairman of the Committee on Aging in the Department of Health, Education, and Welfare in Washington, DC:

The nursing bed shortage in Cleveland is acute. From what I read, I do not believe the condition is worse anywhere else in the country and the only solution is to build more nursing beds under philanthropic auspices. We are about 1,000 beds short and that is a very conservative figure and does not take into account that some of the beds now available are way below standard.

Crucially, those planning the nursing home were aware of and involved in local and national discussions about how best to design their new nursing home. Many of these discussions explicitly or implicitly presented greater medical influence and market discipline as paths to higher standards in nursing home care. For example, a 1956 *Time* Magazine article was discussed according to Board meeting Minutes and the article’s
conclusion was summarized as “most U.S. convalescent homes are not medically oriented – or, indeed, safely oriented,” where the ideal model of medical expertise and safety was assumed to be the hospital. Benefits of a greater commercial awareness were raised in a nursing home administration textbook (Gerletti, Crawford, and Perkins 1961, 26) from the time period, reflected in statements such as “good physical care is good business.”

Margaret Wagner House was intended to begin to solve the three problems listed above. 150 more beds would be available in the city. “Deserving” individuals, in particular the “the pay and part pay patient,” would no longer be left to suffer without needed care. Most importantly, Margaret Wagner and the Institute envisioned Margaret Wagner House as a “model” nursing home that would put the values of the organization into practice.

We would hope to establish a home which might pioneer in demonstrating both standards of care and provide a yardstick for the cost in maintaining such standards…We feel that although it will serve patients in this community, it may also serve as a guidepost to others throughout the country, which has always been one of the aims of The Benjamin Rose Institute in its many fields of endeavor. (April 3, 1957 letter from Margaret Wagner to Miss Geneva Mathiasen, The National Welfare Assembly, Inc., NYC)

The Cutting Edge, Cost Accounting, and Commercialization

The Institute explicitly stated its aspirations and values for care in both internal documents and marketing materials, including this list from the late 1950s:

We are building for the future.
What may appear to be an extravagance today will be a necessity tomorrow.
The institution of tomorrow will have little similarity to the institutions we knew in the past.
We should cast aside old concepts and with courage follow the new trends.
The people we serve are not classified as ‘sick.’ They are suffering from a physical handicap due to chronic disease and/or advanced age.
We should create an atmosphere conducive to living, not vegetating.
This is necessary if we are to maintain good morale and make it possible to obtain and keep staff.
This is a home where people may live for twenty-five years, and differs in every respect from a hospital.
Where the hospital provides scientific therapy, the Home gives solace and comfort.
Emphasis will be on service -- to provide care, prevention and protection.

From an idealistic philosophy of care to the nitty gritty details of kitchen design, the Institute sought out the “state-of-the-art,” visiting and corresponding with respected peers in faraway places, such as the Mary Manning Walsh Home in New York City.

The adoption of what might today be called a “best practice” of “cost accounting” (see description in Figure 7) may have been especially consequential for commercialization in Margaret Wagner House and, more broadly, the Institute. Margaret Wagner praises a Dr. Ernest May in 1958 for his approach to documenting nursing home costs. As Wagner wrote at the time, cost accounting could support arguments for the higher reimbursement amounts needed to provide a high standard of care.

The Surgeon General recently called a meeting in Washington of representative people to discuss the whole field of nursing homes. There it was clearly demonstrated that lack of funds to support good nursing home standards was a primary cause in the present low quality of care. The Conference agreed that more adequate payments from public funds, as well as from private resources, would not be forthcoming until the nursing homes could produce proper evidence of the cost of caring for patients in such a setting. The first step to be taken was the setting up of proper cost accounting methods. Your study would contribute to the development of sound procedures in cost accounting.
A similar view appears in a how-to book on nursing home administration (Gerletti, Crawford, and Perkins 1961, 304) from the period:

Prove that the cost of care justifies the increased assistance. Several administrators expressed the idea that governmental agencies will change their allotments only on the basis of dependable statistics or accounting records which establish factually what the costs are in homes for the aged, including your own.

In other words, cost accounting was seen as a tool to improve quality via adequate reimbursement, rather than one to direct cost-cutting efforts.
Through the aid of accurate information concerning costs the proprietor or administrative officer is enabled to keep in close touch with conditions, shape the operating policy of the future and guide the operations as they mature.

He is enabled:

a. To determine which lines of production or merchandise are profitable and which are unprofitable; to institute methods for extending and increasing the sale of such lines as are profitable and to retard the sale of, or withdraw entirely from the manufacture, or sale of, such lines as are unprofitable; to decide intelligently the lines on which commissions may be allowed to salesmen and the extent of such commissions.

b. To reduce costs; either through a reduction of the elements composing costs, or through an increase in the production.

c. To allocate “leaks” and stop unnecessary waste or extravagance.

d. To develop the highest type of productive efficiency. To bolster up the weak points and harmonize the work of the different departments, or operating groups.

e. To gauge the efficiency of managers, relatively speaking, by comparing one manager with another. The manager, whose cost of producing soil pipe per ton is $7.00, is obviously not as efficient or capable as the man who under precisely similar conditions can produce the same product at a cost of $5.00 per ton.

f. To compare the work of similar foremen, departments, machines, operatives, or other centers of production.

g. To compare costs in general of one period with another.

Figure 7. A description of cost accounting from the early twentieth century Taken from Wildman (1911, 3-4).
The discussion surrounding cost accounting as an accepted standard of documentation ultimately foreshadowed major changes within the Institute in later decades. While the Institute knew that Margaret Wagner House was operating at a loss for some time (it evidently did not run an operating surplus until 1993), a full-on crisis emerged in the 1970s and 1980s in the midst of wider economic problems in the country and locally in Cleveland (Beal 2008, 54). Therefore, Margaret Wagner House solved early problems, yet eventually became a problem itself in subsequent years for the
Institute. Although the Institute remained a non-profit organization, mounting losses pointed to a deceptively simple “solution”: cutting costs, improving efficiency, and/or raising new revenue across the Institute. The Institute re-thought its mission in 1980, aiming to become a “scientific experimental service agency” focused on “developing, demonstrating and evaluating cost-effective models of service to the frail elderly.” The Institute sought to turn its expertise in the area of aging services into revenue sources in the form of consulting services and federally-funded research. From 1970 to the 2000s, new managers were brought in to run the Institute according to “sound business principles” (Beal 2008, 108).

Medicalization and Reimbursement

The influence of medicalization on the Institute appears to have been more subtle than that of commercialization. Medicine was never far from the nursing home experience described in available archival materials, even as Margaret Wagner explicitly stated, for instance, in a 1959 letter that she did not want to build a nursing home that would be a “pseudo hospital.” Admission to the nursing home was usually preceded by a medical evaluation and the Margaret Wagner House stressed that each resident was to have his or her own physician regularly check up on the resident. The sudden appearance of Freudian psychological assessments of applicants to Margaret Wagner House by social workers in individual case reports is more jarring than the presence of medical diagnoses and terminology that had been there all along.
Perhaps the main catalysts for greater medicalization in the nursing home were the standards, set by Medicare and Medicaid, that nursing homes had to meet in order to receive reimbursement from the programs. A 1974 post-Medicaid-certification audit by the Cuyahoga County Medical Review Team cited Margaret Wagner House for deficiencies related to documentation of medications and of skilled nursing care provided, yet also concluded that “The residents seemed content and the overall atmosphere appeared conducive to their health and well-being.” It is unclear if or how caring for residents according to audit criteria more consistent with the “medical model” (Schwarz 1996) would improve upon the House’s own philosophy of care. Nonetheless, the unmatched opportunity of reimbursement created incentives for and imposed a discipline on nursing homes to operate according to program criteria.

Case Study Summary

Commercialization and medicalization significantly, if not completely, reshaped the Institute during the period studied. Despite major changes, echoes of the original caring values expressed by Margaret Wagner are still present. Care goals are, however, now weighed against the desire for financial self-sufficiency and, in addition, cannot come at the expense of medical requirements that affect reimbursement. The quest for “standards” ultimately limited to some degree the ability of the organization to put its own values into practice.

The experience of Margaret Wagner House and the Benjamin Rose Institute offers insights into the prospects for long-term care culture change efforts today. In order
for the movement to spread, it would seem that alternative long-term care models must demonstrate measurable benefits, whether in the language of revenue and costs for organizations and/or health and well-being for elders. Good intentions may only be realized on a sustainable basis if supported through adequate financing, even within non-profit organizations. The ongoing tension among caring, commercialization, and medicalization appears likely to continue in US nursing homes.

**Exploring Current Institutional Conditions via Past and Present Issues in Acute Care**

**Comparing Recent Spending on Nursing Homes and End-of-Life Care**

When trying to determine how nursing homes have come to be the way that they are, it is clear that the issue is not about a refusal to spend any money on older adults, period. In fact, U.S. society devotes a tremendous amount of resources to elders overall (about $615 billion in 2000) (Congressional Budget Office 2000). So, there is a willingness to allocate resources to older Americans, but there are great disparities in terms of the specific areas to which these funds are directed.

One topic receiving additional attention in recent years is the cost of end-of-life care. A 60 Minutes piece (Court 2009) reported on the disproportionate amount (32%) of money that the Medicare program spends on aggressive, intensive care at the end of life. Yet, more startling than the dollar figure is another finding. The Dartmouth Atlas of Health Care (2011) observes that, even though a large percentage of people (over 80%) say they do not want such care and do not want to die in a hospital, many may experience
both. The percent of Medicare decedents (beneficiaries who have died) who, in their last 6 months of life, spent at least 1 week in an intensive care unit or critical care unit has risen consistently over time (Figure 8). Recent statistics (US Department of Health & Human Services 2011, 43) show that, in 2007, 35% of older adults died in hospitals, compared to 28% in nursing homes and 24% at home, though the place-of-death preferences of these people are unknown.

Figure 8. Percent of Medicare decedents spending 7+ days in intensive care unit or critical care unit during the last 6 months of life, 1994-2007. Data from the Dartmouth Atlas of Health Care (2012).

Exact comparisons are difficult to make due to data availability, but putting the cost of end-of-life care in the context of nursing home spending may be instructive. In 2005, total spending from all sources on nursing homes totaled $129.8 billion (Komisar and Shirey Thompson 2007). In 2006, estimated Medicare spending in the last year of
life was approximately $93.5 billion, and $119.7 billion in the last two years of life. Whereas the first figure on nursing homes includes all sources, the Medicare numbers underestimate the true amount because Medicaid and private sources of funding are not included. In addition, the estimate was calculated using the long-term percentage (about 25%, taken from Hogan et al. (2001)) of end-of-life care spending as a proportion of total Medicare costs, rather than the higher figure (32%) cited by the Dartmouth Atlas of Health Care. Therefore, depending on the time period used, a very conservative calculation puts end-of-life Medicare spending at 72% to 92% of total nursing home spending. The real value may very well meet or exceed nursing home spending.

**Seeking Explanations for Surprising Spending at the Very End of Life**

One question, then, is why so much money is channeled into the *very end* of an older adult’s life, rather than being spent to sustain or improve elders’ quality of life over many years. What governs this apparently paradoxical use of resources? Foucault’s concept of governmentality (2000a) can yield insights here. Governmentality analysis is a framework for understanding systems that indirectly guide thought and action in situations where individuals are free (Foucault 2000a). At the risk of oversimplification, governmentality deals with subtle manipulation of behavior, for instance, critiqued by Jones, Pykett, and Whitehead (2011) in the form of “nudge theory,” as opposed to violent coercion or domination. Practices are driven by mentalities, or ways of thinking. In turn, techniques of power, aimed at populations (biopower) and/or individuals (disciplinary power), ground mentalities, though not necessarily in effective ways. A genealogical
governmentality analysis attempts to identify practices, mentalities, techniques of power, and discourses that have helped to produce a historical shift or reversal (Foucault 1998; Ettlinger 2011, 543-44). The main shifts explored in this section of the chapter are interrelated: the commercialization and “technologization” of the hospital, as it became more of a business as well as a privileged site of knowledge, and the medicalization of death. These shifts have had and continue to have enormous implications for the overall relationship between acute care and long-term care, with inadequate nursing home conditions (Kaiser Family Foundation 2009) as one consequence, as well as the quality of later life experiences for older adults and their families.

**Technology as a Source of Disparity between Long-Term Care and Acute Care: A History**

At one point in the 60 Minutes interview (Court 2009) mentioned earlier on the high cost of end-of-life care, Doctor Elliott Fisher of Dartmouth Medical School suggests that the incentives within the fee-for-service health care model in the U.S. are largely responsible for the phenomenon: “Supply drives its own demand. If you're running a hospital, you have to keep that hospital full of paying patients. In order to, you know, to meet your payroll. In order to pay off your bonds.” This phenomenon, known in general as “supply-sensitive care” or “Roemer’s Law,” has been summarized as “Where there is greater capacity, more care is delivered – whether or not it is warranted” (Dartmouth Atlas of Health Care 2007, 1). The 60 Minutes piece (Court 2009) goes on to discuss the
specific incentive to use sophisticated medical equipment in hospitals that increases the quantity, though not necessarily the quality, of life.

In his book *Technology in the Hospital* (1995), Joel Howell describes the same issues raised by Fisher in the *60 Minutes* interview (Court 2009), though the context of Howell’s work is one century earlier, in the period from 1900 to 1925. Howell argues that the technology, broadly defined, that had the greatest impact on U.S. hospitals was the “efficiency craze” (Howell 1995, 30), including Taylorism, that was imported into health care from business. Furthermore, closely tied to this business mindset was a faith in science and, eventually, in scientific medicine and medical technology as the best way to achieve progress in almost all parts of life. Business donors to hospitals and business-based members of hospital boards demanded that hospitals, which at the time were usually charitable institutions that simply managed dependent groups on a non-profit basis (see also the history of the hospital in Foucault 2007b), should be run as efficiently and effectively as businesses. This move could be seen as a feature of neoliberalism, in its goal of turning everything into a competitive “enterprise” (Foucault 2008, 148).

Changing ways of thinking led to changes in hospital management, especially with the rise of accountants as hospital administrators (Table 7 and Figure 9 show the increasing employment of accountants in U.S. hospitals, though it is not clear if these accountants were administrators). These accountants/administrators used the innovative method of cost accounting (see description in Figure 7) to identify the specific parts of a hospital that were making money and the ones that were losing money. In Foucauldian terms, cost accounting might then function as a technique of disciplinary power, a form
of panopticism (Foucault 1975/1995), through which accountants/administrators could monitor the profitability of the whole hospital as well as the profitability of each and every department, including the workers in each department, within the hospital.

Individual hospital staff members, from administrators to doctors to janitors, might (unconsciously) change their behavior once they became aware of this form of surveillance.


<table>
<thead>
<tr>
<th>Year</th>
<th>Accountants</th>
<th>Nurses</th>
<th>Physicians and Surgeons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
<td>N/A</td>
<td>210</td>
<td>75</td>
</tr>
<tr>
<td>1900</td>
<td>N/A</td>
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<tr>
<td>1910</td>
<td>101</td>
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<td>1920</td>
<td>197</td>
<td>57,112</td>
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<tr>
<td>1930</td>
<td>304</td>
<td>105,953</td>
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<tr>
<td>1940</td>
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<td>4,186</td>
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<tr>
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<td>35,528</td>
<td>1,604,754</td>
<td>238,616</td>
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<tr>
<td>2000</td>
<td>40,179</td>
<td>1,877,389</td>
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</tr>
</tbody>
</table>

Source: Compiled from Ruggles et al. (2010).

Note: Missing some or all data for 1890 (excluded above), 1900, and 1940 Census years. Data reported for Occupational Codes (1950 basis) for Accountants and Auditors (Code 000), Nurses, Professional (058), and Physicians and Surgeons (075) in Industry Code (1950 basis) for Hospitals (Code 869). Numbers are based on person-weighted data. Note that large jumps up and down from 1930 through 1950 for Physicians and Surgeons are an artifact of IPUMS’ efforts to make Census codes compatible across several decades and are not trustworthy (personal communication, September 14, 2011).
Indeed, Howell argues that, in the early stages, the primary value of medical technology, such as the x-ray machine, had nothing to do with clinical practice, but instead with attracting patients who could actually pay for at least some of their health care. This further encouraged the shift from the hospital as an institution providing charity care for poor, dependent populations to a large-scale, fragmented, moneymaking enterprise (e.g., Long and Golden 1989). Moreover, once a hospital had struggled through figuring out a way to add a new technology to its overall operation, the same steps could be followed with subsequent technologies, but with far fewer problems.

One common practice in the adoption of new technology was an incentives-based compensation system for the specialist, another technique of power. Later on, hospitals could expand by building centers dedicated to certain diseases and related technologies,
such as the electrocardiogram for heart disease. Howell notes that the hospital would then prominently advertise its high-tech equipment in its annual report, a form of discourse, as a way to show that the hospital was on the cutting edge and also to help with fundraising efforts. These incentives – for better patient outcomes, greater personal wealth, and higher personal and institutional reputation – continue to promote the union of technology and health care today.

Helen Stanton Chapple (2010), in a book based on fieldwork conducted in 2003 and 2004, can be viewed as updating the fundamental issues raised by Howell. Many of the key themes in her book will now be familiar, including the role of technology in hospital competitiveness and the strong incentives for physicians and hospitals to use all available technology. Yet, she also examines the way in which perceptions of “skill” and “technology” direct resources to high-status acute care and away from low-status long-term care.

Hospitals have used technology to compete for physicians, fee-for-service patients, and reputation in a crowded marketplace. Today, medicine is based in a “cultural expectation of rescue” (Stanton Chapple 2010, 8) and a “ritual of intensification” (17). In this context, the use of sophisticated technology in “doing everything possible” for a loved one who is dying is another form of disciplinary power, a way for doctors to show the priceless value of their patients, and to “demonstrate their allegiance to their patients” (142). The symbolism of employing technology in end-of-life care may, therefore, help to enroll individuals in the practice.
The use of technology in health care, research, and economic growth are seen as self-perpetuating. Novel diagnostic technologies identify new diseases that then need to be researched and, as biomedical knowledge becomes more specialized, technologies must be updated or new ones invented to keep up. At every step of this circular chain, new economic activity is generated. Profits are re-invested into more technology and more research as firms try to gain a competitive edge. The forces of capitalism loom large here.

Stanton Chapple would like to see more resources devoted to hospice care, but she understands that this would first depend on changing societal views on dying and death. As of now, it is hard to be optimistic about such a shift, given the deep-seated mentalities (e.g., the unquestioned value of life, individualism, efficiency, productivity, and technology) that exist in society and in medicine, as part of society. Long-term care, including nursing homes, and hospice and palliative care represent another world, one that is viewed as separate from the “skill,” “technology,” and hope that characterize “heroic” acute care in hospitals. As a result, this other world may be perceived as a scaled-up equivalent of “wasting” resources on unproductive, dependent populations who consume funds that, it is believed, could be put to more productive use. However, as the next section will discuss, another interpretation of this system suggests that it may, in a sense, produce “useful” older adults, and even a “useful” death.
“The Use of the Dying for the Living”? A Foucauldian Interpretation of End-of-Life “Overtreatment”

What mentalities would make sense of this practice in which so much money is spent on older adults only at the very end of their lives, when they are clearly suffering, in an effort to prolong their life? There are probably many answers and many avenues worthy of study. For example, Cole (1992) writes of the obsession with longevity in nineteenth century U.S. society, including the belief that a long life was a morally-good life and vice versa. This might lead to a “life at all costs” mindset.

Cole also criticizes American society for increasing average life expectancy, while draining later life of the mystery and meaning that it held in earlier periods. Indeed, one of the most common examples of ageism is the connection made between later life and dependency, or being unproductive. Achenbaum (1978, 39) writes that, by 1914, the majority of Americans, influenced by arguments from popular culture and science that older adults “were incapable of contributing anything to society,” equated aging with “obsolescence.”

Another explanation might draw on political economy, suggesting that certain actors promote a medicalized view of death in order to serve their own interests. If older adults are often stereotyped as unproductive, and therefore a drain on economic growth, end-of-life spending might, on the other hand, perversely create “productive” older adults through the experience of a medicalized death. This is made possible because resources are channeled through older adults as long as possible to the highly “productive” health care industry: older adults are not given money directly (Estes 1979) to spend as they
please (e.g., Medicaid funds go directly to providers), yet their bodies become vehicles for investment and economic growth. The health care industry is usually perceived – and often justifiably so - as highly productive due to the life-saving work of physicians and surgeons, as well as the contribution of the health care sector to national economic growth (Stanton Chapple 2010). Health care’s share of U.S. gross domestic product (GDP) has more than doubled since 1970, from 7% in that year to 15.2% in 2003 (Kaiser Family Foundation 2007). Foucault describes the “economy of health” as “the integration and improvement of health, health services, and health consumption in the economic development of privileged societies” (2000d, 135) and says that in neoliberal society, “there is only one true and fundamental social policy: economic growth” (Foucault 2008, 144).

More specifically, Foucault also discussed how medicine can actually do harm through its effectiveness, in this case, by being so successful in prolonging the quantity of life that quality of life and dignity can be undermined (Foucault 2004, 10). Since the start of the twentieth century, medicine has actually done harm through what it does know (or thinks it knows), rather than merely through ignorance (Foucault 2004, 9). Critics point to the medical establishment’s self-serving interests and this argument may be relevant for the topic of end-of-life care spending. Examples would include the prioritization of clinical teaching over cure (Foucault, 1994) and, from Weisman (1992, Chapter 2), an assertion of control over childbirth. The usefulness of death is a frequent theme in The Birth of the Clinic (Foucault 1994, Chapter 8). The contemporary role of health care in the economy has also been addressed by Foucault (2004, 6-7 and 16-18), where, in his
view, drug companies, rather than doctors, are the real beneficiaries. The general argument that powerful actors in society serve their own interests more than the interests of others is also a major theme in Estes (1979).

Foucault proposed that "[t]he most important moral problem raised by the idea of the clinic” was the idea of somehow benefiting from the needs of poor patients (Foucault 1994, 83). Nonetheless, this practice was eventually justified under the rationale that the medical knowledge that would be gained from treating poor patients would benefit society as a whole and, in addition, encourage physicians to be more compassionate (83-84). Foucault observes that this “structure of reciprocity” (84) was soon seen as appropriate: rich donors to clinical hospitals would, in effect, fund research that would be conducted on the poor patients - who were thought to be of questionable moral stature (85) - and, in return, the benefactor might personally benefit later on from improvements in medical knowledge.

Other issues might suggest that the dependency of older adults implies that they somehow “owe” society and should be useful in whatever way they can be, even if that means being worked on in the dying process. One could draw a parallel with the approach, championed in 1826 by Jeremy Bentham in England, of the use of the bodies of deceased residents of public institutions for anatomical dissection as payment for the charity care that they had received, a practice that had already existed for more than one century in France (Tierney 1998). A friend of Bentham’s wrote an article supporting this plan in 1824 entitled “The Use of the Dead for the Living” (Tierney 1998, paragraph 41). A similar idea was expressed in the eighteenth-century desire to make the poor useful “at
best…by fixing [poverty] to the apparatus of production, at worst to lighten as much as possible the burden it imposes on the rest of society” (Foucault 1980a, 169). In the end-of-life “overtreatment” scenario, a more accurate title would seem to be “The Use of the Dying for the Living”: the money that is generated through end-of-life treatment/repayment by working on dying bodies is then used to support the finances of the doctors and the hospital in their ongoing “rescue” (Stanton Chapple 2010) of “deserving,” “productive” people. Here, through commercialization, medicalization, and “technologization,” it is death and dying that may be rendered productive, “doing their part” for the greater good of society.

**Summary of the End-of-Life Care Analysis**

This section critically analyzed the areas of allocation and the timing of spending on older adults in the U.S. While the major targets, including Social Security and Medicare, are well known, another example was provided in the disproportionate cost of intensive end-of-life care that many older patients reportedly do not want. This phenomenon was explained by examining the long-running marriage of technology and the hospital in U.S. health care, as well as the unfortunate implications for dying experiences and nursing home conditions. This section of the chapter has offered a look at how power, as defined in both political economy and Foucauldian thought, can function within threats to the realization of elders’ preferences and the desired quality of later life experiences.
Conclusion

Processes of commercialization and medicalization have substantially shaped experiences of aging and eldercare, including nursing home life and end-of-life care in the hospital. This chapter has examined the impacts of these processes through historical analysis via a case study of one long-term care institution/organization and a review of changes in the hospital. If the tone of these analyses has been somewhat bleak, there are also occasional hints of alternative paths and opportunities for resistance and reconstruction, topics taken up in the conclusion of this dissertation.

Notes

1 Margaret Wagner House is named after Margaret Wagner, Executive Director of the Benjamin Rose Institute from 1930 to 1959 and consultant on planning for Margaret Wagner House. She died in 1984 at the age of 91 in the nursing home named after her (Beal 2008).

2 The Kaiser Family Foundation (2009) reports that formal deficiencies are quite common: for instance, in 2009, 40% of U.S. nursing homes failed to provide food sanitation up to standard, 36% did not meet expectations of quality of care, and 24% administered unnecessary drugs to residents.

3 In a summary of the historical development of nursing homes, Vladeck (1980, 30-31) writes that "By and large, nursing home policy has been made not only with limited oversight, but largely by people who, at the time, were primarily concerned with doing something different. It has been an afterthought, a side effect of decisions directed at other problems - mostly those of health care or of poverty." At the same time, the position of nursing homes in a system of "progressive patient care" (Vladeck 1980, 43) in which different kinds of facilities handled different levels of patient care, allowed hospitals to move costly patients to nursing homes, even discharging patients who still needed care, so that nursing homes represented a solution to the out-of-control costs facing hospitals. Therefore, while Vladeck's "afterthought" statement above helps one to understand the broad strokes of nursing home policy, particular examples of the sometimes exploitative relationships between hospitals and nursing homes point to more intentionality than the word "afterthought" might suggest at first glance.

4 Homer Folks, the commissioner of charities in New York City, re-named the city’s almshouse along these lines in 1902 (Barusch 2009, 419).

5 Margaret Wagner House was certified for Medicare in 1967 and for Medicaid in 1972 (Beal 2008).

6 Comparisons, however, remain problematic because there is no way to know how much of this figure represents “unwanted” and/or “aggressive” end-of-life care, which is the real issue at hand.
While Howell (1995) is describing events in the period from 1900 to 1925, “efficiency” would again play a key role in health sector changes related to the implementation of diagnosis-related group (DRG) prospective payment systems (PPS) that set reimbursement rates for hospitals as of 1983 (Preston et al. 1997) and, later, for nursing homes beginning in 1997 (Olson 2010).

A similar phenomenon is discussed in Diamond (1992, 203): “Care was not something the industry or the state gave to [the nursing home residents]. It was made into a commodity through which money was exchanged between state and industry. As sources of income for the industry, whether through private or public funds, all residents participated in the production of care.”

The meaning of this trend is ambiguous, however, as many fear that rising health care costs may actually impede economic growth. In this sense, health care may also be seen as “unproductive” as this phenomenon represents a flaw or contradiction in the system.
CHAPTER 6: CONCLUSION

This dissertation has examined issues of objectification and subjectification that affect older adults’ quality of life across a variety of contexts. This final chapter of the dissertation will summarize conclusions from the empirical research and consider possibilities for reconstruction and resistance.

Problems of Objectification in Later Life

Affecting Older Adults

The first chapter of the dissertation defined the successful aging paradigm (Rowe and Kahn 1997) as consisting of three criteria: avoidance of disease and disability, high physical and cognitive functioning, and active engagement with life. The analysis in chapter 3 demonstrated that the vast majority of older adults, whether measured at the national or state level, would be considered “unsuccessful” according to the criteria offered by Rowe and Kahn (1997). The contrast with the perspectives of nursing home residents, presented in chapter 4, could not be clearer. While nursing home residents would be excluded at the outset by the successful aging paradigm, interviews with older adults in nursing homes revealed that a good life in later life was possible, though certainly not guaranteed, in even the most difficult circumstances. An inclusive framework for aging well would satisfy the need to define oneself more than being
defined by others (e.g. as a loving spouse or (grand)parent, someone who worked hard and did the best he or she could, a creative person, etc., rather than a nursing home resident) to act to realize preferences (e.g. to have the freedom and opportunity to use one’s agency to engage in meaningful activities from simply sitting outside or conversing with a friend to making crafts), and to be cared for as one wishes (e.g. where staff are responsive to one’s concerns, where one does not feel like one is in an institution, etc.). Chronic disease and incapacity would not necessarily disqualify anyone from aging well from this broader perspective. Indeed, encountering challenges can create opportunities for meaningful reflection, social interaction, and experiences of resiliency. The concept of active engagement does seem to resonate with older adults, yet the meaning of “active” should be left to each individual because one’s interpretation of “active” may not consist of the kinds of scheduled formal activities often found in senior centers and long-term care facilities (Katz 2000). In short, researchers, policymakers, and practitioners can continue to gain from a wide range of elders’ perspectives on a good life in later life.

**Impacting Organizations that Care for Older Adults**

Chapter 5 offered insights into some of the challenges facing organizations that seek to help older adults. Well-intentioned plans can be thwarted as organizations work to confront issues that threaten the organization’s sustainability and its ability to put its ideals into practice. Many challenges are economic, opening the door to commercialization. Other matters involve the medicalized conceptualization of standards, identities, and problems and hold great consequences for everyday practices.
When commercialization and medicalization join together in issues of certification and reimbursement, organizations face great pressure to conform to the preferred model, a shift that may undermine original intentions. The result is an organization that, due to external influences, has lost control of its own path.

**Possibilities for Greater Subjectification**

Beyond the question of practical ability, the power to “make a difference” (Allen 2008) or not begs the question of the kind of difference one wants to make and why. Now, after having reviewed problems of objectification in later life from a variety of vantage points in this dissertation’s respective empirical research projects and suggested some indication of a desired alternative, the matter of “how” reappears. This section of the chapter will discuss changes in thought and action that may, as individuals and as a society, help to move elders closer to their own good life in later life.

**Resistance at the Individual Level**

If the balance in the constant tension between objectification and subjectification could be shifted more toward the latter, individuals would have a greater opportunity to define themselves. A change in thought or self-understanding matters and, while no panacea, may be enough to re-imagine, if only for a moment, one’s previously “spoiled identity” (Goffman 1963). Foucault (1986, 1988, 2005) discusses the “technologies of the self” or the “practices of the self,” including the practice of writing,
which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988, 18).

This dissertation research provides further evidence that such practices - some of which, for example, in the form of reminiscence therapy, are already used as interventions with elders - would be one way to help older adults realize their own vision of aging well through greater subjectification.

**Reconstruction at the Societal Level**

Reconstruction, material change in the world, is often founded in resistance, changes in thought. Change at the societal level may be able to offer greater possibilities for elders to live their own good life in later life in practice. Changes in health policy and regulations, perhaps especially in terms of certification and reimbursement criteria, could incentivize practices that give older adults more chances to satisfy their considered preferences. Alternative funding mechanisms and more flexible care guidelines could help organizations avoid the pressures of commercialization and medicalization.

Of course, as the experience of “person-centered care” (Koren 2010) has shown, reform is not easy. The concept of person-centered care has received a great deal of attention, but even specific quality measures, for example for inpatient rehabilitation facilities, under consideration that explicitly claim to serve the “overarching goal” of person-centered care (Centers for Medicare and Medicaid Services 2011a, Table 13, 47882) would seem at times to diverge from the deeply-felt concerns of nursing home residents revealed in interviews. Similarly, the requirements for nursing homes,
including discussions of quality of life (§483.15) and quality of care (§483.23), in the

*Code of Federal Regulations* (Centers for Medicare and Medicaid Services 2011b) state repeatedly that the goal of the nursing home is to “attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” However, the quality measures used to create the five-star ratings for nursing homes focus on narrow, and often medically-oriented, issues, such as falls with major injury, depression, ADLs, weight, pain, pressure ulcers, vaccines, and medications, recorded in the Minimum Data Set assessment (Centers for Medicare and Medicaid Services 2012). Such measures may indeed allow for objective comparisons of facilities across the country and offer information about minimum acceptable standards, but they do not adequately capture the subjective views of nursing home residents about the meaning of a good life in later life that one finds in interviews.

There is clearly an awareness of the importance of satisfying individual care preferences, but rhetoric must be translated into effective action. Efforts to tie funding to satisfactory ratings on closed-ended patient surveys such as the Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) (HCAHPSonline.org 2012) point to a promising interest in subjective views, although one might also hope to see open-ended questions included. The public-private Measure Applications Partnership (MAP), organized by the National Quality Forum (NQF), offers another noteworthy example. NQF is a non-profit organization that works to build agreement on and endorse consensus health care quality and performance measures. In order to implement part of the Patient Protection and Affordable Care Act (hereafter, ACA), MAP advises the US
Department of Health and Human Services (HHS), including the Centers for Medicare and Medicaid Services, on choosing quality and performance measures that will ultimately affect reimbursement. MAP lists a number of preference-oriented objectives as areas for consideration in post-acute and long-term care (National Quality Forum 2012). However, very few measures that emphasize preferences have been endorsed and those endorsed measures that do involve preferences simply reflect whether preferences have been documented on a chart or not (a necessary, but not sufficient, step), rather than how well the provider is actually satisfying individual preferences. More broadly, “Ensuring that each person and family are engaged as partners in their care” is one of six National Quality Strategy (NQS) priorities (US Department of Health and Human Services, 2012) that HHS is emphasizing in order to implement major goals of the ACA. Until these worthy objectives are put into practice, incentivizing the satisfaction of care preferences will happen, at best, only indirectly and, at worst, insufficiently to realize elders’ wishes.

Even if one accepts that changing quality criteria to reflect preferences in order to affect reimbursement in eldercare is a worthy goal, questions remain as to how one can actually achieve this objective. Waiting for the health sector to reform itself could be futile. Regulatory changes could be hastened through political pressure, which, in turn, would require collective action by interested actors, from doctors or firms to individuals who do not like the prospect of ever residing in a nursing home. While not a monolithic entity, the cohort of Baby Boomers could potentially be a receptive base and mobilizing even a relatively small percentage of the group could translate into a large number of
people, which could, in turn, draw more attention to the campaign. Many communication tools, from personal conversations to social media, are available today to spread a message and interact with people. Additional research would be needed to explore the potential of a model of “person-centered care” (Koren 2010) focused on realizing diverse preferences. Historical research could investigate relevant social movements, perhaps with the disability rights movement as one example, that have produced beneficial changes over time, even as their missions continue. In addition, participatory action research (PAR) (e.g., Kindon, Pain, and Kesby 2007) would offer a research design consistent with an ontology that seeks to emphasize subjectification over objectification.¹ If it proved difficult to obtain funding for such a project through traditional health policy research channels (e.g., the Robert Wood Johnson Foundation), one can find examples of “crowdsourcing” basic science - (e.g., Palca 2013) - where, in this case, a researcher would post a research project online and then solicit individual donations to complete the work - and one could imagine that this model could be extended into health policy and social science as well. Satisfactorily examining a preference-oriented model might require multiple research stages of a single project, if not entirely different projects, as one would need to engage at least a cross-section of the entire eldercare ecosystem, from older adults themselves and their families to providers and insurers.

Questions to explore with older adults would include their interest in documenting their individual care preferences and the ability to adequately do so, perhaps with assistance. With whom, in what format or setting, and at what time would these conversations be best held? From the perspective of providers, would the resulting
documentation from such a project with older adults be considered useful in guiding the delivery of care? One would want to know whether older adults actually felt like the care they received was better for having documented their preferences than it otherwise would have been. Providers and insurers would need to determine how to most effectively document providers’ success in realizing the unique care preferences of older adults. A modified version of the CAHPS survey for hospital patients, supplemented by random open-ended interviews with older adults and providers, could potentially serve as at least an initial model. From there, decisions about how to incorporate each provider’s record of preference realization into reimbursement systems (e.g., a version of the Five-Star Quality Incentives program in Medicare Advantage that began to pay bonuses in 2012 to providers receiving high ratings across many measures of quality in surveys and administrative data) could proceed. The ultimate goal would be to satisfactorily link payment to the quality, rather than quantity, of care provided, where a major component of quality care would be defined as realizing elders’ unique care preferences.

The ideas outlined above would likely encounter many kinds of obstacles. Some older adults and their families might find it difficult to discuss their care preferences, for example, because it may be difficult to know ahead of time what one really desires or a person might believe that medical professionals know what is best. In addition, it may prove impossible to adequately document what one wants and/or to express one’s wishes in enough detail to make a difference when the time comes to guide others, especially if the person receiving care is cognitively-impaired or even unconscious and cannot be consulted. Any changes in certification and/or reimbursement would likely have
unintended consequences that could, unfortunately, potentially produce the direct opposite of the intended effect. Beyond these issues, bureaucracy and vested political-economic interests could also derail attempts to change eldercare. Understanding and honoring individual care preferences takes time and could threaten efficiency. Hiring more staff may not be economically prudent. Long-running disparities in health and access due to race/ethnicity and socioeconomic status may well persist. More broadly, empowering older adults and families to exert a greater influence on the kind of care they receive and how they receive that care could represent a loss of authority and control to government and industry actors atop the existing structure of the health and long-term care systems. Changes might make the apparent political obsession with deficit and debt reduction planning more uncertain and difficult. A redistribution of funds could threaten the strategies and very survival of for-profit and not-for-profit organizations alike.

The pages of this dissertation offer no panacea. Encouraging older adults and the organizations that serve elders to work toward realizing a highly-individualized good life in later life does not come without other problems. One person’s preference might clash with another person’s wishes. Disagreements continue regarding the appropriate allocation of resources between generations. No one will ever have everything they desire. Resolving conflicts requires negotiation and uneven power relations in society jeopardize fair outcomes. Yet, a concerted shift in emphasis – truly putting the person at the center of care – in thought and practice could improve upon the current state of affairs for the older adults and families who should have been the focus all along.
Final Thoughts

This dissertation began by reviewing the numbers regarding population aging in the US before turning to questions of the quality of later life experiences. In light of this dissertation’s normative ontology, quantitative techniques were used to critique the successful aging paradigm, an influential notion of aging well, for its narrow vision and sheer exclusivity. Interviews with nursing home residents were then analyzed in order to move toward a more inclusive idea of a good life in later life. Processes of commercialization and medicalization in eldercare were put in historical perspective so as to better understand how ideals can be compromised and missions redefined over time. The end result is a wide-ranging account of normative perspectives on aging well, of problems thwarting elders’ ability to live their own good life in later life, and of suggestions for productive responses to these challenges that explored a continuum of later life contexts from aging in place to the nursing home to end-of-life care in the hospital. Employing the epistemology of crystallization, multiple methods were used to advance a critique and offer insights in ways that no single approach would have offered. In the end, the next group of older adults will face both opportunities and challenges to living the kind of later life they desire. It is hoped that this dissertation research has provided a critical, rigorous, grounded, and ultimately useful perspective on aging in America.
Notes

1 PAR is already discussed and practiced in health research. For example, as of this writing, Google Scholar returns 22,600 results for the search string “‘participatory action research’ AND ‘health’” and the Thomson Reuters ISI Web of Knowledge Citation Database lists 630 results for the same query. However, at the same time, at least as of a few years ago, Blair and Minkler (2009, 651) reported that “relatively little PAR has taken place in which older adults have been prominent partners.”
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